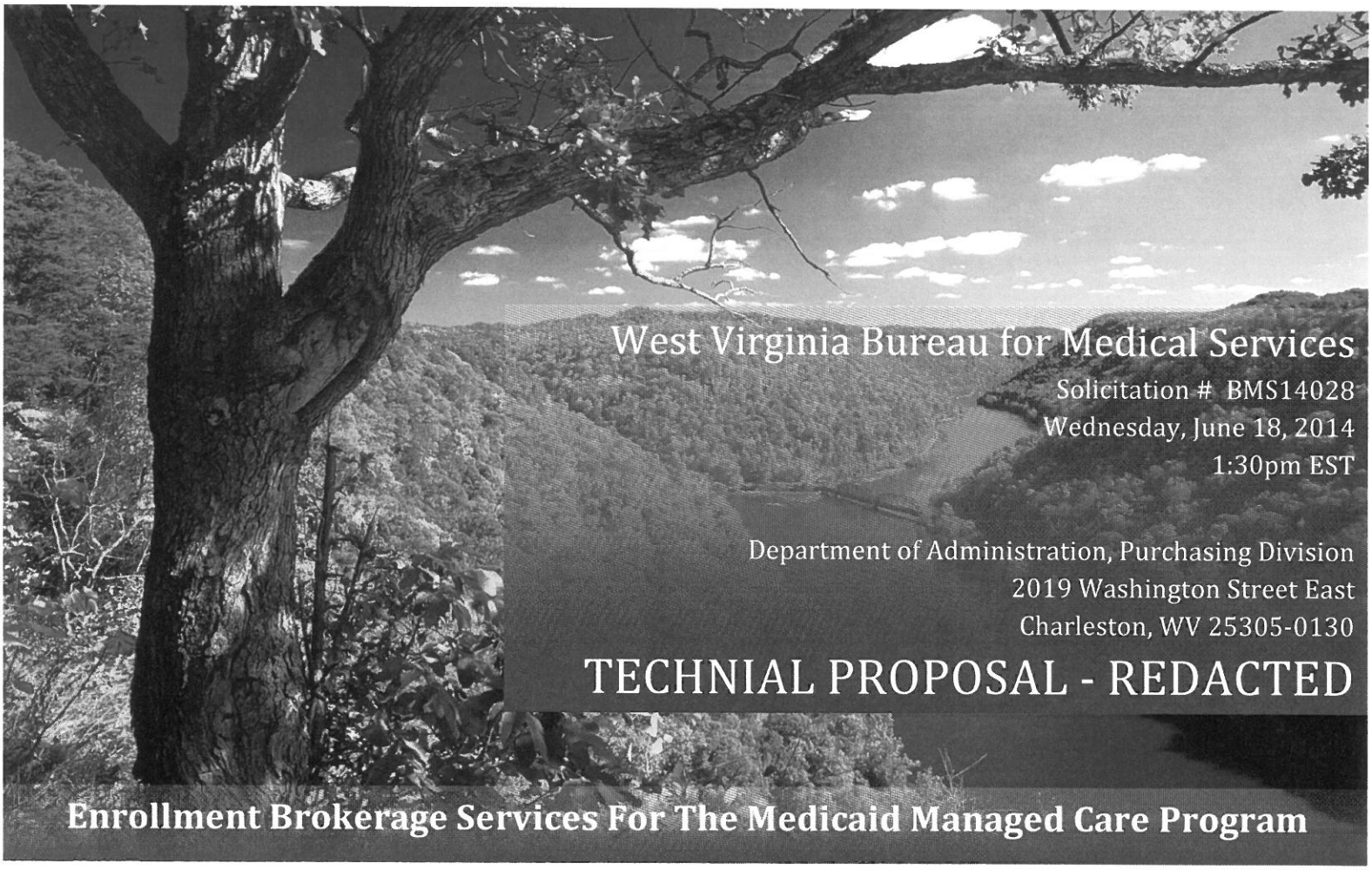


West Virginia Bureau for Medical Services

Solicitation # BMS14028

Wednesday, June 18, 2014

1:30pm EST

Department of Administration, Purchasing Division

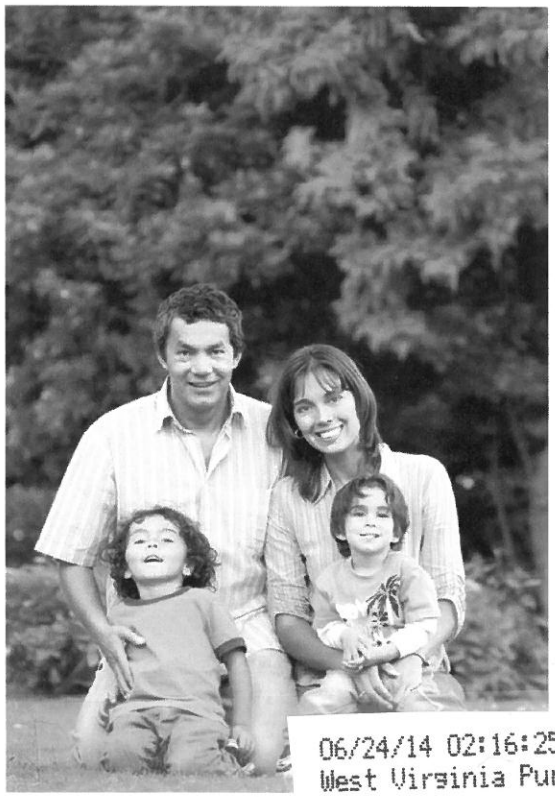
2019 Washington Street East

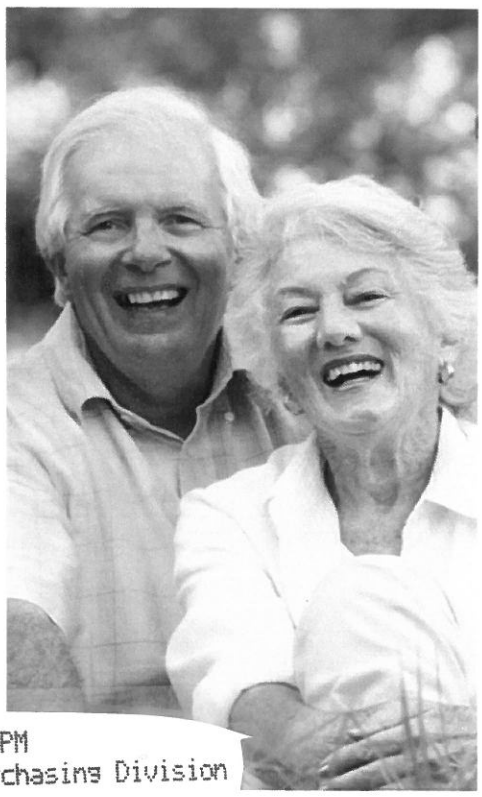
Charleston, WV 25305-0130

TECHNIAL PROPOSAL - REDACTED

Enrollment Brokerage Services For The Medicaid Managed Care Program







06/24/14 02:16:25PM
West Virginia Purchasing Division

AUTOMATED HEALTH SYSTEMS

9370 McKnight Road - Suite 300 - Pittsburgh, PA 15237

BMS14028

Automated Health Systems has asserted that the items listed on the attached page are exempt from disclosure under the Freedom of Information Act.

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Appendix L	Implementation	Admin./Data Systems

Title Page

RFP Subject	Enrollment Broker Services
RFP Number	BMS14028
Vendor's Name	Automated Health Systems
Business Address	9370 McKnight Road Pittsburgh, PA 15237
Telephone Number	412-367-3030- ext 2203
Fax Number	412-367-1213
Contact Person	Joseph W. Nocito, CEO
Email Address	ceo@automated-health.com
Vendor Signature	
Date	June 25, 2014

AUTOMATED HEALTH SYSTEMS

Joseph W. Nocito
Chief Executive Officer

300 Arcadia Court, 9370 McKnight Road, Pittsburgh, PA 15237 • (412) 367-3030 • (412) 367-6184 Fax

June 25, 2014

Robert Kilpatrick
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

Dear Mr. Kilpatrick:

Automated Health Systems (AHS) is pleased to submit its proposal in response to the State of West Virginia's RFP# BMS14028 for enrollment broker services. As the incumbent, we bring an unmatched understanding of the needs of the West Virginia Bureau for Medical Services (BMS) Project stakeholders, potential enrollees/enrollees, and providers we serve. We are confident that our approach will continue West Virginia's tradition of providing first class services to potential enrollees and enrollees, meet the changing needs of the State's Medicaid programs, and offer the State several exciting and innovative services. Key strengths we bring to the Project include but are not limited to:

- A history of outstanding service delivery through the current enrollment broker contract;
- A thorough understanding of the role of the managed care option in providing quality care that ultimately improves outcomes;
- A solid team of dedicated, experienced staff who are excited to launch this new phase of the Project;
- The commitment of our corporate Senior Management Team who will support all Project enhancements and operations throughout the course of the contract;
- A proven history of exceeding performance requirements;
- A long tenure of providing value-added services that exceed the requirements of the contract at no additional cost (for example, we developed and launched the online enrollment module as well as a mobile-friendly website for the State at no charge);
- An unmatched presence in the West Virginia Medicaid community, including established relationships with providers, community based organizations, and other Project stakeholders, many of whom have written letters of support;
- A proposed solution that far exceeds the requirements of the RFP and includes several value-added services for the State of West Virginia; and
- A solution that is scalable and can respond to the changing workloads of the Project.

Please note, the required bid bond is located in our cost proposal.

Further, we have identified portions of our proposal as exempt from public disclosure. The attachment to this cover letter lists those pages with confidential material and the specific exemption that applies. As per the instructions in the RFP, we have also submitted a redacted copy with these sections marked.

Should there be any questions or concerns related to this submission, I can be reached using the following information:

Automated Health Systems
9370 McKnight Road, Ste. 300
Pittsburgh, PA 15237
E-mail: ceo@automated-health.com
Fax: 412-367-1213
Phone: 412-367-3030 ex. 2203

Again, we thank you for the opportunity to submit a proposal in response to the State's RFP, and we look forward to having the opportunity to continue our relationship with BMS and the State of West Virginia.

Sincerely,

Joseph W. Nocito,
Chief Executive Officer

att

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
BMS14028	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
BOB KILPATRICK
304-558-0067

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
ROOM 251
350 CAPITOL STREET
CHARLESTON, WV
25301-3709 304-558-1737

DATE PRINTED: 06/12/2014
BID OPENING DATE: 06/25/2014 BID OPENING TIME 1:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 1

ADDENDUM IS ISSUED:

1. TO PROVIDE A COPY OF THE PRE-BID CONFERENCE SIGN-IN SHEET FOR THE ABOVE SOLICITATION.

2. TO PROVIDE A COPY OF TECHNICAL QUESTIONS AND ANSWERS. ADDENDUM QUESTIONS WITH ANSWERS SHEET IS ATTACHED.

3. TO REVISE SPECIFICATIONS TO DELETE ITEM 5.10 (AND ALL FOUR SUB-ITEMS) FROM THE MANDATORY REQUIREMENTS

4. TO POSTPONE BID OPENDING DATE TO JUNE 25, 2014; BID OPENING TIME (1:30PM EST) REMAINS UNCHANGED.

5. TO PROVIDE ADDENDUM ACKNOWLEDGMENT. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN THE DISQUALIFICATION OF YOUR BID.

**********END OF ADDENDUM NO. 1**********

SIGNATURE	TELEPHONE	DATE
Joseph W. Nuzum	412-367-3030 x2203	June 16, 2014
TITLE: Chief Executive Officer	FEIN: 25-1876460	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
BMS14028	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
BOB KILPATRICK
304-558-0067

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
ROOM 251
350 CAPITOL STREET
CHARLESTON, WV
25301-3709 304-558-1737

DATE PRINTED
05/22/2014

BID OPENING DATE 06/18/2014 BID OPENING TIME 1:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

REQUEST FOR PROPOSAL
(RFP)

THE WEST VIRGINIA PURCHASING DIVISION, ON BEHALF OF THE WV DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES, IS SOLICITING PROPOSALS TO PROVIDE A ENROLLMENT BROKERAGE SERVICES FROM A QUALIFIED VENDOR FOR THE MEDICAID MANAGED CARE PROGRAM IN ACCORDANCE WITH THE ATTACHED SPECIFICATIONS.

ATTACHMENTS INLCUDE:

1. BMS14028 REQUEST FOR PROPOSAL
2. ATTACHMENT A: VENDOR RESPONSE SHEET
3. ATTACHMENT B: MANDATORY SPECIFICATION CHECKLIST
4. ATTACHMENT C: COST SHEET
5. EXHIBIT A: STATE DOCUMENTS
6. EXHIBIT B: CODE OF FEDERAL REGULATIONS
7. HIPAA BUSINESS ASSOCIATE ADDENDUM
8. BID BOND PREPARATION INSTRUCTIONS AND SAMPLE FORM
9. PURCHASING AFFIDAVIT
10. VENDOR PREFERENCE CERTIFICATIONS

****
PLEASE NOTE: A MANDATORY PRE-BID MEETING IS SCHEDULED FOR 6/5/2014 AT 1:30PM EST AT THE BUREAU'S OFFICES AT 350 CAPITOL STREET, ROOM 251, CHARLESTON, WV, 25301
****

SIGNATURE Joseph W. Mann TELEPHONE 412-367-3030 x2203 DATE June 16, 2014

TITLE Chief Executive Officer FEIN 25-1876460 ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
BMS14028	1

ADDRESS CORRESPONDENCE TO ATTENTION OF
BOB KILPATRICK
304-558-0067

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
ROOM 251
350 CAPITOL STREET
CHARLESTON, WV
25301-3709 304-558-1737

DATE PRINTED
06/18/2014

BID OPENING DATE 06/25/2014 BID OPENING TIME 1:30PM

LINE	QUANTITY	UOP	CAT NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
				ADDENDUM NO. 2		
	SEE ATTACHED PAGES.					
				END OF ADDENDUM NO. 2		
001	1	LS		948-74		
	PER THE ATTACHED SPECIFICATIONS					
	****** THIS IS THE END OF RFQ BMS14028 ****** TOTAL:					

SIGNATURE Joseph W. Neal TELEPHONE (412) 367-3030 2203 DATE June 19, 2014

TITLE Chief Executive Officer FEIN 25-1876460 ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS14028

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment fonn. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[X] Addendum No.1	[ ] Addendum No. 6
[X] Addendum No. 2	[ ] Addendum No. 7
[ ] Addendum No. 3	[ ] Addendum No.8
[ ] Addendum No. 4	[ ] Addendum No. 9
[ ] Addendum No. 5	[ ] Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Automated Health Systems
Company

Joseph W. Moulo, C.E.O.
Authorized Signature

June 25, 2014
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

RFQ No. BMS14028

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

MANDATE: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: Automated Health Systems Inc.

Authorized Signature: Joseph A. Nieto, CEO Date: 6-11-14

State of Pennsylvania

County of Allegheny, to-wit:

Taken, subscribed, and sworn to before me this 11 day of June, 2014

My Commission expires January 3, 2015.

AFFIX SEAL HERE

NOTARY PUBLIC Ann E Harris

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Ann E. Harris, Notary Public
McCandless Twp., Allegheny County
My Commission Expires Jan. 3, 2015

Technical Proposal: West Virginia Enrollment Broker Services
(RFP#: BMS14028)

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Firm and Staff Qualifications and Experience

Provide a response regarding the following: firm and staff qualifications and experience in completing similar projects; references; copies of any staff certifications or degrees applicable to this project; proposed staffing plan; descriptions of past projects completed entailing the location of the project, project manager name and contact information, type of project, and what the project goals and objectives were and how they were met.

As the initial and current Program Administrator for the State's MHT and PAAS Programs, AHS offers unmatched advantages over any other bidder:

- We have an unmatched understanding of the State's managed care programs,
- We offer trained staff who are fully versed on all functions of the contract and have West Virginia-Medicaid managed care experience,
- The facilities and phone systems are fully in place and operating smoothly,
- We have a long history of successful partnership with the State,
- We bring to the Project a state-of-the-art enrollment system that mirror's the State's commitment to advancing technology, and
- We have a long history of value-added services we implemented at no charge to the State throughout our tenure in West Virginia.

As a result, we bring an unmatched understanding of enrollee and State needs and a proven commitment to delivering outstanding performance that results in high quality of care.

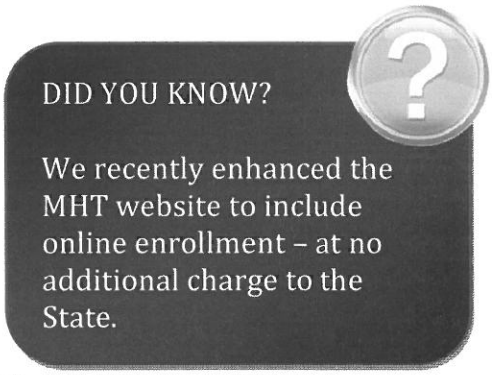
With the rising healthcare costs faced by West Virginia combined with the State's active efforts to improve health outcomes, the Bureau for Medical Services (BMS) will need to respond quickly to a dynamic environment to ensure West Virginia's most vulnerable citizens receive continuity and quality of care. During this time, BMS will need a Contractor who is a true partner and is able to:

- Respond quickly to needed programmatic changes,
- Make valuable recommendations to ensure Medicaid enrollees receive a first-class customer service experience,
- Provide education to potential enrollees/enrollees to support them in making the best decisions possible about their healthcare,
- Alleviate BMS' administrative burden as much as possible,

- Respond to potential population changes and expansions (e.g., the inclusion of the Medicaid expansion and SSI populations),
- Eliminate confusion from potential enrollees/enrollees as the face of healthcare continues to change,
- Demonstrate fiscal responsibility by providing cost effective services and implementing value-added services at no additional cost, and
- Continuously offer the State support and resources as needed.

In addition, BMS needs a vendor who understands the diverse needs of enrollees across the State of West Virginia (for example, enrollees in urban Kanawha have vastly different health care experiences than those in rural Preston County, and yet, the ultimate end outcome is the same – all residents, regardless of background, need to be enrolled in a "best-fit" medical home that provides quality health care services to meet their needs). The Contractor must also understand, and, where appropriate, support the ongoing initiatives in the State (such as the efforts to establish medical homes, including BMS efforts to file a State Plan Amendment to establish health homes for individuals with bipolar disorder; Medicaid payment reforms to achieve better health outcomes; efforts to increase healthcare-related technology, etc.). As West Virginia is undertaking significant work to implement an All-Payer Claims Database (under construction through the Department of Insurance) and the West Virginia Health Information Network, the State has emerged as a leader in working in a cross-cutting manner to improve health services, delivery, and ultimately outcomes. What remains particularly noteworthy is that amidst such active efforts and significant undertakings, West Virginia has also emerged as a leader in Medicaid expansion enrollment with more than 120,000 residents enrolling in the Medicaid program, as of May 2014.[1] The West Virginia Mountain Health Trust (MHT) Contractor must not only support these efforts (as appropriate), but also mirror the same standards of excellence and service improvement in order to meet the needs of BMS and the potential enrollees/enrollees served by MHT. Automated Health Systems' (AHS') expertise positions us well to accomplish all such objectives and we are proud to be such a partner to BMS.

Not only are we a leading nationwide provider of enrollment broker services, but we currently exceed the spectrum of services outlined in the West Virginia Enrollment Broker Services RFP through our administration of the MHT and Physician Assured Access System (PAAS) programs. Through these programs, we regularly interact with West Virginia Medicaid potential enrollees/enrollees, stakeholders, and providers, and we have acute awareness of the breadth of services required to provide appropriate, satisfying programming for potential enrollees/enrollees, providers, MCOs, and BMS. Our unique understanding of the healthcare continuum in West Virginia and the programming demands that follow suit combined with our long history of implementing value-added services



[1] The Charleston Gazette. W.Va. a leader in Medicaid expansion enrollment. February 20, 2014.

With over 30 years as a leader in Medicaid health program management, we have weathered several shifts in the State and national climate and have the flexibility to do so, particularly during the present changing conditions.

at no additional charge to the State, make us an invaluable partner and asset to BMS to move its programming toward the strategic direction envisioned by the State.

As part of our nationwide expertise, we are the enrollment broker Contractor for several Medicaid programs: West Virginia, Florida, Wisconsin, and Ohio. We are dedicated to providing enrollees and potential enrollees with first-class customer service, comprehensive and unbiased choice counseling, and creative enrollment options, all of which result in high rates of customer satisfaction. And, we offer our state partners a full menu of supports and value-added services fully customized to meet each state's unique needs, regardless of the size of the contract. We are confident that our thoughtful, comprehensive approach to the MHT Project (detailed throughout our proposal) is the best solution and overall value for the State.

We believe the best solutions are those that involve true collaboration between State staff and AHS, and are honored to be the face and voice of State Medicaid programs in the communities we serve. (We encourage you to speak with our references, who will undoubtedly boast our partnership, flexibility, and responsiveness to be among our key strengths.) We look forward to continuing such a relationship with BMS as the MHT Contractor.

Our corporate structure and size makes us an ideal partner. We have all of the financial and human capital needed to not only operate the MHT Project as it currently stands and with any forthcoming expansion, but also have the resources to enhance the Project at no additional cost to BMS. Further, as a mid-sized corporation, we offer BMS direct access to senior corporate management (including our CEO), our IT staff, and other corporate professionals – all of whom have extensive Medicaid and enrollment broker knowledge and operational experience and have also developed an expertise specific to West Virginia's Medicaid programs and enrollment broker

We Serve Populations of All Sizes

Regardless of the number of eligibles in the Projects we administer, we provide the same outstanding service to potential enrollees/enrollees and our State partners.

<u>Enrollment Broker Projects:</u>	
Florida:	3,324,000
Ohio:	1,800,000
West Virginia:	210,000
Wisconsin:	700,000
<u>PCCM Projects:</u>	
Illinois:	2,060,000
<u>Enrollment/Eligibility Projects:</u>	
St. Louis:	20,000
Cook County:	115,000
North Dakota:	20,000
Total:	**8,224,000**

operations. This allows us to be maximally responsive to BMS' needs – a characteristic we are excited to continue in the future contract.

In the pages that follow, we present BMS with our corporate resume, including an overview of several of our current projects of a similar scope, as well as a summary of our extensive and relevant corporate history serving a variety of health care programs for low-income individuals and families.

All of this makes us an ideal partner not only for operating and enhancing BMS' MHT Project but also for proactively and creatively addressing changes driven by the implementation of any changes to the Medicaid program.

Since our incorporation in 1979, we have provided program development and administration services specifically related to education and enrollment services in both the fee-for-service and managed health care environments. With the combined expertise of our management, health care, operations, and IT professionals, we help meet the needs of all three interdependent components of a successful health program:

- The families who utilize the service,
- The health and human service professionals who deliver care, and
- The funding source that underwrites the program's costs.

Our operations have been devoted solely to health programs for low-income groups, and we have solutions to cover the entire spectrum of State's needs from program design and implementation through ongoing workflows. Our solutions encompass the full continuum of an enrollee's experience and include eligibility determination, outreach, enrollment, and assistance navigating the health care delivery system. **The diversity of this experience has given us a complete and overarching view of the health-related challenges faced by Medicaid and SCHIP potential enrollees/enrollees and allows us to bring a well-rounded attitude, comprehensive knowledge base, and successful track record to the projects we administer.**

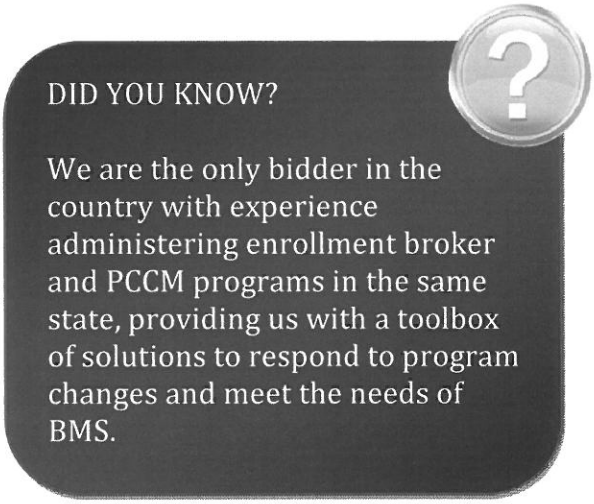
We have addressed the changing needs created by the migration of our client base to the managed care arena by offering new products and services to States. As a result, we now have eight distinct but interrelated lines of business:

- Enrollment Broker,
- Primary Care Case Management (PCCM),
- Medicaid Hotline Administration,
- SCHIP,
- EPSDT,

- Vaccines for Children,
- Enrollment/Eligibility Center Operation, and
- Provider Certification.

The combined experience in each line of business provides us with more than 30 years' experience partnering with states to meet the needs of Medicaid and low-income individuals.

In addition to our overall experience, as we have been the State's Enrollment Broker since 1996, **we bring 18 years' West Virginia-specific experience working with BMS to assure a first-class customer experience to West Virginia's potential enrollees and enrollees**. This partnership has enabled West Virginia to implement its first-ever successful managed care initiative, and we are proud of the accomplishments we jointly celebrated, such as helping thousands of potential enrollees and enrollees access quality of care in a managed care environment and supporting changes to the healthcare environment.



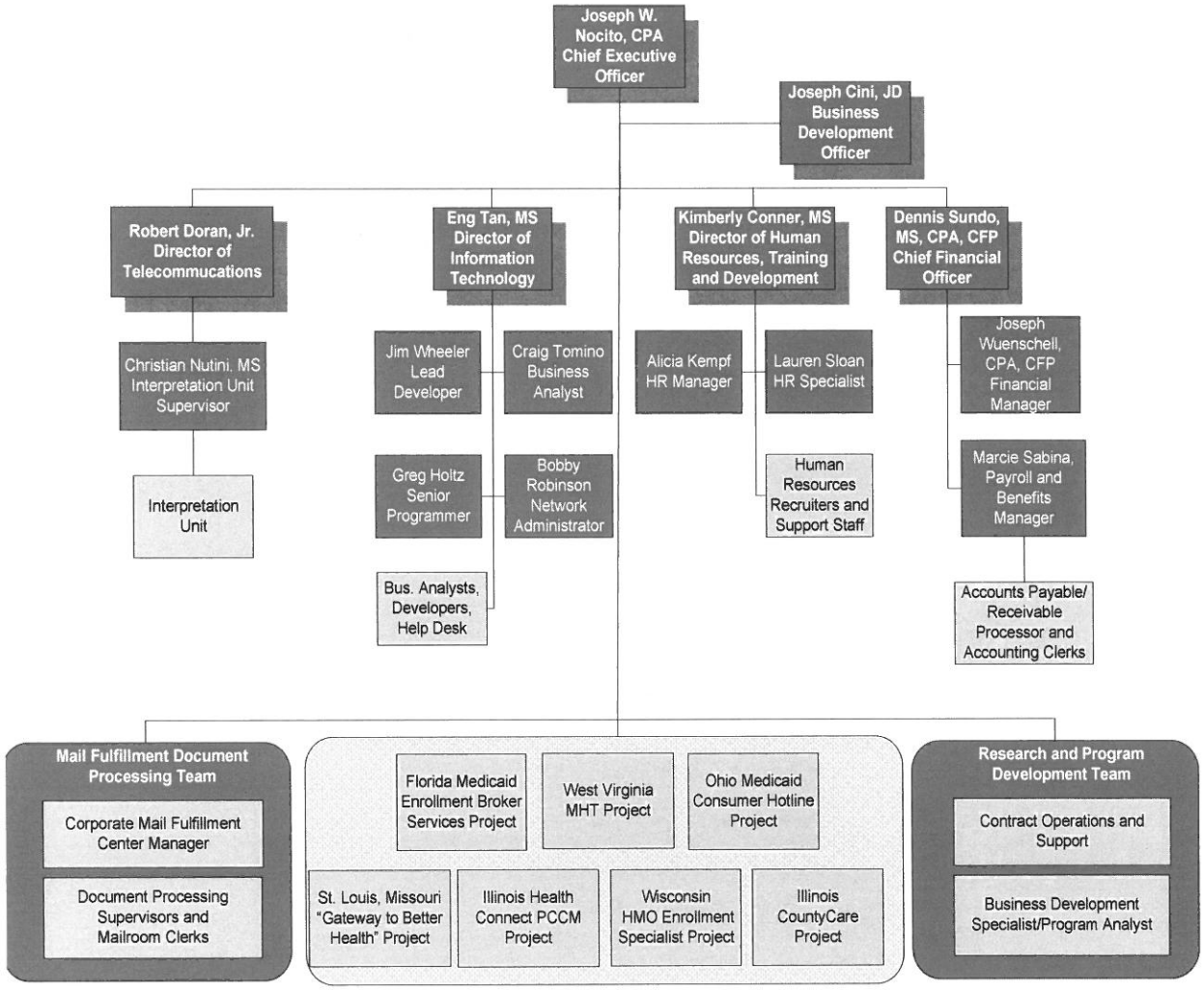
We would also like to point out one other particularly relevant feature of our experience, which is our combined experience administering both West Virginia's enrollment broker and PCCM programs – an experience no other bidder can offer. (Of note, we are the only bidder in the country with direct enrollment broker and PCCM experience.) This special combination of experience affords BMS and West Virginia's potential enrollees/enrollees with particular benefits, which include but are not limited to:

1. We offer staff with experience and training on PCCM enrollments,
2. We are well poised to respond to any changes in the State's PCCM programming,
3. Because we have based our staffing model on our experience performing all responsibilities in the RFP, our staffing model is both appropriate for the Project needs and cost-competitive, and
4. We are best prepared to explain to potential enrollees and enrollees the differences between managed care and PAAS program.

Ownership and Organizational Structure

AHS, a privately held company, is solely owned by Joseph W. Nocito, CEO, who is ultimately responsible for all company operations. He is assisted by a strong Senior Management Team, who in conjunction with the Project's Key Management, will "launch" the next phase of the Project and support all initial and ongoing activities.

Exhibit 1. Corporate Organization Chart



Our corporate structure is deep enough to deliver an exceptional MHT Project while remaining completely accessible to BMS.

Our corporate headquarters are based in Pittsburgh, PA. As with our current, successful West Virginia contract, throughout the course of the contract and particularly during the implementation period, our Senior Management Team will travel extensively to West Virginia to

ensure a smooth continuation of all ongoing services and the incorporation of several programmatic enhancements described throughout our proposal. Because of their involvement in each of our contracts, our Senior Management Team is able to proactively introduce and implement best practices and technologies incorporated into other AHS contracts to the MHT Project. Please refer to Exhibit 1 for our corporate organization chart.

- **Joseph W. Nocito, CPA** (Chief Executive Officer) has been an influential leader with AHS since 1979. He joined the organization as Chief Financial Officer, directing the fiscal affairs of the operation. He expanded his influence in 1997 when he assumed the role of CEO. Under his leadership, he has provided the strategic vision, operational guidance, and financial guidance to the organization, and we have increased nationwide exposure and expertise commencing contracts in West Virginia, North Dakota, Illinois, Florida, Louisiana, Ohio, Pennsylvania, New Jersey, Georgia, Wisconsin, New York, and the city of St. Louis, and Cook County.

  Role for the MHT Project: For the MHT Project, Mr. Nocito will continue to assume ultimate responsibility for all facets of the implementation and ongoing contract service delivery. He will work closely with all appropriate parties to ensure the contract is executed on-time and will direct the Corporate and Key Project Management teams to ensure work progresses according to contract standards.

- **Dennis J. Sundo, MS, CFP, CPA** (Chief Financial Officer) has over 30 years of experience managing day-to-day financial operations for government-funded programs and also has demonstrated financial management and accounting skills. With AHS since 1982, he provides all financial management and accounting functions necessary for this Project.

  Role for the MHT Project: For the MHT Project, Mr. Sundo will continue to take the lead on all accounting functions, including the preparation of all financial statements, verification that all transactions are accurate (and correction of any discrepancies as needed), and preparation of all financial reports. He will also be responsible for processing all the day-to-day and ongoing financial invoices and statements, establishing all internal controls, and managing and reporting the Project's cash flow as well as overseeing the administration of all payroll and benefits activities.

- **Kimberly A. Conner, MS** (Director of Human Resources, Training and Development), was involved in hospital/health care delivery systems for 17 years with overall emphasis in management and staff training before joining AHS in 1994. In addition to currently offering company-wide trainings on low health literacy, she handles personnel issues, staff recruitment, initial training and ongoing development (particularly in the areas of enrollee/employee confidentiality, employee performance evaluations, policy and procedures).

Role for the MHT Project: For the MHT Project, Ms. Conner will continue to be responsible for recruiting, screening and hiring activities of all Project staff in consultation with BMS. She will coordinate the hiring and training with Project management and BMS as appropriate. She will ensure that all staff are fully hired, trained and capable of providing outstanding, culturally competent services to the MHT Project's callers. Further, she will also support the Project Manager concerning all responsibilities related to workforce management, including ensuring available resources to meet operational requirements and performance standards.

- **Eng Tan, MS** (Director, Information Technology) has over ten years' experience working with various State systems as well as interfacing with various MCOs' and other third party computer systems. He currently oversees all operations related to application design, development, testing and implementation as well as all network, data transfer and interface connectivity activities necessary for all of our projects. He is also responsible for all computer hardware and software procurement and aligns IT solutions with business needs.

  Role for the MHT Project: For the MHT Project, Mr. Tan will oversee the development, testing and implementation of the newest iteration of HealthTrack, which we are excited to bring to the Project to support all operational requirements of the Project. He will work closely with Project Management and BMS for HealthTrack's customization and will closely oversee and monitor the work of the IT Department in order to ensure all deliverables and systems are built on time and to the specifications of BMS.

- **Robert Doran, Jr.** (Director, Telecommunications) has been with AHS since 1986, has 27 years' experience with health program administration, and over 15 years' experience administering telecommunication systems for our multi-state call center operations. Mr. Doran ensures the appropriate selection, installment, and functioning of each of our Projects' telecommunications solutions.

  Role for the MHT Project: For the MHT Project, Mr. Doran will oversee all telecommunication operations and ensure maximal uptime. He will continue to ensure that telecommunications hardware and software meet or exceed Project requirements and that new technologies are appropriately deployed. He will also play a key role in our Business Continuity/Disaster Recovery operations.

Please see Exhibit 1 above for our corporate organization chart and Appendix A for resumes of our senior corporate staff.

As evidenced in the preceding discussion, our corporate structure is deep enough to handle the implementation of new features, ongoing administration and expansion of the MHT Project as well as smoothly respond to programmatic changes and expansions, yet our structure still allows us to be completely accessible to BMS.

Our size and corporate structure affords BMS numerous benefits:

Our proven reliability (we bring a solid history of delivering on time and within budget, each time, every time) means BMS can count on us to deliver services, no matter what the circumstances.

- We are focused on quality of service and developing relationships and in-depth program knowledge. We believe that true company growth comes from expanding these qualities. In addition to the Project staff, our corporate staff are similarly invested in meeting BMS' needs and will actively participate in the Project and remain directly accessible to BMS.

- We are focused on caring for the customer, not corporate regulations.

- Because of our size:

    - We can rapidly respond to changing circumstances and customer needs, particularly those needed to successfully support BMS' efforts to reduce budget expenditures, expand managed care, ensure access to care, and implement health care reform;
    - We can quickly resolve problems. Any problem can be immediately escalated to senior management for prompt resolution;
    - We offer direct access to decision makers – a critical feature in the ever-changing health care environment;
    - We offer the best combination of financial stability and flexibility. We have all the financial resources needed to administer programs and respond to evolving needs. Yet, our corporate structure allows for unparalleled flexibility and prompt response times, and
    - [redacted]We have the corporate and financial resources needed to administer several large contracts simultaneously (please refer to Appendix B for the required financial documents). [redacted]

- Because we are a privately held corporation:

    - We are not distracted by mergers and acquisitions;
    - Our first concern is to the customer, not stockholders; and
    - We are not subject to a roller coaster stock market.

- We offer States access to decision makers who:
    - Understand the future goals and direction of the State and are committed to providing services and support to help the State achieve its long-term goals;
    - Are close to program operations, not corporate executives who are many layers removed;
    - Are actively involved in the day-to-day operations; and
    - Are experienced in program delivery and understand/appreciate both the historical context and the future direction of Medicaid programs.

Locations

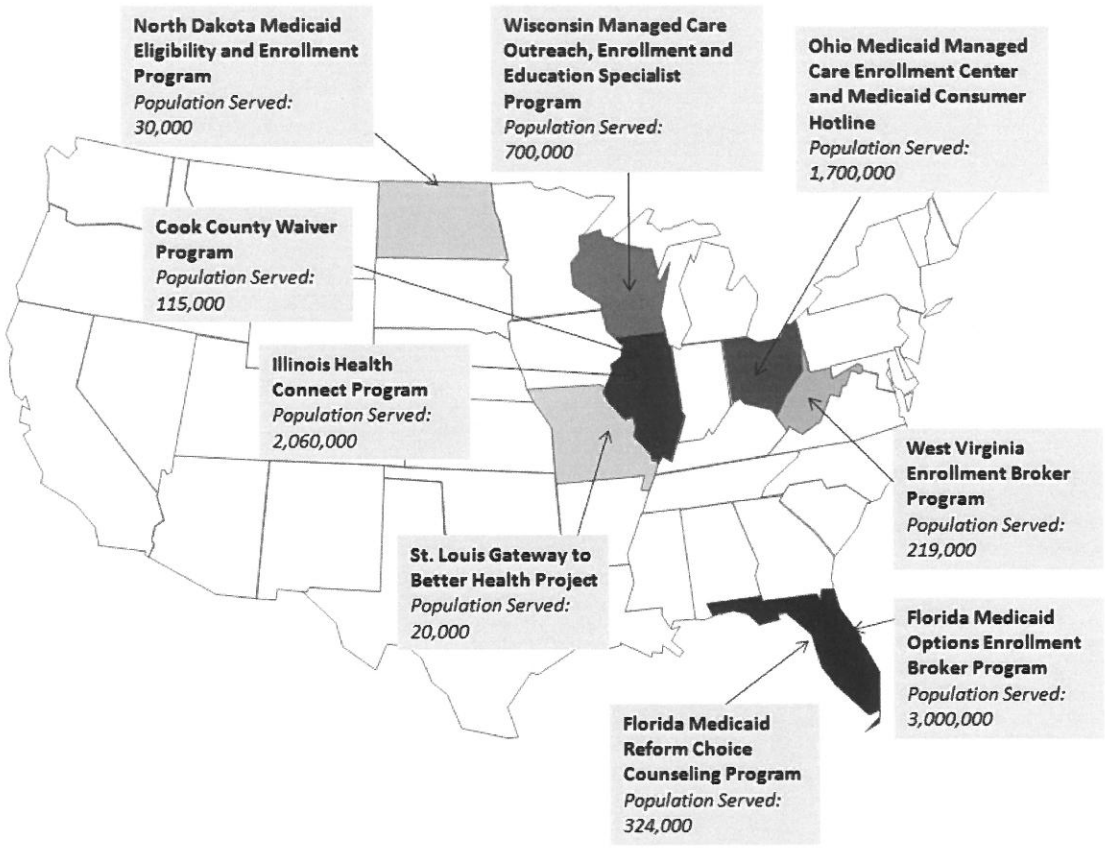
We are headquartered in Pittsburgh, PA, and as evidenced throughout our narrative and below in Exhibit 2, we currently have statewide program locations in seven states, and also have contracts to provide eligibility and enrollment administration services to pilot programs in St. Louis, Missouri and Cook County, Illinois. Yet, the program locations alone do not fully represent the impact of our presence in a state. Within all of our locations we have focused on:

- Investing in long-term partnerships and solutions in the states and communities with whom we partner; and
- Truly understanding the needs of not only the states, but also the local communities and potential enrollees/enrollees we serve. Whenever possible, local partners are part of our solutions, indicating that our solutions have greater buy-in and sustainability than those of our competitors.

"The Jackson County FRN has just executed a reorganization over the past year and AHS' Outreach Specialist has become engaged with that effort. She not only sat on the reorganization Board, but was actively involved with the planning and execution. She regularly attends all sponsored FRN meetings and serves on the FRN Executive Board. The Outreach Specialist has become very involved in all community events and activities. Without that help, the Jackson County FRN would have struggled to gain its effectiveness in the community."

- Executive Director, Jackson County FRN

Exhibit 2. Current Locations



We have a wealth of knowledge related to State health care programming concerns, but are not so large that we cannot focus on the unique needs and future direction of each State.

Experience by Lines of Business

As mentioned, we have experience in effective program administration across many lines of business, including:

1. Enrollment Brokering,
2. Primary Care Case Management,
3. Medicaid Consumer Hotline,
4. EPSDT,
5. Eligibility/Enrollment Center Operation,
6. SCHIP,
7. Vaccines for Children, and
8. Provider Certification.

Enrollment Brokering

Many states now want to alter the focus of medical care for Medicaid families to conveniently located primary care providers linked to backup hospitals and expanded MCOs, thereby providing higher quality, more cost-effective health care. However, the success of this managed care model depends on educating Medicaid potential enrollees/enrollees, and giving them unbiased information about managed care before, during and after program enrollment. **We have reduced enrollee confusion and enhanced informed decision making among families in five states (West Virginia, Illinois, Ohio, Florida, and Wisconsin) during our eighteen consecutive years as an Enrollment Broker.**

DID YOU KNOW?

Our extensive enrollment broker experience affords BMS:

1. A low risk implementation,
2. A proven partner in the health and social services community,
3. Assurance that no operations will be disrupted,
4. Proven ability to respond to changes in the MCO landscape,
5. Proven ability to support additional managed care programming initiatives, and
6. A longstanding commitment to serving BMS and its potential enrollees/enrollees.

Our goals have been to help states achieve:

- More satisfaction among Medicaid families about the move to managed care (documented through surveys),
- Better health among enrollees,
- Increased ability to navigate through the health care system among enrollees,
- Lower Medicaid costs and more Medicaid budget predictability,
- Increased empowerment among enrollees to appropriately access healthcare services, and
- A higher quality health delivery system compatible with national health care and social service reform.

Our strategy is to:

- Involve key stakeholders in planning, implementation, and monitoring;
- Educate Medicaid potential enrollees/enrollees about managed care through the use of well-trained call center and field staff;
- Link enrollees with primary, preventive and behavioral health care providers who assure the availability of needed services while avoiding inappropriate care;
- Diversify the enrollee outreach effort to make sure that as many people as possible enroll;

- Work with existing community agencies to educate enrollees about managed care; and
- Reduce the socio-cultural reasons Medicaid and SCHIP enrollees do not make the best use of health care services by promoting cultural proficiency among providers.

Please see Exhibit 3 for a summary of our Enrollment Broker Contracts.

Exhibit 3. Enrollment Broker Contracts

Time Period	Location	Contracting Agency	Program
1996 – Present	West Virginia	Department of Health and Human Resources	Health Benefits Manager Program
1996 – Present	Wisconsin	Department of Health and Family Services	Managed Care Outreach, Enrollment and Education Specialist Program
1998 – Present	Ohio	Department of Medicaid	Managed Care Enrollment Center
2006 – 2013	Illinois	Department of Healthcare and Family Services	Illinois Client Enrollment Broker Program
2010 – Present	Florida	Agency for Health Care Administration	Florida Medicaid Enrollment Broker Program

A detailed description of our current enrollment broker projects follows.

Project #1. West Virginia Enrollment Services Project

Project Summary

We have been the Enrollment Broker Contractor for the State of West Virginia since 1996, having been awarded subsequent contracts in 1999, 2003, and 2007. Prior to 1996, West Virginia Medicaid consumers all participated in Fee-for-Service. We actively helped design and implement the combination of a risk-based MCO component (Mountain HealthTrust, MHT) and a PCCM effort (Physician Assured Access System, PAAS). As would be expected for a state with no experience with managed care, initial efforts were met with considerable resistance. We worked extensively to network with community and provider groups and promote a successful managed care experience for West Virginia's Medicaid potential enrollees and enrollees.

Key aspects of the Project's efforts that have supported the Project's past and ongoing successes include:

- Active involvement in the work of the dynamic The Health Plan Task Force, a broad-based coalition representing interested health and human service providers and potential enrollees/enrollees.
- Utilization of competent, well-trained call center and field staff and multi-media materials to impact potential enrollee/enrollee knowledge and understanding of managed care.
- Maintenance of a diversified outreach effort, including face-to-face interactions in a variety of settings, a toll-free call center operation, and targeted publicizing.
- Expansion of health education and

"Automated Health Systems (AHS), as the West Virginia Enrollment Broker for the Medicaid Managed Care Program, has supported the mission of our Early Head Start/Head Start program in many ways. A representative has attended our Family Fun Days, Community Baby Showers and our Annual Kiddie Fairs and has shared information about the program to our families. They have gone over and beyond their call of duty to not only provide information, but to truly assist families in the step by step process."

- Director
- Monroe County Early Head Start

"Automated Health Systems (AHS), as the West Virginia Enrollment Broker for the Medicaid Managed Care Program, has supported many of the families our organization serves. The AHS Representative has provided education on the Mountain Health Trust Program to the Family Resource Coordinators as they work directly with children and families who may need information on insurance coverage from your organization."

- Children's Services Supervisor
- NCWV Community Action Association/Head Start

outreach capabilities of community-based organizations through on-site visits and consultations.

- Enhancement of positive provider attitudes toward Mountain Health Trust, PAAS, and Medicaid Redesign initiatives through our work with a variety of provider groups.

Project Achievements

Maintain Low Change Rates

Our change rates in West Virginia are historically less than 1%, indicating that the counseling services we provide indeed help enrollees select the "best fit" MCO.

Supported the State in Medicaid Redesign Initiatives

In 2007, the State implemented Mountain Health Choices (MHC), a Medicaid Redesign initiative intended to dramatically increase the role of the enrollee in health maintenance and disease prevention. During the lifespan of this program, upon redetermination, we enrolled each enrollee in a "basic level" plan and sent an enrollment packet asking him/her to make a choice of MCO/PCP. The packet included a Member Agreement with a letter of explanation. Enrollees then had 90 days in which to meet with their PCPs, agree upon a health goal, return the Agreement to us, and subsequently were enrolled in an "enhanced level" benefit package.

Assumed Responsibilities for Enrollment into the Rural Options Program

In 2005, the State received a waiver to offer the Rural Option Program (another Medicaid managed care option targeting particularly rural counties), and we demonstrated our flexibility and willingness to assume new responsibilities as we were engaged to take on this new responsibility.

Supported the Close-Out of the Mountain Health Choices Program

When the State elected to discontinue the Mountain Health Choices Program, we embarked on four avenues to support the end of the program, depicted on the following page in Exhibit 4.

Exhibit 4. Methods to Support the End of the MHC Program



Mailings:

- As of 10/14/13 we discontined mailing the annual redetermination MHC notices
- Did not resend any returned MHC mailings to members



Processing MHC Forms:

- Field staff followed up with providers who submitted MHC forms via fax notifying the program is discontinued
- Faxed a copy of the MHC Phase Out letter to providers
- Discontined follow-up to obtain missing information on MHC forms



Provider Communication:

- Created a BMS-approved letter announcing the end date of the MHC program
- Mailed the letter to all PCPs
- Field staff updated providers on the end of the program during site- visits



Member Communication:

- Informed callers of the MHC discontinuance
- Emphasized Medicaid coverage was not going away due to the change

With a comprehensive method of provider communication, we fully supported providers, stakeholders and enrollees in understanding the end of the MHC program.

Supported Numerous MCO Expansions

As evidenced in Exhibit 5 below, during the course of our current contract (i.e., from 2007 – present), we have updated our systems, mailings, and processing to accommodate numerous MCO options changes. (Please note, during our nearly 20 year tenure in West Virginia, we have supported many more MCO changes.)

DID YOU KNOW?

From 2007- present, we have supported over 65 MCO expansions in 45 of West Virginia's 55 counties.

Exhibit 5. Plan Changes Supported During Current Contract

County	Effective Date	Plan Options
Barbour	5/2008	Carelink, The Health Plan and Unicare
Berkeley	10/2011	Carelink and Unicare
Boone	9/2012	CoventryCares, The Health Plan, UniCare
	2/2008	Carelink and Unicare
	9/2012	CoventryCares, Carelink and The Health Plan
Braxton	2/2008	Carelink and UniCare
	9/2012	CoventryCares, Carelink and The Health Plan
Brooke	8/2009	Carelink, The Health Plan and UniCare
	2/2008	Carelink and PAAS
Cabell	2/2008	Carelink and PAAS
Calhoun	5/2008	Carelink, The Health Plan, UniCare
Clay	9/2012	CoventryCares, UniCare and The Health Plan
Doddridge	4/2008	Carelink, The Health Plan, and UniCare
Fayette	6/2013	CoventryCares, UniCare, The Health Plan
Gilmer	4/2008	Carelink, The Health Plan, and UniCare
Grant	12/2009	UniCare
	6/2013	CoventryCares and UniCare
Greenbrier	10/2011	Carelink and UniCare
	4/2013	CoventryCares, UniCare, The Health Plan
Hampshire	7/2008	UniCare and PAAS
	10/2011	Carelink and UniCare
Hancock	8/2009	Carelink, The Health Plan, and UniCare
Hardy	12/2009	UniCare
	6/2013	UniCare and CoventryCares
Harrison	4/2008	Carelink, The Health Plan, and UniCare
Jackson	4/2013	CoventryCares, UniCare and The Health Plan
Jefferson	10/2011	Carelink and UniCare
Kanawha	9/2012	CoventryCares, UniCare, The Health Plan
Lewis	4/2008	Carelink, The Health Plan, and UniCare
Lincoln	4/2014	CoventryCares, UniCare, The Health Plan
Marion	4/2008	Carelink, The Health Plan, and UniCare
Mason	6/2009	Carelink
	9/2011	Carelink and UniCare
Mercer	2/2008	Carelink and UniCare
	4/2013	CoventryCares, UniCare and The Health Plan
Mineral	10/2011	Carelink and UniCare
Monongalia	4/2008	Carelink, The Health Plan and UniCare
Monroe	2/2008	Carelink and UniCare
	4/2013	CoventryCares, UniCare and The Health Plan
Morgan	7/2008	UniCare and PAAS
	10/2011	Carelink and UniCare
McDowell	2/2008	Carelink and UniCare
Pendleton	12/2009	UniCare

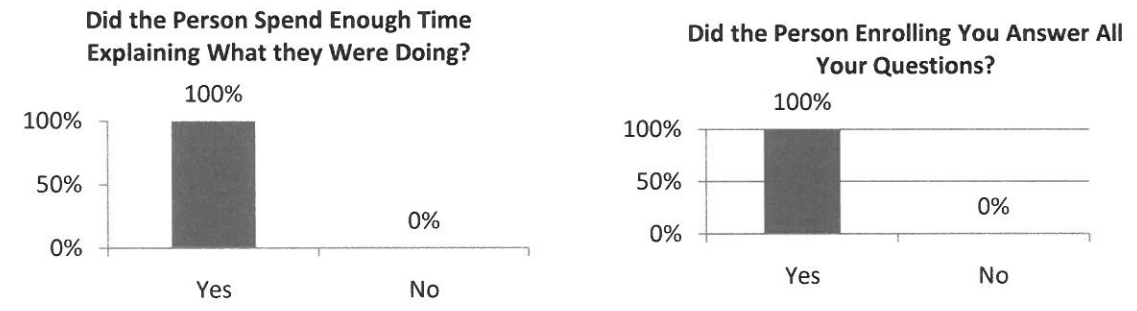
County	Effective Date	Plan Options
	6/2013	UniCare and CoventryCares
Pocahontas	10/2011	Carelink and UniCare
	9/2012	CoventryCares, UniCare and The Health Plan
Preston	4/2008	Carelink, The Health Plan, and UniCare
Putnam	4/2014	CoventryCares, UniCare and The Health Plan
Randolph	4/2008	Carelink, The Health Plan, and UniCare
Ritchie	2/2008	Carelink, The Health Plan, and UniCare
Roane	5/2008	Carelink and UniCare
	9/2012	CoventryCares, UniCare and The Health Plan
Summers	8/2009	Carelink and UniCare
Taylor	5/2008	Carelink, The Health Plan, and UniCare
Tucker	4/2008	Carelink, The Health Plan, and UniCare
Upshur	4/2008	Carelink, The Health Plan, and UniCare
Wayne	2/2008	Carelink and PAAS
Webster	5/2008	Carelink, The Health Plan, and UniCare
Wyoming	2/2008	Carelink and UniCare
	4/2013	CoventryCares, UniCare and The Health Plan

During our current contract, we have supported multiple MCO expansions and changes in almost every county.

Achieve High Satisfaction Rates

As evidenced below, enrollee experiences with our services are overwhelmingly positive.

Exhibit 6. Satisfaction Survey Results



West Virginia potential enrollees/enrollees' satisfaction with our services demonstrates our commitment to representing BMS in the highest manner.

Maintain Outstanding Performance Levels

We believe that our continuous achievement of all Service Level Agreements in West Virginia highlights important features of our company:

- We are flexible in terms of working with changing perspectives and programs;
- We are committed to helping States remain on the forefront of Medicaid program delivery and works collegially with State partners to help achieve goals; and
- Regardless of the size of the Project, we work with the same dedication, determination and energy to deliver outstanding customer service.

Implement Project Enhancements at No Cost

During our tenure in West Virginia, we have voluntarily implemented several enhancements to the Project, at no cost, to improve service delivery to potential enrollees/enrollees. Recent enhancements include:

1. Redesigned MHT and MHC letters,
2. Redesigned MHT brochure,
3. Redesigned MHT website to include secure online enrollment,
4. Launched a mobile-friendly version of the MHT website, and
5. Redesigned the monthly status reports.

Support New Initiatives and Changes to West Virginia's Medicaid Program

As the State has continued to evolve its Medicaid program, we have continued our partnership with BMS in any way possible to support its vision for excellent service delivery. Below follows a list of recent activities to support changes to the State's Medicaid programming.

2012 Activities

1. Expanded the choice window from 30 to 45 days;
2. Implemented a new process to allow members who lose eligibility to be automatically re-linked to their previous MCO for up to one year;
3. Updated the mailing processes and staff training curriculum to support an MCO expansion into six additional counties; and
4. Transitioned to the Fiscal Agent's web-based application.



2013 Activities

1. Provided coordinated support of the State's pharmacy expansion consisting of field support (in-person assistance to pharmacy providers, prescribing providers, and local

DHHR offices) helpline support, and updated our MCO provider directory inventory with the new MCO directories that now include dentists;

2. Created draft MCO Plan Comparison Charts for the MHT Program;
3. Updated all MHT mailings to accommodate the discontinuation of the MCO Provider Directories in the Enrollment Packets for newly eligible members and the discontinuance of MHC in January 2014;
4. Updated our IT processes to accept new rate codes in October 2013 and will continue to support both the legacy and new MAGI rate codes until the legacy codes are replaced;
5. Created a weekly Rate Code Tab Report for BMS;
6. Supported two MCO expansions;
7. Supported the phase out of the MHC program by:
    a. Drafting a provider letter announcing the phase out (effective January 1, 2014), which was mailed to over 5,000 PCPs,
    b. Providing field staff support (in person and over the phone), and
    c. Updating the MHT website, and
8. Provided outreach to 198 dentists to ensure they were aware of administrative changes for children's dental services (we conducted site visits to dentists and provided education and provided DHHR with a list of any issues or concerns).

2014 Activities

1. Responded to a 76% increase in call volume without compromising service delivery January 2014 due to the rollout of Medicaid expansion;
2. Outreached to an additional 300 dentists to promote the administrative changes for children's dental services;
3. Updated our enrollment processes for newborn enrollments (February 2014);
4. Created a draft MHT DHHR Tip Sheet describing the MHT enrollment process and effective dates for newly enrolled Medicaid members, MHT members, etc.;
5. Implemented new enrollee mailing; new mailroom processes; enrollee, agency, provider outreach and education; and updated the MHT website to support the expansion of The Health Plan into two additional counties with an effective date of April 2014;
6. Implemented the above processes to support the expansion of The Health Plan into 13 additional counties with an effective date of August 2014;
7. Launched a mobile friendly version of the MHT website; and
8. As a value-add and at the request of the three MCOs, we assisted with a onetime collaborative group provider mailing as part of joint quality initiative regarding diabetes and asthma to ensure that the participating providers did not receive duplicate mailings. In response, we created a file layout, provided guidance on the requested elements,

eliminated duplicates, created a mailing file and mailed the materials on behalf of the MCOs. We completed the mailings to over 3,700 sites throughout West Virginia and neighboring states.

Project #2. Florida Medicaid Reform Choice Counseling Project

Project Summary

Florida Medicaid Reform began in Broward and Duval counties in July, 2006, and expanded into Baker, Clay and Nassau counties in July, 2007. Under Medicaid Reform, health care services are provided by MCOs, several of which are "specialty plans" that offer services tailored to specific medical group needs (e.g., children with special needs, enrollees with HIV/AIDS, etc.) and provide services currently not offered by Medicaid.

One of the enhancements offered to Medicaid Reform enrollees is the ability to participate in the Enhanced Benefits Reward$ Program, which allows enrollees who engage in healthy behaviors to earn credits in their personal Enhance Benefits Reward$ Program account. These credits can be used to purchase items such as over-the-counter drugs, vitamins, and other health-related products at any Medicaid-participating pharmacy.

Since 2010, our Call Center Choice Counseling Specialists have provided unbiased information and education regarding the Medicaid Reform Program, available MCO options, rights and responsibilities, enrollment timeframes, etc. and process MCO enrollments, changes, and disenrollments as appropriate. Our Field Choice Counseling Specialists do the same; however, these staff may also engage with enrollees during group or one-on-one sessions at community sites or special needs agencies or, in some instances, at the enrollee's home. Special Needs Coordinators are available via the call center to provide more detailed support, research, and follow up for enrollees with complex physical or behavioral health care and other social needs. Additionally, our Enhanced Benefits Reward$ Enrollment Specialists also help potential enrollees and enrollees understand how to earn credits and respond to benefit/balance inquiries.

One year after taking over the Medicaid Reform Enrollment Broker contract in Florida, we expanded operations to include all 67 counties (Reform and non-Reform) and serve an additional three million eligibles in the Medicaid Options Program. We customized HealthTrack, expanded our facilities, increased staffing to accommodate all Medicaid Options additional requirements and seamlessly transfer operations from the incumbent to us.

In 2013, we were also asked to take on the State's Managed Medical Assistance Program, which was created by Part IV of Chapter 409, Florida Statutes, and altered the face of the Medicaid program in Florida. As part of this expansion, we:

- Conducted extensive analyses to determine appropriate staffing models;
- Managed the build-out of the call center, including a new training room with over 100 seats, and cubicles on the call center floor for approximately 400 new agents;
- Recruited, screened and placed approximately 300 additional call center agents, including a complement of bilingual staff (both Spanish and Creole staff);

- Developed a comprehensive training curriculum to train new hired on all counseling activities needed for the Project;
- Upgraded the telecommunications system and infrastructure and installed new call recording and IVR systems;
- Updated all policies and procedures to reflect the State's changing business rules;
- Developed new materials and letters (over 100 letters were created to accommodate various regions, eligibility groups, enrollment dates, etc.); and
- Updated all information technology infrastructure and systems to accommodate all programmatic changes.

We successfully executed all implementation activities and launched the Program in February 2014.

Project Achievements

Successfully Implemented the Project and All Expansions On-Time

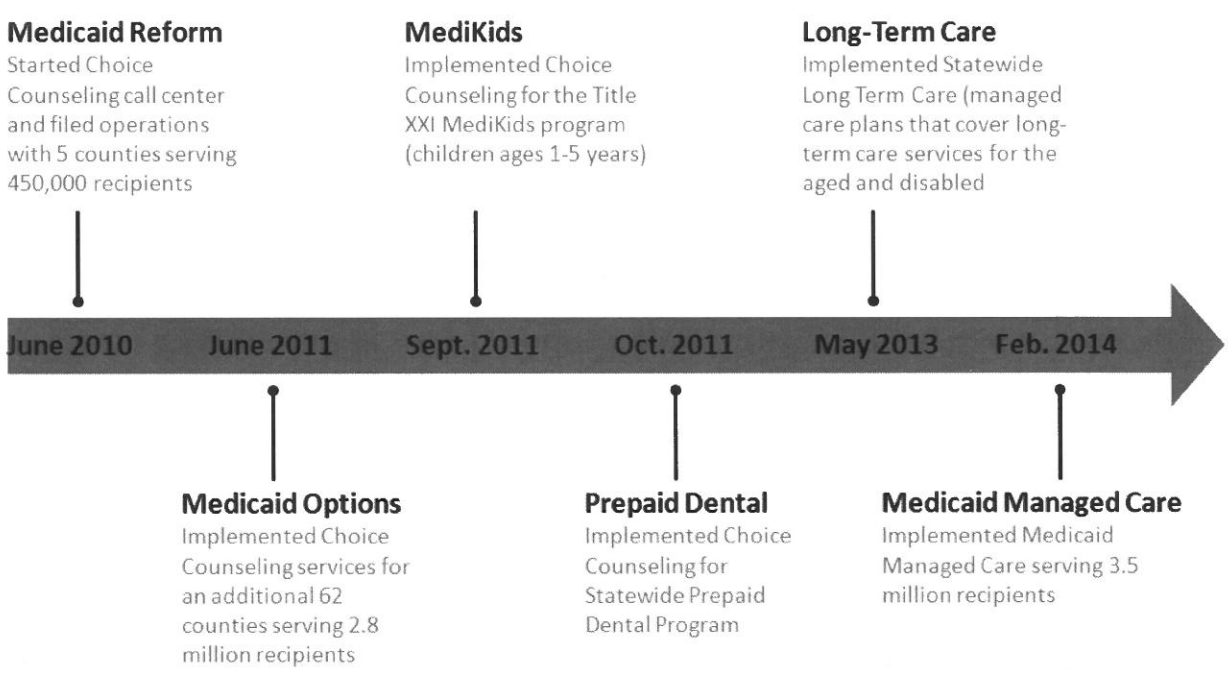
In 2010, AHCA transitioned administration of the Project from the incumbent contractor to AHS. Within the three-month implementation period, we successfully engaged in a true partnership with the State for Health Care Administration (AHCA) to conduct a thorough requirements analysis, define business rules, monitor implementation, and complete readiness review. In addition to building out and fully equipping our office, we successfully completed numerous other tasks that successfully enabled us to provide outstanding services from Day One of the contract.

Further, we successfully implemented all project expansions on time (i.e., MediKids, Long-Term Care, Prepaid Dental, and Managed Medical Care as shown in Exhibit 7 on the following page), all providing excellent service on Day One.

"As usual, you gents impressed. The tour of the build-out and the updates on choice counseling activities exceed our expectations. I know both of you and your teams have put in a lot of hours and a lot of effort – because it shows!

-- Director of Communications
Agency for Health Care Administration

Exhibit 7. Florida Expansions and Transitions



As a result of our successful implementation we have met all Service Level Agreements (SLAs) since Day One of the contract and for all expansions.

Launched the First Ever Online Enrollment System in the State of Florida

Within weeks of receiving approval from AHCA on the design of a new Online Enrollment Application, we successfully implemented and launched the first ever Online Enrollment Application in the State of Florida (after previous attempts by other Contractors had been unsuccessful). The Online Application system has also integrated an advanced Preferred Drug List Comparison tool (described below).

In less than a month, we designed, developed and launched the State of Florida's first ever online application. The application allows an enrollee to log-in securely, become educated on the program and available MCOs, search through the provider database and select/change MCOs and PCPs. Not only that, but consumers can enroll in English, Spanish or Creole.

According to Interim Secretary Elizabeth Dudek, "By providing an opportunity for recipients to enroll online, they have the opportunity to make the best decisions for themselves and their families when it is convenient for them."

Developed a Preferred Drug List Comparison Tool

In Florida each MCO maintains its own formulary. To assist enrollees in making a best fit MCO choice, we developed a Preferred Drug List Comparison Tool (integrated into HealthTrack and available in the online enrollment module). This tool allows enrollees to identify MCOs that offer the best coverage of their medications, which helps them to select the MCO that best meets their specific health care needs and supports adherence to treatment regimens.

Maintained Outstanding Performance Levels

As evidenced above, we achieved impressive performance results, beginning on Day One. In addition, our performance marks a significant improvement over the previous vendor. For example, in the Medicaid Reform Project, the month we went live, we averaged a 0.95% abandonment rate, which has averaged 1.02% since the contract's inception – a significant decrease over the previous vendor's 2009-2010 average of over 25%.

Achieved High Satisfaction Rates

Our satisfaction rates demonstrate our commitment to providing high quality services to Florida's enrollees.

Exhibit 8. Satisfaction Survey Results

Question	Average Answer (9 is maximum)	% Satisfied
How helpful is counseling you received	8.58	90%
Satisfaction with amount of time you waited	8.65	93%
Service provided by the Counselor	8.87	98%
How quickly the Counselor understood why you were calling	8.82	97%
Counselor's ability to help you choose a plan	8.83	97%
Confidence in information given by Counselor	8.77	96%
Treated respectfully	8.91	98%
Recommend Choice Counseling helpline to friend or family	8.79	96%

Developed HealthTrack Web

We developed and implemented HealthTrack Web, an identical version of HealthTrack that could be accessed through the web for an infinite number of State staff. All staff at the 13 area offices are able to access HealthTrack and complete functions/processes as required.

Implemented Services for the Dual Eligible Population

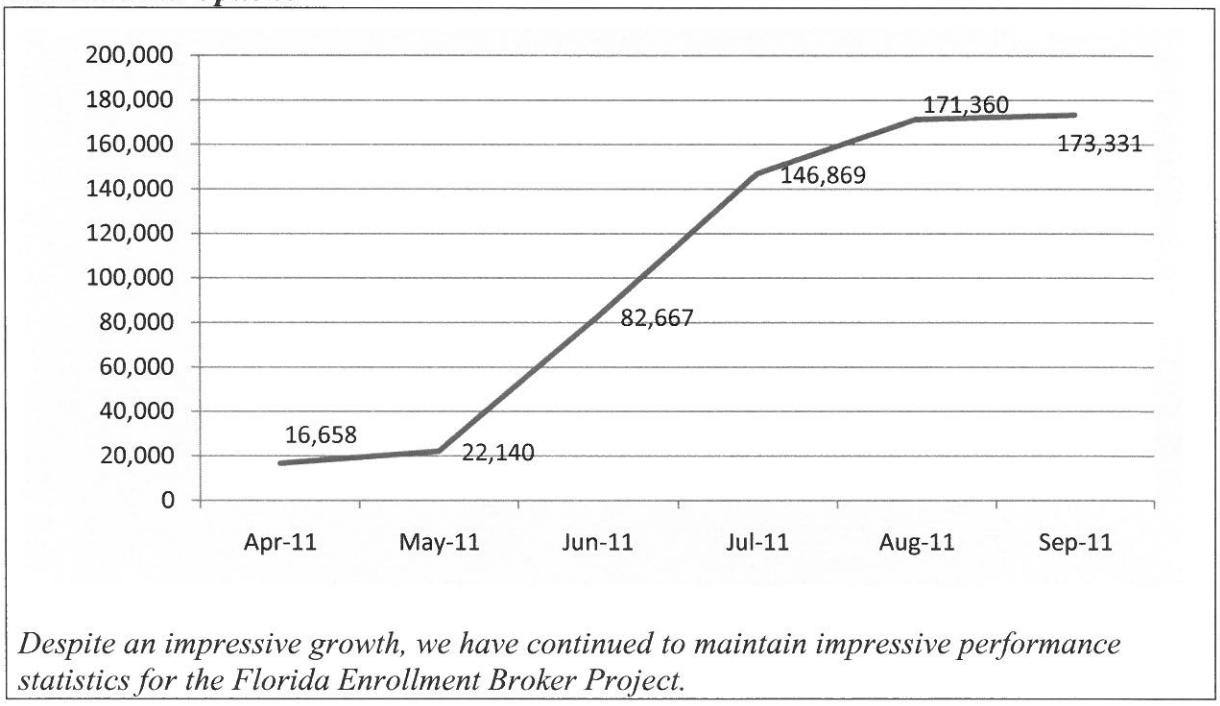
As part of our Long-Term Care implementation, we implemented several components to ensure we provided outstanding services to the dual eligible population, which included but were not limited to sensitivity training for staff; outreach to nursing homes; security features in our IVR and web enrollments so family member acting on behalf of an enrollee could appropriately make the enrollment, but not personal information was disclosed; and training to long-term care facilities. The program was indeed successful, as evidenced in the text box below.

"Thousands of hours went into the preparation, planning and implementation of this program," said AHCA Secretary Liz Dudek. "thanks to the efforts of the Agency staff members, our choice counseling vendor, Automated Health Systems, our partners at the Department of Elder Affairs, recipients and those who represent their interest, the contracted health plans and thousands of providers, the Long Term Care program has been a resounding success."

- *Press Release, Agency for Health Care Administration*
February 28, 2014

Maintained Outstanding Performance Levels

Exhibit 9. Calls Per Month for Florida Enrollment Broker Project for Medicaid Reform and Medicaid Options



Despite an impressive growth, we have continued to maintain impressive performance statistics for the Florida Enrollment Broker Project.

Despite the continual significant expansion of the contract, we have maintained impressive performance levels for the Medicaid Options Enrollment Broker Project since Day One of Go-Live. In fact, as of December 2013, we handle approximately 2,000,000 calls per year, and amount that is projected to significantly increase in 2014 with our recent expansion.

Project #3. Ohio Medicaid Managed Care Enrollment Services Project

Project Summary

In May of 1998, we were awarded a contract with the Ohio Department of Human Services (now the Ohio Department of Medicaid) to administer an Enrollment Services Project for that state's launch of Medicaid managed care. Although the implementation time frames were tight, we met the deadlines and began providing services on July 1, 1998.

Ohio Agencies Trust AHS

A CDJFS Eligibility Supervisor had this to say about us:

"...I know I can call Mr. Jackson and have my questions answered in a timely and professional manner. He is always willing to go the extra mile to assist our agency and the consumers with issues that arise with the MCO, we really appreciate his assistance."

We currently interact with eight MCOs, both voluntary and mandatory depending on the county. Weekly selection, change, and assignment information is sent to each plan for PCP assignment and selection verification. We are also responsible for MCO assignment, a process involving online updates to the State's Client Eligibility System (CRIS-E) that occurs daily, and we assist potential enrollees and enrollees with voluntary PCP selection. We also handle the open selection periods for each county when enrollees can change plans. Through a phone-accessed Managed Care Enrollment Center (MCEC), we assist potential enrollees and enrollees in enrolling in an MCO and selecting a PCP. Information and online enrollment are also available via our Project website – www.ohiomh.com.

All activities are augmented by various mailings ranging from reminder cards to complete enrollment packets and enrollee surveys, conducted from our Corporate Mail Fulfillment Center in Pittsburgh, PA.

Project Achievements

Successfully Expanded Statewide

In 2006, the Medicaid managed care model was expanded statewide (initially Medicaid managed care was available only in eight counties) and also included the TANF and AABD populations. We appropriately updated our systems, modified our mailing operations and hired and trained staff to extend our excellent service delivery to the additional 1.2 million new Medicaid managed care enrollees in Ohio.

According to a Performance Review During this Period:

"With the managed care expansion activities, [AHS'] responsibilities continue to grow more demanding and complex. Nevertheless, all areas of the contract were met for this period."

Rebuilt the State's Managed Care Provider Network

Since 2007, we have taken over the task of maintaining all of Ohio's Managed Care Plans' Provider Networks.

Not only were we able to build a whole new provider network system with commendation from the State and the MCOs, but we actually exceeded all expectations by completing the project ahead of schedule. We developed a new set of file exchange protocols and formats that took into account the needs of all MCOs and the State.

In the State of Ohio we were recognized as the single entity that was able to effectively maintain adequate provider file information. Our provider data is considered the "Gold Standard" when discrepancies in other systems are identified.

Maintain Outstanding Performance Levels

We have provided excellent services to Ohioans and met all performance metrics throughout the history of our contract.

Achieve High Satisfaction Levels

As is standard in our contracts, we maintain excellent levels of enrollee satisfaction. Results of a recent satisfaction survey are provided in Exhibit 10.

Exhibit 10. Recent Satisfaction Survey Report

Question	% Responded Good to Great
The time you had to wait for help	99%
Our explanation of your choice	99%
Our answers to your questions	100%
Our courtesy to you and your family	100%
Overall, how would you rate our staff and services	100%

Project #4. Wisconsin Medicaid Managed Care Enrollment Specialist Project

Project Summary

To assist in their statewide managed care expansion efforts, the Wisconsin Department of Health and Family Services (DHFS) contracted with us to develop and implement an Enrollment Specialist Program in July of 1996 (competitively renewed in 2000, 2004, and 2008). This effort is a variation – suited to Wisconsin's needs – of the model we currently use in our other managed care contracts.

As with the other programs we operate, we outreach via mailings as well as operate a state-wide toll-free call center that potential enrollees and enrollees can call to receive additional information about the Program, and/or enroll in an MCO of their choice. The majority of our enrollment activity occurs through our call center, which is staffed with skilled Benefits Managers trained to help potential enrollees and enrollees navigate the State's complex system of coverage. In Wisconsin, depending upon the level of MCO participation in a given area (often only portions of a county), managed care may be mandatory, partially mandatory, voluntary or fee-for-service; our staff effectively explains these differences to potential enrollees and enrollees. In addition to enrollment assistance, we also conduct a health needs assessment on enrollees and share the results with the MCOs.

Project Achievements

Successfully Expanded Statewide

Wisconsin's initial experience with Medicaid managed care was conducted as a pilot program for enrollees in Milwaukee. Based on the successful outcomes of the Project (including our role as the Enrollment Broker), the state conducted a statewide expansion of their managed care initiative. Not only were we able to successfully forecast staffing and train staff to handle new responsibilities, but we also conducted extensive outreach activities at the local level to foster enthusiasm and support. In an effort to foster change at the local level, we conducted 176 county-based information sessions throughout the State, which provided stakeholders with information about Wisconsin's managed care expansion initiative and the specific role we would play as the Enrollment Broker Contractor. Through these important sessions, we achieved broad-based support not only for the initial expansion, but ongoing as well.

Earned Rave Reviews from Outreach Partners

We have fostered communality awareness and participation by providing critical information to almost two thousand State and agency staff concerning basic Medicaid and SCHIP services and requirements. As demonstrated in the following text box, we have received rave reviews from our community partners.

See What Our Wisconsin Partners Say About Us

"AHS staff has worked hard to maintain an open level of communications with MCPs in a way which is unbiased and safeguards the rights and needs of BadgerCare Plus and Medicaid SSI consumers. AHS staff are always available to assist the consumer and MCPs with issues that involve enrollment and eligibility, whether by phone or in person."

- *Director of Government Programs*
Wisconsin The Health Plan

"Through its telephone and field operations, AHS has consistently provided outstanding consumer outreach and education, enrollment assistance, referral resources and administrative support."

- *Vice President*
Wisconsin The Health Plan

"[AHS] has done an excellent job of assisting consumers with their selection of managed care plans in a professional and caring manner that best meets the needs of the specific member and/or family. They have provided trainings throughout the State on new Medicaid programs that have focused on member education and MCP needs. Over the years they have maintained a great working relationships with our HMO in meeting with us a periodically to discuss updates and programs that are designed for our members."

- *MCO Outreach Manager*

Maintain Outstanding Performance Levels

As with all our contracts, AHS maintains impressive performance levels for this Project and continuously meets all SLAs.

Earn High Satisfaction with the State

As reflected in the text box on the following page, the State of Wisconsin is very pleased with our excellent service and support of their Medicaid programs.

See What Wisconsin's Medicaid Director Says About Us

Dear AHS Staff:

Thank you for your hard work and dedication in implementing the Badger Care Plus Entitlement Reforms and provisions of the Affordable Care Act (ACA).

While I know we still have work to do, it's important to recognize how much work has been accomplished. During the past 4 months, you have become a great partner to us in outreach efforts. The policy changes reach far beyond income calculation, eligibility criteria, and benefits. As you know, this has been a massive project requiring a total team effort to successfully implement solutions that best serve the needs of all Wisconsinites. Please take a moment to reflect on what we have accomplished together:

- Launched statewide outreach effort to some of Wisconsin's most vulnerable population
- Focused on customer service in an environment full of uncertainty
- Met changes and project difficulties with solutions that focused on front line delivery of the Governor's Entitlement Reforms
- Met the diverse needs of many

The State of Wisconsin greatly appreciates your thoughtful, systematic, and responsible approach to the delivery, and insight to nationwide considerations. As with any complex policy, there are numerous ways to meet the needs of many. You are an integral part of why this project has been successful, despite the vast obstacles encountered along the way.

The State of Wisconsin is proud to have partnered with Automated Health Systems on this historic project.

With sincere appreciation,

Brett Davis
Medicaid Director

Primary Care Case Management (PCCM)

We presently administer the West Virginia Physician Assured Access System (PAAS) and the Illinois Health Connect (IHC) PCCM contracts.

These contracts do not represent the full range of skills and experience we have related to PCCM (please refer to Exhibit 11 for our total PCCM experience). In fact, not only do we have 20 years' experience administering PCCM contracts, but we have also proven our ability to implement high-quality, fiscally responsible programs:

- **Our PCCM Program in Illinois saved the State $531 million from 2007-2010, according to the Robert Graham Center.**
- **In 2008 the ACCESS Plus program was one of the top fifteen finalists for the Innovations for American Government Award through the Harvard Kennedy School Ash Institute for Democratic Governance & Innovation.**
- **Combined savings, after administrative fees from the Disease Management component, for the first two years of ACCESS Plus totaled $62.9 million.**

"We would like to take this opportunity to express our appreciation for the exceptional performance of Automated Health Systems, Inc. (AHS) over the past two years administering the CommunityCARE and KIDMED Primary Care Case Management (PCCM) programs. Following a difficult transition from the previous Contractor, AHS assumed the duties relative to the PCCM contract in an extremely short period of time. The state's decision to move from the existing PCCM program to the more comprehensive BAYOU HEALTH system of care is a complex undertaking which AHS has consistently displayed a willingness to assist with whatever requested. The entire AHS Louisiana project staff, under the direction of Ms. Janet Pritchard, is to be commended on its professionalism and responsiveness in interactions with the Department, CommunityCARE and KIDMED providers and enrollees, and the state's general Medicaid population.

It has truly been a pleasure to work with your company."

- *Louisiana Department of Health and Hospitals Program Manager*

Exhibit 11. Primary Care Case Management Contracts

Time Period	Location	Contracting Agency	Program
1994 – 2010	Pennsylvania	Department of Public Welfare	Family Care Network (FCN) program development and administration until 2005. In 2005, Pennsylvania enhanced its PCCM program to include expanded populations and services. The program name changed to ACCESS Plus.
2000 – Present	West Virginia	Department of Health and Human Resources	Physician Assured Access System Program
2006 – Present	Illinois	Department of Healthcare and Family Services	Illinois Health Connect Program
2010 – 2012	Louisiana	Department of Health and Hospitals	CommunityCARE Program

Our strategy is to use the following components to help states improve the access and quality of care delivered to enrollees while controlling costs:

- **PCCM Enrollment**: Process enrollments into medical homes from the phone, field and mail, and conduct outreach to those who have not enrolled. Develop an online enrollment module available 24/7 for web-based enrollment. As appropriate, link all enrollees with primary, preventive and behavioral health care providers who assure the availability of needed services while avoiding inappropriate care;
- **Coordinated Care Education**: Educate Medicaid potential enrollees and enrollees about coordinated care and the PCCM program through the use of well-trained call center and

"The Illinois Chapter, American Academy of Pediatrics believes that quality of care and cost control go hand-in-hand, and that through Illinois Health Connect, Illinois Medicaid has made significant strides in both areas with critical input and guidance from the provider community at every step in the process."

"Illinois Health Connect is a nationally-recognized model which created strong medical homes, ensuring that patients have access to a large network of providers while implementing controls that improve quality and reduce cost. The program has high satisfaction ratings among providers and patients. It includes the positive elements of managed care while avoiding those features that discourage medical providers from participating and frustrate patients and families."

- *Illinois Chapter, American Academy of Pediatrics*

field staff and supplement this education with superior member materials including letters, brochures, pamphlets, handbooks, etc. Educate providers about providing quality care through newsletters, available quality tools (e.g., panel rosters, quality profiles, etc.) and webinars;

- **Enrollee Relations**: Promote quality interactions with potential enrollees and enrollees through regular staff monitoring (for both phone and field staff), and develop sophisticated marketing approaches to engage potential enrollees and enrollees;
- **Outreach/Public Relations**: Work with community agencies to educate enrollees about PCCM through a Train-the-Trainer approach, participate in health fairs and community events, and target groups who provide services to special needs populations. Conduct outbound calling campaigns to increase awareness of PCCM programs and the need to select a PCP; and
- **Data Systems Development and Operations**: Develop a sophisticated health management application (HealthTrack) to log, track and process all facets of enrollments, PCP changes, and provide States with superior reporting capabilities for evaluation.

To briefly highlight the breadth of our capabilities with PCCM and our dedication to serving PCCM enrollees, a description of our work with the Illinois Health Connect Project follows.

IHC Project Summary

In 2006 we were selected as the Illinois Health Connect Project Administrator, and were accordingly charged with developing and implementing the roll-out plan for State's new PCCM initiative. During the implementation period we not only built a call center, customized HealthTrack and hired and trained staff, but we also recruited a network of over 5,000 medical homes to provide care for Medicaid eligibles.[2] On an ongoing basis, we are responsible for providing outreach, education, and enrollment assistance to new eligibles across the State and supporting providers serving as medical homes under Illinois Health Connect.

As a demonstration of our ability to implement sophisticated tools and interact with greater audiences, through this Project, we developed and launched the following provider tools:

Panel Rosters – [redacted]

Provider Profiles – [redacted]

[2] As of May 1, 2014 there were 5,666 medical homes enrolled with IHC, resulting in a total panel size of 5,416,766.

- **Provider Webinars** – We host a series of webinars to educate providers on timely and relevant topics several times a month.

By continuing to work with all key players and offering multiple avenues through which eligibles, providers, and stakeholders can reach PCCM staff, we have supported the Program's goals of: increased access to care, better coordination and continuity (and thus quality) of care, increased provider participation, and improved enrollee education and understanding about health-promoting behaviors.

Additionally, in December 2010, Illinois Health Connect was selected by the Campaign for Better Health Care as the recipient of the "Provider of the Year Award." Illinois Health Connect was selected as the 2010 award winner due to our work to ensure a medical home for 1.8 million patients.

We are a True Partner

As part of our work with Illinois Health Connect, we conducted several partnership activities beyond the scope of our contract (again, all at no charge), many of which involve data sharing initiatives. Examples of such coordination include:

1. Providing the Medical Homes Network (a coalition comprised of providers and hospitals in south Chicago sponsored by the Comer Foundation) with daily file transfers to identify the PCP for patients who present to the ED,
2. Providing data to CHIPRA to help target PCPs as part of the grant's efforts to develop standardized quality measures for children's health,
3. Providing data to the Assuring Better Childhood Development grant to target appropriate PCPs as part of grant activities focusing on improving care coordination between Early Intervention agencies and PCPs,
4. Proving data to the Bright Smiles Fluoride varnish grant to target appropriate PCPs,
5. Providing data to Regional Extension Centers so they can target PCPs from CMS' electronic medical record incentive programs, and
6. Transferring data on pregnancy status to the Family Case Management program to assist with care coordination efforts.

Medicaid Consumer Hotline Administration

We have ten years' experience with Medicaid Hotline administration through our Ohio Medicaid Consumer Hotline contract, which we acquired in 2002.

Exhibit 12. Medicaid Consumer Hotline Projects

Time Period	Location	Contracting Agency	Program
2002 – Present	Ohio	Department of Medicaid	Medicaid Consumer Hotline Services Project

Making full use of the corporate skills acquired during decades of call center management, in this contract we provide, in essence, one-call entry-point access to a host of Medicaid services (the State of Ohio offers approximately 50 different Medicaid-related programs to its residents – ranging from prenatal to long-term institutional care). The Medicaid Consumer Hotline has become recognized as the predominant "information clearinghouse" for callers regarding their Medicaid-related questions. CSRs consistently respond to the following types of inquiries:

- ABD Medicaid
- Billing
- Breast and Cervical Cancer Project
- Children's Buy-In
- Complaints/fair hearings
- Disability Assistance
- General Benefits
- Healthy Start
- HIPAA
- Home Health Care
- Long Term Care
- Managed Care Information Referral
- Medicaid Buy-In for Workers with Disabilities
- Medicare
- Medicare Part D
- Medicare Premium Assistance
- Premium Collection
- Prescription Coverage
- Prior Authorization
- Reimbursement
- Requests for applications
- Third Party Liability
- Tort

In this contract, our overall goals have been to help the State of Ohio achieve:

- More informed enrollees about their health care and programs available to them,
- More satisfaction with the Ohio Medicaid experience, and
- Accurate and timely processing of premium payments.

As part of this contract, we worked with the Ohio Department of Medicaid (ODM) to develop a robust premium collection system for two health care programs where enrollees who meet certain criteria are eligible to receive or maintain coverage by paying a monthly premium: the Medicaid Buy-In for Workers with Disabilities (MBI-WD) and the Children's Buy-In (CBI) Program. Through our operation of the Premium Collection Project, we also established all procedures and protocols necessary to ensure the timely and accurate exchange of data between

all involved systems. In cooperation with the State, we successfully implemented the monthly invoice/remittance slip mailing, daily file processing, monthly reconciliation, and day-to-day lockbox operations. We developed a fully secure system that is capable of tracking all facets of premium collection activities.

Further, in response to the State's budget tightening efforts, we assumed additional responsibilities (at no cost to the State), often to bridge gaps in services when various State-level departments were eliminated. These efforts included but are not limited to:

- Processing legislative inquiries in a prompt manner that relieves ODM of much burden associated with this task (while AHS provides ODM with the final responses for editing, ODM no longer must directly respond to these inquiries. Further, our average response time of 1.7 days is well under the five day allotted time);
- Researching issues associated with the Buy-In for the Medicare Premium program;
- Conducting pre-screening for prior authorization for medical services for enrollees who have waited beyond the 45 day mark;
- Screening, researching and providing tailored verification letters for enrollees to take to their providers who are experiencing difficulty billing for their services;
- Gathering date spans and case details for ODM to generate reports of claims paid on a enrollee's behalf;
- Educating callers on the process for TPL removal;
- Screening requests for the Direct Reimbursement Program;
- Responding to enrollee inquiries regarding mental health services benefits balance; and
- Preparing information and transferring to ODM requests for medical provider changes among enrollees in the Coordinated Services Program.

In 2012, we successfully merged this contract with our Ohio Enrollment Broker Project.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Our corporate groups are grounded in EPSDT, and over two million children under the age of 21 have received comprehensive preventive health services through the Programs we have administered in eight states.

Exhibit 13. EPSDT Contracts

Time Period	Location	Contracting Agency	Program
1979 - 1985	Maryland	Department of Health and Mental Hygiene	EPSDT member outreach and appointment scheduling
1980 - 2010	Pennsylvania	Department of Public Welfare	EPSDT program administration (provider and member outreach,

Time Period	Location	Contracting Agency	Program
			appointment scheduling, tracking, etc.)
1985 - 1990	Erie, Pennsylvania	PA Department of Health	Childhood Lead Poisoning Prevention Project
1983 - 1986	Indiana	Department of Public Welfare	EPSDT program development and administration
1993 - 1995	Hartford, CT	Department of Income Maintenance	Hartford HealthTrack (EPSDT) administration
1993 - 1996	Michigan	Department of Community Health	EPSDT member outreach for providers
1994 - 1998	Georgia	Department of Medical Assistance	Health Check (EPSDT) provider recruitment and member outreach
2006 - Present	Illinois	Department of Healthcare and Family Services	Healthy Kids provider and member outreach
2010 - 2012	Louisiana	Department of Health and Hospitals	KIDMED provider and member outreach

Our goals have been to help States achieve:

- Increased EPSDT rates among Medicaid enrolled children,
- Increased linkages to a primary care provider among children,
- Increased quality of care for relevant HEDIS indicators,
- Increased enrollee awareness of the services available to them, and
- Increased enrollee satisfaction with their care.

While our strategy has been carefully customized based on each State's unique needs and environment, we modeled our overall approach based on our work in Pennsylvania. Contracting for these activities with the State from 1980 - 2010, we coordinated all aspects of the program and centralized operations by:

- Establishing a sole point of contact for all enrollees, agencies and providers,
- Utilizing a computerized system and call center marketing capabilities to contact families and educate them about the Program and services available to them,
- Linking all enrollees to a participating provider,
- Providing transportation assistance services to help increase the show rate for scheduled visits, and

- Providing support tools including appointment scheduling and reminder services to assist providers with increasing EPSDT rates.

Exhibit 14. EPSDT Services Provided

KEY AREAS	PA	CT	MI	IN	MD	GA	IL	LA
Family Outreach and Education	✓	✓	✓	✓	✓	✓	✓	✓
Community Awareness	✓	✓		✓	✓	✓	✓	✓
Program Advocacy via Interagency Networking	✓	✓	✓	✓		✓	✓	✓
Staff Recruitment Training and Supervision	✓	✓	✓	✓	✓	✓	✓	✓
Provider Recruitment Training and Monitoring	✓	✓		✓	✓		✓	✓
Quality Assurance	✓	✓					✓	✓
Case Management (automated information & scheduling)	✓	✓	✓	✓	✓	✓	✓	✓
Referral and Follow-up	✓	✓	✓	✓	✓	✓	✓	✓
Claims Editing and Processing	✓		✓					
Statistical Analysis and Research	✓	✓	✓	✓	✓	✓	✓	✓
Report Generation	✓	✓	✓	✓	✓	✓	✓	✓

To highlight some of the EPSDT work we have performed in Illinois, in a single year, we:

- Reminded 239,854 households about well child appointments via inbound calls;
- Reminded 158,332 households about well child appointments via outbound calls,
- Reminded 375,012 households about adult preventive care, and
- Mailed 1,039,520 Healthy Kids reminder mailings 60 days prior to the recipient's birth date.

During this same time the IHC Quality Assurance Unit had 1,834 contacts with PCPs to help both increase the quality of care for relevant HEDIS measures and improve EPSDT rates. The quality education to PCPs includes the following topics: development screening tools, immunizations/vaccines for children, lead screening, vision screening, and well child care/EPSDT.

In 1983, we were awarded a contract to develop and administer Indiana's EPSDT program. Prior to awarding the contract to us, the State – having recently been sued for non-compliance with EPSDT – had 30 days to implement a functional EPSDT program. At the time, we were the only company in the country with the combined experience of provider network development, conducting client outreach and education, and providing EPSDT support services (e.g., appointment scheduling, transportation coordination, referral and follow-up, etc.) necessary to develop an operational program from scratch. Because of our expertise and experience, we were able to fully implement a statewide EPSDT Program within the court-ordered timeframe, thus saving the State a $10,000/day fine. We administered this program through 1986 when it was turned over to the State.

Enrollment/Eligibility Center Operation

We have six years' experience with enrollment/eligibility operations as detailed in Exhibit 15. We are committed to being a visionary among our competing healthcare administration firms in the midst of healthcare reform, and accordingly we are dedicated to moving ahead with the changing demands and experiences of healthcare. Below we highlight one Project that demonstrates our capacity with this type of effort.

Exhibit 15. Enrollment/Eligibility Center Contracts

Time Period	Location	Contracting Agency	Program
2008 – 2010	Wisconsin	Department of Health Services	BadgerChoice Support Center Project
2011 – Present	St. Louis	St. Louis Regional Health Commission	Gateway to Better Health Project
2012 – Present	Cook County, IL	Cook County Health and Hospitals System	CountyCare
2013 – Present	North Dakota	Department of Human Services	North Dakota Application and Eligibility Assistance

CountyCare Project

In January of 2012, Cook County Health and Hospitals System (CCHHS) together with the Illinois Department of Healthcare and Family Services (HFS) requested an 1115 waiver from the Centers for Medicare and Medicaid Services (CMS) to cover the current uninsured population that will become eligible for Medicaid in 2014. With a focus on enhancing the quality, coordination, and cost-effectiveness of the care provided to this population, CCHHS together with HFS demonstrated their commitment to providing access to and quality of care for an at-risk population in a cost conscious manner. Our direct experience with implementing Gateway to Better Health Project (a similar project for St. Louis, MO launched in 2011) made us an ideal

partner for the State to enroll New Medicaid Eligibles into a coordinated system of care[3], and accordingly in the fall of 2012, we were awarded a contract by CCHHS to provide eligibility and application assistance, enrollment, call center, provider network monitoring, utilization management, claims processing, and outreach services to a population of Childless Adults who will be eligible for Medicaid under the Affordable Care Act.

Activities completed or ongoing for this Project are highlighted below.

Client – Contractor Relationship Services

- Work closely with CCHHS during the implementation of the Project as a partner to put systems in place that drive transformation of their traditional public health and hospital system into an integrated managed network of services for its consumers.
- Share lessons learned from the St. Louis Project and based on this experience, made recommendations to CCHHS regarding strategies for the Cook County Project.
- Work with CCHHS to develop relationships with Project stakeholders and involve them in the implementation efforts as well as the ongoing operations of the Project.

Enrollee Services

- Perform targeted outreach and education to potential applicants who are currently uninsured and getting services from CCHHS to notify and screen for eligibility in the new program. Strategic telephonic outreach strategies include timed phone calls with effective, low literacy (6th grade level or lower), bilingual, high-quality, culturally competent scripting.
- Staff a call center equipped with culturally proficient representatives dedicated 100% to the Project who understand Illinois' Medicaid programs and are committed to supporting New Medicaid Eligibles in a "best-fit" PCP selection.
- Support Active Choice of a "best fit" PCP that functions not only as a gate-opener to promote the use of preventive as well as all medically necessary services, but also as a gatekeeper to reduce the inappropriate utilization of medically unnecessary care.
- Provide ongoing Enrollee Services functions such as referral education, coordination of benefits, explanation of covered services, etc.

Application and Eligibility Services

- Train field staff and call center representatives to be Application Assistors, completing the CountyCare Medicaid Waiver online application with applicants, and educating applicants on documentation requirements.

[3] Third Party Administrator Services for the Cook County Health and Hospitals System Proposal, September 2012

- Provide application assistance services in CCHHS hospitals and health centers and over the phone.
- Conduct eligibility documentation review to determine if documentation supports all required components to necessitate an approval for the CountyCare Medicaid Waiver application, and submit documentation to the State to make the eligibility determination.
- Train Application Assistors from in-network Federally Qualified Health Center sites, and select not-for-profit organizations to provide application assistance to potential enrollees, with over 500 Application Assistors trained County-wide.

Provider Services

- Develop a sophisticated Provider Portal available to network providers, providing electronic requests for Prior Authorization services, referrals, eligibility look-up, panel rosters showing patient panel assignments, and claims status.
- Provide needed education to providers to support optimal delivery of care via in-person assistance as well as over the phone through the Project's call center.
- Provide prior authorization services through our subcontractor, Permedion, to help ensure the appropriate utilization of care and services.
- Provide care coordination functions for patients discharged from both in-network and out-of-network facilities, ensuring a smooth transition of care and prevention of hospital readmission and/or unnecessary ED use.

IT/Systems Services

- Utilize our customized healthcare administration system (AHS' proprietary system is called HealthTrack) to complete all project tracking functions, including recording of all interactions via the call center and PCP enrollments.
- Provide full claims processing for medical, professional, institutional, and dental claims for services provided to CountyCare enrollees utilizing the AHS Claims Processing Unit and claims software provided by Beacon Technologies Group, Inc.

All such activities took place on an extremely aggressive timeline (AHS participated with a kick-off meeting with CCHHS on October 29, 2012, agreed to an expanded contract including an additional 100 FTEs on November 12, 2012, and went live with operations on November 30, 2013).

Overall this Project demonstrates several of AHS' key strengths, which are described below.

Ability to Respond to Increasing Call Volume without Compromising Performance

Similar to IHC, as this Project is new, there were no population estimates from which we could base staffing assumptions. Based on previous experience with call center operations, we developed a staffing model with appropriate flexibility to allow us to respond to initial inquiries. As the Project has continued, inbound call volumes have continued to increase, in fact **from March 2012 to August 2012 AHS' inbound call volume increased by 64%, and not only did our abandonment rates not increase, but they actually decreased from 7% to 3%.**

Ability to Successfully Implement an Expanded Scope of Work in an Accelerated Timeframe

On October 23, 2012, we were notified of our contract award for the CountyCare Project, and on October 29, 2012, we met with CCHHS to discuss the scope of services for the Project (the initial scope of work included enrollee services, provider services, network monitoring, prior authorization, and claims processing). In early November, the vendor's call center responsible for eligibility processing was shut down and AHS was asked to expand the contract and assume eligibility processing responsibilities. On November 15, 2012, we created a new implementation work plan to include the expanded scope of services – including an additional 100 FTEs. In the two week period from November 15, 2012 – 29, 2012, AHS:

- Developed enrollee materials,
- Developed scripting for staff,
- Developed approval letters,
- Developed all systems (including HealthTrack and website content),
- Developed the phone tree,
- Submitted all materials to CCHHS for review,
- Received feedback on all submitted materials,
- Updated the materials and script based on feedback from CCHHS, and
- Participated in a successful readiness review.

Despite the rapid execution of these contract activities (summarized in Exhibit 16 on the following page), we successfully launched the call center and website on November 30, 2012 – approximately one month after notification of contract award and two weeks after notification of an expanded scope of work.

Exhibit 16. CountyCare Implementation Timeline

Date	Implementation Activity
10/19/2012	Oral presentation for RFP
10/23/2012	Notification of Award
10/29/2012	Kick-off Meeting to Determine Scope of Services (e.g., Call Center Services, Referral Services, Claims administration) for Original Contract Components, requiring 23 FTEs
11/12/2012	Existing Eligibility Call Center Shut Down: AHS was requested to expand contract and assume responsibility for eligibility processing
11/15-20/2012	AHS developed Member Guide, script, approval letters, website content, HealthTrack design, and phone tree
11/20/2012	AHS submitted all materials to CCHS for approval
11/26/2012	AHS received feedback on all materials
11/27/2012	AHS updated materials and script, finalized phone tree and queues. AHS completed Readiness Review
11/29/2012	CCHS Board of Directors approved fund allocation for AHS contract
11/30/2012	Call Center and website Go-Live

Despite an accelerated implementation, we achieved considerable success with this Project.

Ability to Support Rapid Eligibility Processing and Decreased Administrative Burden on the State

We have implemented numerous workflows to support efficient eligibility processing, thereby decreasing the burden on the State. These include:

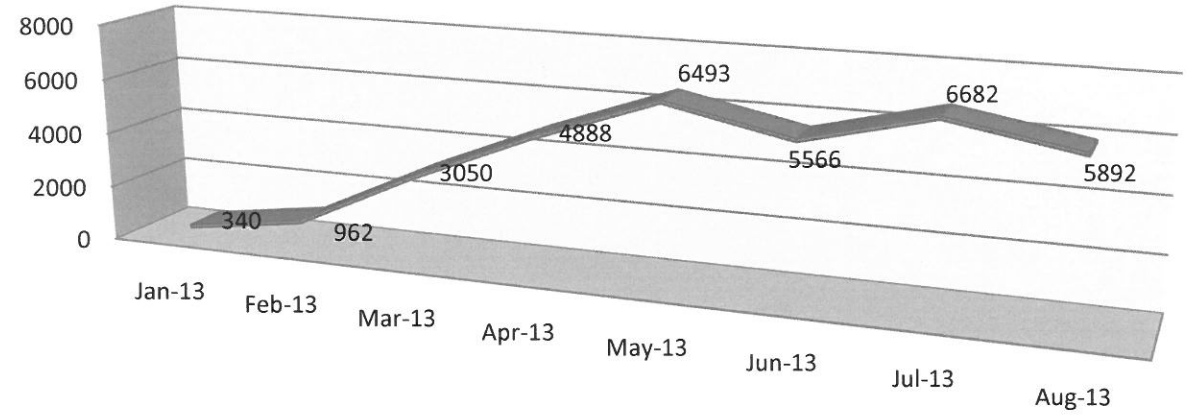
- Comprehensive review to ensure all documentation is attached prior to submission to the State,
- Comprehensive review to ensure applications are complete and correctly filled out, and
- Initial eligibility determinations to increase likelihood of successful determination.

Through these processes, our approval rating is approximately 90%.

Ability to Support Increasing Workload

We have dramatically increased the number of CountyCare applications submitted over a six month period, as evidenced in Exhibit 17 below.

Exhibit 17. Number of Applications Submitted



We have more than risen to the challenge of maximizing the number of individuals who apply for CountyCare.

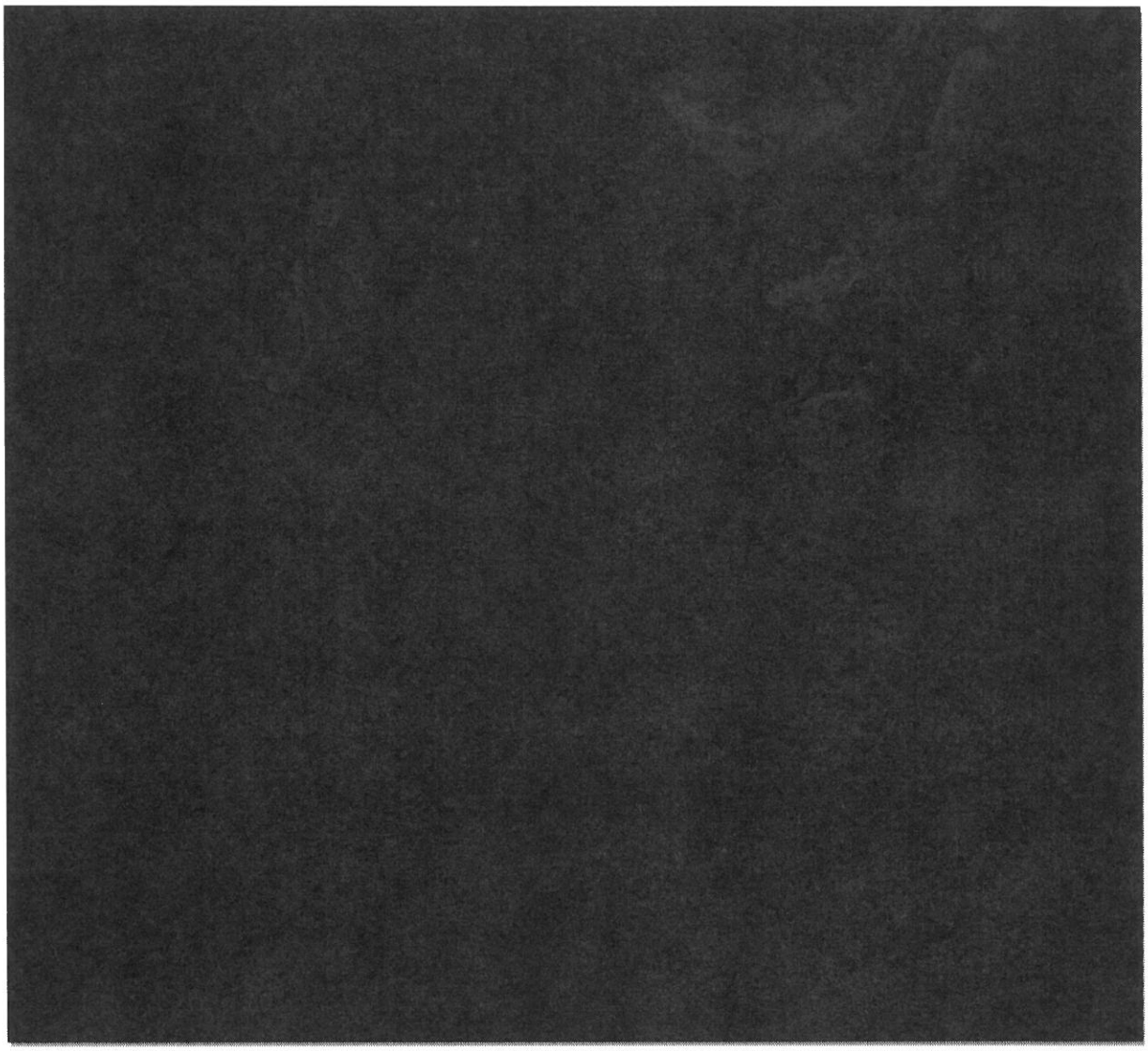
Ability to Develop Cutting-Edge Tools to Improve Project Operations

We developed a HIPAA-compliant "app" and workflow for Application Assistors working in the field that allows them to use their Smart Phone to:

[redacted]

Images of our app are provided in Exhibit 18.

Exhibit 18. CountyCare App Screens



By staying on the cutting-edge of technology, we have helped streamline operations, and increased the number of applicants we serve in the CountyCare Project, all of which ultimately helps increase access to care for enrollees.

State Children's Health Insurance Program (SCHIP)

As mentioned earlier in this section and detailed in Exhibit 19 below, we have 23 cumulative years' experience administering SCHIP contracts.

Exhibit 19. SCHIP Contracts

Time Period	Location	Contracting Agency	Program
1983 – 1986	Pennsylvania	Department of Health	Jobs Bill administration (medical portion) - a precursor to SCHIP that provided health insurance to newly unemployed and underinsured families
1989 – 1994	Pennsylvania	Department of Health	CHAPS Program - a precursor to SCHIP that provided EPSDT-like services to low income children
1999 – 2002	Hamilton County, Ohio	Department of Human Services	SCHIP outreach and application assistance
2000 – 2001	Cuyahoga County, Ohio	Department of Health and Nutrition	SCHIP outreach and application assistance
2001 – 2005	West Virginia	Department of Health and Human Resources	SCHIP Hotline
2003 – 2010	New York	Department of Health	Child Health Plus (SCHIP) Enrollment Hotline

In each of these contracts, while we have tailored our approach to the specific needs of the State, our overall goals have been to help states achieve:

- Increased awareness and enrollment into SCHIP programs,
- Timely processing of enrollments facilitated by application assistance,
- Lowered numbers of uninsured children, and
- Greater satisfaction with enrollee healthcare.

Within our New York hotline contract we consistently provided excellent customer service and also provided eligibility screenings as well as enrollment and renewal assistance for Child Health Plus (New York's SCHIP Program) hotline for seven years. As part of our responsibilities, we provided a convenient way for members to learn about New York health insurance programs, request mailed applications and information, and receive assistance with filling out paperwork or submitting needed applications. Additionally, we performed initial screenings for program eligibility and assisted callers with the completion of the Access New York (ANY) and Growing Up Healthy (GUH) applications and submitting needed documentation as needed and appropriate.

We have provided an overview of our SCHIP work as it illustrates our ability to engage with larger audiences than Medicaid recipients, explain various programs and eligibility criteria (and how these programs compare to Medicaid), and facilitate enrollment into the correct program.

Vaccines for Children

We ventured into providing VFC services as an offshoot to our work with EPSDT and the Family Care Network (FCN) in Pennsylvania. Since we were already interfacing with a large number of family practice and pediatric providers, we were asked to incorporate the VFC Program into our other Pennsylvania operations by the Pennsylvania Department of Health and Department of Public Welfare late in 1995. We then used the model we developed for Pennsylvania in our New Jersey effort.

Exhibit 20. Vaccines For Children Contracts

Time Period	Location	Contracting Agency	Program
1995 – 1998	Pennsylvania	Department of Health	VFC program development and administration
1998 – 2005	New Jersey	Department of Health	VFC program development and administration

In each of these contracts, while we have tailored our approach to the specific needs of the State, our overall goals have been to:

- Enroll providers (as appropriate) into the Vaccines for Children program;
- Provide assistance with inventory management and inventory tracking of vaccines (including number of each vaccine administered, returned, etc.);
- Provide quality assurance activities related to vaccine administration (including how many were administered for each age group, etc.);
- Provide in-person or phone based assistance to providers in understanding and adhering to vaccines administration; and
- Increase quality of care as related to vaccines.

Provider Certification

As a logical extension of our provider relations work conducted on behalf of our PCCM and Enrollment Broker Projects, we have recently obtained a contract to perform pre- and post-enrollment site visit screening requirements for moderate and high risk providers in accordance with the Centers for Medicare and Medicaid Services (CMS) provider screening and enrollment requirements in the State of North Dakota.

Exhibit 21. Provider Certification

Time Period	Location	Contracting Agency	Program
2014 - Present	North Dakota	Department of Human Services	Provider Pre- and Post-Enrollment Site Visit Screening

Corporate Skill Set

Our experience administering our current contracts represents only the tip of the iceberg in terms of our experience and capabilities. Our true expertise and unique offerings lay in our full involvement with what we consider to be four integral components of exceptional programming:

1. Workforce Development,
2. Project Design, Development, and Implementation,
3. Outreach, Education, and Material Development, and
4. State-of-the-Art IT Development.

1. Workforce Development

Our experience with workforce development includes the following components:

- Experience Hiring Staff, and
- Experience Developing Comprehensive Training Plans.

Experience Hiring Staff

We have successfully forecasted the staffing models needed for each contract, recruited, screened and hired appropriate staff for all aspects of the Project. Such positions have included not only Project management and call center staff, but also, when needed and appropriate, field-based outreach staff, special needs clinical staff, training and quality assurance staff, as well as support and clerical staff. Further, we have experience hiring and training staff in short periods of time. Not only have we been able to quickly respond to tight timeframes to hire staff for major expansions, but we have also been able to hire and train temporary staff quickly and efficiently when needed for busy periods such as open enrollment, program expansions or media campaigns.

Experience Developing Comprehensive Training Plans

In all of our contracts, we have successfully developed training plans in conjunction with our State partners, and ensured that training addressed the numerous topics needed for successful contract administration including but not limited to:

- Understanding the history of the State's Medicaid and Medicaid and related programs,

- Understanding the roles of the State,
- Processing all enrollment related activities,
- Using all relevant AHS and State systems,
- Understanding outreach, adhering to HIPAA, the HITECH Act and AHS' requirements for confidentiality,
- Reporting and processing suspected fraud and abuse,
- Maintaining quality, and
- Serving special needs populations, etc.

The development of training plans has included initial training curriculums, ongoing refresher trainings, and quality assurance trainings. We have even coordinated with major universities for staff certification when needed.

2. Project Design, Development, and Implementation

AHS' experience with Project Design, Development, and Implementation includes the following components:

- Experience with Project Implementation,
- Experience with Developing and Implementing Quality Assurance Programs,
- Experience with Reporting,
- Experience Serving Enrollees with Special Needs, and
- Experience with Implementing Special Projects.

Experience with Project Implementation

We bring three decades of experience developing and implementing programs that meet the needs of the states we serve. The success of our method is best demonstrated in two recent implementations.

- Louisiana CommunityCARE and KIDMED Project Implementation
  In February 2010, we were notified of a May 1, 2010 Go-Live date for our Louisiana PCCM Project. Within a three month period, we worked with the State to complete all necessary tasks related to start-up. These tasks included

DID YOU KNOW?

In approximately two weeks, we implemented our North Dakota Application and Eligibility Assistance Project. In approximately one month, we implemented the CountyCare Project, which involved an expanded scope of work and hiring an additional 100 FTEs!

but were not limited to:

- Meeting with the Louisiana Department of Health and Hospitals to explore our readiness for launch;
- Coordinating cut-over procedures for three helplines to ensure enrollees and providers had seamless, uninterrupted service;
- Collaborating with the Fiscal Agent, to establish the necessary file transfer processes for member eligibility, provider linkage data, MMIS access, and EPSDT reports;
- Customizing our internal systems to meet the current and expanding needs of the Project;
- Enhancing the website to provide an updated look and a specialty care provider search;
- Completing build out operations in two locations: our corporate office in Pittsburgh, PA (where the call center was located) and Baton Rouge, Louisiana (where the Project's administrative office was housed); and
- Hiring and training management, call center, and provider relations staff.

Go-Live was indeed a success. During our first month of operations, we answered 25,891 calls and over 96% of these calls were answered in less than 120 seconds. Additionally, during our first month of operations, we completed nearly 600 EPSDT reminder calls, responded to over 3,800 provider inquiries for assistance, and processed nearly 1,500 faxes for hospice services (including hospice recipient/election/cancellation/ discharge notices, certification of terminal illness and prior authorizations).

- Florida Medicaid Reform Enrollment Broker Implementation

  In February 2010, we were notified of a June Go-Live date for our Florida Medicaid Reform Enrollment Broker Services Project. Within four months, we completed all necessary tasks to successfully operate the Project. While all activities (e.g., completing facility build-outs, hiring and training staff, developing systems, developing materials, etc.) were completed under tight timeframes, our takeover process was indeed a smooth one. **On our first day of Go-Live we maintained less than a 1% abandonment rate for all calls.**

Experience with Developing and Implementing Quality Assurance Programs

Our commitment to quality is not merely on paper, or even relegated to a single department. Rather it is a value, imbued Project-wide, that is shared among all staff. It is reflected in all we do – from hiring and retaining talented, motivated staff; building world-class, sophisticated IT solutions; developing outstanding materials that positively promote programs to striving for excellence in every phone call, letter and even every internal e-mail – we strive for excellence. **We often take on additional quality initiatives above and beyond the scope of the contract**

in order to improve the services afforded to potential enrollees and enrollees and wherever possible, save the State valuable dollars.

Perhaps nowhere better is this illustrated than our Pennsylvania PCCM program, where we experienced several notable improvements in our HEDIS results, including:

- Immunizations,
- Well care (ages 3-6 years),
- Dental visits (ages 2-21 years),
- Access to care (ages 45-64 years), and
- Chlamydia screening.

Even in instances when we are not responsible for HEDIS measures, we still implement robust quality assurance programs. For all of our contracts we craft individualized quality assurance programs based on each project's specific contractual obligations. Quality assurance programs specify the distinct monitoring requirements for each position, corrective actions if performance is not achieved (e.g., corrective and refresher trainings, mentoring, and, if needed, a corrective action plan), and also determine each staff's role for ensuring quality customer service.

Within our Florida Medicaid Enrollment Broker project, we are responsible for mailing over 110 different letters each month. During our six month implementation period we:

- Received approval for all letters, and
- Acquired the business rules for each letter, and successfully programmed letters into our system.

As a result of our approach, we successfully mailed approximately 200,000 letters during our first full month of operations.

Experience with Reporting

In all of our contracts, we develop and produce a wide variety of reports to meet the needs of our State partners. Reports are comprehensive and designed to cover all facets of our contract operations. Not only do we produce reports on common data elements (e.g., call center metrics, enrollment statistics, mailroom activity, etc.), but we also produce reports on a variety of more complex program areas when needed.

Experience Creating Processes to Serve Enrollees with Special Needs

We have developed numerous mechanisms to provide effective counseling and enrollment services to enrollees with special needs. These have included direct outreach and enrollment sessions to agencies that serve special needs enrollees (including involving family members and case workers in the choice process), Train-the-Trainer sessions with special needs agencies, specialized staff to provide additional research and support to enrollees with complex needs,

specialized scripting to account for various scenarios and specialized training for staff to handle escalated needs.

Experience Implementing Special Projects

Whenever possible, we look to develop innovative special projects that bridge gaps in service, help improve access to care and quality of care, and support cost saving strategies. For example, we implemented a comprehensive Emergency Department (ED) Reduction Program in the Pennsylvania ACCESS Plus PCCM Program in 2007 to reduce unnecessary ED use, by providing resources to enrollees, providers and hospitals. The interventions were three-fold and included:

- **Call Center Intervention**. The Call Center Intervention identified enrollees with high ED utilization and increased the percent of enrollees with high ED use seen by the PCP by asking about ED usage for all household members and facilitating appointment scheduling as needed.
- **Mailings Intervention**. The Mailings Intervention increased the percent of enrollees who understood which conditions warranted treatment in the ED by sending enrollees with high ED use (identified through a weekly claims analysis) a mailing on appropriate ED use.
- **Care Coordination Intervention**. The Care Coordination Intervention increased the percent of enrollees with high ED utilization who followed-up with their PCP, increased the percent of providers who were aware of their patients who regularly sought treatment at the ED, and increased the mechanisms through which enrollees were outreached and educated. These goals were accomplished through a series of reports targeted to hospitals, providers, and the PCCM program that were used to identify enrollees with high ED utilization for outreach, education and follow-up.

The program was indeed successful. From 2006 to 2009, the ED visits per 1,000 member months among the total PCCM population decreased 34.8% (Exhibit 22). Further, ACCESS Plus compared favorably relative to the MCOs (Exhibit 23). With national estimates suggesting that the median expense for an ED visit of $299 (the average is approximately $560) is more than twice the median expense for a hospital outpatient visit ($131) and nearly five times an office-based visit ($63), the potential for cost savings is staggering.[4]

[4] Agency for Healthcare Research and Quality. Medicaid Expenditure Panel Survey, Statistical Brief #111. January 2006.

Exhibit 22. Decrease in ED Rates Among ACCESS Plus Members Per 1,000 Member Months

2006	2007	2008	2009
61.08	55.32	37.76	39.85

Exhibit 23. HEDIS Rates of ACCESS Plus vs. MCOs for ED Visits

	2008	2009
ACCESS Plus	37.76	39.85
MCOs	71.15	73.88

Exhibit 24. Estimated Median Costs of Care

Care Type	Median Cost
ED	$299
Hospital Outpatient Visit	$131
Office Visit	$63

3. Outreach, Education, and Materials Development

Our experience with outreach, education, and materials development includes the following components:

- Experience Developing and Mailing Materials, and
- Experience with Outreach and Education Campaigns.

Experience Developing and Mailing Materials

For all of our projects, we have produced materials and generated mass mailings. We have developed countless materials, all with appealing designs and at appropriate literacy levels. Examples include but are by no means limited to: enrollment packets, enrollee handbooks, plan comparison charts, reminder and confirmation letters, provider directories, and provider handbooks. We invite you to check out sample materials on each of our Projects' websites. (Please refer to Section 4.1.18 for more detail on the MHT Project website.)

Going hand in hand with our materials development expertise is our longstanding success mailing large volumes of program materials according to our contract standards. Unlike many vendors who subcontract their mailing responsibilities, we directly mail all materials ourselves, which allows us to maintain more direct control over mailing activities and prevent inadvertent breaches of confidentiality due to issues with file transmissions. With a sophisticated IT solution and state-of-the-art equipment, we are well-equipped to meet all Project mailing needs.

Experience with Outreach and Educational Campaigns

We have extensive experience with outreach and educational campaigns. Over the last three decades, we have worked with increasing effectiveness to outreach and educate low-income

individuals and families, and enhance their awareness and appropriate utilization of large-scale publicly funded health services. For a detailed description of our outreach work in West Virginia, please refer to Section 4.1.

4. State-of-the Art IT Development

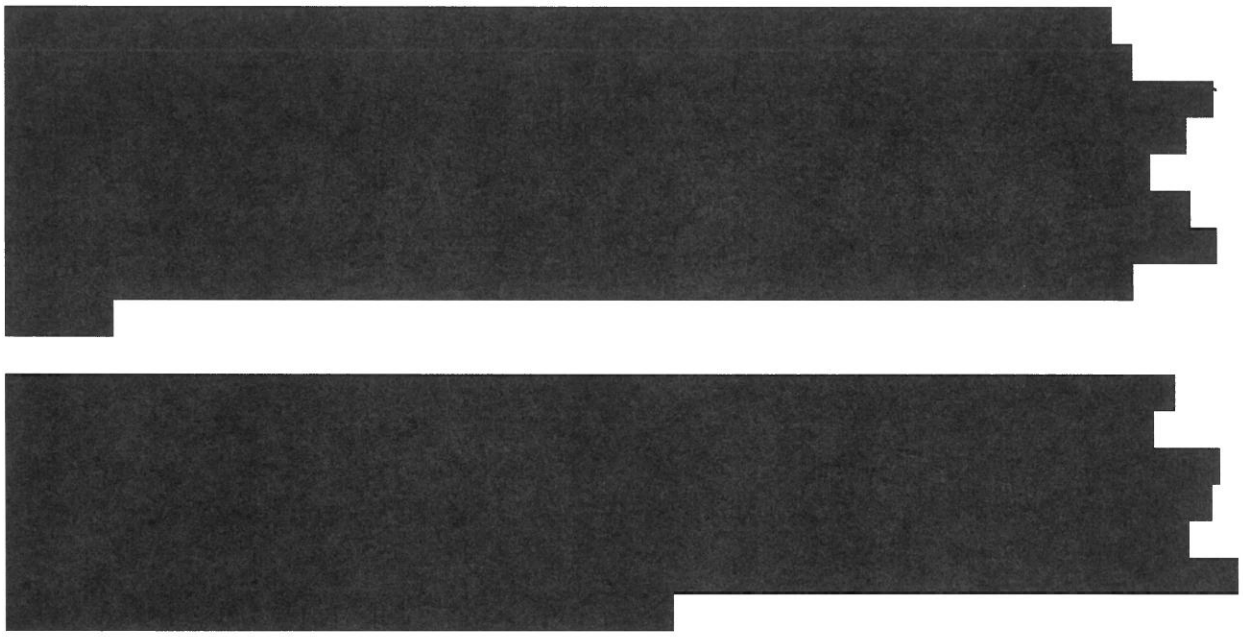
Throughout our corporate history, we have designed systems that meet the ever changing needs of the large-scale Medicaid and SCHIP programs we administer. To briefly highlight two recent examples:

Our Florida client has been so impressed with our technical capabilities, specifically HealthTrack, that all the local county and state headquarter staff are now using our HealthTrack system as the primary enrollment information system.

Florida Medicaid Reform

We successfully launched our Florida Medicaid Reform Enrollment Broker operations in 2010. We completely customized and expanded our HealthTrack system for the Florida Project in order to accommodate the complex requirements in the State. Our enrollment processing algorithm has to take into account various eligibility scenarios, allowing users and supervisors to override depending on the circumstance (per state requirement), and allow for at least three different enrollment workflows in our system due to special plans and eligibility.

[redacted]



Not only did we successfully implement the entire Florida Enrollment Broker project on time, but we also received rave reviews from the state staff with whom we worked with during implementation. In fact, the Project has been so successful, that the State has recently amended our contract to **expand our Enrollment Broker services statewide**.

Florida Medicaid Options

In 2011, we were asked to expand our enrollment broker operations from the five county service area for Medicaid Reform into the 62 remaining Medicaid Options counties in the State of Florida and provide services to a total population of 3.3 million eligibles. As part of this expansion we made the programming changes necessary to accommodate the nearly three million additional enrollees, additional MCOs, various enrollment processing requirements, mailings (the expansion required over 50 different letters), and operational changes. We collaborated with the State at every step of the process to (please note the list below is not exhaustive by any means):

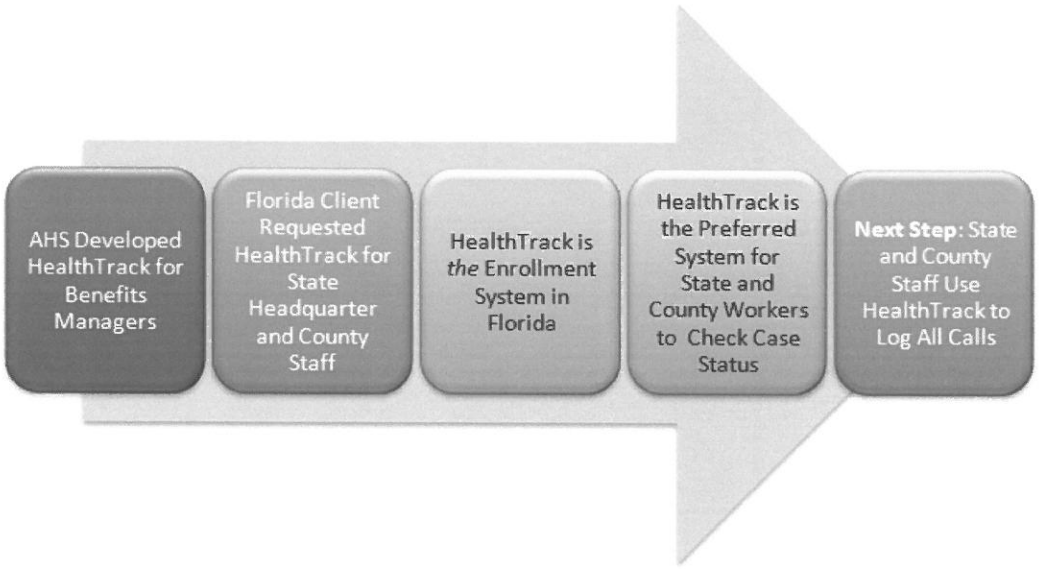
- Receive and process all new data files (including special conditions file and recipient files) to accommodate the newly expanded file specifications and requirements,
- Update the auto-assignment process for all counties, including county-specific requirements and a much larger expanded MCO and Provider network, including the State's PCCM program (MediPass),
- Establish connectivity and file exchange protocol with all new MCOs,

[redacted]

- Program all new mailings and update the HealthTrack Mail Console to not only address the increased volume and letter complexity, but also to simplify and increase productivity of our Mail Fulfillment Center operations,
- Refactor HealthTrack's Enrollment Wizard to handle the much more complex enrollment business rules,
- Program all new reports customized to the specific State program (Reform, Options, MediKids, etc),
- Update and take over the management of the Medicaid Options website,
- Implement Online Enrollment for the statewide Medicaid Options enrollees, and
- Build a new "HealthTrack Web" edition to accommodate the large increase of State users in different security roles that need to access our HealthTrack system.

We are particularly proud of our work in Florida, as it has not only allowed us to provide excellent service to Medicaid enrollees, but it has provided the State with a solution to their problems with enrollment broker systems. We are excited to bring many of these tested and proven features to the West Virginia Project (for additional details, please refer to Section 4.3.6.1). Florida's enrollment broker system operated outside the State's MMIS system for over ten years, and in 2008, the State began conducting all enrollments through the MMIS system, which resulted in delays for enrollments due to inefficiencies in the system. Recognizing the work of AHS and the flexibility and scalability of HealthTrack, in 2010 when we implemented the Medicaid Reform Enrollment Broker program, **the State requested that HealthTrack be used as the system for all enrollments for not only our staff, but State and county staff as well.**

Exhibit 25. Expansion of HealthTrack in Florida



Recognizing the numerous benefits of HealthTrack, the State of Florida has been very excited to implement the system for its State and county workers.

Further, HealthTrack has already proven its ability to expand and support additional users, while being completely customized to meet specific business rules for various programs. Initially developed for AHS' Medicaid Reform Choice Counseling staff (77 users), the system has been installed for the following enrollment broker programs: Medicaid Options (June 2011), MediKids (September 2011), and Prepaid Dental Health Plan enrollment (November 2011). Currently supporting over 500 users, the system has received rave reviews by AHS, State and county users alike.

Additionally, as HealthTrack truly represents a "best of breed" solution that was developed by experts in the enrollment and call center operations, it is not part of a larger conglomerate system; yet, it interacts and interconnects with other systems easily. All such qualities are aligned with MITA principles, including the ability to exchange information in real-time with other systems, adhering to common standards, and seamless interoperability with other systems and organizations.

References

AHS provides the following references:

Client Reference 1: Florida Enrollment Broker Project

Exhibit 26. Florida Medicaid Enrollment Broker Project Reference Information

Client Name and Address	Agency for Health Care Administration Medicaid Contract Management 2562 Executive Center Circle E Montgomery Bldg, Suite 100 Tallahassee, FL 32301
Primary Contact	Damon Rich AHCA Administrator Medicaid Contract Management 2562 Executive Center Circle E Montgomery Bldg, Suite 100 Tallahassee, FL 32301 805-412-3448 Damon.rich@ahca.myflorida.com
Time Period of Project	2010 - Present

Client Reference 2: Ohio Medicaid Hotline Project

Exhibit 27. Ohio Medicaid Hotline Project Reference Information

Client Name and Address	Ohio Department of Medicaid 300 East Broad Street Columbus, OH 43215
Primary Contact	Jim Poremba Senior Contract Administrator 30 East Broad Street, 31st Floor Columbus, OH 43215 614-752-4559 James.poremba@medicaid.ohio.gov
Time Period of Project	1998 - Present

Client Reference 3: Illinois Health Connect Primary Care Case Management Project

Exhibit 28. Illinois Health Connect Primary Care Case Management Project Reference Information

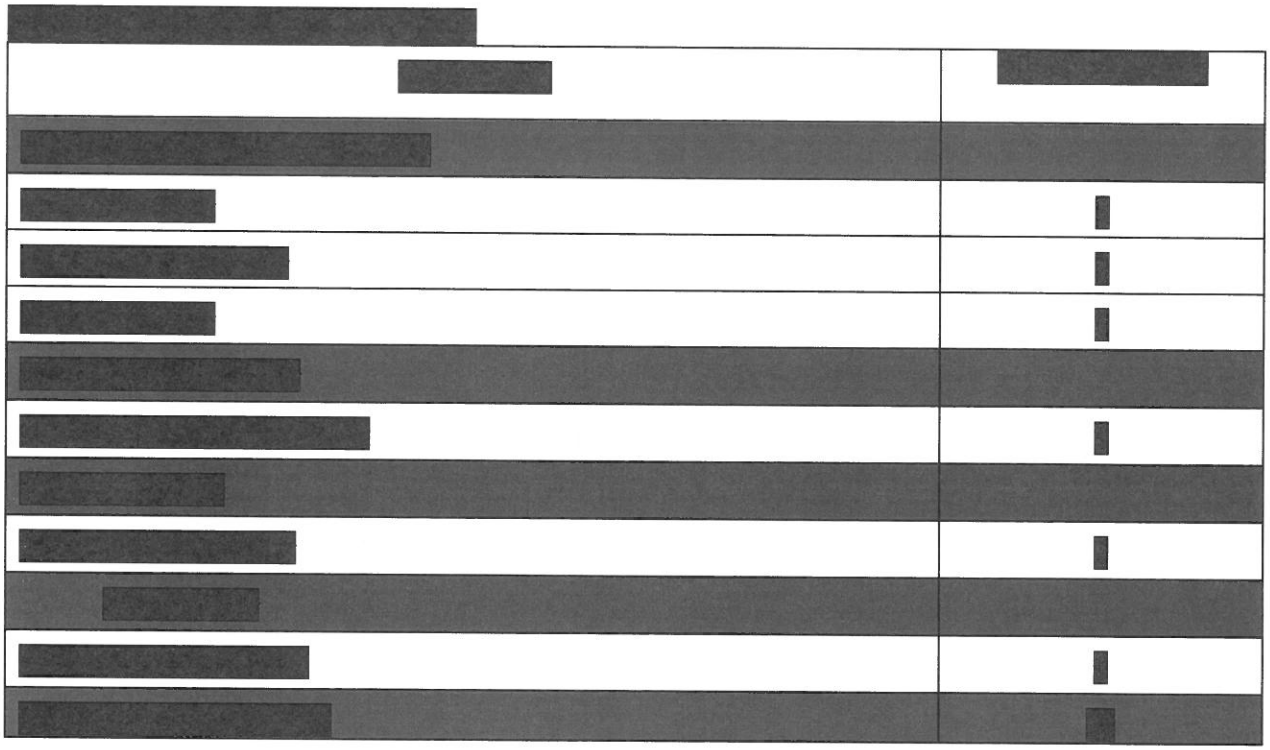
Client Name and Address	Illinois Department of Healthcare and Family Services Bloom Building 201 South Grand Avenue, East Springfield, IL 62763
Primary Contact	Amy Harris-Roberts Bloom Building 201 South Grand Avenue, East Springfield, IL 62763 217-524-7163 Amy.Haris-Roberts@illinois.gov
Time Period of Project	2006-present

Staff Certification and Degrees

Please refer to Appendix C for resumes of key staff for the MHT Project.

Proposed Staffing Plan

A summary of our proposed staffing plan follows below in Exhibit 30. Please refer to Section 4.4 for a detailed description of our approach to staffing the Project, to Section 4.1.15 for a description of our approach to providing field staff, and to Section 4. 2.15 for a description of our approach to staffing the telephone unit.



Descriptions of Past Projects Completed

We are pleased that the overwhelming majority of our projects are continuing (please refer to the narrative described earlier in this section). Below follows a summary of three projects that have been completed:

1. Illinois Client Enrollment Broker,
2. Louisiana CommunityCARE and KIDMED, and
3. Pennsylvania Primary Care Case Management.

Project #1. Illinois Client Enrollment Broker Project (ICEB)

Project Summary

We provided comprehensive, unbiased phone- and field-based outreach, education, and enrollment services to enrollees residing in counties where risk-based managed care and PCCM are jointly offered, which include Adams, Brown, Cook, Henry, Jackson, Kane, Lee, Madison, McHenry, Mercer, Perry, Pike, Randolph, Rock Island, Scott, St. Clair, Washington, and Williamson counties from 2006 - 2013. We also provided comprehensive mailings, including initial New Enrollment Welcome mailings, enrollment reminder letters, and auto-assignment confirmation letters. Our ICEB Project website included not only all of our educational materials and a calendar with links to our outreach events, but also a robust, secure online enrollment module. Operated from our Schaumburg office, the goals of the Project were to:

1. Successfully launch Illinois Medicaid managed care program,
2. Serve all populations, and
3. Achieve all service level agreements.

See What ICEB Clients Said About Our Customer Service

"I want to compliment [AHS' CSR] on her amazing customer service. I have never felt so comfortable, respected and cared about while being on the phone with a CSR."

"I want to compliment [AHS' CSR]. He did a wonderful job of explaining everything to me and I felt that I was thoroughly educated. [AHS' CSR] really touched my heart with his kindness today."

"I had wonderful service from [AHS' CSR]. I am pregnant, very irritable and very confused about the need to enroll and the difference between the Health Plans. [AHS' CSR] was informative, patient and did not mind my repeated questions."

Project Achievements

Successfully Launched a New Managed Care Model

In 2007 we worked closely with the State to effectively outreach to stakeholders regarding the transition to the new managed care delivery model. The State's previous attempts to implement Medicaid managed care were not successful, and our work with community agencies, providers, potential enrollees, and enrollees supported a smooth and successful transition to managed care.

Successfully Expanded into New Geographic Areas

Since our contract started in 2006, we expanded geographically and provided services for additional MCOs. The initial ICEB Project focused on the Cook County (Chicago) area, and by the end of 2007, we expanded to the southern regions (including Washington, Williamson, St. Clair, Perry, Randolph, Madison, and Jackson counties). By the end of 2008 as Meridian provided services in the Northwest/Central regions, we began providing ICEB services in Scott, Rock Island, Pike, Mercer, Henry, Brown, and Adams counties. We also accommodated the expansion of Meridian Health Plan into Cook County in July 2010. When Harmony Health Plan moved into Kane County in 2010, we began providing services in that county as well. Last, we most expanded into Lee and McHenry counties in 2011.

Successfully Expanded to Include the AABD Population (Integrated Care Program)

In March 2011, we assumed enrollment broker responsibilities for the AABD population. To ensure high service delivery to the approximately 40,000 eligibles included in this special needs population, we reached out to Enrollment Facilitators (community partners responsible for assisting eligibles with enrollment selection and enrollment), coordinated the completion of contracts and Business Associate Agreements, and trained and provided follow-up assistance to Enrollment Facilitators. In addition, all information technology activities, such as coordinating file transfers and updating systems, were coordinated with the State in advance of the expansion. We hired an additional 40 customer service staff, who were provided with State-approved training regarding both the operational details as well as refresher trainings on more "soft" skills such as customer service training. We also programmed and incorporated a sophisticated auto-assignment algorithm for those AABD enrollees who do not make a voluntary selection.

Maintain Outstanding Performance Levels

As with all our projects, we maintained impressive performance levels throughout this contract. We processed a high volume of enrollments, plan changes, inquiries, etc. all with a 0% blockage rate and low abandonment rate. (Our abandonment rates are consistently less than 5% - a mark well under our contract performance standard of 7%.) Further, we exceeded contract standards by supporting the MCOs in their provider recruitment efforts (e.g., we sent the names of any

provider had been requested by an enrollee but was not participating in the ICP to the MCOs for recruitment.)

Project Manager Name and Contact Information

Ms. Christine Cazeau currently oversees all Projects from our Illinois office, and can be reached at the contact information below:

Exhibit 30. Project Manager Name and Contact Information

Name	Ms. Christine Cazeau
Mailing Address	1375 E. Woodfield Road, Suite 600 Schaumburg, IL 60173
Phone	847-610-8422
Email	ccazeau@automated-health.com

Project #2. Louisiana CommunityCARE and KIDMED

Project Summary

We administered the State of Louisiana's CommunityCARE and KIDMED Programs (PCCM and EPSDT) from 2010 – 2012 when the state elected to move to a Medicaid coordinated care model. In addition to providing extensive outreach, mailings, and telephonic support to the State's potential enrollees and enrollees regarding a medical home selection, as part of our responsibilities we served the State's 900 providers by performing:

- New site certifications,
- Annual site certifications
- Routine provider visits,
- Trainings,
- Verification of 24 hour coverage, and
- Quality assurance support.

To complete this scope of work, in addition to customer service staff for the Enrollee Call Center, we hired a team of Provider Representatives to provide overall programmatic guidance, recruitment, and certification activities combined with a team of QI Nurses to provide all clinical/quality activities. Operated from our Baton Rouge office, the goals of the Project were to:

1. Administer a high-performing call center,
2. Achieve positive relationships with providers,
3. Help transition the CommunityCARE Program to new delivery systems, and
4. Enhance the enrollee experience for the Project.

See What Louisiana Callers Said About Our Customer Service

"You are always so professional and I can always count on you to help me."

"Your personalities beam on the phone! You are always wonderful and pleasant and ton top of things – no matter when I call to ask a question, you are always diligent and get the job done."

"I am amazed you answer in three rings and your staff is so gracious. Everyone is so kind and it is like talking with family."

"The hold time to speak to a live voice is only a minute or so! This is such a huge improvement from what the previous vendor did, when the average hold time was 50 minutes or more!"

Project Achievements

Improved Call Center Performance Relative to Previous Vendor

We revisited the organization and queue structure for the call center, and were able to successfully improve call center performance, for both the enrollee and provider queues. In fact, we decreased hold time by over forty minutes compared to the previous vendor!

Achieve Positive Relationships with Providers

There are two primary ways we demonstrated our positive relationships with providers. First, through our successful collection of the Project's Attestation Forms, and second through our comprehensive monitoring of providers.

Attestation Form Collection

When the State transitioned to the enhanced PCCM Program called CommunityCARE 2.0 (CC 2.0), all providers wishing to participate in the enhanced program were required to submit an Attestation Form. Our field-based Provider Representatives were instrumental in securing 95% of the Attestation Forms within the first two months of the initial notification to providers, which allowed DHH to meet its first quarter 2011 P4P payment schedule.

After Hours Monitoring

We launched the after-hours monitoring process to verify 24-7 coverage for all providers and provided additional training on the standards for failed providers. **We completed monitoring for 100% of providers.**

Supported Providers in the Transition to New Programs

We supported the Louisiana Department of Health and Hospitals (DHH) in the rollout of two important program changes, which shaped providers' scope of work. The first was the transition of the State's original PCCM Program, CommunityCARE to CommunityCARE 2.0 (CC2.0), an enhanced model that included Pay for Performance (P4P) measures. We provided education, mailings, trainings, and reports to assist with maximal participation under the new program. The second was the transition to BAYOU HEALTH, the State's full-risk Coordinated Care Networks model. Again, we provided targeted education and outreach to promote optimal participation in the new program.

Enhance the Enrollee Experience

We enhanced the enrollee experience through an updated Project website and redesigned enrollee materials as described below.

Launched an Enhanced Project Website

We launched a new Project website that included an updated look and a specialty care provider search to provide additional services to potential enrollees/enrollees.

Redesigned Enrollee Materials

Upon contract award, we redesigned the existing enrollee communications to more effectively carry Project messages, including Medicaid, CommunityCARE and KIDMED program information. As an integral component of enrollee outreach and education, our goal was to create materials to not only inform and educate enrollees, but also to provide a cue to action (e.g., voluntarily select a "best-fit" medical home).

Project Manager Name and Contact Information

Ms. Janet Pritchard was the Project Manager for the CommunityCARE Project and can be reached at the contact information below:

Exhibit 31. Project Manager Name and Contact Information

Name	Ms. Janet Pritchard
Mailing Address	9370 McKnight Road Pittsburgh, PA 15237
Phone	412-367-3030 ext 2201
Email	jpritchard@automated-health.com

Project #3. Pennsylvania EPSDT and Primary Care Case Management

Project Summary

We performed enrollee education, outreach and customer services as well as provider recruitment, enrollment, certification, screening, and education activities for the Commonwealth of Pennsylvania for the Commonwealth's Early Periodic Screening Diagnosis and Treatment (EPSDT) from 1980-2010and Primary Care Case Management (PCCM) programs from 1994-2010.

EPSDT

From 1980 – 2010, we recruited, trained, maintained and evaluated health care facilities for EPSDT enrollment. (We also coordinated EPSDT activities with local public welfare departments and other health and human service to promote participation.)

We were responsible for providing ongoing support to the EPSDT providers to increase their EPSDT screening rates. Although the providers did not have a panel, they did establish guidelines on the number of patients they would accept and the appointment times for screenings, etc. To help improve rates, we mailed monthly "Screen Due" Reports according to the Commonwealth's periodicity schedule.

We were also responsible for EPSDT screening "quotas" in each county to achieve the statewide EPSDT goals. We monitored the show rates (i.e., number of patients who attended the scheduled appointment) and the number of scheduled appointments. In areas where there were shortages of EPSDT providers, we created "screening clinics", where we certified the location, recruited a provider, and scheduled appointments.

As part of this contract we also:

- Created the first ever statewide toll-free helpline (1-800-KIDSMED) for EPSDT,
- Processed all EPSDT forms and data entered the information to send to the Commonwealth for payment, and
- Conducted quality assurance reviews on the EPSDT data.

PCCM

As part of our work in Pennsylvania, we also support the transition to the State's first PCCM Program, the Family Care Network. We outreached to enrollees, established a toll-free helpline, networked with stakeholders, and built the provider network from zero to 1,600 providers when the Commonwealth elected to implement this program in 1994. In 2005 when the

Commonwealth moved to an enhanced PCCM program called ACCESS Plus that included disease management and pay for performance measures and served an expanded population, we:

- Strengthened outreach and recruitment efforts for primary care providers and specialists,
- Streamlined enrollment processes,
- Conducted site visits to each provider office (during recruitment, enrollment, and as a part of ongoing program participation),
- Resolved provider barriers to participation,
- Monitored network adequacy and shortage areas,
- Verified provider compliance with program participation requirements, and
- Implemented provider retention strategies to maintain a strong network.

Based on these processes we successfully expanded the network to over 2,500 providers, a strong achievement given the largely rural nature of Pennsylvania.

See What Providers Said About Us:

An ACCESS Plus PCP Office Manager stated that our Provider Relations Representative was the only The Health Plan representative who visited the office regularly, always answered questions, and followed up on issues.

Our QI Nurses were commended on their high levels of professionalism, outstanding work ethic and genuine interest in measuring the quality of services delivered, despite the challenges associated with HEDIS data collection. The outstanding work completed were "incorporated into valuable reports that were used to guide current and future quality improvement initiatives as well as the design of the ACCESS Plus program."

In addition to provider network management activities, we were also responsible for PCP monitoring to evaluate the documentation of care from a legal, practical, and medical standpoint as part of our administration of ACCESS Plus. We employed Quality Improvement (QI) Nurses to complete at least 120 provider audits each year using a chart audit tool developed jointly by the Commonwealth and us, which included growth and development items (for EPSDT participation) as well as adult preventive screening and disease management measures.

Following the chart audit, QI Nurses issued reports to the providers that detailed their results, both individually as well as in relation to a comparable sample (based on panel size and demographics). Based on these reports, the QI Nurses provided targeted education to increase

scores on pertinent HEDIS measures. As evidenced below, **using this successful approach, we supported providers in improving several HEDIS scores.**

Operated from our Pittsburgh, PA headquarters, the Project goals were as follows:

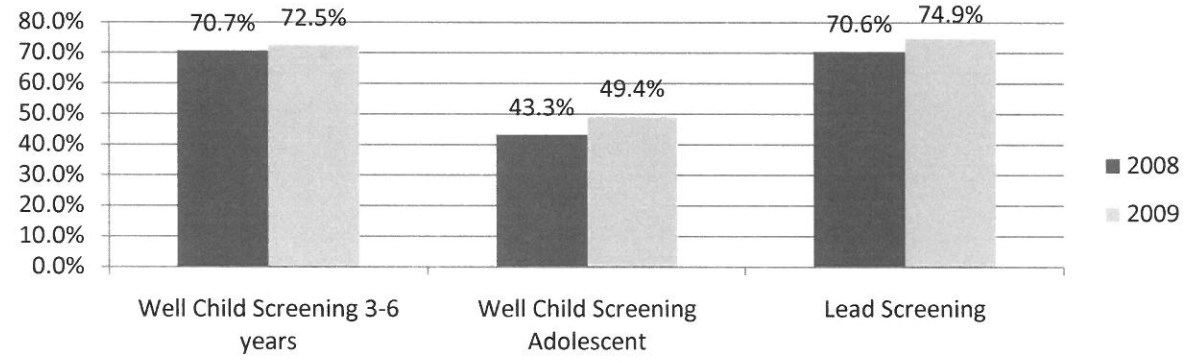
1. Achieve high-quality care for enrollees,
2. Coordinate with all stakeholders to improve care,
3. Maintain a stable Provider network, and
4. Achieve cost savings.

Project Achievements

Improved HEDIS Measures

Through our comprehensive quality assurance activities we successfully improved HEDIS measures among participating providers.

Exhibit 32. Sample of Improvements in HEDIS Measures



With a proven approach to auditing, reporting, and education, we increased a number of HEDIS measures among participating providers.

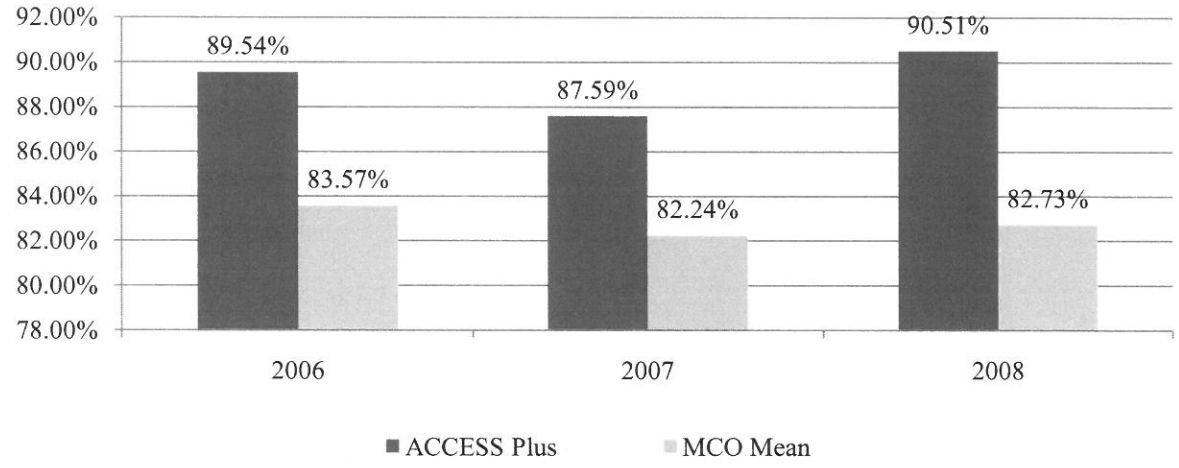
Implemented a Maternity Care Coordination Program that Improved Care

We implemented a Maternity Care Coordination Program to ensure pregnant enrollees were afforded quality continuity of care from the onset of pregnancy throughout the postpartum period, was staffed by RN level staff with extensive experience in obstetrics/ gynecology and maternal and child health, to provide services for both providers and enrollees.

Our results in this program demonstrate that we not only have the tools and skills needed to interact with consumers, providers, and community groups, but also the ability to do so in a way that results in measureable improvements in care.

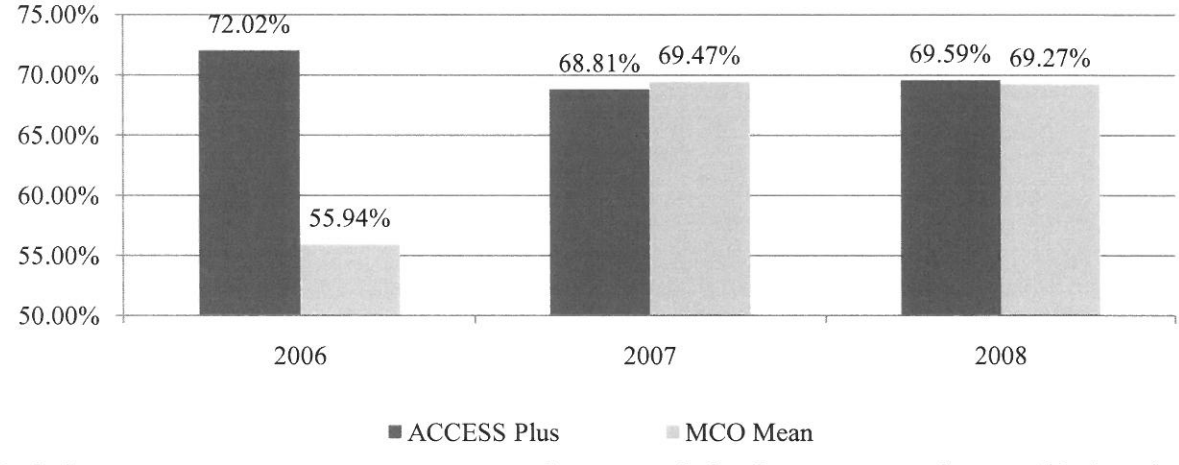
We consistently demonstrated favorable results to the MCOs and scored well above the national averages on all of these measures, as detailed in the following exhibits.

Exhibit 33. Percent Women Receiving Prenatal Care in the First Trimester (2008 National Average: 81.84%)



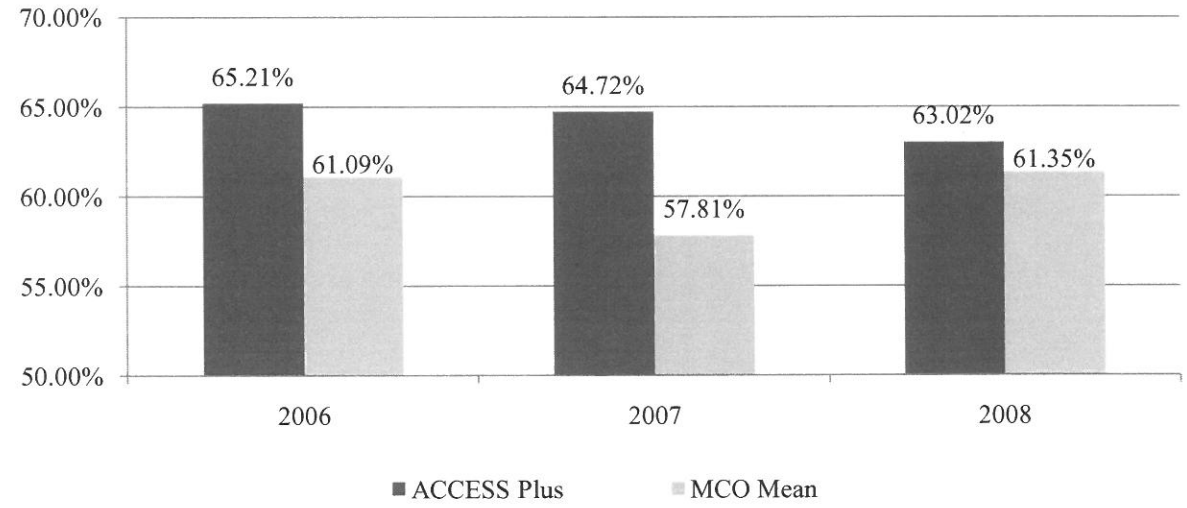
We helped women access first trimester prenatal care, which ensured risk factors for an adverse birth outcome are identified early and treatment can begin promptly.

Exhibit 34. Percent of Women with at least 81% of Required Visits (2008 National Average: 58.87%)



By helping women receive ongoing prenatal care, we helped ensure providers could identify and intervene on ongoing changes in risk status.

Exhibit 35. Percent Women Having a Postpartum Care Visits between 21 and 56 Days after Delivery (2008 National Average: 62.88%)



By helping women receive postpartum care, we promoted interconception care and helped providers deliver treatment for any complications at an early stage.

Implemented an Innovative Data Sharing Project

In the ACCESS Plus Project, McKesson Health Solutions administered the disease management component of the Project, and with together with McKesson we discovered that the complexity of educating Medicaid enrollees about the concept of a medical home while assisting them in coping with a variety of chronic disease conditions, all the while providing ongoing care coordination activities posed significant challenges. Losing patients to follow-up or even finding them in the first place was an ongoing challenge. Additionally, as many as one quarter of the enrollees identified with a condition eligible for disease management also had a behavioral health diagnosis, further compounded challenges associated with assistance, education and care coordination. In discussing these issues with the Behavioral Health MCOs it was discovered that they too faced the same problems of care coordination and ongoing patient tracking.

To address this issue we developed an electronic file sharing strategy between a Behavioral Health MCO, AHS, and McKesson Health Solutions. On a daily basis information was shared between these entities and loaded into our Health Track application. From there if a Behavioral Health MCO identified a patient as lost to follow-up, the patient was automatically flagged in our internal application, so when one of our staff interacted with that person we knew immediately that s/he should be warm transferred to his/her behavioral health case manager (the information for which was provided by the Plan). Conversely, we supplied a Behavioral Health MCO with similar information, including updated telephone numbers, so they knew to refer enrollees we had been trying to reach. As a result, enrollee outreach and care coordination plans were initiated to link enrollees to needed services.

Stable Provider Network

Using a combination of in-person, telephonic, and mailed outreach, we successfully expanded the provider network from the initial 1,600 providers at the start of the program to 2,500. We further built a directory of over 3,000 specialists/dentists. Additionally, the network was remarkably stable, and we were able to continuously assure every enrollee had a choice of at least two PCPs who were accepting new patients within the designated travel time set by the Commonwealth.

Achieve Cost Savings

As mentioned earlier in this section, **combined savings, after administrative fees from the Disease Management component, for the first two years of ACCESS Plus totaled $62.9 million.**

Project Manager Name and Contact Information

Ms. Janet Pritchard was the Project Manager for this Project, and can be reached at the contact information below:

Exhibit 36. Project Manager Name and Contact Information

Name	Ms. Janet Pritchard
Mailing Address	9370 McKnight Road Pittsburgh, PA 15237
Phone	412-367-3030 ext. 2201
Email	jpritchard@automated-health.com

4.1 Plan to Provide Choice Counseling & Enrollment

The Vendor should propose a plan to provide choice counseling to and enroll eligible participants into an approved Medicaid MCO or primary care provider (PCP) that is enrolled in the PAAS Program, according to the counties outlined in Exhibit A. All enrollment tasks detailed in this section apply to both new enrollments and changes in MCOs/PCPs and should comply with 42 CFR 438.6 which can be found in Exhibit B – Code of Federal Regulations.

As mentioned earlier in Firm Staff and Qualifications, we bring over 20 years' experience providing enrollment broker services to millions of enrollees. With current enrollment broker contracts in multiple states, including West Virginia, we are well prepared to not only deliver services that are fully compliant with all Federal and State regulations, but also to ensure West Virginia's potential enrollees and enrollees have a first-class customer service and enrollment experience.

For ease of review, our response to Section 4.1 consists of the following sections as specified in the RFP:

- 4.1.1 Process for Enrollment in Each of the 55 Counties
- 4.1.2 Identify Prevalent Non-English Languages
- 4.1.3 Sample Enrollment Forms and Phone Scripts and Mailing Processes
- 4.1.4 Development of Materials and Passive Enrollment
- 4.1.5 Process for Reviewing Member Materials
- 4.1.6 Multiple Approaches for Enrollment
- 4.1.7 Process to Follow-up on Returned Mail
- 4.1.8 Educate Members on Accessing Services through FFS
- 4.1.9 Collect and Submit TPL Information to BMS
- 4.1.10 Outreach and Education Strategy
- 4.1.11 Written and Visual Materials
- 4.1.12 Plan for Engaging Stakeholders
- 4.1.13 Sorting Enrollment Forms and Processing
- 4.1.14 Approach for Informing County Offices of Changes in Managed Care or PAAS Programs
- 4.1.15 Process for Providing Field Staff
- 4.1.16 Plan for Performing Outreach to Members Who Are Hard to Reach

4.1.17 Plan for Mailings and Electronic Communications

4.1.18 Designing and Maintaining a Website

4.1.19 Designing Educational Materials

4.1.20 Recommendations for Educating and Engaging Enrollees in High Quality Health Outcomes

We are excited about the inherent opportunity to enhance our enrollment broker offerings to the State that goes hand-in-hand with a re-procurement and new contract period. These new and innovative solutions maximize the use of new technologies, thus allowing our operations to be maximally efficient, our reach broader, and our accessibility to potential enrollees and enrollees on-demand 24/7. The most significant of these is the customization and deployment of our new, robust HealthTrack system (a fully integrated system solution designed specifically to support comprehensive enrollment broker and PCCM operations). Details about HealthTrack and our other proposed innovations are fully discussed throughout our proposal response.

4.1.1 Process for Enrollment in Each of the 55 Counties

The Vendor should include in its plan a process for assisting the State with enrollment in each of the fifty-five (55) counties, including addressing the unique enrollment needs of each county. Such circumstances may include the participating MCOs and PAAS in the county, rural/urban location, the number of Medicaid enrollees, and the number of providers. The plan for choice counseling and enrollment services should be in accordance with counties served by each MCO or PAAS Provider, including objectively informing enrollees regarding the choices available, their rights and responsibilities regarding both the enrollment process and the ensuing enrollment, processing the forms and calls to perform enrollment, and acting as an educator on the MHT program.

The plan should indicate how the Vendor may remain impartial in assisting Medicaid enrollees with the Managed Care system and primary care provider (PCP) of their choice and not discriminate against individuals eligible to be covered under contract on the basis of health status or need for health services.

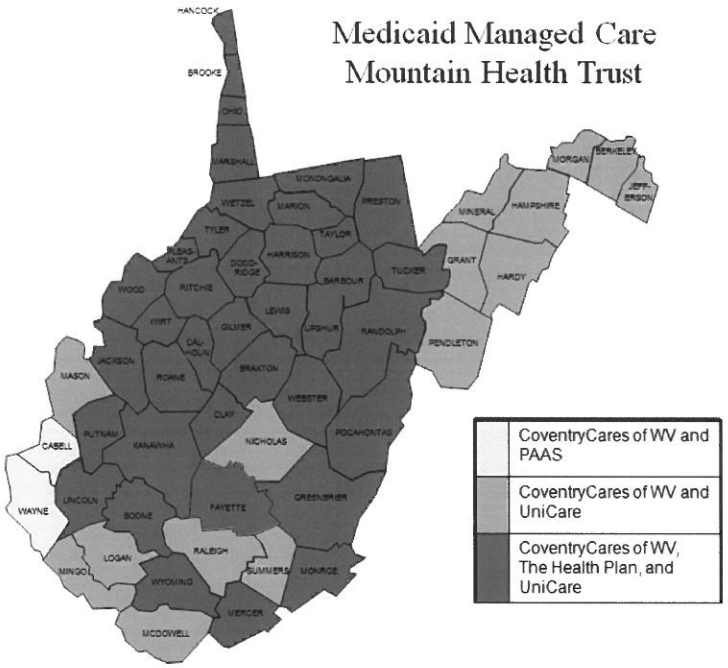
The plan should ensure that all enrollment tasks comply with all Federal and State laws and regulations, including Title 42, Section 438.6 of the Code of Federal Regulations (CFR 438.6) found in Exhibit B.

Outreach, Education and Enrollment Services that Are as Unique as the Enrollees We Serve

As a rural state, wild and wonderful West Virginia is well-known for its mountains and diverse topography, winding rivers, and breathtaking scenery. While recognized for its substantial agricultural and mining industries, West Virginia also has a reputation for renowned higher education establishments and travel/tourism venues. The variation in land, lifestyle, education and industry across West Virginia's counties (combined with other factors, of course), naturally promotes some pretty significant variations among residents in terms of their health literacy, attitudes and beliefs regarding health care, interest in and access to health care, and overall health care decision making.

While awareness of the diversity of West Virginia, its residents, and varied MHT Project offerings (see Exhibit 37) is important, having a true understanding of that diversity and integrating it into specific targeted outreach, education, and enrollment efforts requires talent and expertise. It requires an appreciation of and respect for that diversity, which can only come from long-term engagement with potential enrollees, enrollees, providers, and community leaders across the State.

Exhibit 37. MHT Enrollment Choices, by County[5]



MHT enrollment options vary among the State's 55 counties.

We are proud of the longstanding community presence we established in each of West Virginia's counties during our 18 years of service to the State and its residents as their trusted enrollment broker contractor. (Please see Appendix D for a roster reflecting some of our current community partners.)

To provide tailored in-person service and appropriate field coverage statewide, we assign Field Benefits Managers among four regions. These staff reside within their region, travel it extensively, and are experts in the socio-cultural nuances and health care landscape within it. (Regional profiles are included below.) **No other contractor can bring to the West Virginia Enrollment Broker Project the high level of seamless integration into communities across the state (which can only result from long-term relationship building and dedicated service) that we do.**

Region I: Northwestern and Northern Panhandle Counties

Northwestern and northern panhandle counties (including Hancock, Brooke, Ohio, Marshall, Monongalia, Wetzel, Marion, Tyler, Pleasants, Doddridge, Harrison, Wood, Wirt, Ritchie, Calhoun, and Gilmer) tend to have enrollees who are more experienced with managed care since they were among the first counties to be brought into MHT at its inception and many are border counties to Ohio and Pennsylvania. Since 2009, all three MCOs (i.e., Coventry Cares of WV, The Health Plan of Upper Ohio, and Unicare) have been available to MHT enrollees in the northwest with a diverse choice of MCOs and PCPs. Given the proximity to Ohio and

Less encumbered by unemployment, poverty, and low literacy levels, residents in northwestern and northern panhandle counties tend to be accepting of MHT and managed care.

[5] This map reflects current MHT health plan options as of April 2014. We are fully prepared to support the August 2014 expansion of The Health Plan of Upper Ohio Valley's to 13 additional counties.

Pennsylvania, referrals for specialty care are often made to providers across the state line. The "carve in" of pharmacy and children's dental into managed care in 2013 and 2014 were implemented smoothly and without fanfare. Dental coverage in the area is substantial compared to other regions, and dental practices responded well to the changes.

Literacy levels tend to be higher in this area than in the rest of the state, and cultural diversity is lower. Recent developments in the natural gas industry have impacted this area, with the proposed electric generating plant planned for Marshall County and the ethane fracker in Wood County promising to create new job opportunities while also adding to the debate about the future of coal in West Virginia.

Outreach to community groups, schools, provider offices, churches and local businesses continue as the mainstay to increase community and potential enrollee awareness about the MHT Program, benefits, services, and enrollment routes. Additionally, there are 15 Family Resource Networks (FRNs) representing the needs of children and families in these 16 counties. Substance abuse and truancy are the focus of many of the collaboratives within the region. Our Field Benefits Manager (who has directly served residents of these counties for the past 15 years) works closely with the FRNs to network with an array of agencies actively involved in identifying the needs in each service area to understand the culture and fabric of each community, and provide a forum to promote coordination of services. He is also active with the Appalachian Council Head Start and works closely with many Parent Educator Centers in the schools, annually participating in the Back to School Fun Fairs which provide access to hundreds of children and their families. Fostering a sense of continuity, openness and trust among stakeholders, his tenure has undoubtedly contributed to the smooth ongoing operation of the MHT Program and acceptance of Program changes in the region.

Region II: Southwestern Counties

MCO choices across West Virginia's southwestern counties, include three MCO options available in Jackson, Roane, Putnam, Lincoln, Kanawha, Wyoming, and Boone counties; two MCO options currently in Mason, Logan, and Mingo counties; and the state's only two remaining PAAS counties, Cabel and Wayne, with a choice of one MCO. The Health Plan of Upper Ohio Valley will be expanding into Mason, Logan and Mingo counties as a third MCO option in August of 2014.

With low literacy rates and high Medicaid participation, our outreach, education, and enrollment across southwestern West Virginia focuses on explaining often complicated concepts associated with managed care as simply and understandably as possible.

Literacy and unemployment rates are a factor in our activities in Boone, Logan, and Mingo counties. Special skills are needed to reach out to those who have greater difficulty in grasping the concept of Medicaid managed care. Lincoln, Logan, Mingo and Boone score lowest in adult literacy levels. While several counties appear to be reducing their high school dropout rates, several are experiencing an increase in births to

mothers with less than a 12th grade education (2012 Kids Count report). Unemployment and/or underemployment levels are high across southwestern West Virginia. This is partly due to idled mines and recent developments in the natural gas industry.

Longstanding partner relationships with churches across these counties have supported effective outreach and education, particularly among minority groups.

This region is also home to most of the minorities in the State, mostly in the Kanawha Valley, so outreach and education need to be tailored for these targeted audiences. Strong relationships with community partners bolster the effectiveness of and diversify our outreach. A close working relationship with minority church groups has proven to be a successful outreach strategy in the past and will continue especially as if additional populations and/or services are considered for future managed care enrollment and/or benefit expansion.

We maintain a strong partnership with the multiple FQHCs in Southwestern West Virginia, as well. While ongoing, targeted education persists, appropriate accessing of primary care services is hit or miss. Many enrollees in these counties still utilize the Emergency Department (or more recently Urgent Care Centers popping up across the region) for primary and acute health care.

School-based health centers are also making a comeback. While the scope of services varies slightly from school to school, school-based health centers are making it much easier for some children to get their Health Check (EPSDT) screenings and immunizations and/or to see a behavioral health provider.

To maximize our impact in these counties, we have been working closely with an array of community based groups, including the 10 Family Resource Networks serving the 11 county area. We are actively involved in the Partners in Prevention of Child Abuse and Neglect campaigns in Kanawha, Putnam, Boone, Cabell, Mason, and Mingo counties. FRNs have been the center of Anti Drug Coalitions in the community. This is another area where Mental Health and DHHR interface, usually on a CPS level. Our Field Supervisor directly served counties in Southwestern West Virginia for over 10 years and is a certified trainer for Family Centered Practice (FCP), Our Town, Family Youth Engagement Strategies (FYES) and Brain Under Construction Zone. FCP and FYES are required trainings for DHHR staff and highly recommended for behavioral and mental health providers. FCP is an evidence based training and has also been used in the anti drug coalition to meet community training requirements. Our availability to offer these trainings to a variety of groups and agencies helps to increase the visibility of the MHT Project.

Region III: Northeastern Counties

Outreach and education among the 15 counties in northeastern West Virginia have consistently been a challenge primarily due to the strong allegiance providers and community service agencies have to Northern Virginia and Maryland. Eight counties in particular lie within the

eastern panhandle with five bordering counties comprising part of north central West Virginia. The remaining two counties lie within central West Virginia. Due to the varying regional breakdowns, agency services often overlap and county focuses vary depending on office location, FRN and interagency participation, and community support. Anecdotally, the eight counties of the eastern panhandle refer to themselves as "removed from the state" due to their distance from the State capitol. Further, access within much of the area is limited to rural highways, making travel times extensive.

With migrant workers and pockets of Spanish-speaking enrollees at the tip of the panhandle, strong allegiance to Northern Virginia and Maryland in the eastern panhandle, and isolated counties the center of the State, our outreach among northeastern counties is as diverse as its residents.

Choices of MCOs in the region range from all three MCOs in seven counties and two MCOs in the remaining eight counties. Effective in August 2014, The Health Plan of Upper Ohio Valley will be expanding into Morgan, Jefferson, Mineral, Grant, Hardy and Pendleton counties offering enrollees in these counties a choice of all three MCOs.

Our Field Benefits Manager has supported and directly served these counties for over 10 years, providing the area providers, agencies and enrollees with outreach and education to support MHT. Her knowledge of the regional makeup and cultural differences is extensive. The consistency of community partners among these counties has allowed us to build a deep-rooted relationship in each of these communities. Participation at FRN and collaborative meetings has provided the opportunity to stay informed of new developments, assist with planning health-related activities, and provided essential networking opportunities to DHHRs, educators, community-based agencies, and county residents.

There are 10 FRNs representing the 15 counties in the northeast. Morgan, Berkeley, and Jefferson counties have a Health & Human Services Collaborative under the FRN of the Panhandle that attempts to identify, coordinate, and facilitate services. Hampshire, Hardy, Grant, and Pendleton counties comprise the Eastern Regional Family Resource Network. Mineral County tends to stand alone on its services and activities.

Our Field Benefits Manager interacts with the Shenandoah Valley Medical System, Inc. and the Migrant Health Care Center, both of which serve seasonal and migrant farm workers who work primarily in Berkeley, Morgan, and Jefferson counties.

The tip of the panhandle has a high population of migrant workers and Spanish speaking individuals, as does Hardy County. Migrant farm workers in the area are typically Hispanic, Jamaican, Haitian and Appalachian Caucasian individuals.

Residents often receive Medicaid related services across state lines in Virginia and Maryland as opposed to travelling to Monongalia County in north central West Virginia which is home

to two large hospitals and many specialists. Yet, many times extensive travel is often the only choice for these residents since there are few specialty providers participating with the MCO choices in this area.

Of the five counties in the north central area of this region, Preston, Taylor, and Barbour share of the same many service providers while Tucker and Randolph do the same. Each of these counties has its own active Family Resource Director coordinating community services and coalition building. These counties are rural but have easier access to necessary medical services. Randolph County houses several primary care and specialty providers followed by Upshur, Preston, Taylor, and Barbour counties. Access for the MHT enrollee has always been easier due lower county populations and higher provider participation with the MCOs.

Lewis and Upshur counties, located near the heart of the state, each have its own FRN Director. (Although recent staffing and board changes within the last two years in Lewis County have dramatically affected opportunities to participate in community outreach activities.) Individual service providers in both counties remain cooperative in assisting residents. Medical providers continue to participate with MHT MCO choices and welcome visits from our Field Benefits Manager to discuss changes and updates.

Region IV: Southeastern Counties

Thirteen counties (Braxton, Webster, Pocahontas, Clay, Nicholas, Fayette, Greenbrier, Raleigh, Summers, Monroe, Wyoming, Mercer, and McDowell) are located in Southeastern West Virginia. The area includes the Allegheny Highlands Region, which is part of the Appalachian Mountain Range and houses much of the southern coalfields of the state. Many of the counties feel cutoff from the rest of the state because of the mountainous terrain.

Three MCO options are available in all but four of the 11 counties in the region. The Health Plan of Upper Ohio Valley will be expanding in Nicholas, Raleigh and Summers in August 2104, leaving McDowell as the lone county in the region with only two MCO choices for enrollees post-expansion.

In this area where "generational" Medicaid persists and community acceptance is difficult to secure, we are seen as a valued contributor to progress in communities where progress can be limited and acceptance is important.

Travel in the these counties is difficult due to the mountains and limited interstate roads. Literacy level in the southern coalfields is low; unemployment is high. Southeastern counties have recently been impacted by several mine closures, thus exacerbating poverty levels in the area. The greatest challenge in educating enrollees has been presenting the concept of managed care in a way that penetrates many enrollees' engrained Medicaid perceptions and deep-rooted familial norms. While there are very few non-English speaking consumers, many represent "generational" Medicaid consumers.

In this region, we have found that acceptance by the community is the most important first step. We are pleased to have achieved much success in this regard. We are seen as a valued contributor to progress in communities where progress can be limited and acceptance is important. We are also a critical conduit for many of the providers working in isolated areas throughout the region. **Many providers do not have Internet access so in-person visits and mailings continue to be the preferred method of receiving information. Often, statewide informational meetings are not scheduled for the southernmost counties, reaffirming the importance of our role as educator.**

The relationships with the DHHR offices in this region have proven vital in reaching the potential enrollees and enrollees we serve. Community service agencies are very active in this area and our Field Benefits Manager serving these counties brings over 10 years experience with MHT. She is an active participant in their meetings, updating the numerous agencies on MHT and Medicaid managed care, and volunteering at community events to expand our reach in the community.

There are 11 FRNs representing 13 counties in southeastern West Virginia. All of the FRNs provide us with an opportunity to meet an array of providers and community groups, participate in joint trainings and meetings, and support the coordination of services with a common focus (e.g., substance abuse prevention, drugs/tobacco/alcohol, etc.).

Collaboratives in the region are organized in clusters of counties around common interests. The 4C Collaborative maintains a focus on substance abuse prevention and serves Braxton, Clay, Webster and Nicholas counties. The Greenbrier Connections Collaborative is currently focusing on recruiting foster care givers and establishing permanency for children in Greenbrier, Pocahontas, Monroe and Summers counties. The Fayette/Raleigh County Collaborative comes together to address substance abuse prevention, the increase in teen pregnancy rates and high school dropouts, with a future focus on bullying prevention. The Southern Collaborative for Wyoming, McDowell and Mercer counties is working on substance abuse issues as their primary focus, as well.

In McDowell, the most southern county in the state, 90% of residents are at the Federal Poverty Level. The Community Coalfields Action Group associated with McDowell County Schools and Head Start also has an additional focus on nutrition due to the obesity rates in the county. Many of McDowell County schools now serve breakfast, lunch and dinner due to children not receiving proper meals since many homes do not have working stoves and/or refrigerators. Partnering with these groups allows us inroads to helping residents access and effectively use MHT benefits while other basic human needs are fulfilled.

Consistent, Unbiased Choice Counseling and Education

The most significant reasons States use the services of an enrollment broker is to assure that potential enrollees/enrollees receive unbiased information about the MCOs and providers

available to them, and that the information is accurate, culturally sensitive, and presented in a non-threatening manner. Whether over the phone, in person, or through the web, our staff is responsible for appropriately educating potential enrollees and enrollees about the variety of services available and providing culturally sensitive, unbiased information to assist them in choosing a "best fit" MCO and/or PCP.

DID YOU KNOW?

Throughout our nearly 20 year history in West Virginia, we have never been cited for a single incident of staff failing to provide unbiased services.

Leveraging West Virginia-specific expertise and applying best-practices learned from our enrollment broker and PCCM experience in other states, we will continue to ensure that our phone and field staff are fully trained on quality customer service, cultural sensitivity, and all aspects of BMS' MHT programming. All choice counseling provided to potential enrollees and enrollees regarding their health care options will follow BMS-approved policies and procedures and scripts. Thus, our staff will be able to assist potential enrollees and enrollees with any questions they have and provide appropriate support during the education, enrollment, disenrollment, and change processes. Critical topics we address include:[6]

1. An explanation of the role of the MCOs;
2. An explanation of Medicaid and managed care;
3. A description (and PDF copies) of all outreach, education, and enrollment materials;
4. MCO selection including:
    a. Enrollment options in each county,
    b. Differences between MCOs vs. PAAS,
    c. The deadline for making a selection,
    d. The Auto-Assignment process,
    e. Resources available to select an MCO including the call center, enrollment materials, face-to-face interviews, group meetings, and high-tech web-based resources (such as the Project website and Smart Phone enrollment capabilities); and
    f. Ensuring voluntary selections are not made under duress or due to threats;
5. The importance of selecting a PCP and the benefits of a medical home;
6. PCP participation;
7. Specialist participation;

[6] The elements listed are for an enrollment, such as for the Medicaid expansion population; however, we can develop scripts to accommodate any program updates, policy changes, or initiatives desired by the State.

8. Hospital participation;
9. Medication coverage;
10. MCO or PAAS Provider enrollment;
11. Completion of the Health Needs Assessment;
12. How to access care through the MCO, including education on the full range of benefits available;
13. How to access services available outside of the MCO;
14. Special needs coverage and services;
15. The MCO change process;
16. The role of an MCO's Member Services Unit;
17. MCO disenrollment;
18. Enrollee rights and responsibilities;
19. Appeals and grievances;
20. Fraud and abuse;
21. Availability of oral interpretation, oral translation, and interpreter services at no cost to the caller;
22. Availability of TTY/Relay Services at no cost to the potential enrollee/enrollee;
23. Referral resources (local DHHR offices, MCO Member Services Units, MCO Medicaid Advocate, transportation resources, WIC, other health and human services agencies, etc.), criteria for referrals, and responsibilities of each referral resource; and
24. Other items as identified by the State or us, and as approved by the BMS.

Integrated, Interactive Scripts Ensure Accuracy of Choice Counseling and Enrollment Services

BMS and potential enrollees/enrollees need the MHT vendor to consistently deliver accurate, unbiased information that is understandable and actionable. Further, given the dynamic nature of the managed care environment in West Virginia, BMS needs the vendor to be flexible, and able to develop scripts for new programs or modify existing scripts quickly when needed. Our experience with and approach to scripts meet these objectives and will offer BMS several benefits.

Scripts

These documents will be pivotal for education and enrollment activities. The scripts will be appropriate for use with all potential enrollees and enrollees regardless of their special needs or varying levels of experience with Medicaid. The modular nature of the scripts also allows our MHT Project staff to tailor their interactions to meet individual needs. Stressed during staff training, adherence to the scripts ensures coverage of all topics relevant to the potential enrollee/enrollee's optimal comprehension about the health care options available and enrollment/change timeframes.

Our Benefits Managers already provide consistent, accurate choice counseling, enrollment assistance, and referral services and will continue to do so under the new enrollment broker contract. (Please refer to Appendix E for sample scripts.) Not only are our scripts interactive and provide different levels of counseling and assistance based on potential enrollee/enrollee needs and responses to our questions, but they also:

- Include features to protect potential enrollee/enrollees' privacy (e.g., no information is discussed if the caller cannot appropriately confirm his/her identity);
- Assist callers with correcting/updating demographic information;
- Provide appropriate counseling, education and assistance with regard to MCO/PAAS Provider selection and/or change;
- Assist with the resolution (if appropriate) and documentation of all complaints;
- Were developed with input from the MCOs and PAAS Providers; and
- Currently meet all RFP and contractual standards.

The benefits of our scripts include but are not limited to:

- BMS will have minimal burden with regard to script review and approval during the implementation period;
- Scripts promote maximum understanding and voluntary enrollment; and
- Potential enrollees will receive the same accurate, unbiased, consistent information about MHT and their health care choices by each of our staff members.



DID YOU KNOW?

In the new contract we will fully integrate scripts into HealthTrack, which will enable our staff to provide enhanced customer service.

DID YOU KNOW?

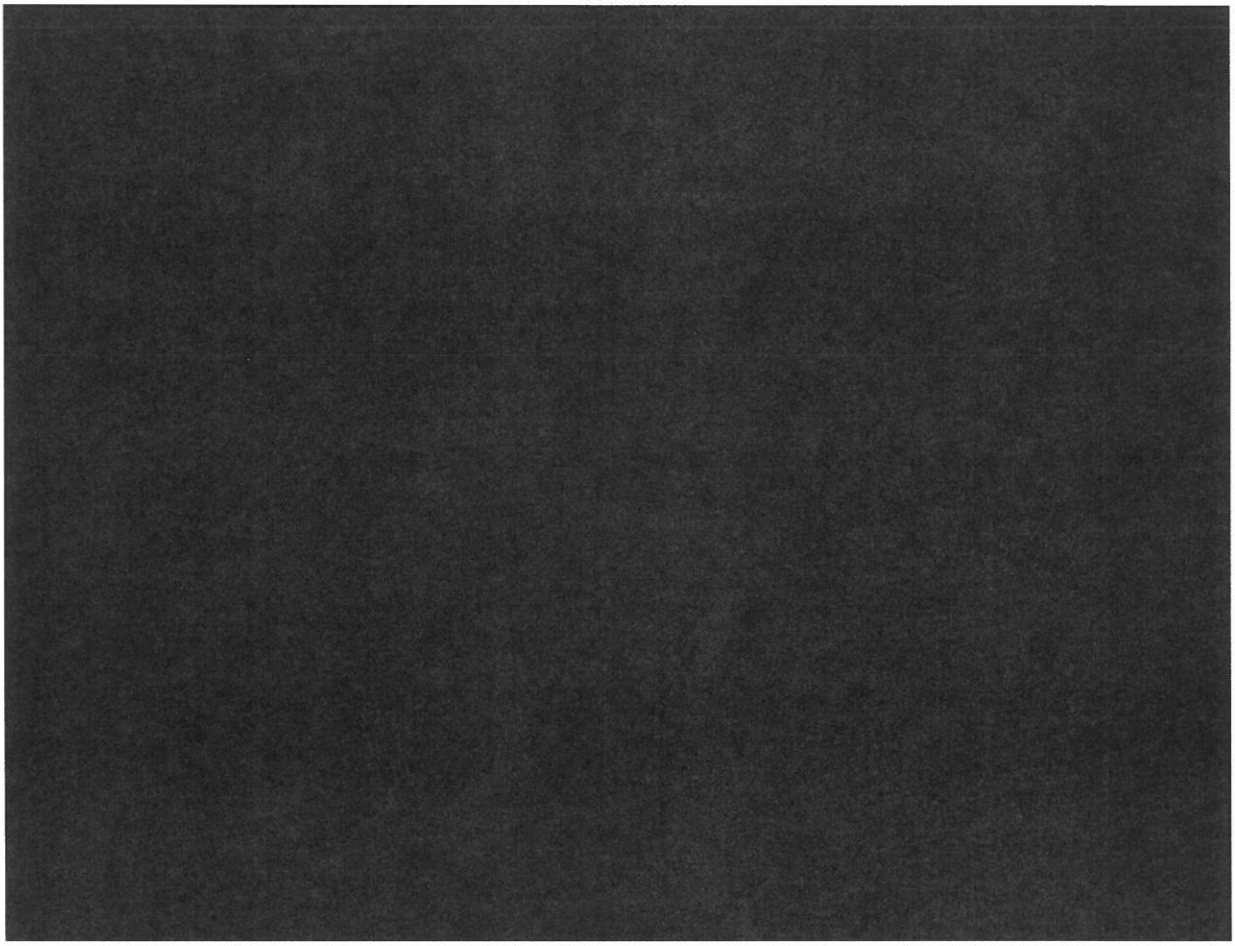
Scripts can be developed or modified at any time. For example, we can develop scripting to support new managed care initiatives (as we did for the recent Pharmacy Expansion) or program changes (e.g., the close out of Mountain Health Choices [redacted]

For the new contract, we will review all our current scripts and make any needed modifications to them. All revisions will be submitted to BMS for approval within contract specifications. After approval of all scripts, the Project Manager and Call Center Supervisor will be responsible for reviewing scripts on no less than an annual basis.

We are excited to offer BMS enhancements with regard to our scripts. Initially, when we designed and implemented the scripts, staff were provided with hard copy manuals and then trained to integrate the contents into their interactions with potential enrollees and enrollees. However, since those days**, we have leveraged advances in technology to improve the user-friendliness of the scripts and truly assimilate them and other complementary resources into our staff's workflow via full integration into HealthTrack (our proposed system solution), and we are excited to bring this technology to the MHT Project in the new contract.**

[redacted]

[redacted]



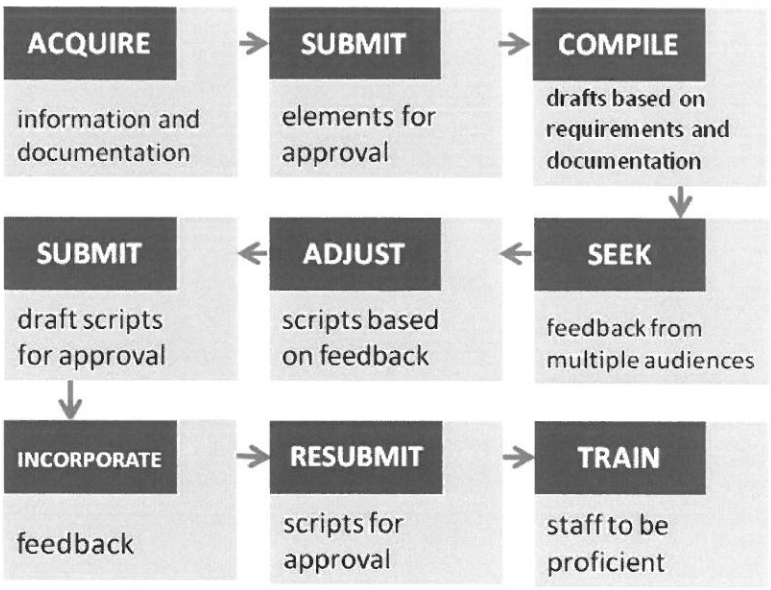
Ensuring Scripts Are Accurate and Understandable

As highlighted above, we bring a long history and wealth of experience to the MHT Project from our experience in West Virginia and other states. We will draw upon this experience and lessons learned when fine tuning and developing new scripts for the West Virginia Enrollment Broker Project. Specifically, we will:

1. Continue to work closely with BMS to acquire all needed program and/or background information and documentation – the vast majority of which we already have;
2. Submit a list of elements to include in the scripts for the State's approval and comment;
3. Compile drafts based on BMS requirements and documentation;
4. Seek feedback from multiple audiences including:
    a. Internal reviews from project management who will be responsible for verifying drafts meet contractual requirements as well as project needs,

b. Internal reviews from corporate staff who will determine if there are improvements that can be made based on successful scripts used in other projects and will verify appropriate grammar usage,

Exhibit 39. Process to Ensure Scripts Meet Requirements



With a comprehensive process for script development, approval and integration that includes multiple reviews and feedback from several audiences, we not only ensure scripts are accurate and understandable, but staff are fully proficient with administering them.

c. Internal reviews by Call Center Benefit Managers who will not only provide their feedback, but also conduct mock role-play sessions using the scripts and provide comments based on the ease of navigation from scripts, and

d. External reviews by MCO partners who will verify their Plans are presented accurately and in an unbiased manner (if so desired by our State partners).

5. Make adjustments to scripts based on feedback received and verify the revision adheres to the 6th grade Flesch-Kincaid level;
6. Submit the draft scripts to BMS;
7. Incorporate all BMS feedback;
8. Resubmit scripts for approval; and
9. Train staff on all aspects of scripts and provide with ample time to practice to ensure they are fully proficient with all aspects of scripts prior to taking calls.

In 2014, we provided our staff with scripting to provide Medicaid expansion callers with resources on their health care decisions.

Our nine step process is thorough and comprehensive, yet places minimal burden on the BMS: we take the time and effort to plan, develop, and refine scripts so they are complete and accurate upon submission. We rely on the State only for initial feedback and final approval. We are committed to producing error-free materials to

We understand the demands on BMS' employees and are committed to producing error-free materials to State staff the first time to ensure they are able to use their time most wisely.

BMS the first time to ensure State staff are able to use their time most wisely. We are confident that this successful, time tested approach to scripts, which has allowed us to deliver unbiased education and enrollment assistance to millions of potential enrollees and enrollees nationwide (including hundreds of thousands of MHT potential enrollees and enrollees for 18 years), will meet all of BMS' needs.

[redacted] It has been our experience that most changes to scripts are required due to a change in State policy, an emergency (e.g., a participating MCO expanding their territory), the adoption of a new program requirement, etc. In these cases we have been tasked with making script changes in very short periods of time. [redacted] When such a need arises, we will work with BMS to develop and quickly incorporate whatever changes need to be made to the specific scripting and promote it out to production. As this is being completed, all staff will be alerted/trained on the new information to ensure they have a complete understanding of the situation. [redacted]

Ensuring Unbiased Choice Counseling and Prohibiting Enrollment Discrimination

It is a fundamental tenant of enrollment brokering to ensure all consumers are provided with unbiased information, counseling and assistance services. Our approach to providing unbiased, non-discriminatory information and assistance services is built on four components:

1. Developing BMS-approved scripting,
2. Training staff to adhere to scripting,
3. Monitoring staff, and
4. Taking immediate corrective action when needed.

DID YOU KNOW?

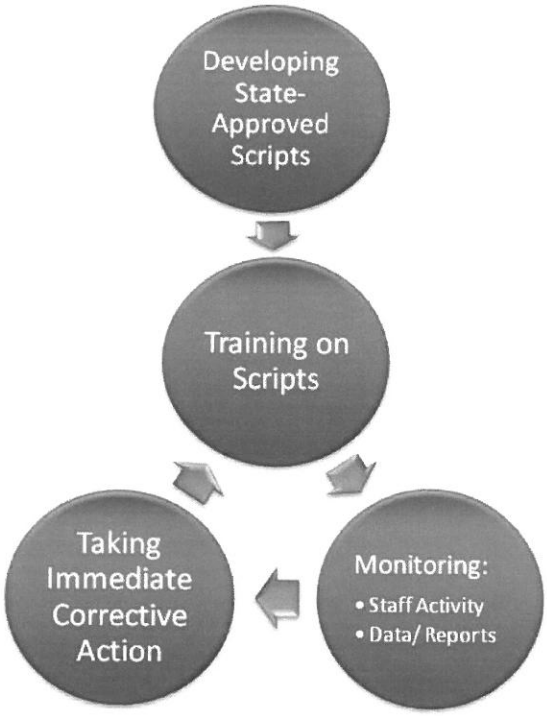
During our tenure in West Virginia, we have never had a complaint or any indication that any staff member has ever delivered services to any member in a biased manner.

First, as discussed above, we equip our staff with BMS-approved scripts to guide staff through the provision of unbiased, non-discriminatory services.

Second, we incorporate scripts into HealthTrack and stress adherence to scripting during training. During training, all scripting is reviewed and employees are given opportunities to practice scripts during role-play. Staff are monitored during training and if deviations from scripting are detected, they are discussed with the individual employee and the employee is given opportunities to correct the deviation during the following practice sessions.

Third, to ensure that all forms of discrimination does not occur (e.g., based on health status, national origin, race, etc.), we rely on monitoring two primary sources of data. First, as part of ongoing quality assurance efforts the Call Center Supervisor will monitor live calls of all staff, and one of the items that is assessed is staff adherence to scripting. Should defects in this area be detected, they are discussed with staff and the staff member is monitored more frequently for adherence to scripting. (Please refer to Section 4.1.20 for a description of our QA plan and approach to monitoring.) Second, we will also review ongoing data reports. The Project Manager and Call Center Supervisor will routinely review daily, weekly and monthly reports for deviations in the data suggesting potential discrimination.

Exhibit 40. Approach to Non-Discrimination



We use a comprehensive approach to non-descrimination.

Fourth, monitoring is pointless if corrective actions are not taken promptly if warranted. Thus, if data indicates staff has a preference towards one MCO, or may be enrolling on the basis of race, color or national origin corrective action (including discussions with the employee, training and possible more stringent interventions such as termination if warranted) will be immediately taken. Further, should any unlawful activities be suspected or identified (from any party), we will immediately inform BMS, and work with BMS in any manner necessary to resolve the situation.

Steps two through four occur in an ongoing cyclical manner. Thus, as new hires join the Project they are trained on adherence to scripting. In addition, adherence to scripting are routinely emphasized during ongoing training sessions throughout the contract. As part of ongoing quality assurance efforts, all staff are continuously monitored. Even staff who routinely demonstrate competency with scripting are still monitored on an ongoing basis.

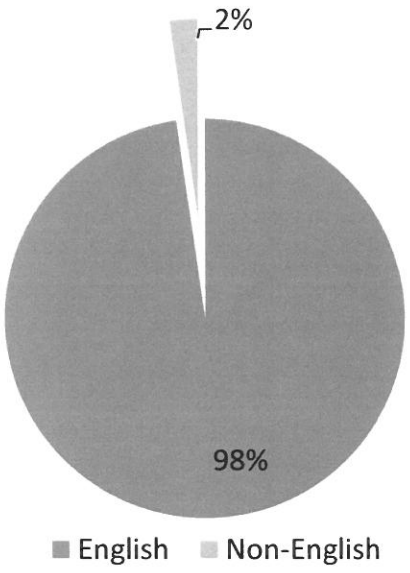
4.1.2 Identify Prevalent Non-English Languages

The plan should include how the Vendor, working with BMS, may identify the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State in accordance with 42 CFR §438.10 found in Exhibit B. The plan should indicate how the Vendor might make all information available in each prevalent non-English language (if BMS and the Vendor determine a prevalent language other than English is present) to the same extent as the information available in English. Provider and other stakeholder communications may not require prevalent language translation.

The plan should ensure that all information for enrollees or potential enrollees complies with the requirements of 42 CFR438.10, found in Exhibit B, and is at or below a sixth grade reading level.

Identifying Prevalent Languages

Exhibit 41. Percentage of English vs. Non-English Speakers in West Virginia[7]



The vast majority of West Virginians speak English as their primary language.

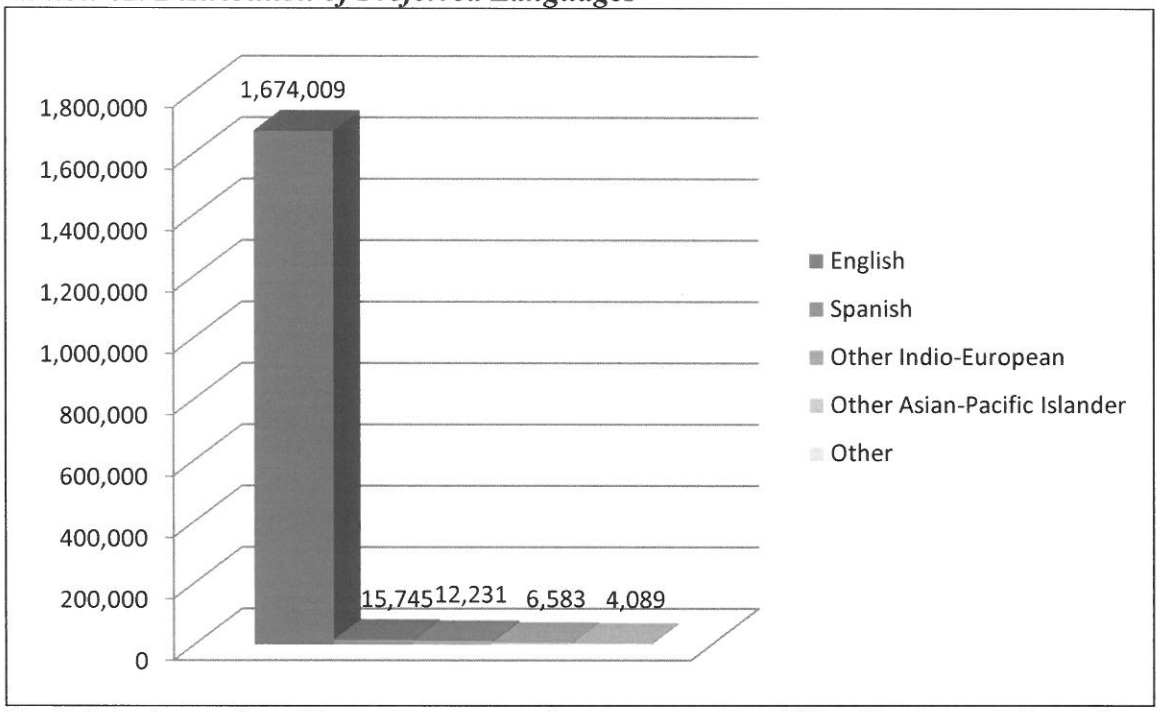
Upon reviewing CDC language distribution data as well as potential enrollee and enrollee data available under our operation of the current MHT Project, we do not currently see a need to make all potential enrollee/enrollee materials available in any languages other than English. As "preferred language" data is captured on enrollment forms, we will track and report on language preferences of the potential enrollees/ enrollees we serve. If there is a change in language distribution that necessitates the provision of potential enrollee/enrollee materials in other languages we will develop, produce, and distribute them. Our distribution methods for non-English materials will mirror those for English materials (i.e., phone, field, mail, and web). In addition, if the need for non-English materials is identified, we will also place tag lines on all English materials in the specified language indicating that assistance on materials in other languages can be accessed via the call center.

Although we do not currently propose the mass translation of potential enrollee/enrollee materials into non-English languages, **we will develop and provide targeted translated**

[7] http://www.census.gov/compendia/statab/cats/population/ancestry_language_spoken_at_home.html

materials as needed for special outreach projects as desired and approved by the State. If at any time the language distribution in West Virginia changes, we have the skills and proven experience to develop, receive approval for, and quickly implement high quality materials for non-English speakers. Of note, we have experience developing materials in Spanish, Vietnamese, and Haitian Creole. Our expertise with and proven approach for developing accurate, high quality non-English materials follows later in this Section.

Exhibit 42. Distribution of Preferred Languages[8]



English is the preferred language among the vast majority of West Virginians; Spanish is the second most preferred (<1% of residents).

Compliance with 42 CFR §438.10

Our written materials[9] will be:

- Made available in English, as well as any additional needed languages as determined by BMS and us as described above;
- Offered in alternative formats and through a variety of routes; and
- Written at or below a 6th grade literacy level.

[8] Ibid.

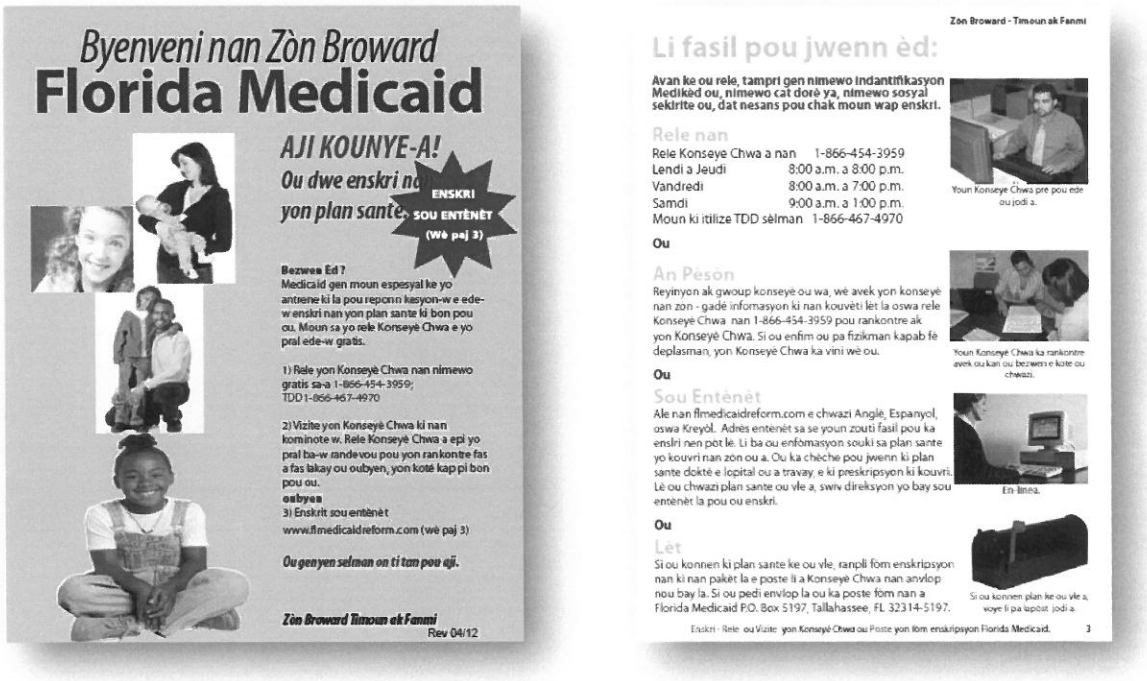
[9] All written materials, including translations of written materials, will be subject to prior approval by the State. A certification that materials are translated accurately and completely will accompany all non-English drafts submitted by us to the State.

As BMS has recognized, only when potential enrollees and enrollees receive an accurate, understandable, culturally sensitive and medically knowledgeable presentation can the benefits of managed care be realized. Potential enrollees' and enrollees' informed participation largely depends upon the Vendor's ability to successfully educate them. **Our effective strategy ensures that our discussions with potential enrollees and enrollees are not just accurate, consistent, and objective, but also understandable and racially, culturally and socio-economically responsive. Further, our phone and field staff will be medically sensitive and take potential enrollees' and enrollees' health status and special needs into account during their interactions as well.**

Translated Materials

Throughout our more than 30-year corporate history, we have developed and distributed written materials in English and non-English languages aimed at educating low-income individuals and families about available health care programs and encouraging active participation. While we provide Spanish materials under nearly all of our contracts, we provide materials in additional translated languages when a language is determined to be prevalent in a state we serve or as required by our clients. Currently, we provide additional prevalent language translations in Spanish and Haitian-Creole in other States. (We have also provided materials in Vietnamese.) All translated materials provided by we will continue to comply with 42 CFR §438.10(c).

Exhibit 43. We Produce High Quality Translated Materials



We are skilled at providing high-quality, easy-to-understand enrollee materials that explain important health care topics and prompt appropriate action in languages other than English.

Our process to ensure translated materials are complete, accurate, and understandable begins [redacted]

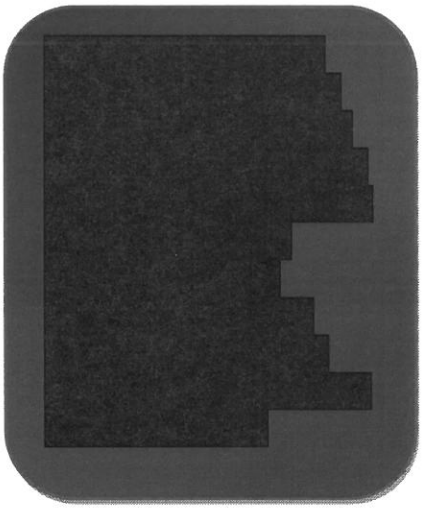
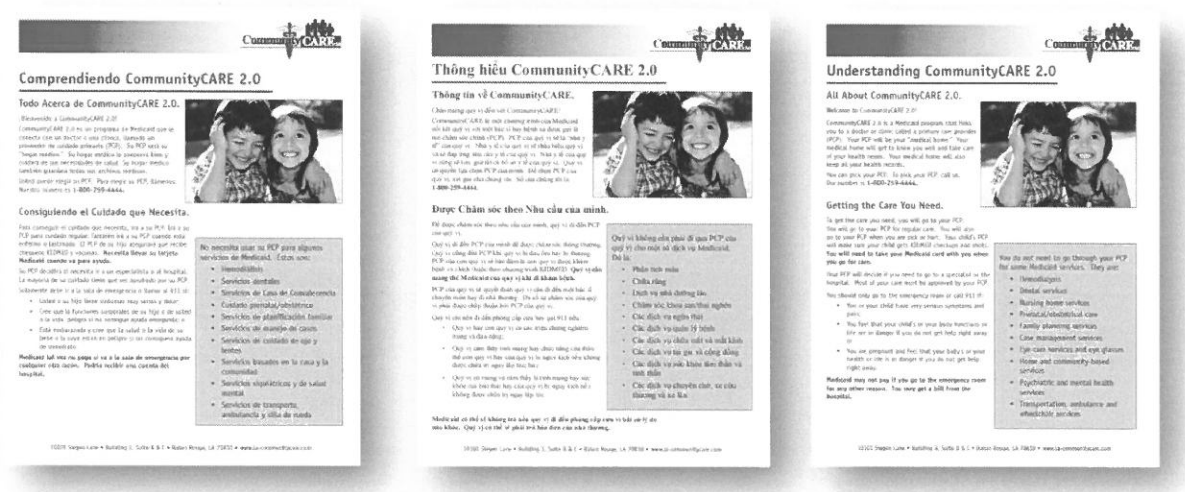


Exhibit 44. We Produce Branded Translated Materials



Our translated materials are designed and produced according to the same branding, color schemes, and quality standards as our English materials.

Our Corporate Materials Development and Design Team then ensures that the layout and design of translated materials are culturally appropriate and parallel the look and feel of their English counterparts, and work with Project Management to develop a proof for field testing. A final proof, translation accuracy certification, and QA Memo are sent to the State for review and approval prior to production or distribution.

We will use the above translated materials development process as materials when non-English materials are needed.

Alternative Format Materials and Accessibility

Development of Alternative Materials

We place high importance on understandability and accessibility when developing and designing materials. (For a description of our process for designing high-quality materials, please see Section 4.1.4 later in our response.) We understand that some of the potential enrollees and enrollees with whom we will interact will have special needs – some of which necessitate the provision of materials in alternative formats.

For all translations into alternative formats, we will comply with all required laws, regulations and policies, including 42 CFR § 504 of 8.10(d), the Rehabilitation Act of 1973, and Title II of the Americans with Disabilities Act of 1990, in order to ensure that all materials are available in appropriate alternative formats for potential enrollees and enrollees who are visually or hearing impaired or unable to read. We will also include a statement on all materials that clearly indicates the availability of translation services at no cost to the potential enrollee/enrollee.

We will continue to include statements on all of our materials that materials in other languages and formats as well as additional support are available by calling the toll-free MHT Call Center. We will also address the need for materials in media other than the written word. Part of our message will be that voice assistance is available through the MHT Call Center, which also offers translation help, and TTY and recorded materials for potential enrollees and enrollees who have special needs. As an additional enhancement, we will place audio recordings on the MHT website as well as links to print copies of narratives for families/friends to access if interested. As described we describe in Section 4.2.18, our audio recordings adhere to key principles for enhancing comprehension.

Distribution of Alternative Format Materials

Our Project staff, materials, and website will all inform potential enrollees and enrollees about the various routes for accessing project materials, the availability of materials in alternative formats, as well as the support (i.e., translation, TTY/TDD/Relay) services available through the Call Center.

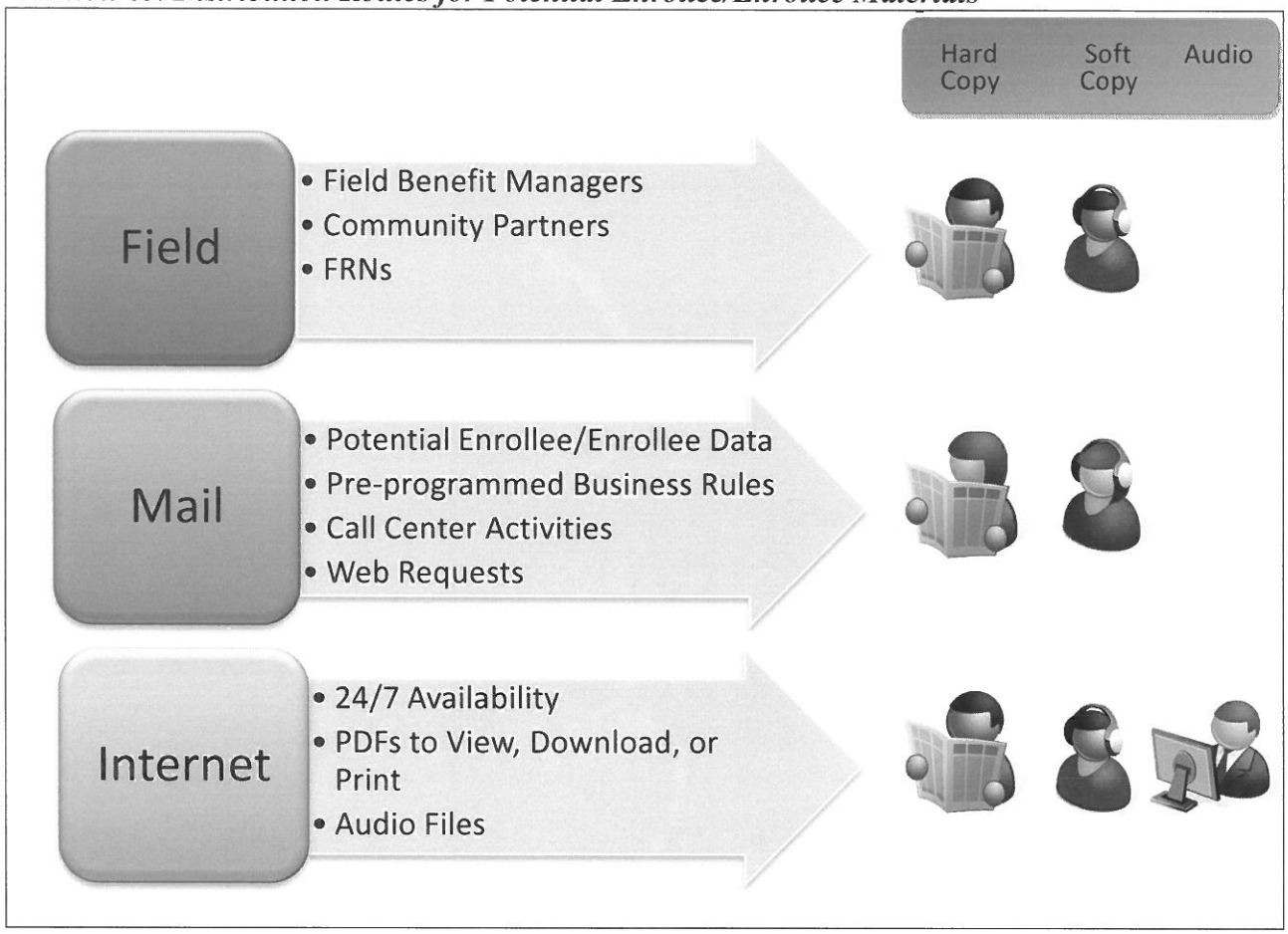
MHT Project materials (including any translations and all formats) will be available upon request and distributed through three primary routes (see Exhibit 45):

1. Field locations, activities and events;
2. Mail; and
3. Internet.

In addition to providing written materials through these routes, we also offer assistance understanding any project material via the MHT Call Center. All Benefits Managers are provided with copies of all Project materials and are fully versed on providing clarification as needed.

[redacted]

Exhibit 45. Distribution Routes for Potential Enrollee/Enrollee Materials



Distribution of Materials through the Mail

Whether a mailing is prompted by our processing of the Eligibility File, logging a mailing request in HealthTrack, pre-programmed business rules (for example, mailing a reminder notice to potential enrollees who have not made a timely voluntary enrollment choice), or other activity, our proprietary HealthTrack system will ensure that potential enrollee and enrollee materials are generated and mailed according to all BMS-defined business rules and that all mailing-related performance standards for timeliness are met or exceeded.

As detailed in our response to Section 4.1.17, we will have policies and procedures, state-of-the-art technology, national change of address (NCOA) and barcode technology, and quality assurance protocols in place to ensure that mailings are processed correctly and within service level agreements.

If so desired by BMS, we will updated all written materials to indicate that materials are available in alternative formats and encourage the reader to contact the Call Center or visit MHT Project website for further assistance and/or no-cost translation services.

Accessibility of Materials through the Internet



Program materials will be made available 24/7 via our Americans with Disabilities Act-compliant project website. Potential enrollees, enrollees, agency staff, and other interested parties are able to access PDF materials for online viewing or printing to hard copy. Because PDF files are opened using Adobe Acrobat Reader, we include a hyperlink to the free, downloadable program for those users who do not already have the program installed. Audio files will also be posted to our website for users who would prefer to hear the information.

In addition to accessing copies of enrollee materials online, as noted above, community entities and FRNs will also be able to order bulk materials via our website.

Regardless of the format or route for sharing the materials (e.g., sent via mail, distributed in the field, or accessed through the MHT website), no materials will be implemented without BMS' prior approval.

Low Literacy Materials

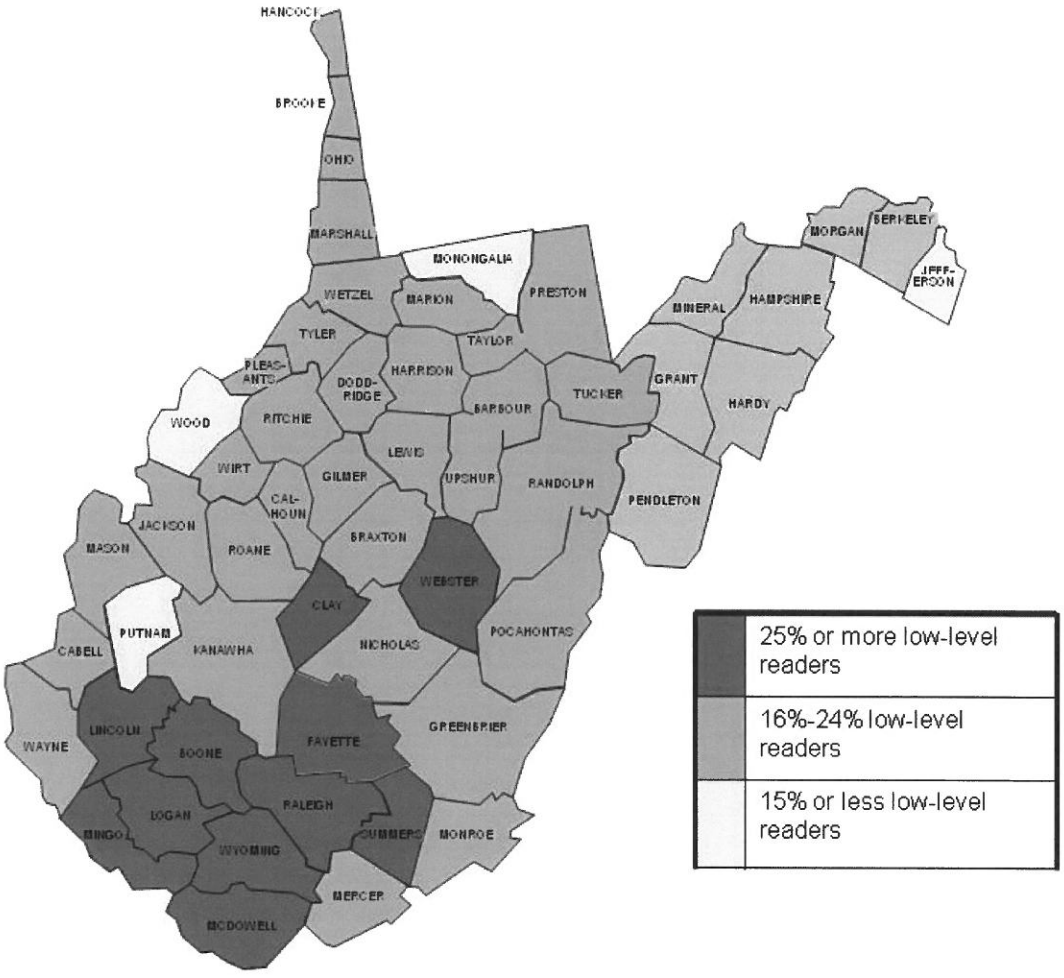
While the overall appearance of the materials produced for the MHT Project is highly important, the importance of delivering critical and compelling messages in an understandable manner is not lost (see Exhibit 46 above). **Ensuring the readability of MHT materials is critical given that 20% of West Virginia's residents lack "basic prose literacy skills" (a percentage reaches or exceeds 25% in 11 counties, most of which lie south of the Kanawha River in the southern coalfields, and that is undoubtedly higher among Medicaid recipients).**[10] As part of our approach to developing and designing low-literacy materials, when developing written materials we will:

- Find and use common alternatives for complex words, jargon, and abbreviations;
- Keep sentence length short;
- Ensure that we adhere to recognized principles of design[11] (proximity, repetition, alignment and contrast) for both text as well as graphics to produce a pleasing image;
- Provide definitions and context to help facilitate comprehension;

[10] http://www.wvencyclopedia.org/articles/1413
[11] Williams R. The Non-Designers Design Book. 1994.

- Include drawings, photos, and appealing colors to engage the reader;
- Use headings that cue the reader to the available context;
- Use an active voice and action verbs with a strong emphasis on "you" to personalize the information; and
- Provide cues for action that demonstrate to the reader the importance of their role in establishing and maintaining health coverage.

Exhibit 46. West Virginia Literacy, by County



Low literacy, more than limited English proficiency, significantly impacts potential enrollee's and enrollee's ability to make informed decisions about their health care, and must not be ignored.

Exhibit 47. We Produce High Quality, Easy-to-Read Materials

Logical Heading →

Step-byStep Instructions →

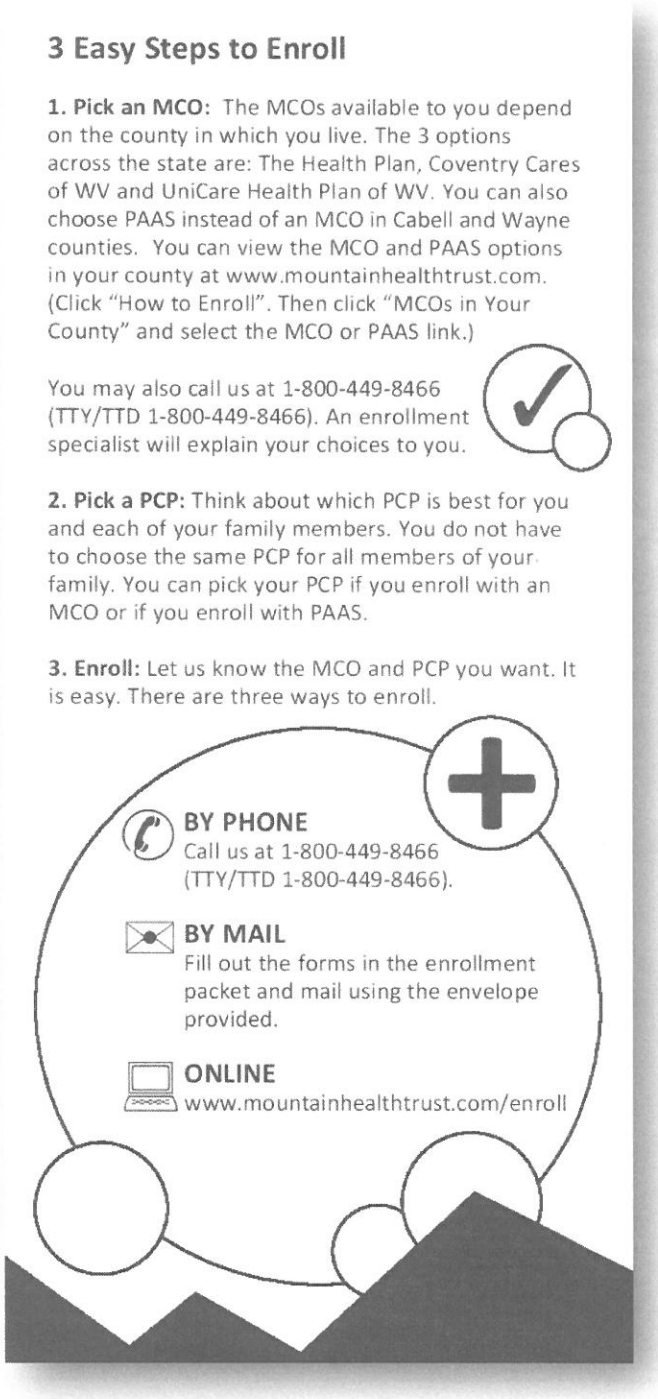
One Concept per Paragraph →

Friendly Tone →

Low Literacy Language, Readable Font →

Carefully Selected Pictures Draw the Eye and Match Key Concepts →

Theme Colors Promote Branding →



Above is an example of our approach as applied to enrollee materials used in our curent MHT contract. We take the time to implement thoughtful language, layout, color and graphics to simplify enrollment.

Testing Materials for Reading Level and Ease of Understanding

Exhibit 48. Measuring Readability of Our Materials

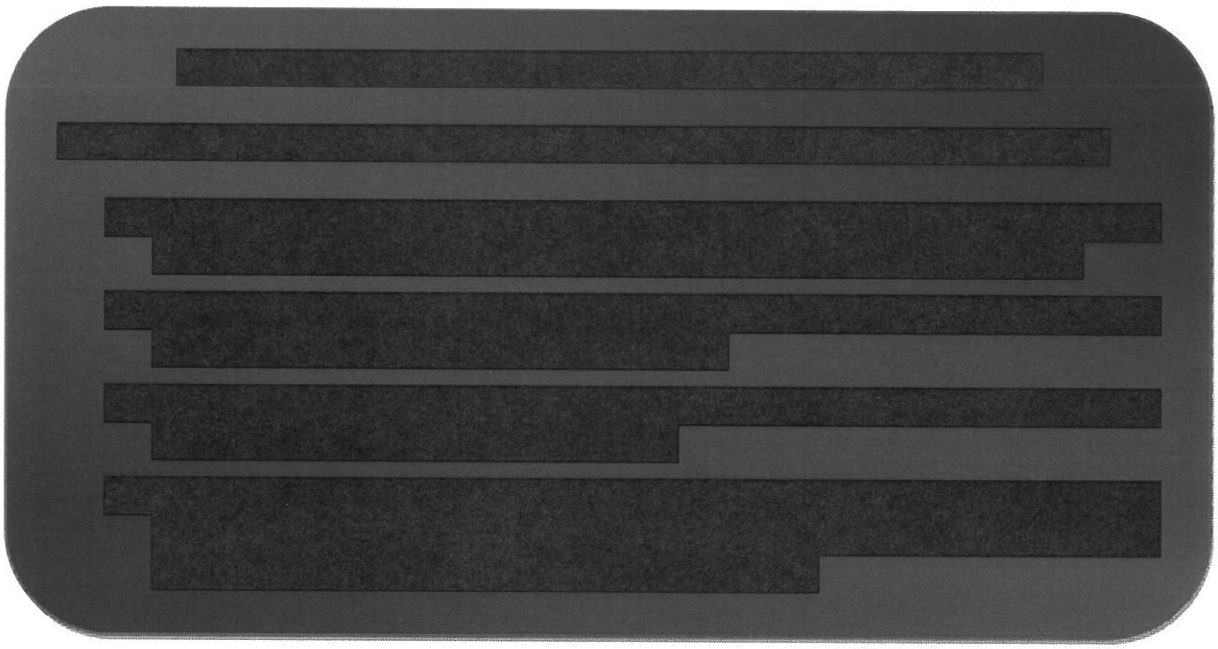
Counts	
Words	393
Characters	1771
Paragraphs	21
Sentences	35
Averages	
Sentences per Paragraph	2.5
Words per Sentence	10.0
Characters per Word	4.3
Readability	
Passive Sentences	8%
Flesch Reading Ease	79.3
Flesch-Kincaid Grade Level	4.6

While we ensure that our materials are written at a 6th grade or lower Flesch-Kincaid score, we also consider other critical data and identify opportunities for further improvement.

One critical step in ensuring understandability of our materials (and scripts) that is based on our decades of effective enrollee outreach, education, and enrollment, is to seek feedback from our Call Center and Field Benefits Managers on how enrollees commonly refer to program elements and include that familiar language in our education materials prior to Flesch-Kincaid scoring. For example, in West Virginia our enrollees do not use the phrase "Fee-for-Service Medicaid", but rather use "Straight Medicaid" as that is the enrollees' preferred common language.

Then, we use commercially available software packages to determine the literacy level and ease of reading scores for potential enrollee and enrollee materials, The Flesch-Kincaid grade level is the most commonly accepted standard for readability and is used by us under all of our current contracts.

Going beyond merely considering the final Flesch-Kincaid Score to determine readability, [redacted] **We are committed to producing error-free and compliant materials to BMS the first time, thus minimizing amount of time needed by State staff for review and approval.**



4.1.3 Sample Enrollment Forms and Phone Scripts and Mailing Processes

The Vendor should develop sample enrollment forms and phone scripts for potential enrollees that comply with the requirements of 42 CFR §438 Subparts A-J found in Exhibit B. A sample enrollment form should be provided to BMS. The enrollment form and scripts should ask potential enrollees to indicate: his or her choice of MCO or PAAS provider; the name of his or her existing provider(s); and his or her race, ethnicity, primary language spoken and health status. The form should specify that information on race, ethnicity, primary language and health status is not mandatory for enrollment.

The plan should include a process for mailing the enrollment form and accompanying enrollment materials, as described in Section 4.1.4, to potential enrollees within two (2) business days of receiving the eligibility file from the fiscal agent.

BMS anticipates approving the enrollment form and enrollment phone script at least thirty (30) calendar days prior to use. BMS reserves the right to alter the enrollment form and the script at any time. In the event that BMS alters the enrollment form, the Vendor has thirty (30) calendar days to implement the BMS requested changes. The Vendor may not make changes to the enrollment form or script without prior approval from BMS.

The Vendor should attach a draft copy of the enrollment form and scripts in its response to this RFP.

Enrollment Forms

We are pleased to have worked with the State to provide MHT enrollees with a visually appealing, unintimidating looking enrollment form that not only is accessible by most of our target audience, but also addresses all critical informational requirements desired and needed by BMS. (Please see Appendix F and our response to Section 4.1.4 for a sample.)

With large font, a clean and organized look, friendly tone, and ample space for enrollees to mark their responses, our enrollment form:

- Is personalized with the appropriate MCO and, if appropriate, PAAS enrollment options;
- Clearly and concisely indicates needed actions;
- Is written at a or below a 6th grade reading level;

- Verifies and/or requests contact information, Medicaid ID number, birth date, non-required data (such as race, ethnicity, and primary language spoken), and the enrollee's selected MCO or PAAS PCP; and
- Includes a health needs assessment on the reverse side.

Scripts

As described earlier, we take numerous steps to ensure our education is effective and our messages are conveyed in a manner that is understood and acted upon by the intended recipient. Thoughtful scripting integrated into HealthTrack and adequate training will support effective counseling. We take several steps to ensure our scripting is successful. First, when drafting scripts, we work closely with BMS to ensure all critical elements are addressed. Naturally, all scripts are written at a low literacy level (i.e., below 6th grade at a maximum). Second, scripts are field tested and reviewed among staff. Drafts are submitted to BMS for review and approval, and all scripts are prior approved before programming into HealthTrack. Last, staff are trained on all aspects of the scripts and provided with ample time to practice following them prior to working in the call center.

Please see Appendix E for our sample MHT scripts.

4.1.4 Enrollment Materials and Passive Enrollment

The plan should include the development of materials to notify members of the expectation to select an MCO or PAAS provider within forty-five (45) calendar days or be assigned to one (1) by the State. The Vendor should also recommend a process for accommodating passive enrollment as needed. The plan should also propose a process to develop additional materials that meet the requirements of 42 CFR §438.10 (found in Exhibit B) to help members in making their choice (e.g., member handbooks, network provider listings, letters related to MHT and PAAS programs). Such information may include

4.1.4.1 MCO/PAAC availability in the service area (county);
4.1.4.2 Information specific to each MCO or PAAS program operating in the county, such as benefits covered, service area, and names, locations, telephone numbers, and non-English languages spoken for current contracted providers and identification of providers not accepting new patients (including information on primary care physicians, specialists and hospitals for current contracted providers.
4.1.4.3 How to obtain services that are accessed through the FFS system and any value-added services the MCO provides;
4.1.4.4 The role of the primary care provider in MCO/PAAS;
4.1.4.5 Process for enrollment, disenrollment, exemptions, and grievances;
4.1.4.6 Availability of oral translation services free of charge for persons who do not understand English materials; and
4.1.4.7 Information on the benefits available under the State plan but not covered under the contract, including how and where the enrollee may obtain these benefits.

Written materials should include, but are not limited to:

4.1.4.8 A general informational pamphlet than can be used in any of the enrollee counties
4.1.4.9 Specific pamphlets that describe in detail the choices available to enrollees depending on their place of residence; and
4.1.4.10 Letters or other materials that advertise changes in delivery systems and promote preventive care.

The plan should also include a process to mail additional materials, including those created by BMS and/or the MCOs, to help enrollees in making their choice (e.g., network provider listings, any BMS-approved marketing materials, question and answer sheets, letters related to the managed care program.

We are proud to have partnered with BMS in the development and implementation of a variety of materials since MHT's inception. Not only did we work together to create effective materials

for introducing and garnering acceptance of MHT to West Virginians – many of whom had no prior managed care experience – but we also established a track record for timely and thoughtfully updated, modified, and/or newly drafted materials as BMS' Medicaid programming evolved and changed over the years.

DID YOU KNOW?

We developed and implemented updated and enhanced West Virginia Enrollment Broker materials in August of 2013 at no additional charge to the State.

While we are quite pleased with the enhanced materials from our most recent redesign in August of 2013, our commitment to continually improving and providing the most accessible, user-friendly, and helpful materials continues. We are happy to revisit the content and design of all MHT materials. And, we will continue to recommend modifications, additions and enhancements to materials under the new enrollment broker contract. For example, as presented later in this section, with BMS' approval, we are excited to include quick response (QR) codes on enrollment materials to bolster the helpfulness of MHT's materials and facilitate Smart Phone enrollment. With BMS' approval, enrollment materials (and the MHT website) would be modified to promote and support enrollment via Smart Phone. We are also happy to explore the incorporation of a four-color process for MHT materials, such as the MHT brochure. We are skilled with providing single color plus black materials (such as those currently used for the MHT Project), but we are able to provide full color materials.

However, if BMS prefers that existing materials continue to be used, we are happy to oblige. Regardless, should we make any modification to any materials, all content will be approved by BMS prior to production.

As mentioned earlier, we have over three decades' experience developing potential enrollee and enrollee education and enrollment materials for a variety of Medicaid programs. However, we not only bring decades' experience working with educational materials, but **we are also the only bidder to offer BMS decades of West Virginia-specific experience developing educational enrollment broker materials that help West Virginia's potential enrollees and enrollees.**

We have talked extensively about our experience and expertise developing education and enrollment materials that comply with 42 CFR §438.10 above. However, below follows an additional summary that highlights not only our overall approach to developing materials effective materials, but also some of the features we incorporate to facilitate potential enrollee/enrollee understanding and appropriate action.

DID YOU KNOW?

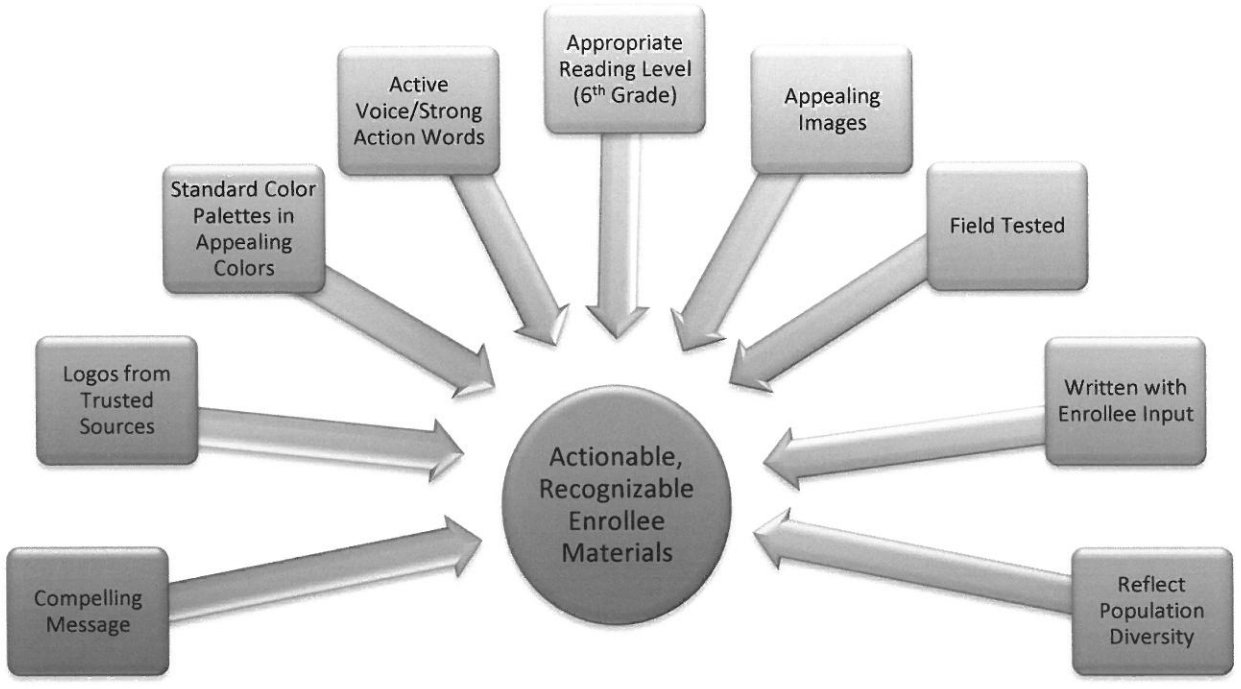
Our high volume of MHT enrollments via mail (typically 60% of all voluntary enrollments) and low change rates (<1-2%) are a testament to the effectiveness and user-friendliness of our education materials and enrollment forms.

While additional detail about our MHT materials is included later in this section, the following paragraphs highlight our overarching approach for developing effective materials. To assist the reader with navigation, our response to this section is organized as follows:

1. Process for Ensuring Materials Meet Their Goals,
2. Types of Enrollee Materials,
3. Additional MHT Education and Materials, and
4. Mailing Processes.

Process for Ensuring Materials Meet their Goals

Exhibit 49. Process for Producing Potential Enrollee/Enrollee Materials

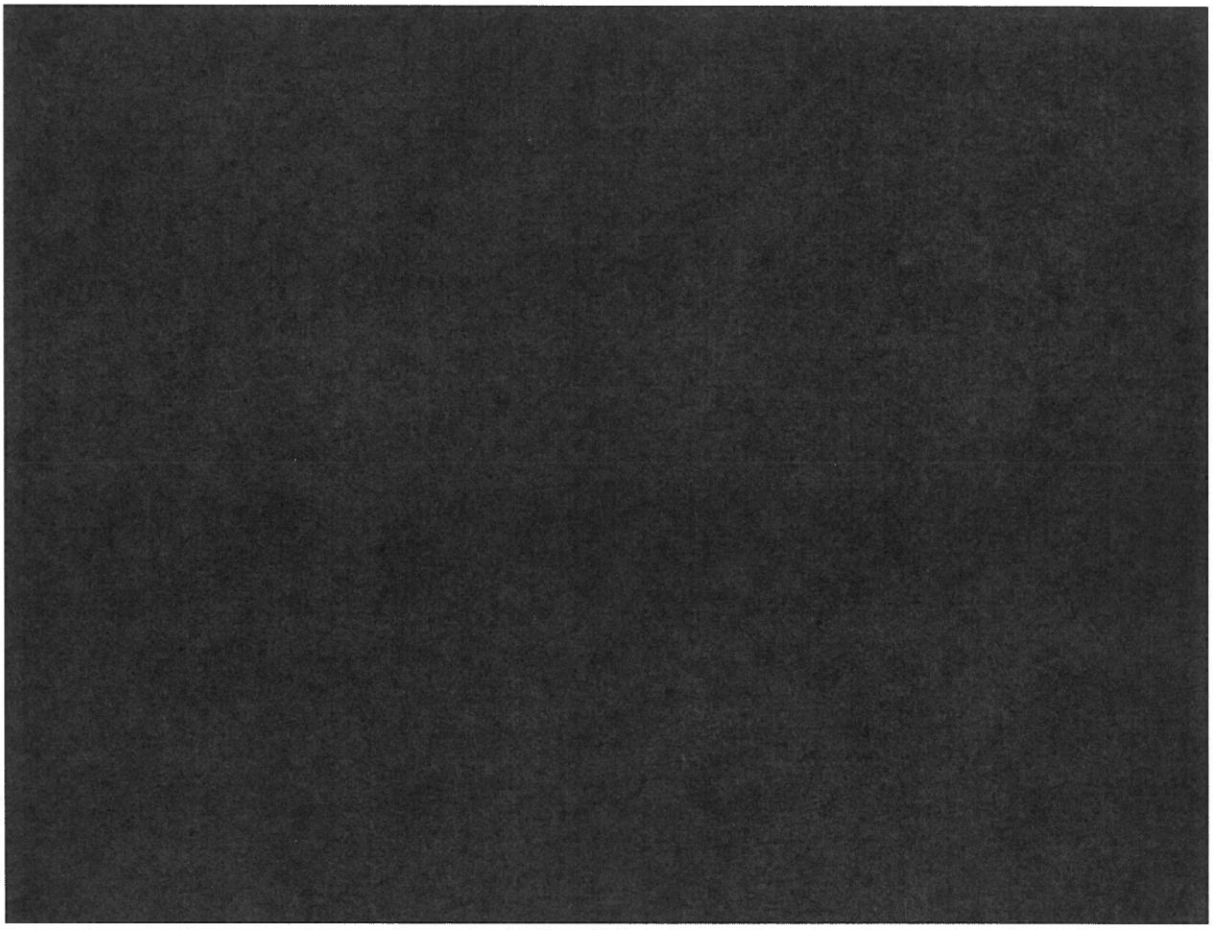


Our multifaceted approach to materials results in materials that are actionable, recognizable and promote informed decisions.

The ability of enrollment materials to meet their goals (to ensure comprehension and retention, encourage a high response rate and enhance without bias the ability of potential enrollees to

make a voluntary and informed choice about MCO/PCP option) depends on the audience receiving the message we want to convey; if the materials are not sensitive to the composition of the target groups or are not understandable to the potential enrollees, the message could easily be disregarded or distorted. The creation of user-friendly, informative and standardized information for potential enrollees is a hallmark of all of our education efforts. To ensure that our current materials met the needs of BMS and potential enrollees, we followed a multi-faceted process (see Exhibits 49 and 50) and will continue to do so new materials are developed.

Exhibit 50. Materials Development/Revision Process



Our comprehensive materials development and revision process results in materials that best meet the needs of potential enrollees/enrollees and provide the right information at the right time.

For all aspects of the Project, we will produce materials that are accessible to most of our audience – written at a 6th grade or lower reading level[12] (as verified by the Flesch-Kincaid

[12] BMS requires that all materials be written at no higher than a 6th grade reading level. In our current contracts we accommodate literacy levels as low as 4th grade.

Readability Test), easy to read (as documented through computer-generated Ease of Reading scores) and available in multiple media. We will also make materials available in alternative formats and languages.

Types of Enrollee Materials

We have developed a wide array of potential enrollee and enrollee materials, including but not limited to program brochures, letters, posters, flyers, newsletters, handbooks, etc. in all of our Medicaid projects. We are happy to provide the same for the MHT Project, and will continue to identify and seek out appropriate new materials to add.

Enrollment Packets

Upon review of the sample enrollment packet included in Appendix F, you will see that our enrollment packets empower potential enrollees to make a timely enrollment choice, encourage potential enrollees to call the MHT Call Center to enroll or obtain answers to questions, and include:

- A personalized and pre-populated enrollment form indicating the name, contact information, Medicaid ID number, date of birth, and enrollment options available for the potential enrollee;
- A Health Needs Assessment to identify the presence of special needs or health conditions that may require specific services;
- A Welcome Letter that clearly indicates the health care choices to be made, encourages enrollment in "Three Easy Steps", alerts potential enrollees of the multiple routes to enroll;
- A Mountain Health Trust informational brochure that explains key MHT concepts such as the importance and roles of an MCO and PCP, reinforces the importance of enrollment, and explains what happens after enrollment;
- A county-specific MCO Plan Comparison Chart highlighting the contact information for as well as the benefits and services provided by each available MCO;
- MCO developed and provided educational materials for the plans available in the potential enrollee's county;
- A MHT Checklist for Enrollment to guide the potential enrollee through reviewing enrollment packet materials, making their MCO and PCP choice, and submitting the enrollment;
- A Doctor's Approval Form and the Member Rights and Member Responsibility insert (for PAAS counties); and
- A self-addressed, postage-paid envelope to return the completed form to us.

Further, while the current MHT program does not call for passive enrollment, we are also able to customize the enrollment packet contents to include pre-populated passive enrollment information (e.g., the MCO to which the enrollee will be assigned if a timely choice is not made and the timeframe for making an enrollment choice.) We currently provide this to potential enrollees in Florida and Ohio.

As a value added service and enhancement to our enrollment materials, we propose incorporating Quick Response (QR) codes (described later in this section) and relevant instructions so that when potential enrollees scan the code with a Smart Phone, they are taken to a mobile-friendly, secure website for instant online enrollment.

Enrollment Form

A pre-populated, personalized enrollment form will continue to be included in MHT Enrollment Packets so that potential enrollees who wish to make their MCO/PCP selections via the mail are able to do so. Hardcopy enrollment forms are a particularly nice option for enrollees who are able to read and assimilate the information included in the Enrollment Packet, who have some form of prior managed care experience, and/or know the MCO and PCP with which they want to enroll.



We have developed the MHT enrollment form after consultation with BMS to ensure that all desired enrollment form data are collected, the style meets the State's expectations and requirements, and the form is as easy to understand and complete as possible.

As an enhancement to our enrollment form processing, we will barcode each application. By doing so, the Administrative Assistant receiving the forms will be able to use a barcode scanner to automatically and immediately identify that specific enrollee in HealthTrack and, subsequently, our Benefits Managers will only have to data enter the enrollee-provided information (e.g., MCO and PCP selected, and race/ethnicity/language if provided) – **a quick process that eliminates the need for time consuming data entry while increasing accuracy.**

We have several techniques we have incorporated into the MHT enrollment forms to ensure ease of use. When we designed the MHT enrollment form, we:

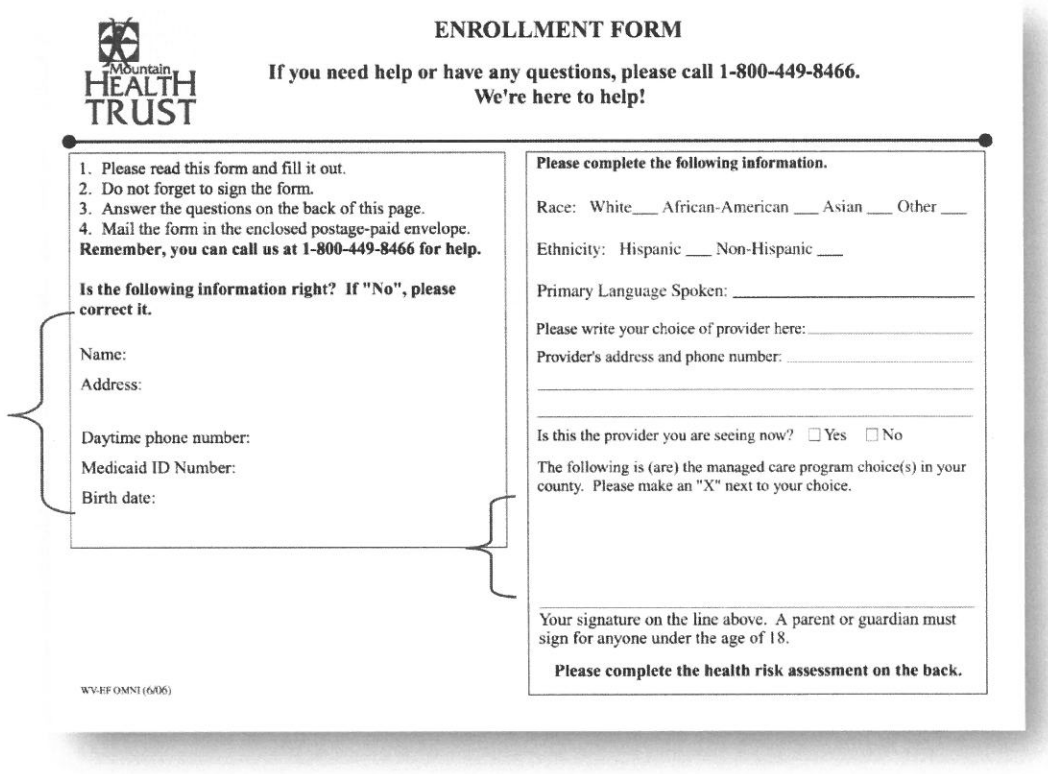
- Ensured there is ample space to write, so individuals with large handwriting or long names can fit all their information on to the form,
- Avoided abbreviations that may be confusing and compromise the integrity of the information,

- Included all data fields on one page of the form, so important data elements are not overlooked, and
- Strived to provide an unintimidating form that is accessible to potential enrollees.

We will add language that race, ethnicity, and language spoken are not required for enrollment. Further, we will make any additional modifications desired by BMS to ensure our MHT enrollment forms meet or exceed all of BMS' needs and expectations.

Exhibit 51. MHT Enrollment Form

Enrollee name, Medicaid ID number, contact information and date of birth, and available health plan choices are pre-populated on our enrollment form.



Mountain HEALTH TRUST

ENROLLMENT FORM

If you need help or have any questions, please call 1-800-449-8466.
We're here to help!

1. Please read this form and fill it out.
2. Do not forget to sign the form.
3. Answer the questions on the back of this page.
4. Mail the form in the enclosed postage-paid envelope.

Remember, you can call us at 1-800-449-8466 for help.

Is the following information right? If "No", please correct it.

Name:

Address:

Daytime phone number:

Medicaid ID Number:

Birth date:

Please complete the following information.

Race: White___ African-American ___ Asian ___ Other ___

Ethnicity: Hispanic ___ Non-Hispanic ___

Primary Language Spoken: _____

Please write your choice of provider here: _____

Provider's address and phone number: _____

_____

_____

Is this the provider you are seeing now? ☐ Yes ☐ No

The following is (are) the managed care program choice(s) in your county. Please make an "X" next to your choice.

_____

Your signature on the line above. A parent or guardian must sign for anyone under the age of 18.

Please complete the health risk assessment on the back.

WV-EF OMNI (6/06)

Our enrollment form is unintimidating in appearance and user friendly.

Health Needs Assessment

While not mandatory for MHT enrollment, we also include a health needs assessment on the reverse side of the enrollment form. Again, we strived to make this as user-friendly and accessible as possible. All health needs assessment will be entered into HealthTrack and forwarded to the enrollee's MCO.

Exhibit 52. MHT Health Needs Assessment

1. Do you use smokeless tobacco? No _____ Yes _____
2. Do you smoke? No _____ Yes _____
3. Are you seeing a doctor for any of the reasons listed below? If you are, please put an "X" next to each one that applies.
   - _____ Problem pregnancy
   - _____ Planned surgery in the future
   - _____ Receiving home care or hospice services
   - _____ On an organ transplant list
   - _____ Receiving chemotherapy
   - _____ Receiving physical/occupational/speech therapy
   - _____ Heart condition such as congestive heart failure
   - _____ Lung disorder such as asthma
4. Are you pregnant? No _____ Yes _____ Expected Delivery Date: _____
5. Do any of these apply to you? If one or more does, please put an "X" next to each one that applies.
   - _____ Are you in the last three months of your pregnancy?
     If you are, who is your OB/GYN? _____
   - _____ Will you be hospitalized on the first day of enrollment?
   - _____ Are you currently under treatment for a specific health problem?
   - _____ Does your doctor think that changing doctors would cause harm?
   - _____ Do you have a terminal illness?
   - _____ Are you receiving Medicare?
6. Do you have any health insurance other than Medicaid? If you do, please complete the following information.
   - Name of insurance company: _____
   - Group Name: _____
   - Group Number: _____
   - Policy Number: _____
   - Name of Insured: _____
7. Are you enrolled in the Health Insurance Premium Program (HIPP)? (This means that your health insurance premium is being paid by Medicaid.) _____ No _____ Yes

Medical Release Statement: I authorize any health care provider having information related to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me (or my dependent) to give the above information to the managed care program.

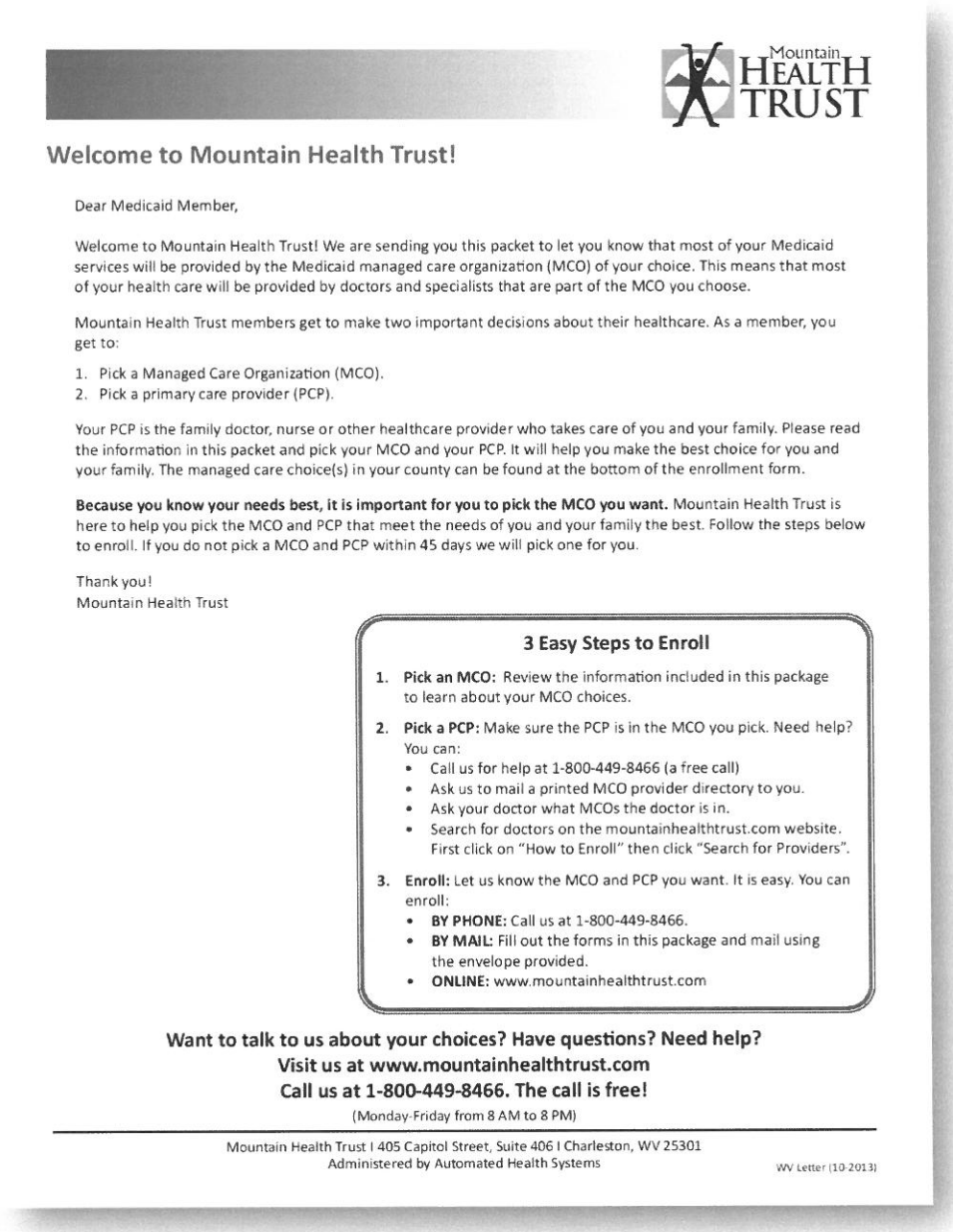
_____

Your signature goes here. A parent or guardian must sign for anyone under age 18.

Our health needs assessment helps identify the presence of special needs or health conditions that may require specific services. It also allows us to capture third party insurance coverage.

Welcome to MHT Letter

Exhibit 53. MHT Welcome Letter



Mountain HEALTH TRUST

Welcome to Mountain Health Trust!

Dear Medicaid Member,

Welcome to Mountain Health Trust! We are sending you this packet to let you know that most of your Medicaid services will be provided by the Medicaid managed care organization (MCO) of your choice. This means that most of your health care will be provided by doctors and specialists that are part of the MCO you choose.

Mountain Health Trust members get to make two important decisions about their healthcare. As a member, you get to:

1. Pick a Managed Care Organization (MCO).
2. Pick a primary care provider (PCP).

Your PCP is the family doctor, nurse or other healthcare provider who takes care of you and your family. Please read the information in this packet and pick your MCO and your PCP. It will help you make the best choice for you and your family. The managed care choice(s) in your county can be found at the bottom of the enrollment form.

Because you know your needs best, it is important for you to pick the MCO you want. Mountain Health Trust is here to help you pick the MCO and PCP that meet the needs of you and your family the best. Follow the steps below to enroll. If you do not pick a MCO and PCP within 45 days we will pick one for you.

Thank you!
Mountain Health Trust

3 Easy Steps to Enroll

1. **Pick an MCO:** Review the information included in this package to learn about your MCO choices.
2. **Pick a PCP:** Make sure the PCP is in the MCO you pick. Need help? You can:
   - Call us for help at 1-800-449-8466 (a free call)
   - Ask us to mail a printed MCO provider directory to you.
   - Ask your doctor what MCOs the doctor is in.
   - Search for doctors on the mountainhealthtrust.com website. First click on "How to Enroll" then click "Search for Providers".
3. **Enroll:** Let us know the MCO and PCP you want. It is easy. You can enroll:
   - **BY PHONE:** Call us at 1-800-449-8466.
   - **BY MAIL:** Fill out the forms in this package and mail using the envelope provided.
   - **ONLINE:** www.mountainhealthtrust.com

Want to talk to us about your choices? Have questions? Need help?
Visit us at www.mountainhealthtrust.com
Call us at 1-800-449-8466. The call is free!
(Monday-Friday from 8 AM to 8 PM)

Mountain Health Trust I 405 Capitol Street, Suite 406 I Charleston, WV 25301
Administered by Automated Health Systems

WV Letter (10-2013)

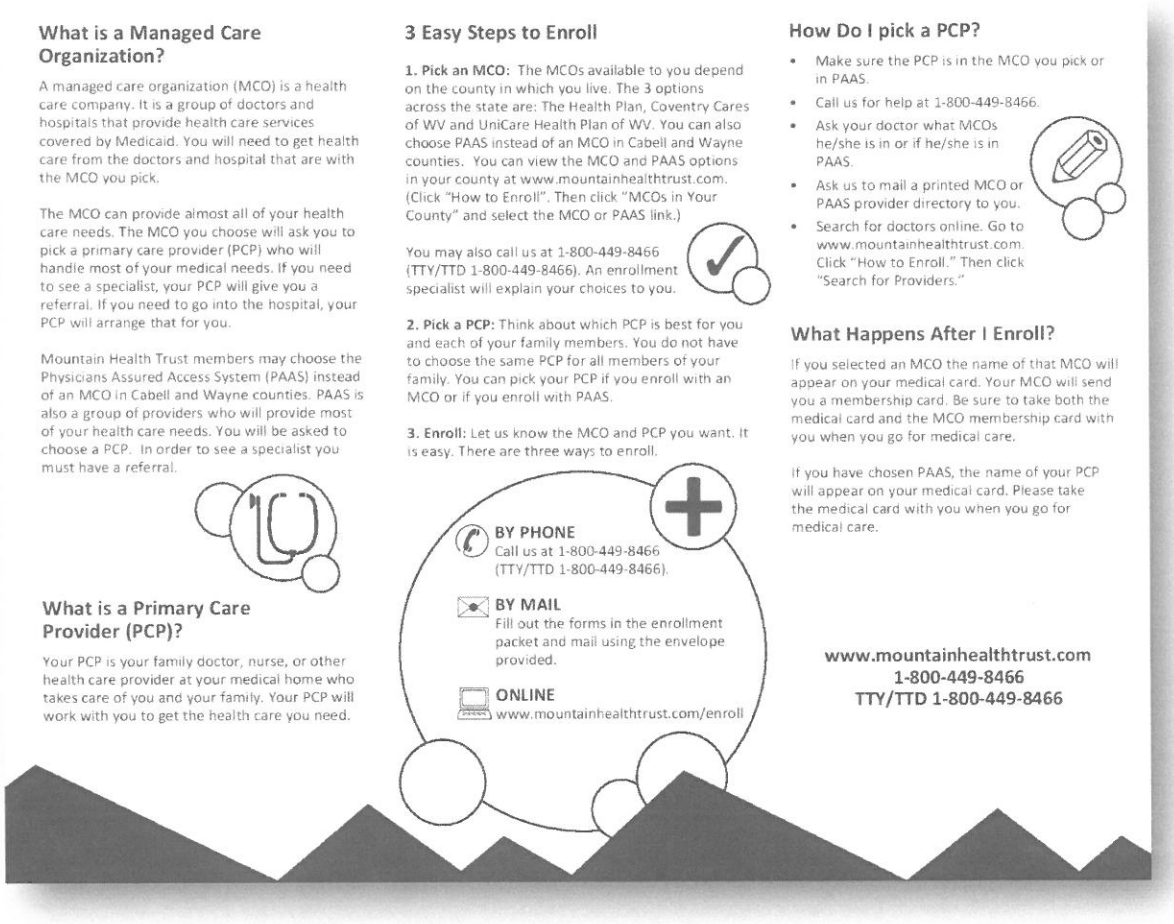
This letter is a cost-conscious, yet highly effective letter for prompting enrollee action.

The welcome letter included in MHT enrollment packets, too, was developed in consultation with BMS. Written with an up-beat, empowering tone, this letter:

- Welcomes the enrollee to MHT,
- Introduces MCO and PCP selection as a program benefit and important choice to make,
- Uses active language to prompt action,
- Incorporates the MHT logo to promote recognition,
- Educates the enrollee on the ease of enrollment and the availability of additional supports (e.g., MHT Call Center, website), and
- Uses a touch of color to draw the reader to the routes of enrollment.

MHT Brochure

Exhibit 54. Sample Page from our MHT Brochure in West Virginia



What is a Managed Care Organization?

A managed care organization (MCO) is a health care company. It is a group of doctors and hospitals that provide health care services covered by Medicaid. You will need to get health care from the doctors and hospital that are with the MCO you pick.

The MCO can provide almost all of your health care needs. The MCO you choose will ask you to pick a primary care provider (PCP) who will handle most of your medical needs. If you need to see a specialist, your PCP will give you a referral. If you need to go into the hospital, your PCP will arrange that for you.

Mountain Health Trust members may choose the Physicians Assured Access System (PAAS) instead of an MCO in Cabell and Wayne counties. PAAS is also a group of providers who will provide most of your health care needs. You will be asked to choose a PCP. In order to see a specialist you must have a referral.

What is a Primary Care Provider (PCP)?

Your PCP is your family doctor, nurse, or other health care provider at your medical home who takes care of you and your family. Your PCP will work with you to get the health care you need.

3 Easy Steps to Enroll

1. Pick an MCO: The MCOs available to you depend on the county in which you live. The 3 options across the state are: The Health Plan, Coventry Cares of WV and UniCare Health Plan of WV. You can also choose PAAS instead of an MCO in Cabell and Wayne counties. You can view the MCO and PAAS options in your county at www.mountainhealthtrust.com. (Click "How to Enroll". Then click "MCOs in Your County" and select the MCO or PAAS link.)

You may also call us at 1-800-449-8466 (TTY/TTD 1-800-449-8466). An enrollment specialist will explain your choices to you.

2. Pick a PCP: Think about which PCP is best for you and each of your family members. You do not have to choose the same PCP for all members of your family. You can pick your PCP if you enroll with an MCO or if you enroll with PAAS.

3. Enroll: Let us know the MCO and PCP you want. It is easy. There are three ways to enroll.

BY PHONE
Call us at 1-800-449-8466 (TTY/TTD 1-800-449-8466).

BY MAIL
Fill out the forms in the enrollment packet and mail using the envelope provided.

ONLINE
www.mountainhealthtrust.com/enroll

How Do I pick a PCP?

- Make sure the PCP is in the MCO you pick or in PAAS.
- Call us for help at 1-800-449-8466.
- Ask your doctor what MCOs he/she is in or if he/she is in PAAS.
- Ask us to mail a printed MCO or PAAS provider directory to you.
- Search for doctors online. Go to www.mountainhealthtrust.com. Click "How to Enroll." Then click "Search for Providers."

What Happens After I Enroll?

If you selected an MCO the name of that MCO will appear on your medical card. Your MCO will send you a membership card. Be sure to take both the medical card and the MCO membership card with you when you go for medical care.

If you have chosen PAAS, the name of your PCP will appear on your medical card. Please take the medical card with you when you go for medical care.

www.mountainhealthtrust.com
1-800-449-8466
TTY/TTD 1-800-449-8466

Our brochures help provide critical information in a user-friendly format.

Program brochures can be used for many purposes, and with each brochure we have developed we have coordinated with our State partner on the goals and objectives for such brochures. Such is the case for our MHT brochure. We use this brochure to:

- Explain the role and benefits of having an MCO and PCP;
- Highlight how to enroll, with an emphasis that enrollment is easy;
- Provide information on the available resources to select an MCO and PCP;
- Promote the toll-free MHT Call Center;
- Provide answers to frequently asked questions; and
- Promote our Project website for more information.

As evidenced in Exhibit 54, when developing brochures, we paid close attention to the design, layout and overall look of the material. Features to improve comprehensive and attract the target audience are incorporated (e.g., we used appropriate headings with bulleted lists rather than long paragraphs, and we used graphics that are appealing and provide contextual cues, etc.).

We carefully and strategically determined the appropriate distribution for MHT brochures – they will not only continue to be disseminated directly to potential enrollees/enrollees via the mail and community based field events, but also indirectly via distribution by community partners throughout the State, as well as at FRNs and other agencies as directed and approved by BMS. Project brochures will also be made available on the Project website.

County-specific MCO Plan Comparison Chart

When MCO Provider Directories were eliminated from enrollment packages in the Fall of 2013 (discussed below), we recommended the development and inclusion of MCO plan comparison charts to better present MCO options in a more user-friendly fashion. By December of 2013, we:

- Developed and received BMS-approval on all needed variations of the comparison chart,
- Updated all enrollment materials and website information to reflect the changes in materials, and
- Initiated the changes and new materials simultaneous to the State's elimination of the Mountain Health Choices Program.

Our MCO plan comparison charts provide potential enrollees with important information about the benefits and services provided by the MCOs available to them. With several variations available to ensure that each potential enrollee only received comparison information about the MCOs available in their county of residence, this chart provides at-a-glance information to support self-selection of a best-fit MCO. This is a particularly helpful resource for those that are more visually inclined.

Including easy-to-understand guidance on how to enroll provides an additional call to action for potential enrollees.

Exhibit 55. MHT MCO Plan Comparison Chart

MCO Plan Comparison

Mountain HEALTH TRUST

Standard Services and Benefits			
Services and Benefits*	CoventryCares of West Virginia Phone: 1-888-348-2922 TTY 711; TDD 1-800-877-8973 Mon-Fri. 8:30 am-5:00 pm www.coventrycareswv.com	The Health Plan Phone: 1-800-624-6961 TTY: 1-800-622-3925 Mon-Fri. 8:30 am-5:00 pm www.healthplan.org	UniCare Phone: 1-800-782-0095 TTY: 1-866-368-1634 Mon-Fri. 8:00 am-6:00 pm www.unicare.com
Inpatient Services	✔	✔	✔
Outpatient Services	✔	✔	✔
Physician/Nurse Practitioner/ Midwife/Rural Health Clinic/ Federally Qualified Health Centers	✔	✔	✔
Home Health Services	✔	✔	✔
Durable Medical Equipment	✔	✔	✔
Family Planning Services and Supplies	✔	✔	✔
Hospice Services	✔	✔	✔
Ambulance	✔	✔	✔
Prescriptions	✔	✔	✔
Tobacco Cessation	✔	✔	✔
Skilled Nursing Care (Up to Age 21)	✔	✔	✔
EPSDT (Up to Age 21)	✔	✔	✔
Vision (Up to Age 21)	✔	✔	✔
Hearing (Up to Age 21)	✔	✔	✔
Dental (Up to Age 21)	✔	✔	✔

*This is not a list of all Medicaid services. Please check the West Virginia Guide to Medicaid for more information on benefits. http://www.dhhr.wv.gov/bms/Documents/YourGuideMedicaid.pdf

Picking your MCO and PCP

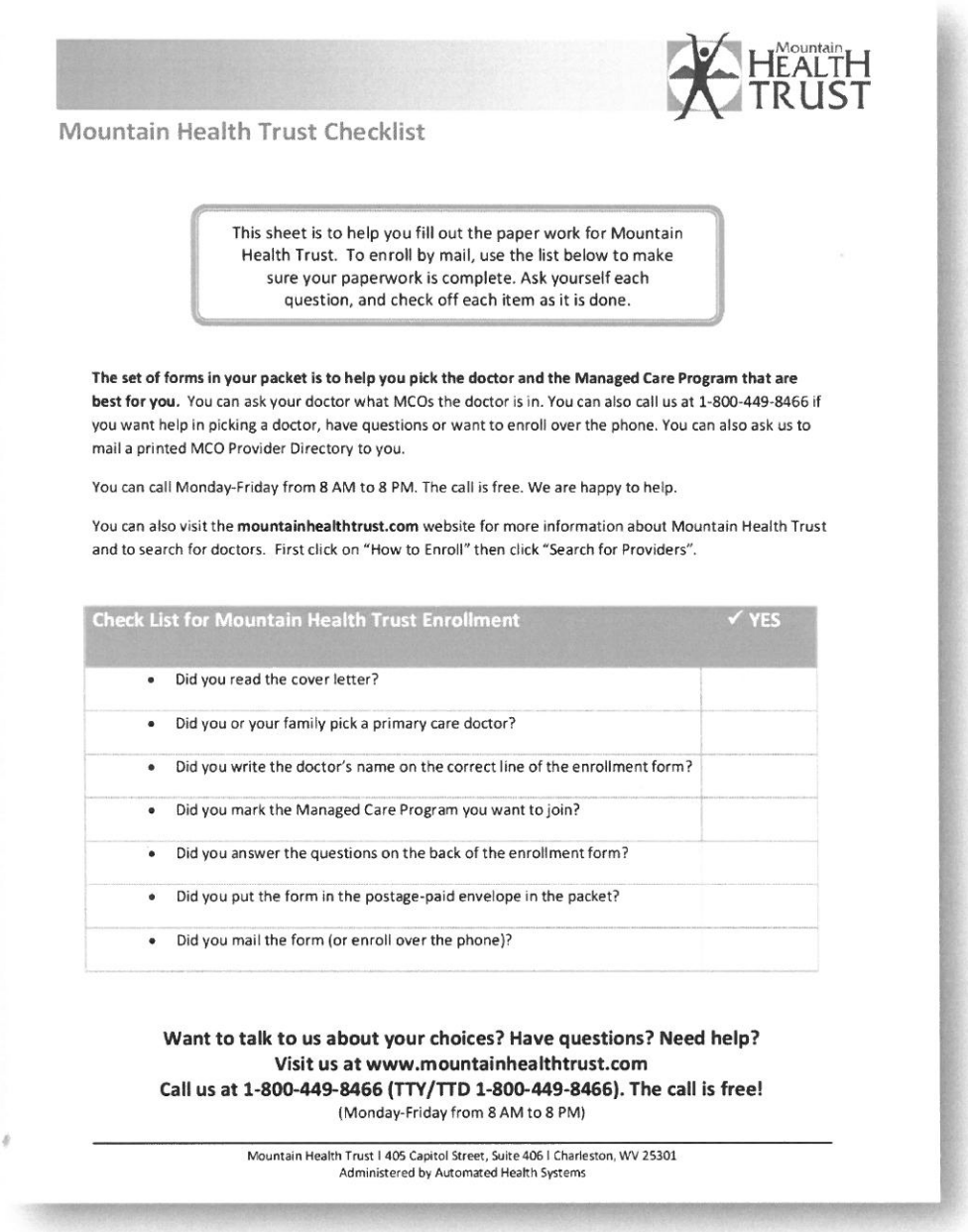
There are three MCOs in your county to pick from. Chances are your own PCP may be in one of the MCOs.

- You can ask your PCP which MCOs the PCP is in.
- You can call the Mountain Health Trust Helpline at 1-800-449-8466; TTY/TTD 1- 800-449-8466 (a free call) to ask us.
- You can ask us to mail a hard copy of the MCO Provider Directory to you.
- You can also visit the mountainhealthtrust.com website. First click on "How to Enroll" then click "Provider Search" for the most up to date listing of PCPs.

3 Plan Chart 12/2013

We provide MHT potential enrollees with MCO comparison charts to help them make the best enrollment decision for themselves. Comparison charts are customized to only present information about the MCOs available in the potential enrollee's county.

Exhibit 56. MHT Enrollment Checklist



Mountain Health Trust Checklist

This sheet is to help you fill out the paper work for Mountain Health Trust. To enroll by mail, use the list below to make sure your paperwork is complete. Ask yourself each question, and check off each item as it is done.

The set of forms in your packet is to help you pick the doctor and the Managed Care Program that are best for you. You can ask your doctor what MCOs the doctor is in. You can also call us at 1-800-449-8466 if you want help in picking a doctor, have questions or want to enroll over the phone. You can also ask us to mail a printed MCO Provider Directory to you.

You can call Monday-Friday from 8 AM to 8 PM. The call is free. We are happy to help.

You can also visit the **mountainhealthtrust.com** website for more information about Mountain Health Trust and to search for doctors. First click on "How to Enroll" then click "Search for Providers".

Check List for Mountain Health Trust Enrollment	✓ YES
• Did you read the cover letter?	
• Did you or your family pick a primary care doctor?	
• Did you write the doctor's name on the correct line of the enrollment form?	
• Did you mark the Managed Care Program you want to join?	
• Did you answer the questions on the back of the enrollment form?	
• Did you put the form in the postage-paid envelope in the packet?	
• Did you mail the form (or enroll over the phone)?	

Want to talk to us about your choices? Have questions? Need help?
Visit us at www.mountainhealthtrust.com
Call us at 1-800-449-8466 (TTY/TTD 1-800-449-8466). The call is free!
(Monday-Friday from 8 AM to 8 PM)

Mountain Health Trust I 405 Capitol Street, Suite 406 I Charleston, WV 25301
Administered by Automated Health Systems

Our Enrollment Checklist helps potential enrollees navigate the contents of the MHT enrollment packet and increases the likelihood of an enrollee successfully completing an enrollment.

We understand that some potential enrollees may feel overwhelmed by just opening a multi-piece mailed enrollment package, let alone reading and acting on it all. We developed our BMS-

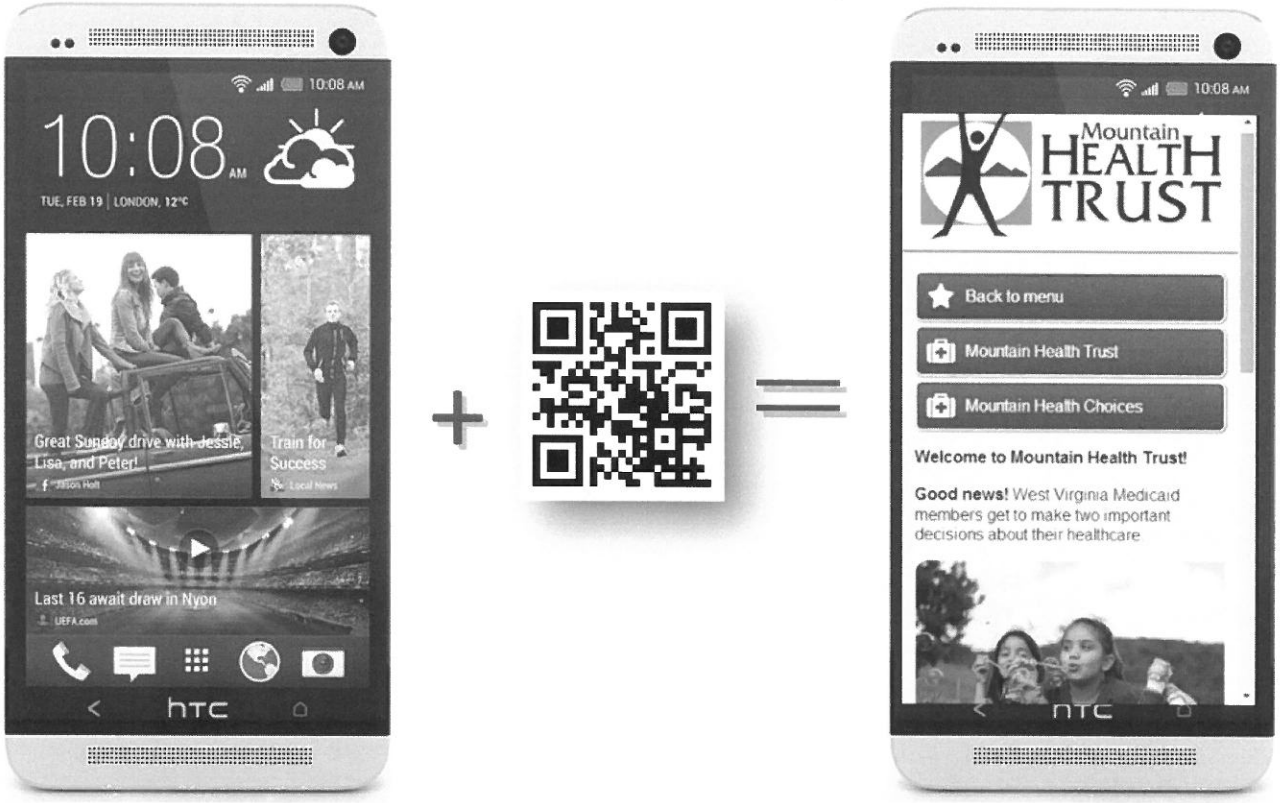
approved MHT enrollment checklist as a support to potential enrollees reviewing enrollment packet materials. This tool supports each potential enrollee's navigation of enrollment packet contents, provides encouragement and resources for questions and support, reinforces routes of enrollment, and increases the likelihood of a complete enrollment submission.

Leveraging Mobile Technology to Support Enrollment

As mentioned, with BMS' approval, we would like to include QR codes on our MHT enrollment materials. QR codes can be read by a variety of Smart Phones and software including the iPhone, Google's Android, Blackberry and a growing list of others. While mainly used for marketing products, promoting businesses, etc., they do have application for Enrollment Brokering. As the RFP mentions, the Enrollment Broker must ensure that all potential enrollees have access to enrollment services, and incorporating such technology into our operations makes MHT even more accessible to our potential enrollees.

Exhibit 57. QR Coded Materials Support Smart Phone Access to MHT

Use any barcode reader on your Smart Phone to scan this QR code and check out our mobile-friendly MHT website right now!



Including QR Codes on our materials makes increases accessibility and puts MHT enrollment right at potential enrollees' fingertips at home or on the go.

Further, over one-third of households with incomes under $30,000 have Smart Phones and their ownership of other mobile technologies (such as e-readers and tablets) is rapidly increasing.[13] Expanding the avenues through which potential enrollees can do so by leveraging technology provides another opportunity to elicit a voluntary MCO selection.

For our purposes, when the user scans the QR code with his/her Smart Phone, it will open our mobile-browser friendly enrollment application on the potential enrollee's Smart Phone, thus affording the user the opportunity to enroll directly. For security purposes we will still require potential enrollees to log in per our standard online enrollment protocol as a precaution against data or identity theft. Of course, potential enrollees without this technology can still visit the program website directly for our Web-based online application or enroll via another route.

We have already developed and received State approval to deploy our mobile browser friendly website that has been designed to fit the vast majority of Smart Phones on the market currently. Please refer to Section 4.1.18 for a description of our mobile friendly website.

Reminder Notice

Reminder notices are a cost-effective tool for prompting potential enrollees who have yet to select an MCO to do so in a timely manner. We worked closely with BMS on our current reminder notice that:

- Reminds potential enrollees of their enrollment options,
- Emphasizes the ease of making their choice and the various routes to do so, and
- Encourages potential enrollees to call the MHT Call Center for help.

With BMS' approval, the reminder notice will provide yet another opportunity for potential enrollees to be afforded the convenient option of enrolling via Smart Phone.

Reminder notices will continue to be mailed to all potential enrollees who have not chosen an MCO on a timeframe agree upon with BMS prior to auto assignment.

Provider Directories

Throughout our tenure as West Virginia's enrollment broker contractor, we have collaborated with the MCOs to ensure that the provider directory for each MCO is inserted in the MHT enrollment packet according to MCO coverage within each county. Under the direction of Commissioner Atkins and in consultation with the State and MCOs, as of October 2013, we eliminated each MCO's provider directory from the enrollment packets.

[13] Smith, Aaron. "Nearly Half of American Adults Are Smart Phone Owners," Pew Internet and American Life Project, March 1, 2012. http://www.pewinternet.org/Reports/2012/Smartphone-Update-2012.aspx

Upon request, we send provider directories to potential enrollees. While the MCO directories are provided to us by the MCOs, we generate the provider directory for PAAS. The provider directory mailings we send contain only the directories of those managed care options available in the enrollee's county of residence. Enrollees already enrolled with an MCO are directed to the MCO to request a copy of the provider directory.

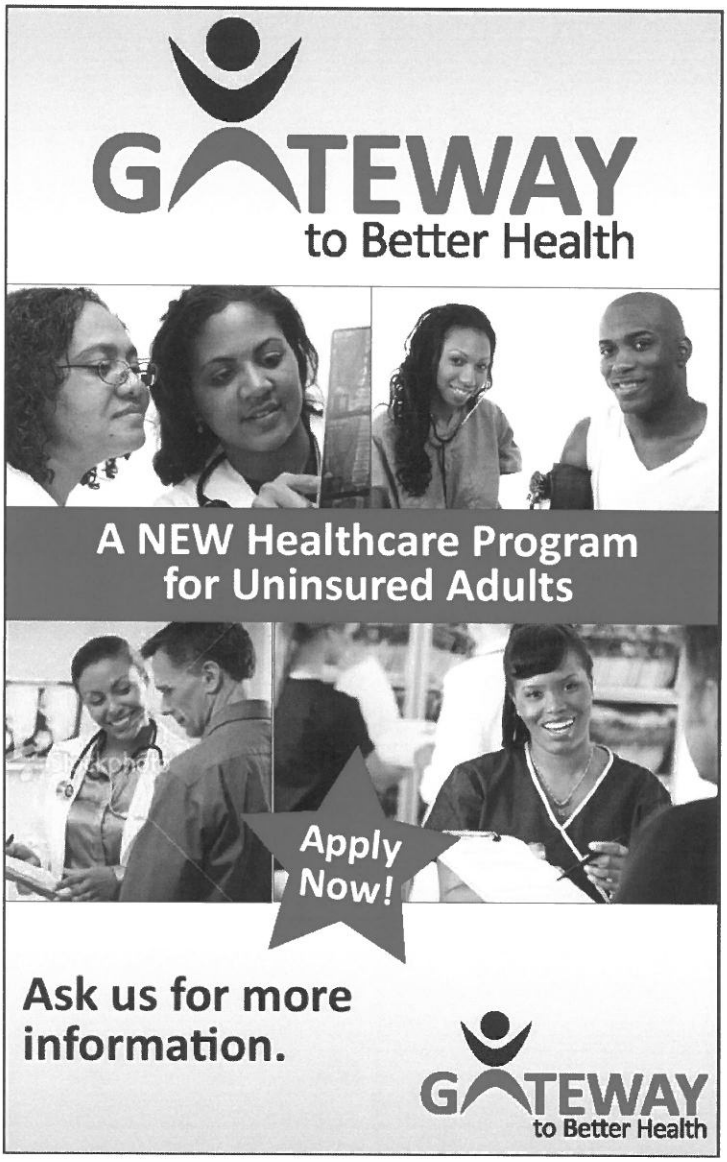
Other Materials

In additional to the materials described above, we are skilled with developing additional outreach, education, and enrollment materials. Should BMS desire, we are happy to provide additional collateral such as flyers, posters, handbooks, additional letters, and handouts.

Flyers

We have experience developing a number of flyers for various Enrollment Broker and PCCM Projects. Flyers may include simple tips on approaches to select a best-fit MCO, program information, or, if so desired, information about specific issues or health topics.

Exhibit 58. Gateway to Better Health Poster



This poster is aimed at engaging low-income, uninsured adults and encouraging them to apply for health care coverage.

For example, in our CommunityCARE PCCM contract in Louisiana, we developed a series of flyers on the CommunityCARE program, KIDMED (EPSDT) program, and the availability of the Nurse Triage Line. As with all materials, we adhered to the reading level (4th grade for this

contract) and developed the flyers to have a similar look and format. Each flyer provided critical information on accessing care, navigating the health care services in a responsible manner, and resources for help.

Similarly, in other Enrollment Broker Projects, we are responsible for providing educational materials on the services available for enrollees with special needs, WIC program as well as prenatal care programs. We would be happy to either develop specific flyers related to these topics or incorporate appropriate content into other MHT Project materials we develop.

Posters

Developing posters is also a common component for our enrollment broker projects. Designed to be eye catching, raise awareness about the program and support prompt enrollment, we adhere to the same principles described in Section 4.1.2. Our posters reflect our target audience, pique viewers' interest, and call them to action.

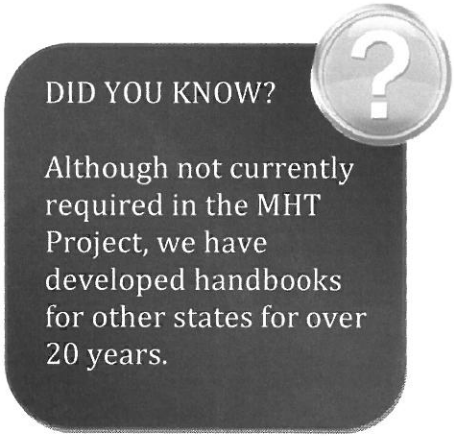
Please see Exhibit 58 for a poster we developed and launched under our St. Louis Gateway to Better Health (GBH) Demonstration Project. Because GBH is only available to low income adults who do not qualify for Medicaid and who are current patients at certain FQHCs, these posters include simple messaging and reflect the program's target audience.

These posters were distributed to FQHC sites. Viewers were encouraged to talk to health center staff, who are available to facilitate patient application using GATES (our Gateway Application Tracking and Eligibility System).

Handbooks

We point out our experience developing, producing, and distributing enrollee handbooks to demonstrate our ability to identify and provide written education concerning a variety of health delivery models to enrollees. We believe this experience will supplement our ability to communicate with enrollees and help them appropriately access care. More commonly used in our PCCM programs, we have developed appealing, easy-to-use handbooks to help enrollees understand:

- The Program and how to receive appropriate care through it,
- The role of a medical home and how to select and change a PCP,
- How to access additional services (e.g., services for tobacco cessation, dental care, vision care, drug and alcohol treatment, etc.),
- Their rights and responsibilities,



- The process for making a complaint/grievance,
- The Program's role in protecting privacy and confidentiality, and
- How to access additional help and information.

We commend DHHR for the updates to the "Your Guide to West Virginia Medicaid" publication. If DHHR so desired, we can produce a companion guide for MHT members and the West Virginia Health Bridge Plan members (if so included in managed care) to provide the member with information on enrollment, call center support, etc.

Mailing Materials

Our mail fulfillment services for the MHT Project require us to provide county-specific materials developed by BMS, the MCOs, and us in personalized enrollment packets and other mailings, and we consistently meet timeliness and quality control standards for these mailings. We have the experience, systems, policies, and procedures to ensure that all MHT Project mailings occur within their established timeframes. (Please see our response to Section 4.1.17 for a detailed discussion on our mailing operations.)

Please note: We understand and agree to be fully responsible for the development, printing, fulfillment and postage requirements for all costs associated with outreach, education and enrollment materials.

4.1.5 Process for Reviewing Member Materials

The Vendor should describe its approach for reviewing MCO and PAAS member materials and other information in any medium. BMS may also request the Vendor to assist in the review and approval of marketing materials and proposed marketing/outreach efforts. Any review of marketing materials should ensure that they comply with the requirements of 42 CFR § 438 Subpart C found in Exhibit B.

We understand that all of our efforts under the MHT Project ultimately reflect on BMS. And, while we are dedicated to designing, developing, producing and distributing a range of high-quality materials, we fully appreciate and support BMS' interest in and need to review and provide input/final approval on all materials developed by us. Yet, we also understand the need for BMS review and approval of materials prior to distribution and the overall demands on State staff's time. **We are committed to producing error-free materials to BMS the first time to ensure State staff are able to use their time most wisely.**

Our proposed materials approval process will be overseen by the Project Manager who will be responsible for coordinating with relevant in-house staff and translators to submit proofs of printed and audio materials within required time frames.

The Project Manager will review all proofs of hard and soft copy materials and ensure 42 CFR §438 compliance prior to submitting them to BMS. As part of her final review, she will complete a Materials Use and Quality Assurance (QA) Checklist for each piece of material. The Checklist will cover:

- Definition of material usage and business rules for distribution;
- Accuracy of information and content;
- Correct spelling and grammar usage;
- Confirmation of included phone numbers, fax numbers, web addresses;
- Conduct a reading level assessment as per BMS guidelines;
- Consistency in formatting and appropriate branding;
- Appeal and diversity of graphics;
- Inclusion of any BMS taglines;
- Cultural relevance and appropriateness; and
- Confirmation of translation accuracy (as appropriate).

The QA checklist for the piece will be attached to the proof of each piece of material upon its submission to BMS. A reading level assessment and related documentation (described in our response to 4.1.2 above) will be submitted as well. For each piece of material that does not pass

the QA review, the Project Manager will follow up and ensure the prompt resolution of any deficiency, repeat completion of the QA Checklist, and upon passing, submit it to BMS with the QA Checklist attached.

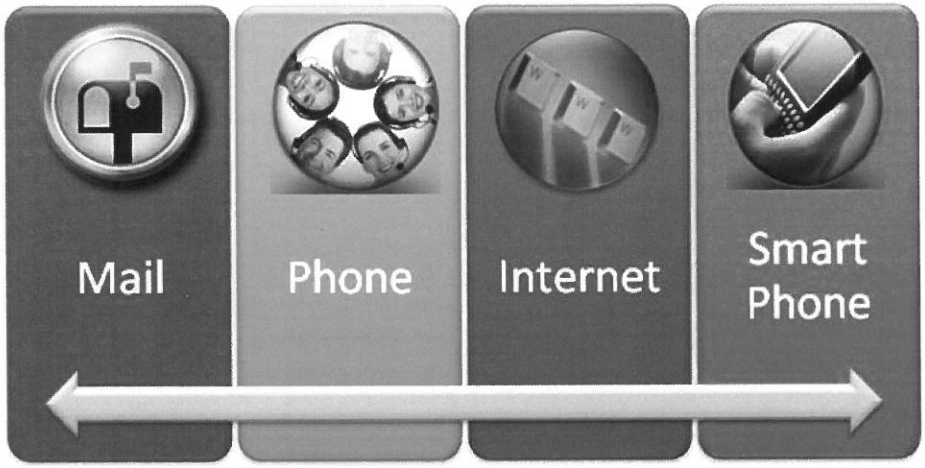
We are also more than happy to lend our materials development and compliance expertise to support review and approval of marketing materials and proposed marketing/outreach efforts as desired by BMS. Not only will our Project Manager be available to provide such support, but our Corporate Materials Development and Design Team will be available as well.

4.1.6 Multiple Approaches for Enrollment

The Vendor should offer multiple approaches for members to enroll, including by mail, telephone, text, web-based applications and other innovative and unique vehicles. The Vendor should address its approach for receiving enrollment forms via mail, telephone and internet. The vendor should also propose timeframes not to exceed 24 hours for processing enrollment forms and for returning forms received from eligible participants that cannot be processed due to incomplete or illegible information.

Enrollment Process Overview

Exhibit 59. MHT Enrollment Routes



We offer potential enrollees and enrollees a menu of avenues for enrollment ranging from traditional to tech savvy approaches.

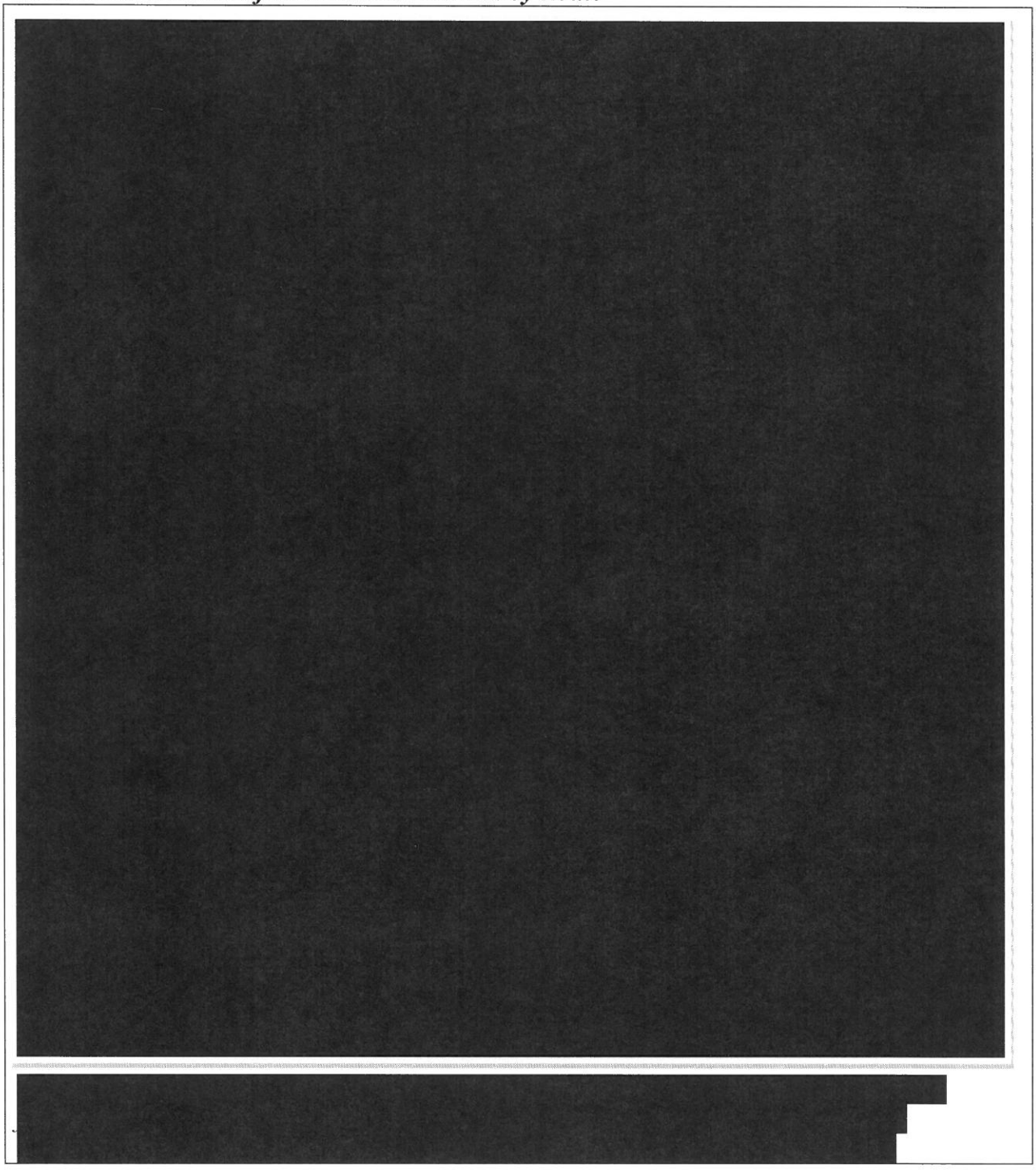
Having served as West Virginia's enrollment broker contractor for almost two decades, we are highly committed to bringing helpful and accessible enrollment services to MHT's potential enrollees and enrollees. Offering multiple avenues for potential enrollees to select a best-fit MCO or PAAS Provider is a critical to maximizing voluntary enrollment. **Enhancing our MHT enrollment offerings by introducing emerging technology recently and successfully deployed by us in other contracts, we are excited to offer enrollment routes ranging from traditional (mail and phone) to tech savvy (web and Smart Phone) approaches.**

A process flow of enrollment-related activities from our receipt of the eligiblity file to phone/mail outreach, enrollment (by type and route) and through the final transmisison of enrollment and health needs assessment information to the MCOs in the is included in Exhibit 60.

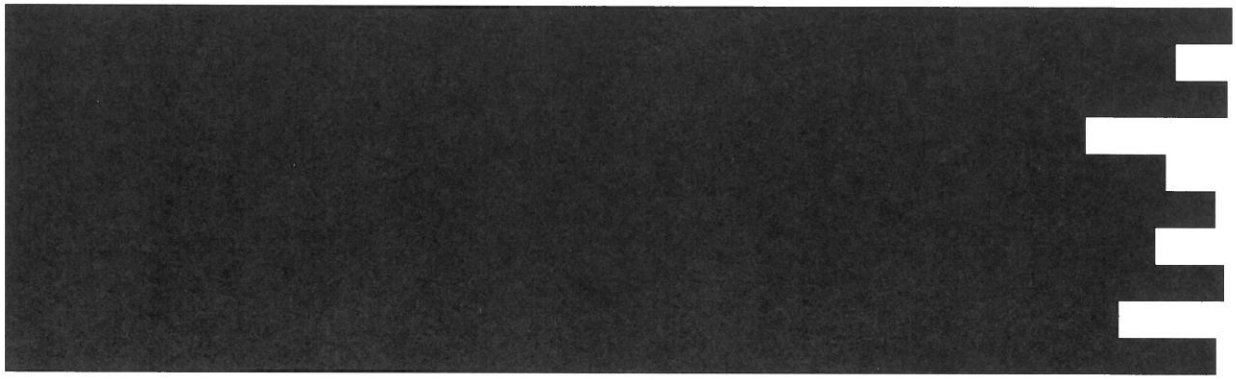
But, before a potential enrollee can make an informed, voluntary selection, s/he must first be aware that the need to make a choice exists and empowered with the right information and tools

to make such a choice. The first attempt to alert and equip potential enrollees about the importance of self-selecting a managed care option (and the timeframes for doing so) is through the mail.

Exhibit 60. Overview of Enrollment Processes by Route



Informing Potential Enrollees of the Need to Enroll



One of the messages we will convey in the Enrollment Packet is that there are many ways to enroll including:

Hard Copy Forms: User friendly, low literacy forms with an appealing design are included in Enrollment Packets. A pre-addressed, postage-paid envelope is included in the package for ease of return.

Toll-free Call Center: The MHT Call Center is dedicated solely to the MHT Project and provides unbiased choice counseling regarding the MHT and enrollment services – all in a caller's preferred language.

DID YOU KNOW?

By offering multiple enrollment routes, we increase the voluntary enrollment rate *and* enrollees' satisfaction with the services we provide.

Project Website: Our MHT website includes secure online enrollment for potential enrollees interested in 24/7 self-service options.

Smart Phone: If approved by BMS, we will embed a QR code into enrollment and reminder materials. Scanning this code using a Smart Phone barcode reader will instantly connect the user with a mobile-browser friendly Web-based interface for immediate enrollment through a Smart Phone. The mobile-friendly website would provide users the same features as the full site.

Reminding Potential Enrollees to Make a Timely Voluntary Selection

Potential enrollees who do not promptly respond to the mailed Enrollment Packet will be flagged for reminder outreach activities. Our approach to reminder activities (fully detailed in our upcoming response to Section 4.1.10) calls for tiered mail-and phone-based outreach that exceeds RFP requirements.

Providing Choice Counseling, Enrollment Assistance, and Support

Because a potential enrollee is unable to make a fully informed self-selection without appropriate education about his/her MCO and PCP options, the narrative below addresses our approach to educating and supporting potential enrollees.

We will include all required member materials in the enrollment packets we send to potential enrollees. This includes materials developed by us, as well as those developed and provided to us by the MCOs. Along with making such materials available in hard copy, program-specific information and soft copy materials will be available through the MHT website. For some potential enrollees, no further discussion of information is needed for them to consider their health care options and make a voluntary enrollment. However, for many others, this is not the case.

For potential enrollees who wish to speak about their health care choices over the phone, we will operate a toll-free MHT Call Center that offers TTY/Relay and translation services at no cost to the caller. During business hours, callers will have the opportunity to speak with one of our Benefits Managers regarding the MCOs and PCPs available to them. (Please see our upcoming response to Section 4.2 for a complete discussion of our approach to creating and providing a telephone unit.)

Those seeking information on the MHT Project's website will be able to review copies of all education and enrollment materials. They will also be able to email our Benefits Managers securely via the "Contact Us" portion of the website (see Sections 4.1.17 for more about "Contact Us" and 4.1.18 for a complete description of the MHT website).

In the pages that follow, we present a walkthrough of how phone enrollments will be processed.[14] The screen shots included highlight our enhanced, proven HealthTrack system, which will be customized and deployed under the new Enrollment Broker Project. (Please note: The screen shots below were taken from our Florida iteration of HealthTrack. We acknowledge that not all features are currently applicable for the MHT project as it currently stands. However, we want to show BMS of additional capabilities we can integrate and deploy if needed by BMS in the future. Again, we will fully customize HealthTrack to meet West Virginia's unique and specific needs.)

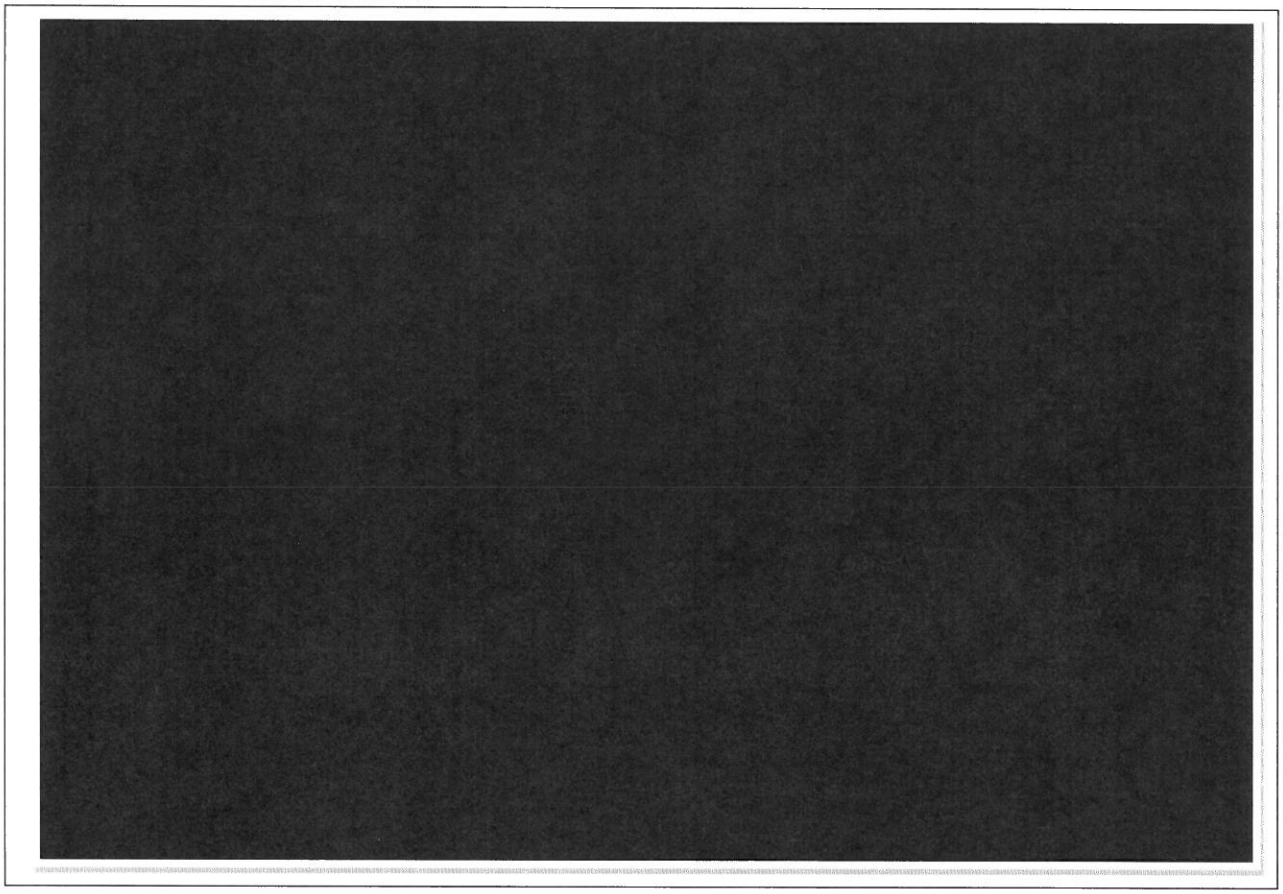
We will continue to ensure that our Benefits Managers staff are fully trained on quality customer service, cultural sensitivity, and all aspects of the MHT Program served by the enrollment broker. All choice counseling provided to potential enrollees and enrollees regarding their health care options will be unbiased and follow BMS-approved scripts (as was described above). Thus our Benefits Managers will continue to be able to assist eligible potential enrollees and enrollees

[14] Because all enrollments are processed virtually the same in HealthTrack, we elected to feature phone enrollments because it requires the greatest level of involvement from our staff. Also, please see Section 4.1.13 for details about how we process hard copy enrollment forms.

with any questions they have and provide appropriate support during the enrollment, disenrollment, and change processes.

When a potential enrollee is ready to make a voluntary enrollment, our Benefits Managers will now launch the new HealthTrack's Enrollment Wizard by clicking on "Enrollment/Plan Change" in HealthTrack's Call Actions Screen (see Exhibit 61).

Exhibit 61. Call Actions Screen

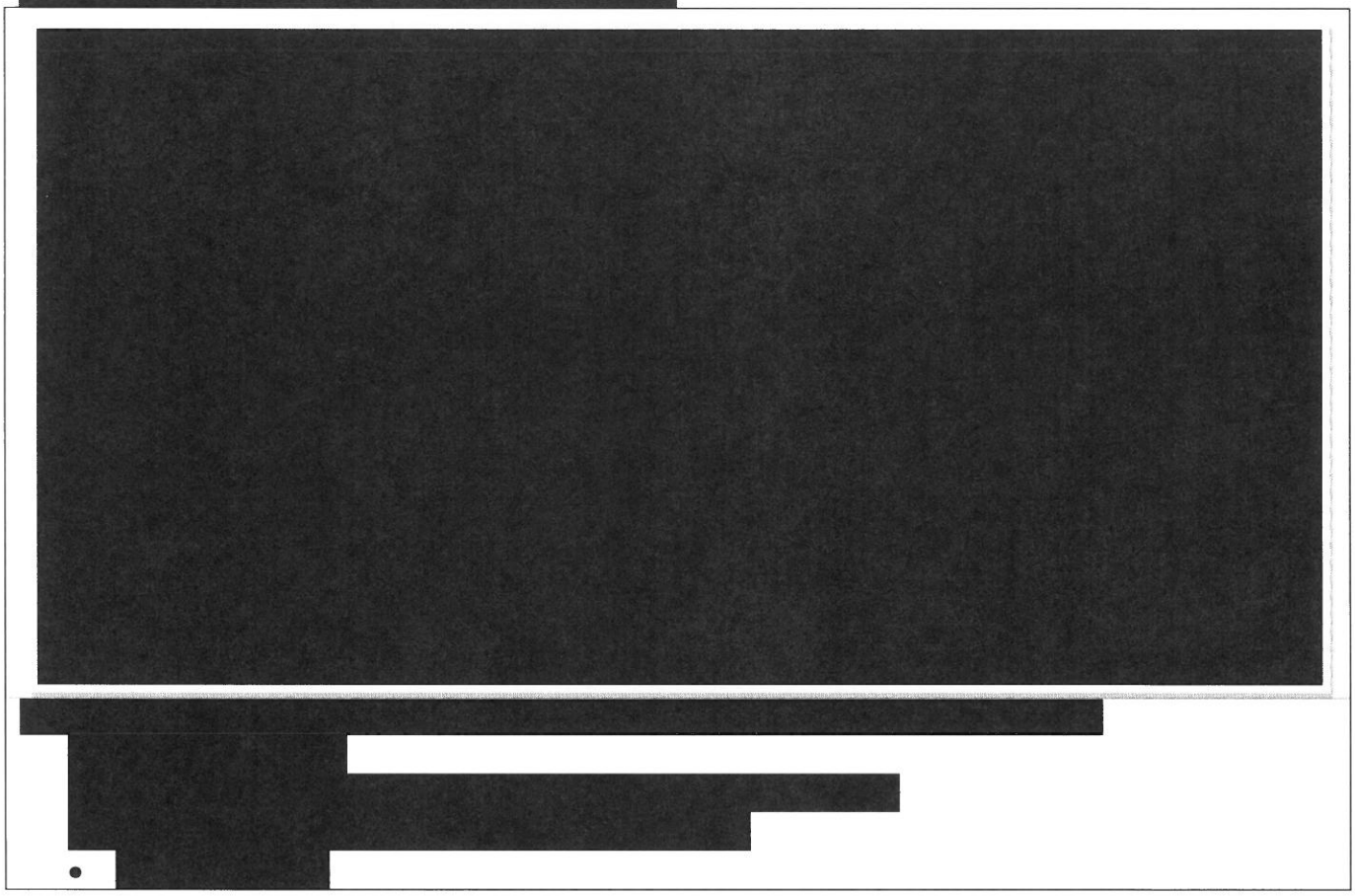


Benefits Managers select the potential enrollee(s) for whom an enrollment will be made. We incorporate flags for each enrollee to quickly convey each individual's ability to make an enrollment or change to our Benefits Managers. HealthTrack's Enrollment Wizard will prompt our staff to take appropriate actions that are driven by the enrollee's status.

DID YOU KNOW?

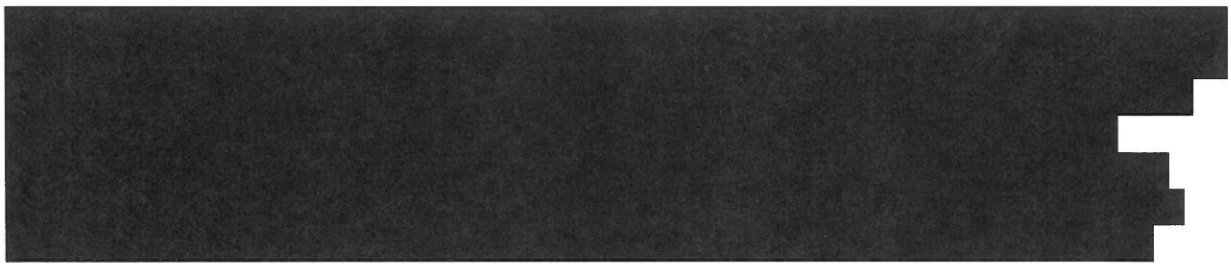
HealthTrack's Enrollment Wizards standardize how our Project staff process enrollments. Integrated quality assurance features help to ensure that all enrollments performed are appropriate based on defined (and programmed) business rules.

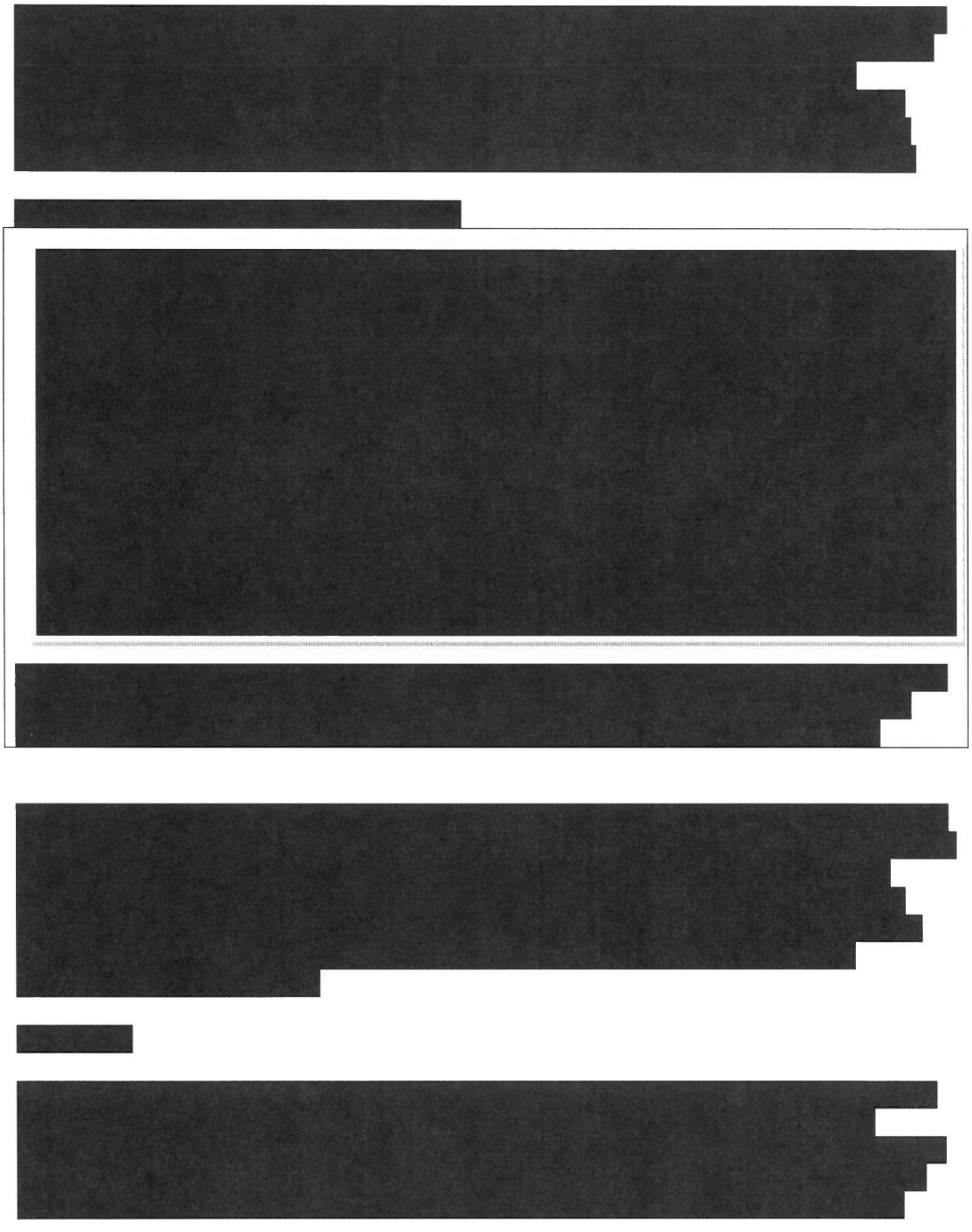
[redacted]



As part of their choice counseling activities, our Benefits Managers will conduct voluntary health needs assessments as well as work with potential enrollees to determine what is important to them when choosing a best fit MCO. **We are excited to bring to BMS and the MHT Project our enhanced "Choice Drivers Tool" – a sophisticated, yet easy to use resource that exceeds RFP requirements to provide provider network information and helps ensure a truly best fit MCO and PCP are selected.** Developed as recently as 2010 and fully tested under our Florida enrollment broker projects, the Choice Drivers Tool is a critical component of the new HealthTrack's sophisticated Enrollment Wizard workflow.

[redacted]





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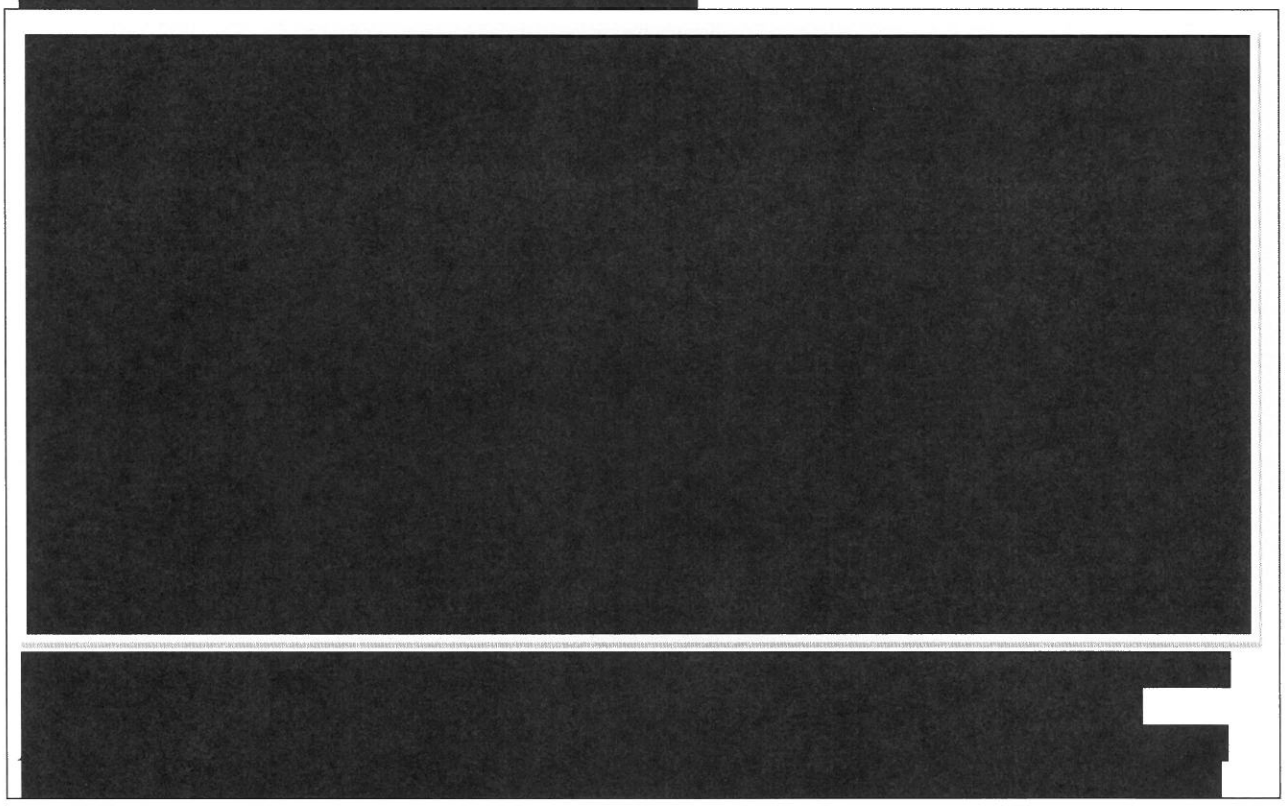

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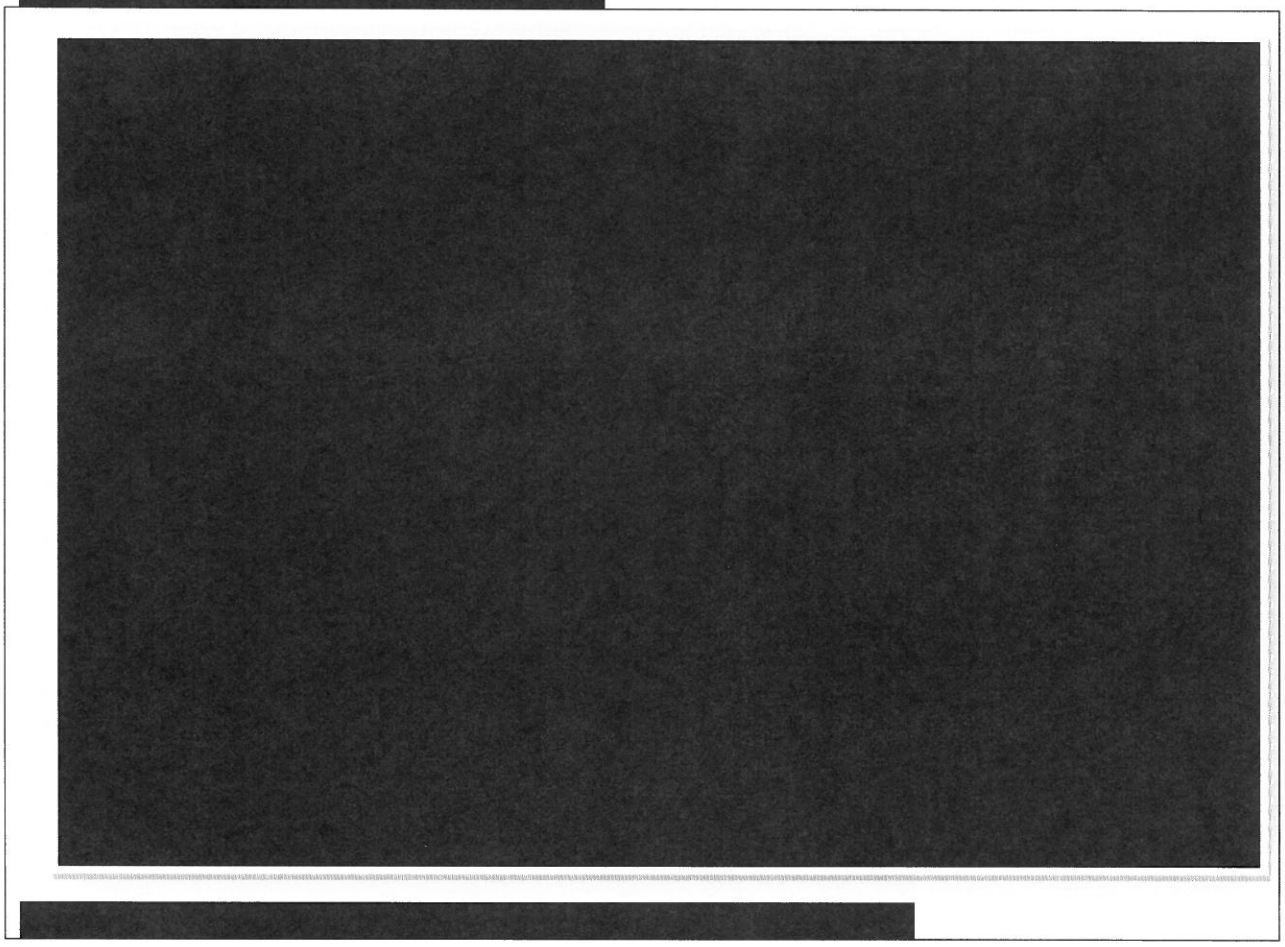

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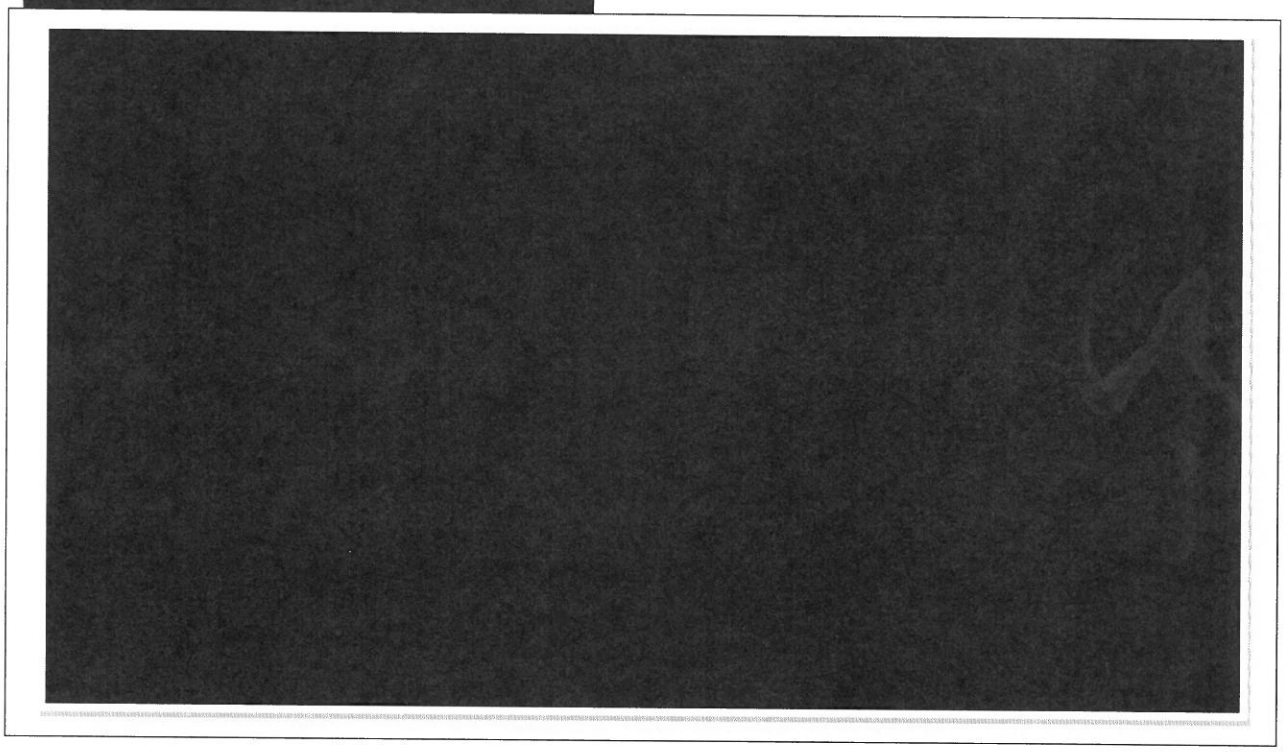

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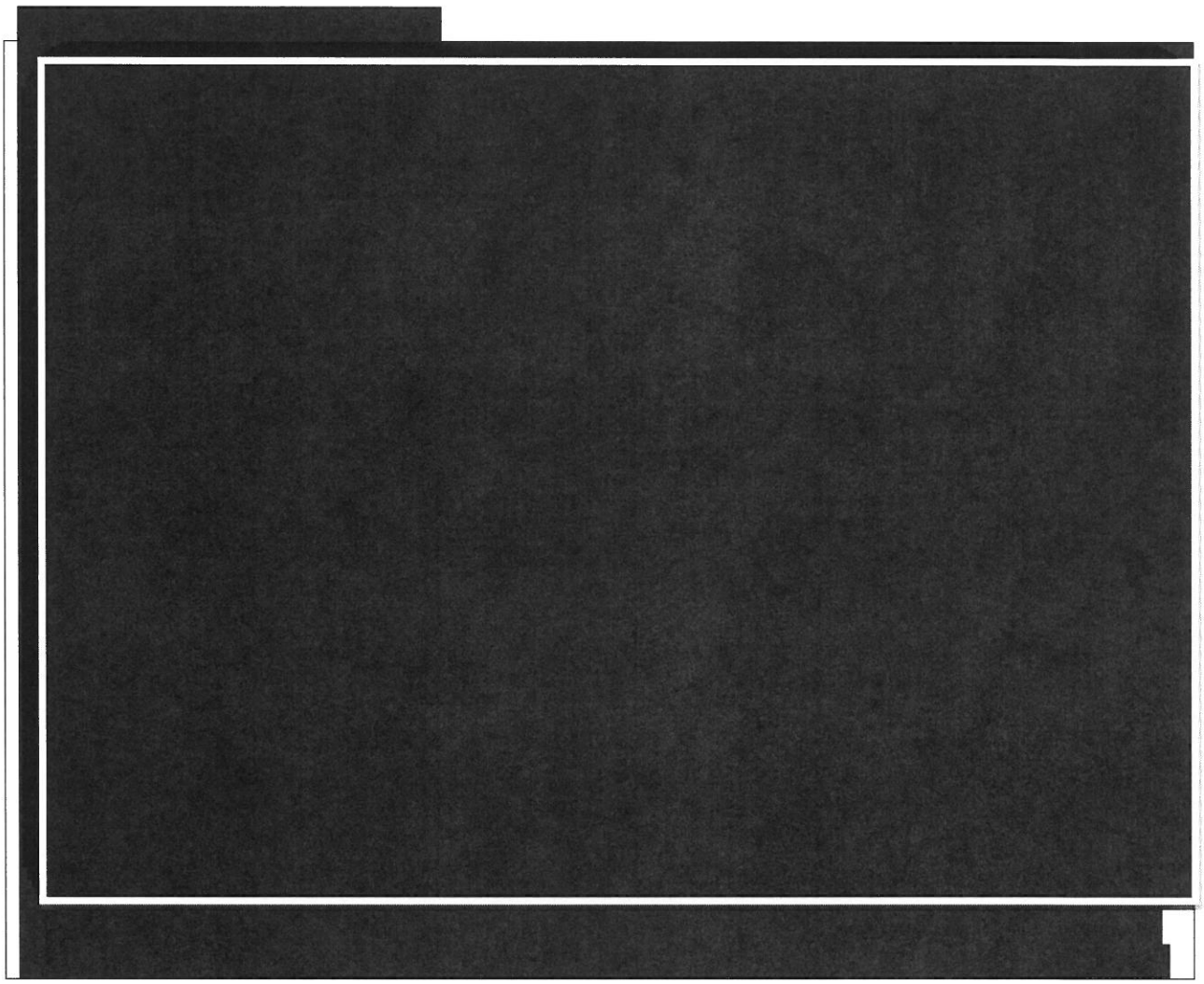

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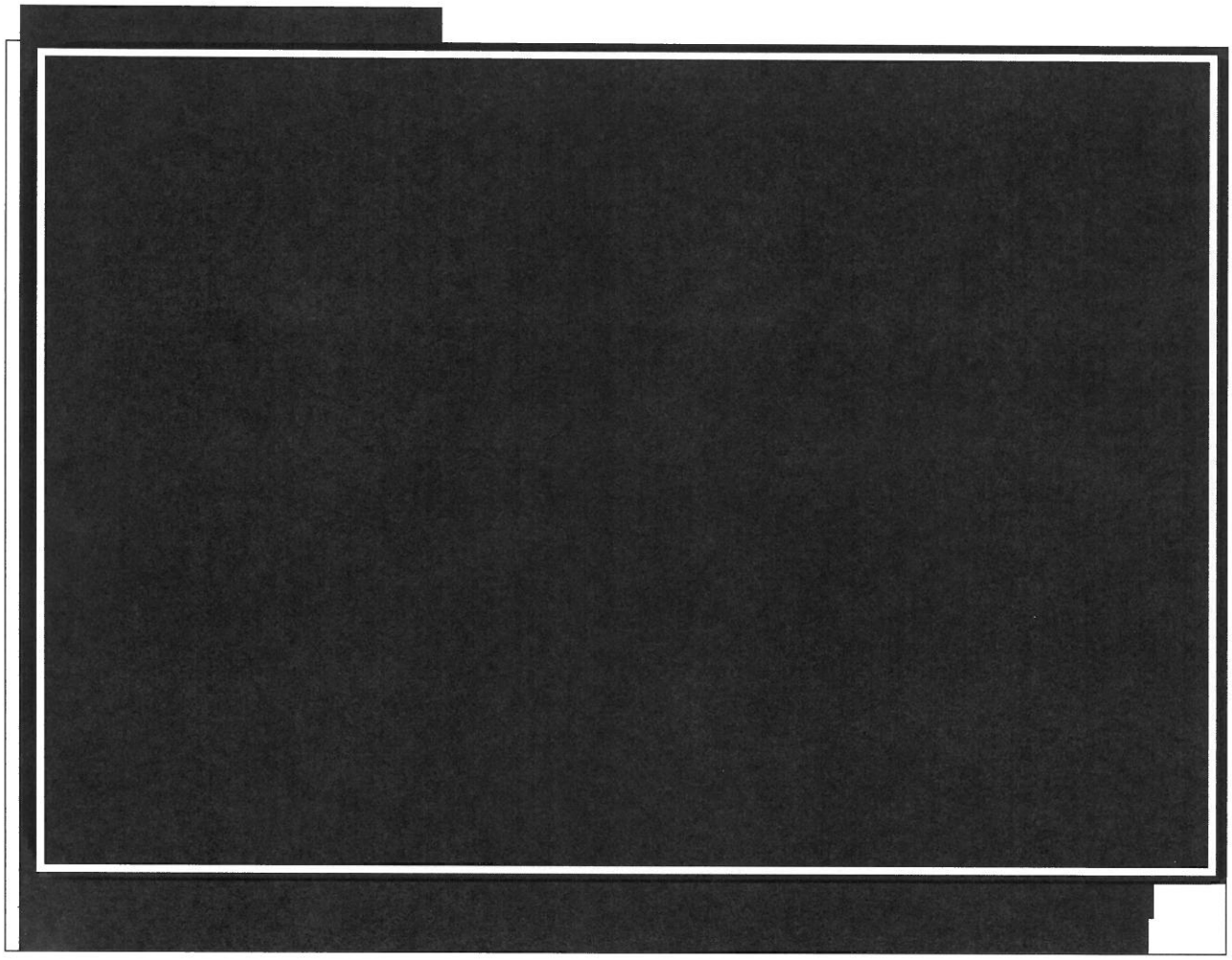


After the counseling and enrollment session, one final task for our Benefits Managers will be to continue to let enrollees know the MCO will send an MCO card in the mail, and that they can contact the MHT Call Center at any time and that we will be happy to assist them if they have any questions or concerns. As detailed in various sections of our proposal, and as standard operating procedure for all of our call centers, the MHT Call Center has the capability of allowing Benefits Managers to conduct three-way calls with enrollees and other entities (e.g., FRN offices, MCOs' Member Services Departments, etc.) and to provide warm transfers to ensure potential enrollees and enrollees are linked to the services they need.

Processing Enrollments in MMIS

After initial enrollment notification and appropriate education are provided to potential enrollees, many will make a voluntary enrollment of MCO and PCP. Once logged in HealthTrack, any enrollment, disenrollment or plan change, regardless of its point of origin (mail, phone, web, or Smart Phone) will be entered into MMIS. The Fiscal Agent will process these transactions and provide the MCOs with a HIPAA 834 compliant file of confirmed enrollments and other related transactions.

Changing MCOs

It is not uncommon for individuals enrolled with a particular MCO or PCP to desire to change their health care provider, although more rare in West Virginia than other states, as we have a 1-2% change rate. Currently is it permissible for MHT enrollees to change MCOs/PCPs for any reason at any time.

All of our Benefits Managers are trained to discuss the reason the consumer is requesting a change as well as other issues that could impact the consumer by making the change (e.g., transfer of records, impact on other family members, establishing a new doctor/patient relationship, etc.). At all times our counseling of the enrollee will be provided in an unbiased and culturally sensitive manner.

If the enrollee still wants to make a change, the Benefits Manager will document the reason for the change in HealthTrack. The Benefits Manager will then review the MCO/PCP choices available to the enrollee and enter that information as well. The Benefits Manager will inform the enrollee of the expected effective date of the changes and that he/she will receive a new MCO card in the mail. We also stress to the enrollee that until the effective date of the change, all medical services still need to be provided by the enrollee's initial MCO/PCP.

HealthTrack will ensure that no disenrollment will be processed for any enrollee required to be in an MCO without the concomitant enrollment with a new MCO/PAAS Provider. As with all transactions conducted by us as the enrollment broker, all changes will be fully documented in HealthTrack including the date and reason for the change as well as the identity of the Benefits Manager who effected the change. This information is also entered by our Benefits Managers into MMIS for processing by the Fiscal Agent and transmittal to the MCOs.

4.1.7 Process to Follow-up on Returned Mail

The Vendor should describe a process for following up on returned mail, including MHT and PAAS.

NCOA and Barcode Technology

DID YOU KNOW?

We use a combination of NCOA and barcode technology to maximize the enrollees we reach through the mail.

We have processes and procedures in place to maximize the number of potential enrollees who receive their outreach, education and enrollment materials. To increase the likelihood that we will successfully reach potential enrollees by mail, we utilize the National Change of Address (NCOA) service through the US Postal Service (USPS). This service uses USPS name and address logic to correct address lists by identifying individuals who have moved within the last three years. Prior to any bulk mailing, we send the USPS a file of addresses and the NCOA service standardizes our addresses and matches them against the NCOA database, a robust database containing approximately 110,000,000 new address changes that is updated on a biweekly basis. In return, we receive a detailed error report identifying any change of address that was reported to USPS. Accordingly, we will update our records, which not only increases the accuracy of our mailing, ensuring higher contact rates with potential enrollees, but also reduces the amount of returned mail. We will send updated contact information to the State, if desired by BMS.

Despite these efforts, we recognize that returned mail is a routine part of any large scale project. To that end, we have established, BMS-approved procedures for tracking returned mail that are currently in place. However, under the new contract we will leverage newer technology and HealthTrack's capabilities to streamline and increase accuracy and efficiency of mail received at our West Virginia office where returned mail is received. All returned mail will be entered by the Administrative Assistant into the mail tracking module of HealthTrack using a barcode scanner system.

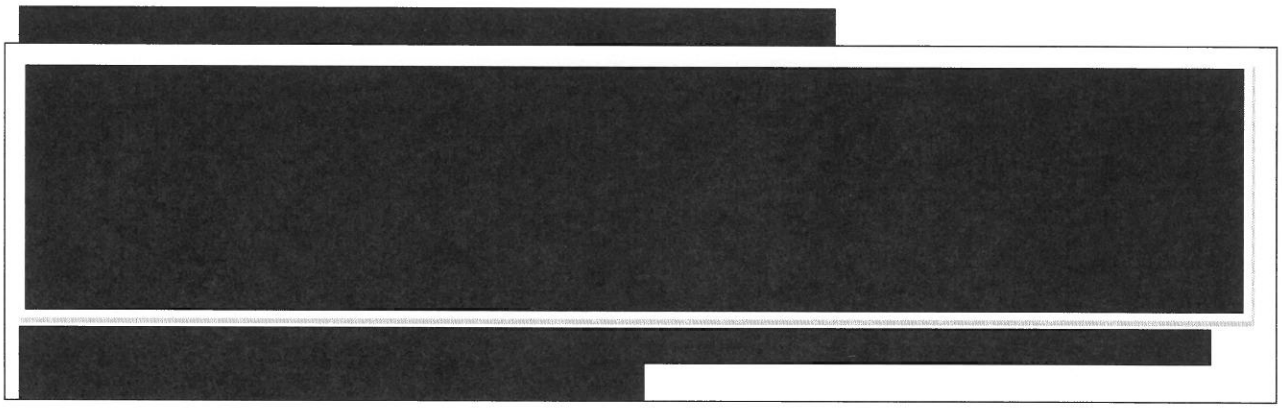
Exhibit 70. Barcode Header

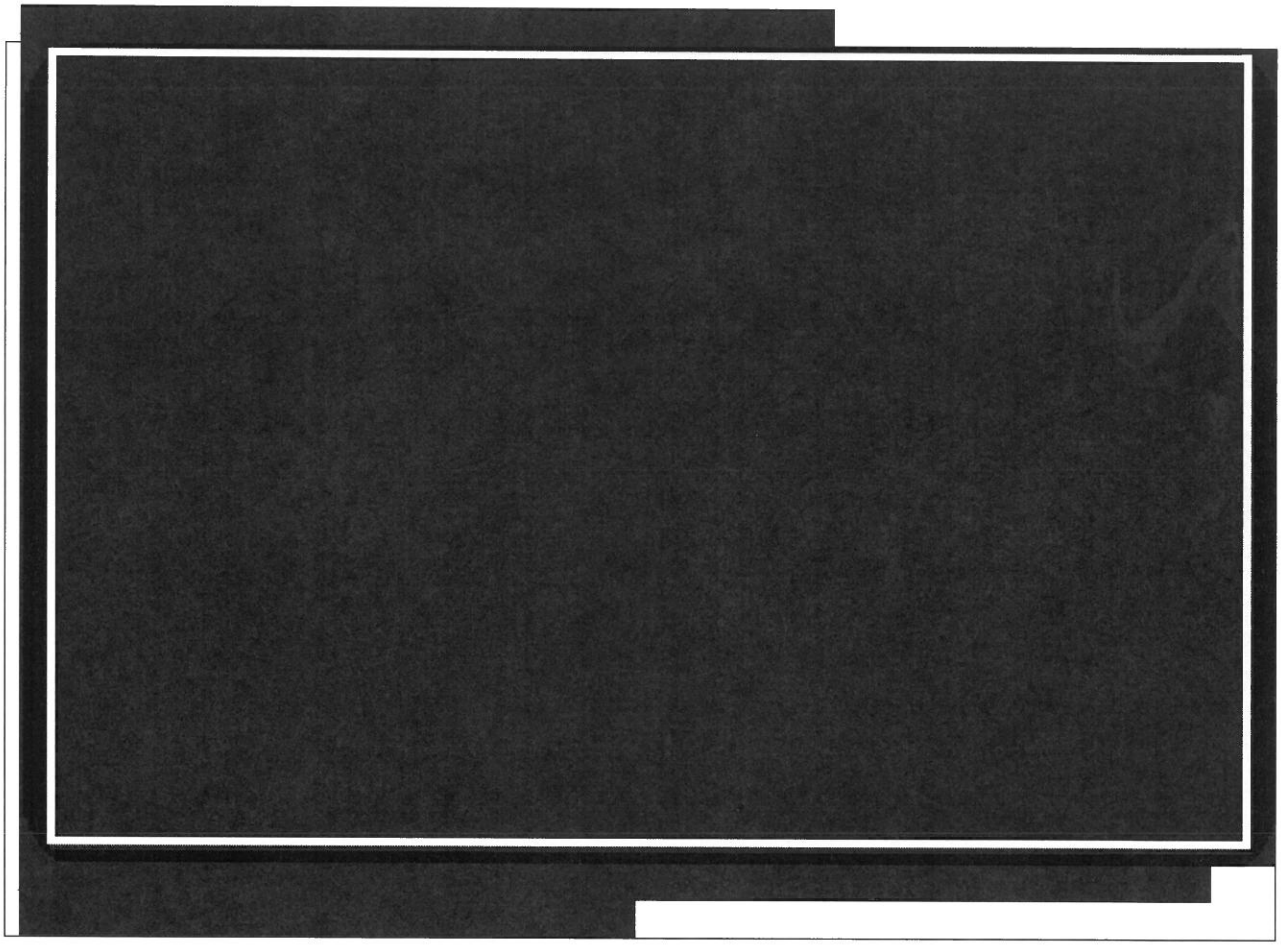
<PAYEE NAME> *<ADDR-LINE1>* *<ADDR-LINE2 >* *<CITY> <STATE> <ZIP CODE>*
We now include barcodes in the address header of the notices we generate through HealthTrack so that returned materials can be easily and accurately tracked and acted upon without unnecessary data entry.

Because we will barcode all HealthTrack-generated MHT mailings, the Administrative Assistant will be able to use a barcode scanner to automatically identify that specific mail document within HealthTrack – a quick process that eliminates the need for time consuming data entry, and allows our Benefits Managers to provide first-class customer service to the potential enrollees and enrollees with whom our staff interact.

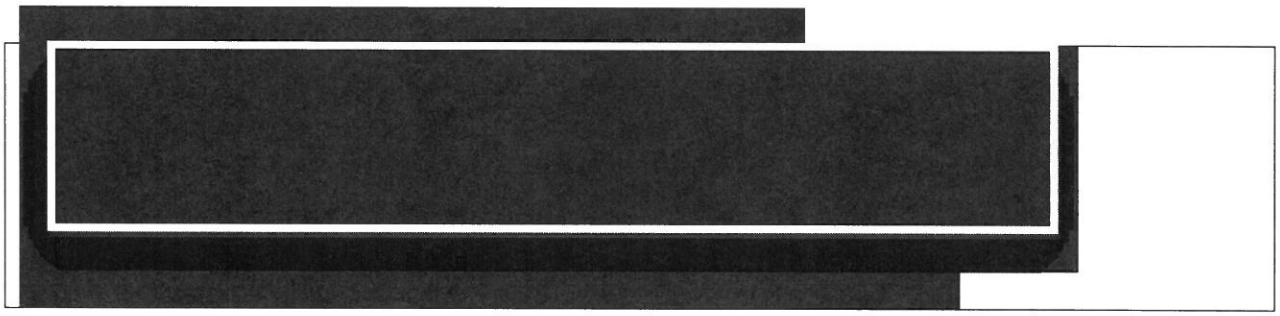
Mail Console's Returned Mail Functionalities

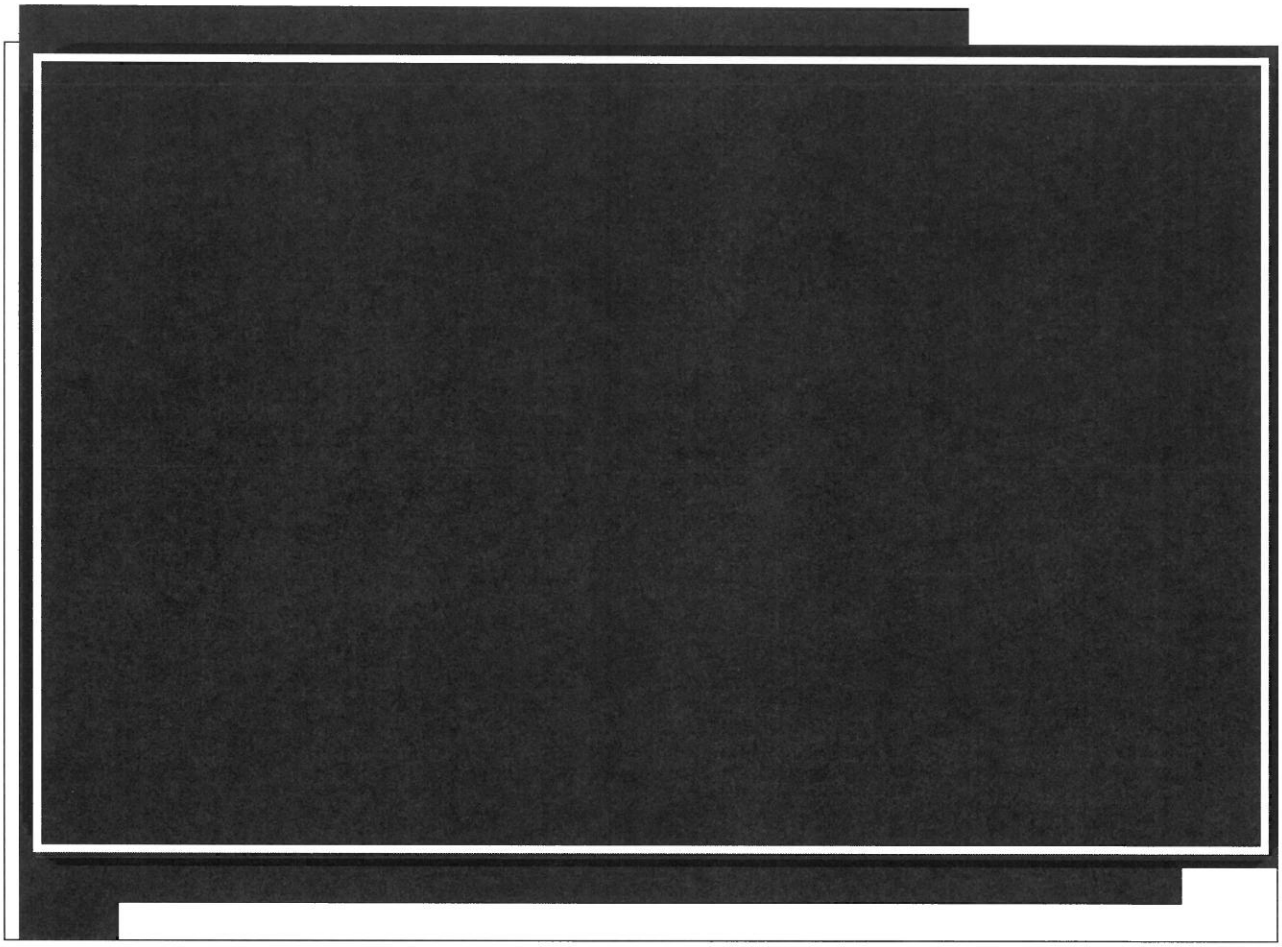
Mail generated by HealthTrack that is returned to us as undeliverable is sorted from other mail, and assigned staff use the barcode reader to find the original mail record in HealthTrack (Exhibits 71 and 72). If there is a new address on the envelope, it is scanned and the image is saved as a PDF and attached to the mail record, which is then marked as "Returned." If a new address is available, it is entered into HealthTrack and a new mailing request is created. The mail is then printed and resent to the new address. If a new address is not available, HealthTrack evaluates the mail type and creates a Returned Mail Callback Task in My Tasks for mailings that require a follow-up phone call to the member from the MHT Call Center. (See Section 4.3.6.1 for more information about My Tasks.) We will make a minimum of two telephone attempts to the head of the case for the potential enrollee whose packet was returned. All outbound calling attempts will be logged in HealthTrack. If we are unable to reach the potential enrollee by phone, we check RAPIDS to see if there is an alternate address listed or if there is a more recent address listed for the enrollee. If yes, we resend the packet to that address. In our experience those packets that are resent using the updated or alternative addresses in RAPIDS are not returned as undeliverable.





In addition, returned mail can also be accessed for review using HealthTrack's Returned Mail Search. To use the Return Mail Search, front line staff can set the date range that they wish to view (Exhibit 73) and then select the record to be viewed and once the record is selected the information can be viewed or edited as needed (Exhibit 74).



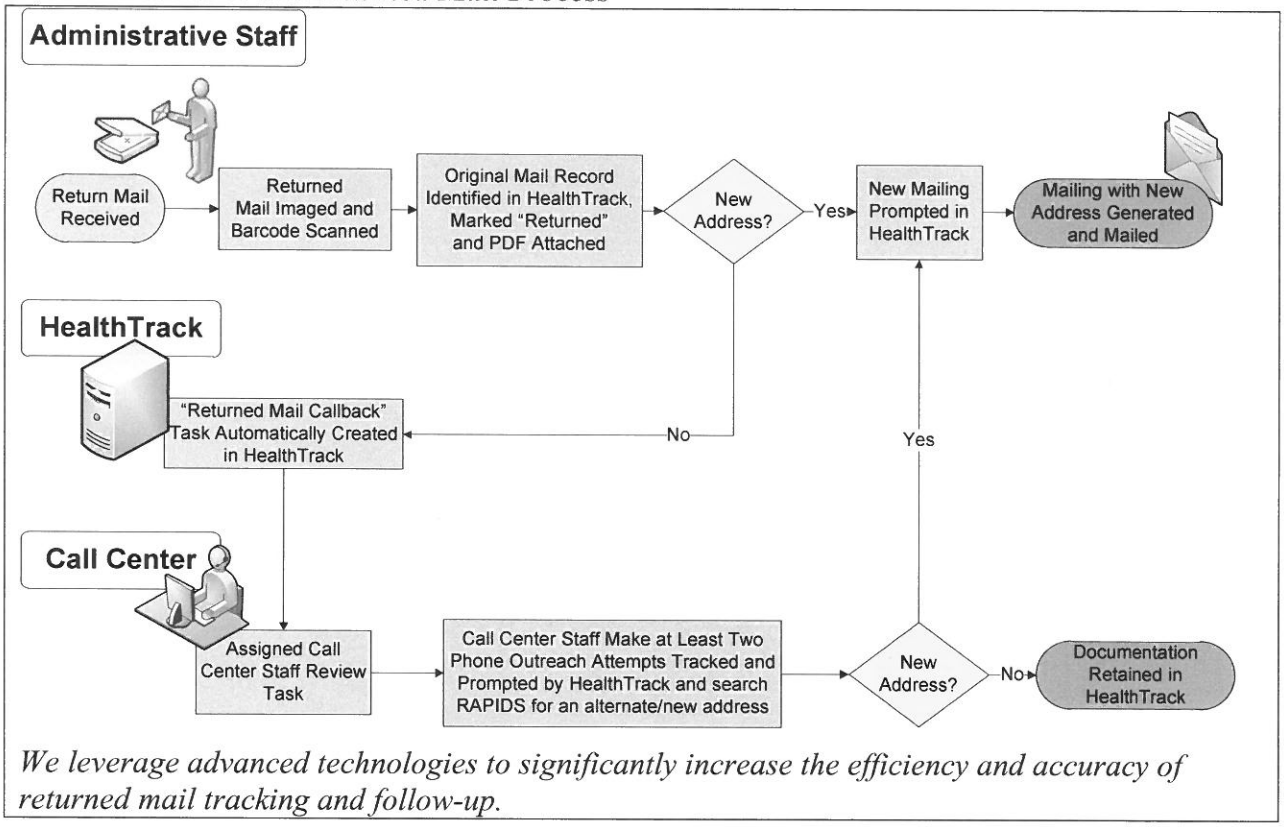


HealthTrack's Returned Mail Processing functions provides several benefits:

- Information can be updated directly into HealthTrack and appended straight to the case record,
- Returned mail can be processed more efficiently, meaning that information can be promptly resent to potential enrollees/enrollees,
- All processing functions take place within a singular system, so there is no risk of data or information getting lost among file transfers,
- Mail fulfillment staff can troubleshoot issues directly with IT,
- HealthTrack creates a task for outreach follow-up to potential enrollees/enrollees who did not receive an Enrollment Packet or other mailing,
- If a new address is identified, we can educate the enrollee to contact the Change Center if the new address does not match what is current in MMIS, and
- Front line staff have access to important information concerning which potential enrollees/enrollees did not receive their materials, outreach accordingly, and update the potential enrollees/enrollees' address as needed.

A summary of our approaches to returned mail are provided below in Exhibit 75.

Exhibit 75. Barcoded Returned Mail Process



We leverage advanced technologies to significantly increase the efficiency and accuracy of returned mail tracking and follow-up.

4.1.8 Educate Members on Accessing Services through FFS

The Vendor should describe the process for educating members at the time of their MCO enrollment on how to access services that are accessed through the FFS system and carved out of managed care.

Merely enrolling Medicaid enrollees into an MCO is not the sole responsibility of an enrollment broker vendor. In fact, we view our role as a trusted enrollment broker to also include equipping and empowering enrollees to take ownership of their health care decisions and to appropriately access services. Understandable, effective enrollee education is essential.

Our West Virginia enrollment broker scripts and written educational materials will not only cover choice counseling and enrollment services, but will also address a variety of Medicaid and managed care related topics. For example, scripts will include, but not be limited to the following educational topics specific to accessing care:

- Role of the MCO/PAAS provider;
- Importance and role of the medical home;
- Appropriate use of the Emergency Department;
- Direct access services;
- Importance of referrals for non-direct access services;
- Any value-added services provided by each MCO; and
- Access to carved out services through FFS.

Exhibit 76. MHT Carve Out Services vs. National Trend[15]

Service Type	Carved Out of MHT	# States with Service Carved Out
Dental	No*	24
Outpatient Behavioral Health	Yes	21
Inpatient Behavioral Health	Yes	21
Outpatient Substance Abuse	Yes	19
Non-emergency Medical Transportation	Yes	17
Drugs	No	15
Inpatient Detox	No	12
Vision	No	5
Other	No	15

** As of January 2014, pediatric dental is not carved out.*

Whether over the phone, in-person, or a written communication, we will make sure that enrollees are educated about benefits (both those required by the State's Health Plan as well as "extras")

[15] http://kff.org/medicaid/state-indicator/managed-care-benefit-carve-outs/

covered by each MCO. Our recently developed and implemented plan comparison charts are one example of how we provide such education. Additionally, we will explain the concept of "carve out services" (i.e., benefits that are not included in the MCO's coverage), educate on services that are carved out, and explain that such services are still available to them through FFS.

4.1.9 Collect and Submit TPL Information to BMS

The Vendor should propose an approach for collecting and submitting third party liability information to BMS regarding discrepancies between the eligibility system information and information the Vendor collected.

When Congress established the Medicaid program, it was mandated that Medicaid be the "payer of last resort." That is, if Medicaid beneficiaries have another source of health care coverage—such as private health insurance or an MCO purchased individually or provided through an employer—that source, to the extent of its liability, should pay before Medicaid does. This concept is referred to as "third-party liability" (TPL). When such coverage is used, savings accrue to the federal government and the states.

While potential enrollees are required to report additional insurers, if any, during the Medicaid application process, TPL is not always accurately reported by potential enrollees and/or is not updated in a timely manner when changes occur. As West Virginia's enrollment broker vender, we assisted the State and its Fiscal Agent in retaining accurate, up-to-date TPL information on MCO and PAAS enrollees since 2000. Our proven process for doing so and, in turn, supporting the State's billing process, is summarized below, and will continue to be implemented under this new contract.

During our choice counseling and enrollment contacts (regardless of the route), we will inquire about any additional health insurance coverage for the enrollee and/or the enrollee's family members including employer sponsored insurance, individual insurance, etc. Any reported TPL information (including cardholder's name, date of birth, policy number, group number, and name of insurance) will be entered into HealthTrack. Our Benefits Managers are responsible for reviewing TPL information in the MMIS. If the information in the system matches with what is self-reported by the enrollee, no further action is taken. However, if there is missing or erroneous TPL information is the system, our Benefits Manager will flag the case indicating a discrepancy in TPL.

The introduction of HealthTrack's My Tasks feature will enhance our ability to assign and monitor timeliness of TPL verification by Project Staff. TPL verification tasks will be included in staff's My Tasks roster of daily work to be completed. When such TPL follow up is assigned, our Benefits Managers will follow already established and BMS-approved policies and procedures for verifying the reported TPL information, including:

- **Contacting the Third Party Insurance Provider:** Our Benefits Manager will call the reported insurance provider, provide the cardholder name, date of birth and/or social security number in order to attempt to confirm coverage.
- **Receiving Confirmation of Coverage:** To verify third party coverage, the insurer must confirm coverage in writing via fax or email.
- **Indexing Documentation:** PDF copies of all written communications received during the verification are uploaded into HealthTrack and indexed to the enrollee's case. Images of communications will be easily retrievable in HealthTrack.

- **Tracking Outcome in HealthTrack:** The Benefits Manager will document the outcome of the TPL verification in HealthTrack.
- **Reporting TPL:** We will continue to provide any and all TPL reports as desired by BMS. We are happy to work with BMS to provide the most desirable TPL reports (in terms of content, frequency, and mode of reporting) for the MHT Project.
- **Enhancing Quality of TPL Verification and Reporting Using HealthTrack:** HealthTrack's inherent audit trails automatically document the source (including staff name), date, and time for any action taken in HealthTrack.

4.1.10 Outreach and Education Strategy

The Vendor should propose a comprehensive outreach and education strategy, which includes the development of materials and an approach for engaging stakeholders. The Vendor should submit to BMS its proposed outreach, education, and enrollment plan for review and approval. The Vendor should request BMS approval for any subsequent adjustments.

In our response to this Section, we describe our comprehensive outreach and education experience and approaches for potential enrollees and enrollees, as well those aimed at engaging community based organizations and stakeholders across communities statewide.

Outreach and Education of Potential Enrollees to Self-Selection of a Best-Fit MCO or PAAS PCP

We are pleased to offer an approach to enrollee outreach and education that is responsive to BMS' needs and is ultimately aimed at maximizing voluntary enrollment into a best-fit MCO/PAAS Provider. While our key strategies are introduced in the paragraphs that follow, virtues of our overall approach include but are not limited to those detailed in Exhibit 77 below. Please see Appendix G. for a Draft Outreach and Education Plan.

Exhibit 77. Features and Benefits Associated with Our Approach to Outreach

Feature	Benefit to BMS and MHT Enrollees
Our approach for outreach and education is based on time-tested, successful practices.	Our resources are appropriately and efficiently used, and enrollees will still receive the education and assistance they need.
Our approach to outreach and education makes use of every avenue available.	By using not only methods for phone, field, and mail outreach, but also more sophisticated tech-savvy options like web and Smart Phone outreach, we maximize enrollee service as well as voluntary enrollment.
Our approach is very flexible.	We can deploy field staff targeting outreach to groups and enrollees in response to Medicaid program changes. Yet, we do not employ an over abundance of staff who will sit idle. This careful combination and selection of resources allows us to offer BMS a competitive price.
Our approach to outreach and education builds on existing resources and relationships.	With sound relationships throughout the State, our approach to outreach not only ensures we target groups with close interactions with the enrollees we serve, but it also allows us to use our resources effectively.
Our approach bridges communication gaps to community agencies throughout the State.	Our fax/email blast capabilities will help provide consistent BMS-approved information to community agencies throughout the State – another important layer in making sure enrollees receive accurate information to reduce confusion.

Our comprehensive approach to enrollee outreach not only supports the maximum voluntary selection of a best-fit MCO and PCP, but also allows us to be responsive to BMS needs, especially during Medicaid program changes.

Overall Approach to Maximizing Voluntary Enrollments



We are proud to bring over 20 years' successful experience assisting individuals in voluntarily enrolling into an MCO and/or PCP. As such, we have developed a series of time tested procedures and approaches to produce high voluntary enrollment rates. **All of our enrollment broker procedures are designed to maximize the number of eligible potential enrollees who actively choose an MCO and PCP as opposed to being auto-assigned.** We will continue to employ multiple methods to assist potential enrollees in making a timely, best fit MCO choice. These methods have helped us achieve impressive results in our enrollment contracts. While we use some of these methods under the current MHT contract, additional enhancements to our approach will be implemented with BMS' approval.

The key steps we will take to achieve an optimal voluntary enrollment rate for the MHT Project are:

1. Offering multiple avenues for enrollment, including the new option for Smart Phone enrollment;
2. Identifying potential enrollees who do not make a timely voluntary enrollment;
3. Implementing an enhanced phone- and mail-based reminder campaign that goes beyond contractual requirements;
4. Setting individual targets to facilitate a high voluntary enrollment rate and providing Benefits Managers with new tools to monitor their performance;
5. Using empowering statements;
6. Conducting targeted outreach to special needs groups;
7. Promoting project messages;
8. Searching for good phone numbers; and
9. Using effective counseling.

Multiple Avenues for Enrollment

Because our experience has shown that no single method can be used to achieve a high voluntary enrollment rate, we use multiple avenues for enrollment, as depicted in Exhibit 78. While the foundation for any enrollment broker project is providing mail and phone-based enrollment, we also offer web-based and mobile browser-friendly enrollment (described in Section 4.1.6), which allows potential enrollees to access educational materials and select an MCO/PAAS Provider at times when it is convenient for them. As many potential enrollees must deal with complex issues throughout their daily lives and may not be able to enroll during operating hours, these options are particularly attractive for those with complicated work schedules, child care needs, etc.

Exhibit 78. We Provide Multiple Avenues for Enrollment



We provide multiple avenues through which the potential enrollee can make a voluntary enrollment choice. In doing so, we respond to potential enrollees' needs for multiple convenient enrollment methods that accommodate their diverse lifestyles.

We currently offer online enrollment in West Virginia, Illinois, Ohio, and Florida. In fact, **we are proud to have offered and implemented online enrollment for BMS before it was requested or required of us. We are also proud to be the first enrollment broker to offer online enrollment in the State of Florida despite the state having a previous enrollment broker contractor until 2010.** Our online enrollment modules are simple and easy to use, and continue to grow in popularity as a source of voluntary enrollment. Further, as an additional offering to the State of West Virginia, we recently received approval under our current contract to offer a mobile-friendly website that includes enrollment functionality for potential enrollees with access to Smart Phones.

Providing high quality enrollment materials is yet another way potential enrollees are encouraged to avail themselves of our services. Whether mailings result in the completion of a hard copy enrollment form being mailed to our office or simply provide the spark to get someone to access the MHT Call Center or website, ensuring potential enrollees get the necessary information into their hands provides yet another productive way to empower enrollees to make important health care decisions.

DID YOU KNOW?

We have longstanding ties to CBOs throughout the state and have helped them understand the role and services provided through us as the enrollment broker for nearly 20 years. CBO staff know that as the face of the Medicaid program changes, they can continue to count on us for assistance, accurate information, and help understanding new requirements.

Moreover, one of the cornerstones of our enrollment broker efforts is to work with grassroots community based organizations within the community who routinely serve the target population. By either providing venues for our field staff to conduct face-to-face enrollment interviews, or by directly working with their customers to link them to our enrollment services (face-to-face, over the phone, or via the web), we have found that community stakeholders can be effective resources for reaching the hard-to-reach. Further, by utilizing our Train-the-Trainer approach we can effectively expand our reach as well as establish a level of credibility and trust within the community. To execute our Train-the-Trainer approach, Field Benefits Managers visit organizations who express an interest in partnering with us to help spread the word about MHT and West Virginia's Medicaid programming. During the visit, our Benefits Manager educates agency staff on the MHT Program, enrollment, our role as the enrollment broker (including the training and support we provide to the community), and the role of Agency Advocates. This results in fully trained and equipped community resources who subsequently train other consumer-oriented staff and their agencies about managed care and the MHT Project. We have successfully used this approach in West Virginia, Ohio, Illinois, and Wisconsin to maximize our reach into the communities we serve. (More about our Train-the-Trainer approach is included later in this section.)

For those agencies who express interest in working with us we will conduct a site visit. During the site visit, our staff will further explain the training we provide, introduce and familiarize the agency with us and the MHT Project, and explain the role of an Agency Advocate and the Train-the-Trainer sessions (described below). We will fully describe the tasks with which we would like the agency's support. If the agency is interested and willing, they will be invited to participate in our trainings.

The primary focus of the Train-the-Trainer sessions will be to create a cadre of Agency Advocates who will subsequently train other consumer-oriented staff at their agencies about managed care and the MHT Project. Again, having a team of Agency Advocates who are able to promote our message and support our goals will be paramount in the success of any new or expanded managed care program.

We have found this option is particularly valuable for reaching out and enrolling populations that are typically "hard-to-reach." Of note, we have had much success using this approach to target special populations, such as those with behavioral health needs. (Additional detail on our approach to working with community partners is included later in this Section.)

Identifying Potential Enrollees Who Do Not Make a Timely Voluntary Enrollment

[redacted] Tracking and monitoring voluntary enrollment periods is one of the standard processes we perform in all of our enrollment broker contracts. [redacted]

For example, if SSI consumers are mandatorily enrolled in managed care in the future, we can easily accommodate a longer voluntary enrollment period for these more complex enrollees, as desired and instructed by BMS.

For the MHT Project the following process will be employed to identify and track individuals who fail to make a choice within the appointed time. Most time sensitive actions within HealthTrack are set up to occur automatically, thus removing the chance for error.

When we receive the eligibility file from the Fiscal Agent, we will process it (including all required checks and edits for accuracy) and create a mailing file for all new cases that need to have an enrollment packet sent to them within two business days. The packets will be assembled and mailed according to contractual SLAs. Once the packets are mailed, HealthTrack is automatically updated with the date the mailing was sent and an internal clock begins running to count the 45 day voluntary enrollment period from the date the file is received. This information will continue to be viewable in HealthTrack so that our Benefits Managers will be able to see how much time is left before the 60 day limit is reached and the potential enrollee is auto-assigned.

[redacted]

[redacted]

DID YOU KNOW?

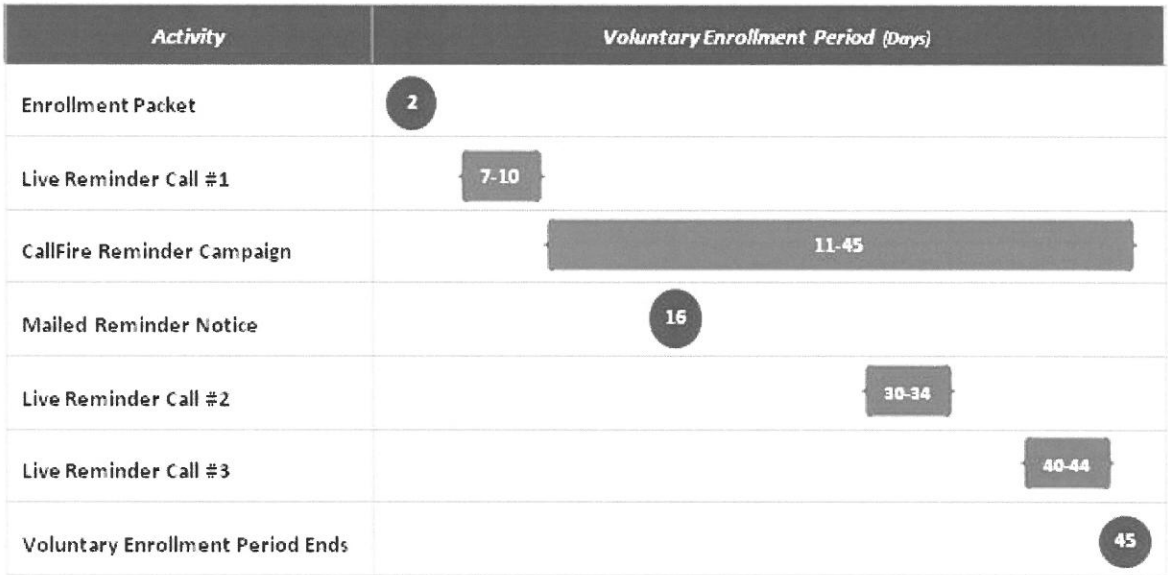
If desired by BMS, we can accept and process eligibility files from the Fiscal Agent on a daily, rather than weekly, basis. This would provide enrollees with a 60 day voluntary enrollment choice period.

Enhanced Reminder Campaigns

Once we receive the eligibility file, the potential enrollee's record is marked with a date flag 45 days in the future. After a potential enrollee shows up on the Eligibility File, we will mail an Enrollment Packet and count down the timeframe for voluntary enrollment. While the printed materials included in the Enrollment Packet are designed to elicit a prompt response from the target audience, some potential enrollees will fail to respond within the time limit. If we have not heard from a potential enrollee by Day 7 of the voluntary enrollment period, we will commence reminder outreach activities.[16] Please note, the schedule for all proposed reminder activities is flexible and will be solidified based on ongoing communication with BMS. Our approach to reminding potential enrollees about the importance of and timeframes for voluntary enrollment:

- Includes tiered outreach that exceeds RFP requirements,
- Maximizes attempts to engage the potential enrollee,
- Encourages potential enrollee action/response,
- Makes efficient use of staff's time, and
- Is cost-effective.

Exhibit 79. Schedule of Reminder Activities



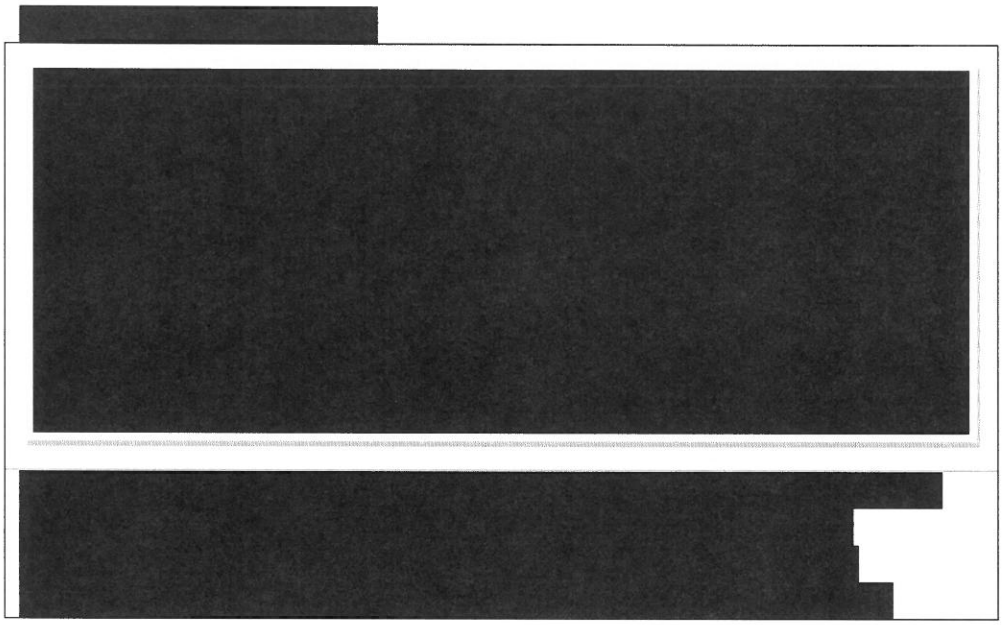
We will not give up on potential enrollees who do not promptly respond to the mailed enrollment packets. Starting nine days after mailing the enrollment packet, we will start reminding and encouraging potential enrollees to select an MCO/PAAS Provider, and we will continue to do so until the potential enrollee voluntarily enrolls or is auto-assigned.

[16] We wish to point out that as this outreach exceeds contract requirements and current outreach, the scheduling for all time-sensitive reminder activities can be easily adjusted in HealthTrack to meet the BMS' exact specifications.

Schedule of Enrollment Reminder Outreach Activities

[redacted]

[17] We propose CallFire only as an option for outreach. If BMS prefers all outreach calls be conducted manually, we will refrain from using CallFire.



CallFire will log the outcome of every call and identify incorrect or disconnected numbers as well as completed calls, allowing us to monitor and report on CallFire activities.

Any potential enrollee who has not selected an MCO by Day 35 will automatically be included in HealthTrack's reminder notice file. Our Mail Fulfillment Center will run the file, generate the reminder notice print job, and mail the notices on Day 36. These notices will inform the potential enrollee that his/her time is running out to make a choice of an MCO and prompt them to call the MHT Call Center immediately for assistance, go to the website to enroll, or scan the QR code (as described in Section 4.1.4) to enroll via Smart Phone (if approved by BMS).

Additional live reminder calls will be placed by our Benefits Managers between Days 30-34 and (as a final attempt) Days 40-44 in order to secure a voluntary enrollment into a best-fit MCO/PAAS Provider prior to Day 45. However, because enrollments are not effective until processing by the Fiscal Agent on the monthly cut-off date, we perform targeted CallFire outreach (with the option to speak to a live voice) to enrollees flagged for auto-assignment in a final attempt to secure a voluntary choice prior to cut off. For enrollees that we successfully contact and from whom we secure a voluntary choice, our Benefits Managers will update the enrollment choice in HealthTrack and MMIS to reflect the voluntary enrollment.

Any enrollee who has not communicated his/her enrollment choice prior to the monthly cut-off date will be auto-assigned. (Please see Sections 4.3.6.4 and 4.3.6.5 for more about auto-assignment.)

DID YOU KNOW?

We continue to provide enhanced, targeted outreach after Day 45 and until the monthly cut-off date to enrollees flagged for auto-assignment.

Effective Benefits Manager Reminder Calls

We will conduct a number of reminder calls to potential enrollees who have yet to select an MCO/PAAS Provider. We will take several proven steps to ensure our outreach calls are effective:

DID YOU KNOW?

All of our reminder calls are completely HIPAA compliant. No Protected Health Information is *ever* left on an answering machine.

1. **Performance standards:** Benefits Managers are tasked with a minimum number of outbound calls they must make each day. Completion of each call and each call's associated outcome are documented in HealthTrack and monitored by management and supervisory staff.
2. **Random order the auto-assignment outbound call queue:** Each day, potential enrollees' names who have not yet selected an MCO are presented in a different order. In doing so we ensure that potential enrollees are called at different times of the day, increasing the likelihood of successfully reaching them. We also ensure that there is no preference for outreach to large cases and that *all* enrollees receive equal priority for outreach.
3. **Automated messages:** We have created a HIPAA-complaint automatic message that can be left on a potential enrollee's answering machine so that when Benefits Managers do not reach a live person, they can save valuable time by pressing an option to leave the message. In addition, this also ensures consistency of all messages related to voluntary enrollment.
4. **Local caller identification numbers:** As many potential enrollees and enrollees are distrustful of 800 numbers, we have changed the number that displays on caller identification systems so it displays a West Virginia-area phone number. However, all messaging instructs potential enrollees to call back using the toll-free number so they do not incur any charges.

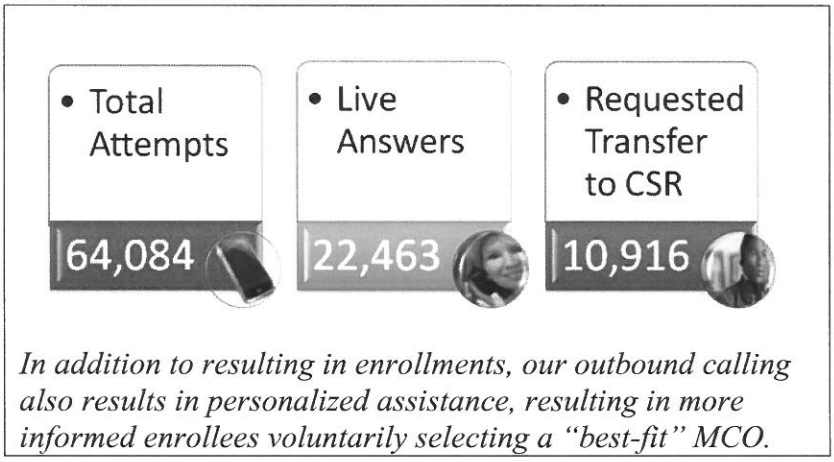
Effective CallFire Outreach

[redacted]

Our Daily Eligibility File campaign is one type of auto-dialer campaign we can offer BMS. In this campaign, CallFire extracts information from the daily file and populates the outbound calls to potential enrollees who are newly eligible. When the call is answered, CallFire encourages enrollees to select an MCO before they are assigned, and provides the potential enrollee with the option to "press one" to speak directly with a Benefits Manager who will provide enrollment counseling and assistance. **The Daily File Campaign is effective: in our**

Ohio Medicaid Managed Care Enrollment Center Contract from July 1, 2010 – December 31, 2010, the Daily File campaign generated 15,842 enrollments (25%) of the total outbound call volume. Further, as demonstrated in Exhibit 81 in addition to the 15,842 enrollments generated from the campaign, nearly 50% of calls answered by a live person requested transfer to a Benefits Manager, indicating that these callers received individualized enrollment assistance specifically tailored to their particular needs.

Exhibit 81. Our Outbound Calling Campaigns Result in Personalized Enrollment Assistance



In addition to resulting in enrollments, our outbound calling also results in personalized assistance, resulting in more informed enrollees voluntarily selecting a "best-fit" MCO.

We carefully stagger the times the call campaigns are run. While running campaigns first thing in the morning may initially seems appealing as inbound call volumes are typically low, they do not generate successful results in terms of contact rates and enrollments. Thus, we run campaigns at varying times of the day, often in the afternoons or early evenings, to yield best results.

This system truly offers the best of both worlds – we are able to effectively use resources (CallFire makes the outbound calls so Benefits Managers do not need to spend their time manually dialing each number and the system can be set up to run at times conducive to the call center) but all potential enrollees are given the option to speak to a live person for individualized assistance.

CallFire allows us to do extensive reporting to better determine the effectiveness of the predictive dialing outreach. Examples of data we can report on include how many:

- Potential enrollees were contacted per campaign,
- Live voices we reached,
- Answering machines were reached,
- "No answers" occurred,
- "Error/invalid" calls occurred,

- Busy signals were received,
- Transfers back to the MHT Call Center were made, and
- Bad phone numbers (out of service) were dialed.

Additionally, we review the results of each CallFire outbound dialer campaign and conduct additional outreach to potential enrollees who are not reached (e.g., no answer, left message on answering machine, etc.).

Individual Benefits Manager Targets

HealthTrack's My Stats not only allows individual Benefits Managers to monitor personal achievement of targets but also team progress and overall impact on performance metrics.

To ensure optimal achievement of the voluntary enrollment rate, all members of the MHT Project team must actively work in tandem towards the goal of helping as many individuals as possible make a proactive selection. To facilitate maximal participation and support of this goal, all Benefits Managers will be challenged with meeting targets that contribute to the Project's achievement of a high voluntary enrollment goal. Benefits Managers will be tasked with meeting targets associated with making a set number of outbound calls as well as processing a set number of enrollments each month. Targets will be modified appropriately based on full-time vs. part-time status.

Each month Benefits Managers will work toward achievement of the targets. Achievement of each month's targets will be an item included as part of ongoing performance reviews. **To help Benefits Managers monitor progress toward attainment of their targets, as a value added feature, we will provide them with tracking functionalities in HealthTrack through its My Stats feature (described more fully later in our response to Section 4.3.6.1).** My Stats will include two mechanisms to help monitor progress:

1. Individual progress toward targets, and
2. Aggregate MHT Call Center progress toward the voluntary enrollment rate, including the month's projected voluntary enrollment rate based on current activity.

First, My Stats will allow each individual Benefits Manager to determine, in real time, their current progress compared to their targets. Benefits Managers can access this feature at any time to note their progress and modify their activities as needed. Second, My Stats will also include a feature that displays the current, aggregate voluntary enrollment rate for the MHT Call Center at any time. In addition, this feature will display a projected voluntary enrollment rate for the end of the month that is calculated based on all activities completed to-date. All members of the Project (including Benefits Managers and Project supervisory and management staff) will have access to this function in real time through HealthTrack.

Empowering Statements

We place careful thought in all of our messaging (including our scripts, brochures, flyers and letters) to promote making a voluntary enrollment, reminding potential enrollees that enrollment is easy and results in the best health care for each potential enrollee's specific needs. While simple, it is yet another way we reduce barriers to enrollment.

Promote Project Messages

We will continue to promote educational and enrollment messages throughout the community. Such messages will be reiterated at every available venue, including the myriad community based organizations that are willing to work with us to display such messages as well as local DHHR and FRN offices and other community partners deemed appropriate by BMS.

Research Good Addresses and Phone Numbers

For those potential enrollees who we are unable to contact due to bad addresses, we continue to research good addresses using two primary avenues. First, we use the NCOA database available through the USPS for all mailings to determine if the USPS has a good address on file. Second, we use electronic versions of the White Pages to research additional phone numbers for potential enrollees with nonworking numbers. It has been our experience that the White Pages often has updated contact information for potential enrollees and we use this resource as an additional avenue through which we can locate potential enrollees.

Effective Counseling

With 18 years of successful choice counseling experience in West Virginia, we take numerous steps to ensure our counseling is effective and our messages are conveyed in a manner that is understood and acted upon by the intended recipient. Our approach to developing scripts and incorporating them into HealthTrack ensures education is consistent, accurate, and understandable. Staff receive comprehensive training on using the scripts and are provided with ample time to practice prior to taking calls. All staff are then regularly monitored to ensure the quality of the message and adherence to scripts.

As an additional note, we also understand that providing effective counseling extends beyond following scripts and includes additional "soft skills" such as maintaining a pleasant tone of voice. As such, assessment of "soft skills" is incorporated into our monitoring and Benefits Managers are counseled on their importance. (Please refer to Section 4.2.20 for a description of our QA Plan and monitoring approach for the Project.)

Outreach and Education to Community Based Agencies

> "Certificate of Appreciation awarded to [AHS] for your generous sponsorship of the 2013 Back to School Fun Fair. We couldn't do it without you!"
>
> *-- Susie Baker, Parent Educator Resource Center*

We recognize that often we are the face and voice of MHT to the community based organizations and stakeholders with whom we partner. Through reciprocal, trusted relationships with our field staff, we have developed a cadre of community entities supporting and "spreading the word" about MHT and the virtues of managed care in their home towns. As demonstrated in the narrative below, we are proud to be so interwoven into the health, human services, and community support infrastructure in each of West Virginia's 55 counties. (Please see Appendix D for a sampling of our community partners.) Yet, even as an established vendor, we do not let our field relations become stagnant. We will continue to fuel our current relationships while also seeking out and engaging new partners.

Leveraging Deeply Rooted Agency Relationships

We know that many Medicaid enrollees are already being served by the medical professionals and the community based organizations that have been a part of West Virginia Medicaid for years, if not decades. We have actively pursued these relationships and partnerships, which have allowed us to have the most success promoting continuity of care as well as helping prevent any issues relating to MHT and MCO/PCP selection from escalating. Particularly during any expansion of MHT, we will actively seek out relationships with these groups as our first priority. Maintaining and leveraging these relationships will be especially valuable, and will afford BMS the benefits detailed in Exhibit 82.

Exhibit 82. Benefits of Maintaining Relationships from Community-Based Agencies

Problem	Benefit
Enrollees may have questions about the transition, but not call the toll-free telephone number.	By being available at community based organizations, we can address the questions/needs of enrollees who do not elect to call.
Enrollees may not have current addresses on file and may not receive mailed information.	Enrollees who do not receive their enrollment packet and materials are still aware of the transition due to our presence in community based organizations.
Enrollees are often confused by new changes.	We explain the changes associated with West Virginia Medicaid, and by leveraging the relationships of community organizations, we increase the likelihood that the message will be heard and accepted.
Special needs groups may need additional assistance to ensure continuity of care.	We can work with CBOs to involve case workers, case managers, caregivers, and family members to facilitate a best-fit selection that promotes continuity of care.

Our deeply rooted community relationships and approach affords several solutions to problems that may arise during the expansion of managed care to new populations.

Outreach to New Agencies

Once a potential agency has been identified, we will reach out to that agency to determine their level of partnership. Levels of partnership may range from agreeing to have MHT materials on hand or available in their waiting rooms to actively promoting MHT and voluntary MCO enrollment.

Once we have finalized our partnership with an organization, we will organize an established schedule for informational sessions (group and individual) to promote the MHT and voluntary enrollment. We will coordinate with community based organizations to determine a schedule that not only meets their needs and accommodates use of their facilities, but is also a best fit with the flow of traffic through their organizations.



We will supply all educational and enrollment materials to our community partners (as approved by BMS). Community agencies will also be able to contact us via the website or Call Center to request additional materials. Any potential enrollee/enrollee can take any material home to review or discuss their options with other family members prior to selecting an MCO/PAAS provider. We will continue to coordinate our materials distribution to ensure all community partners have an ongoing supply of all such materials.

We will continue to develop and make available an Outreach and Education Calendar that indicates our planned activities via our website and via the websites and bulletin boards of our community based partners. The calendar will detail the dates, times and locations of sessions. Prior to disseminating the calendar or posting on any website, we will submit them to BMS for approval. Additionally, as is our current practice, we will strive to participate in as many different events (e.g., health fairs, etc.) that target as many different audiences as possible (e.g., seniors, parents of school-age children, etc.). In addition to dates/times of informational sessions, our presence at these events will also be included on our calendar. By participating in as many appropriate venues as possible, we will increase our availability to potential enrollees/enrollees. If approved by BMS, in the new contract we will make this calendar available on the MHT website.

Train-the-Trainer Sessions

For those agencies who express interest in working with us we will conduct a site visit. During the site visit, our staff will further explain the training we provide, introduce and familiarize the agency with us and the MHT Project, and explain the role of an Agency Advocate and the Train-the-Trainer sessions (described below). We will fully describe the tasks with which we would like the agency's support. If the agency is interested and willing, they will be invited to participate in our trainings.

The primary focus of the Train-the-Trainer sessions will be to create a cadre of Agency Advocates who will subsequently train other consumer-oriented staff at their agencies about managed care and the MHT Project. Again, having a team of Agency Advocates who are able to promote our message and support our goals will be paramount in the success of any new or expanded managed/coordinated care program. Trainings will:

- Focus heavily on the available MHT enrollment options programs,
- Explain our role as the enrollment broker,
- Promote the key concepts related to accessing care via the MCO/PAAS Provider, and most importantly,
- Explain the enrollment process and timeframes.



As it has been our experience that many CBOs will facilitate enrollments via the online enrollment module, we will guide CBO staff through all facets of an online enrollment and provide guidance on both the technical aspects (e.g., preventing error messages) and the counseling elements (e.g., using the provider directory to its fullest capacity to ensure continuity of care). For a full description of our online enrollment module, please refer to Section 4.1.18. We wish to stress that all such outreach activities will be closely coordinated with BMS to ensure that potential partners have no conflict of interest issues, and that only partners approved by BMS (if any) are able to provide enrollment assistance.

In order to best accommodate the various needs of the offices, we will coordinate a training schedule that meets their needs. While we will be happy to conduct trainings in-person at the various offices, we will also conduct webinars and teleconferences if so desired by our partners. We are very experienced in conducting webinars and use them both internally and externally.

When coordinating training times, we will conduct as many trainings as needed to fully equip all community partners with the information they need, and will work with the offices to arrange dates and times that pose the least inconvenience to staff.

Training Special Needs Organizations to Actively Support Outreach, Education and Enrollment Efforts

We have experienced great success in reaching out to special needs organizations, commonly including assisted living facilities, behavioral health organizations, and drug and alcohol abuse facilities, among numerous others.

As continuity of care is critical for this group, we often provide coordinated counseling sessions where we work closely with case workers, case managers, caregivers and family members to facilitate a 'best-fit' selection that will allow the potential enrollee to maintain care. Thus, as part of our outreach strategy, we will identify agencies and organizations that serve these groups and reach out to them accordingly should managed care enrollment be expanded to include SSI consumers.

Our Train-the-Trainer sessions with case workers and case managers will provide a special focus on the various benefits/covered services that most directly impact the group's target population.

Fax and Email Blasts

As an additional value-added service, we will incorporate email blast capacity into the Project if approved by BMS. Using our web-based Provider Contact Manager application for email and faxes (fully described later under Section 4.1.14), we can quickly provide community partners with important updates concerning West Virginia Medicaid. Currently there is no centralized distribution method to provide community based agencies across the State with programmatic updates, and our Provider Contact Manager will help fill this gap.

As the only vendor with longstanding ties to West Virginia's Medicaid community, we are pleased to offer this value-added service to BMS as it:

- Serves as an additional mechanism through which BMS can disseminate information quickly;
- Allows BMS to quickly reach partners across the State with no additional administrative burden;
- Bridges the gap in communication between BMS and community stakeholders; and
- Is a cost-effective solution (e.g., does not rely on expensive printing of materials or mailing costs).

4.1.11 Written and Visual Materials

The Vendor should develop written and visual materials for use in outreach and educational efforts to educate Medicaid members, advocates, providers, community agencies, caseworkers and DHHR staff about any changes in Medicaid delivery systems. These materials should include, but not be limited to, enrollment forms, notices, letters, pamphlets, presentations, videos, internet websites and other information.

The Vendor should obtain BMS approval for outreach and educational materials in any medium prior to production and distribution. Production, reproduction, updates and distribution of materials should be at the Vendor's expense.

Each material submitted for approval should be accompanied by a concise memo indicating the material's purpose, expected use, target audience and printing specifications/BMS reserves the right to edit all or portions of materials prior to distribution. Upon BMS approval, the Vendor should print all written materials, maintaining a sufficient stock of materials, and distributing materials as needed at the Vendor's expense. The Vendor is responsible for supplying and distributing any pamphlets and other mailing materials in addition to DHHR approved materials supplied by the MCOs/PAAS and DHHR.

When determining the appropriate information to be included in the development of written and visual materials (e.g., enrollment forms, notices, letters, pamphlets, presentations, videos, internet websites, etc.), we follow a six step process detailed in Exhibit 83.

The first step in the process involves working closely with BMS to determine not only their goals and objectives for any material, but also to obtain any written documentation concerning programmatic updates or changes. We will hold meetings with BMS as needed to discuss any questions we have and ensure we are correct in our understanding of all changes to be included and topics to be addressed.

Second, we will bring our corporate experience to the development of materials. We will review relevant materials and visuals from our current Projects that involve similar programmatic elements, determine what has been successful about the material, and determine what, if anything, is appropriate to incorporate (or serve as a basis) for the West Virginia material. The benefits of this step allow us to build from successful experiences and incorporate best-practices into new materials.

Exhibit 83. Process for Obtaining Information to Incorporate into Enrollee Materials



Our approach to obtaining information ensures all materials and visuals are comprehensive and meet the needs of our diverse audiences.

Third, we will actively seek the input of appropriate stakeholders on the content and development of all materials. Historically we have sought feedback from the West Virginia Community Action Partnership, and Kanawha Literacy Coalition, among others. We will also coordinate with any other partners, agencies or groups as specified by BMS during the course of the contract.

Fourth, we are pleased to have the opportunity to continue to work with our network of community partners. When determining the content to include in materials, we will seek input and feedback from our community partners, who have very valuable perspectives on the types of information potential enrollees, enrollees, agency staff, DHHR staff, and caseworkers need and how to present information to help maximize understanding. The Project Manager and Field Benefits Manager will coordinate with the community partners to solicit their input.

Fifth, we will follow our materials development and revision process whereby we identify the revision and development needs, draft materials, conduct internal Q/A reviews, verify the literacy level (i.e., 6th grade) using the Flesch-Kincaid test (for enrollee materials), verify the ease of use, translate as appropriate, field test, obtain BMS approval and produce according to specified requirements.

Last, we will submit drafts to BMS for review and approval. As discussed in Section 4.1.5, our Project Manager will complete and attach a QA Checklist and reading level assessment to each item to ensure business rules are accurate, federal requirements are met, and each item meets our internal standards. Any feedback received from the State will be promptly incorporated into the material and then resubmitted for approval. At no time will any material ever be disseminated to any audience without the explicit approval of BMS.

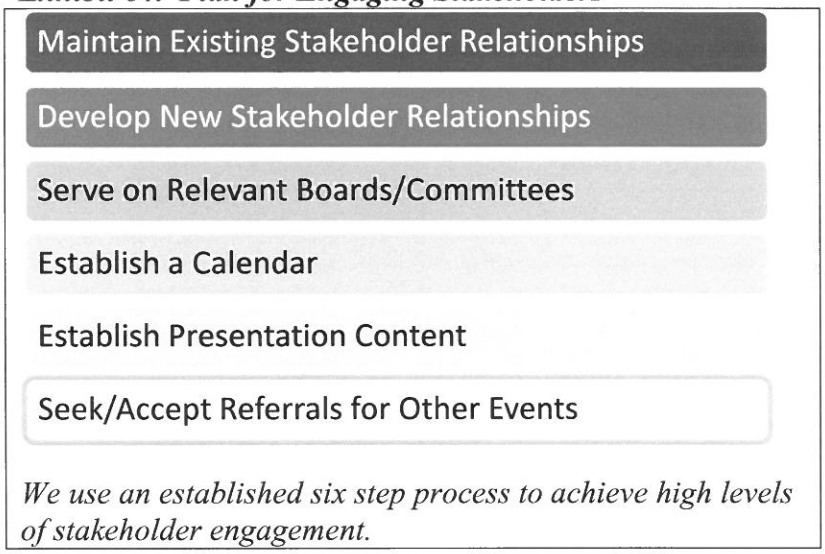
4.1.12 Plan for Engaging Stakeholders

The Vendor should include in its strategy a plan for engaging stakeholders. The Vendor should address how it plans to schedule educational presentations with these stakeholders on an ongoing basis and serve as a resource on the managed care and PAAS programs for stakeholders in the community. The Vendor's strategy should include participating in statewide annual provider workshops, where the written materials for each session should be provided by the Vendor. Historically, BMS has conducted seven (7) provider workshops at various locations throughout the state.

We offer BMS a proven, comprehensive plan for engaging stakeholders, built around a six steps process that results in:

1. Maximum stakeholder participation and engagement,
2. Continuous identification of new stakeholders,
3. Effective communication methods through multiple avenues,
4. Community participation, and
5. Positive representation of BMS, the MHT Program, and the Medicaid program as a whole.

Exhibit 84. Plan for Engaging Stakeholders



We use an established six step process to achieve high levels of stakeholder engagement.

In fact, we have already developed a comprehensive Strategic Outreach Plan to support all functions and responsibilities associated with this section, which is provided in Appendix H.

First, as mentioned earlier in this section, we bring to the MHT Project an extensive network of stakeholder partners throughout the State. (Please refer to Appendix I for letters of support received from many of these partners.) We will continue to maintain positive relationships with these stakeholders through routine site visits from Field Benefits Managers, participation in stakeholder events, involvement in community boards/advisory groups, and ongoing fax and email blasts to keep them up-to-date on new program changes or initiatives (please refer to Section 4.1.4 for a description of Provider

> "Very glad that we get updated in person. Makes it so much easier for us to explain to our customers."
>
> - *Feedback received from Berkley DHHR*

Contact Manager, our solution for blast fax and emails that will be incorporated into the Project.) In the new contract, we will make contact (via phone or in-person site visit) with each stakeholder on a quarterly basis at a minimum.

Second, whenever possible, we continue to expand our network of stakeholder partners. We routinely engage with consumers, providers, and existing partners to identify any new stakeholders with whom we should network. Immediately upon identifying any new stakeholder, we will assign a Field Benefits Manager (depending on the territory) to introduce the MHT Project and identify any ways we can support their mission while promoting the MHT Project and its goals.

Third, wherever possible we serve on existing boards and committees. Serving on such committees allows us to support the stakeholders with whom we collaborate, provide resources where appropriate, and maintain positive relationships. In addition to FRN meetings in each county, examples of committees and boards our staff have served on include but are not limited to:

- Hardy County Family Issues Task Force (our Field Benefits Manager is the current Vice President for this Task Force),
- Barbour County Interagency Meetings,
- Berkeley County Health & Human Collaborative,
- Hampshire County Family Resource Council,
- Hardy County Family Issues Task Force,
- Pendleton County Information Exchange,
- Preston County Caring Council,
- Barbour County Early Childhood Coalition,
- Berkeley County Head Start Healthy Advisory Committee,
- Hampshire County Partners in Prevention,
- Taylor County Planned Approach to Community Health Coalition,
- Appalachian Council Head Start Family Services Advisory Committee,
- McDowell Head Start Health Advisory,
- Regional Young Child Task Team,

"Teresa is very dedicated to Monroe County and we appreciate her participation in our meetings and events."

- *Feedback received from Early Head Start/Head Start*

"AHS, as the West Virginia Enrollment Broker for the Medicaid Managed Care Program, has supported the mission of our Early Head Start/Head Start program in many ways."

- *Director, Monroe County Early Head Start/Head Start*

"Teresa has worked extensively with our organization and has been integral in helping us to complete our mission."

- *Executive Director, Monroe Coalition for Children and Families*

- Kanawha Literacy Coalition, and
- Logan Boone Mingo Collaborative.

In the new contract, we will attend meetings posted on the Consumer Assistance Resources WV Marketplace calendar of events to share MHT information with consumers in the audience who may qualify for Medicaid, collaborating with the In-Person Assistors as appropriate. (We will also establish contact and share information with the In-Person Assistors stationed at local DHHR offices.)

Fourth, in the new contract we will establish a calendar of events that will be publicized on our website. The calendar will detail presentations and events that we will be attending, and will show the dates, times, and locations of the events. In this manner, we will further promote the events and activities of our stakeholders. As shown in Exhibit 85 below, we currently use such a calendar feature in our Illinois Health Connect Project to help promote meetings.

Exhibit 85. Illinois Health Connect Website Calendar



Our web-based calendar helps publicize and promote important stakeholder events. By clicking on any event, the user can access the relevant details (e.g., date, time, location, description, etc.).

Fifth, we will develop professional, high quality materials and content for all meetings and presentations we will conduct. Such materials will include PowerPoint presentations, and Project brochures and handouts (please refer to Section 4.1.4 for a description of our approach to

materials development). The Project Manager will submit all presentation and outreach materials to BMS for approval prior to incorporating into any presentation/material for distribution. Content for presentations may include but not be limited to:

- An overview of the MHT Project,
- An overview of the PAAS Program,
- An overview of the enrollment options,
- Updates on any changes or expansions to the Project, and
- Available resources.

DID YOU KNOW?

We have a proven method of developing high quality, professional materials. Please refer to Section 4.1.4.

Our Field Benefits Managers are all experienced outreach and education staff, and all bring excellent presentation skills to the Project. When conducting presentations, Field Benefits Managers adhere to the following best practices for public speaking in order to ensure BMS is represented professionally:

- Adhere to the timeframe,
- Maintain eye contact with the audience,
- Use appropriate gestures,
- Do not read from a script,
- Maintain good posture,
- Face the audience (not presentation screen), and
- Speak loudly and clearly.

DID YOU KNOW?

As an enhancement to the current statewide provider workshops, if BMS would like, we are willing to host webinars of these events on behalf of the State to further increase attendance.

Field Benefits Managers also collect Feedback Forms at the end of each presentation, which allows them to identify any areas for improvement.

Sixth, as appropriate, we will work with our contacts and stakeholders to identify other events and committees where our participation will be of value. Any new event will be added to our web-based calendar.

Our process for attending and supporting annual provider workshops follows much of the same strategy detailed above. Currently, the workshops are developed by DHHR and the Fiscal Agent, and we participate with a display table and answer questions from the audience, and, if so desired by DHHR, deliver content as appropriate. If desired and approved by BMS, we can also integrate webinar technology into the provider workshops and host the webinar on behalf of the State, so that providers who are unable to physically attend the

workshop will still be able to attend virtually. All materials/handouts from the session can then be archived on the website for easy reference.

Additionally, we would be happy to incorporate the registration form on our website to further publicize the event and encourage attendance.

Second, we will develop professional content. As described above, all content will be submitted to BMS for approval, and will be professional and high-quality. Content may include PowerPoint slides, handouts, fact sheets, etc. We will ensure ample copies are available for all presentation attendees, and, if desired by BMS, can also post any material on our Project website.

Third, as part of our commitment to quality, we will also continue to use our feedback from, which will allow us to identify areas for improvement in our presentations.

The benefits of our comprehensive approach to engaging the stakeholder community and participating in statewide annual provider workshops include:

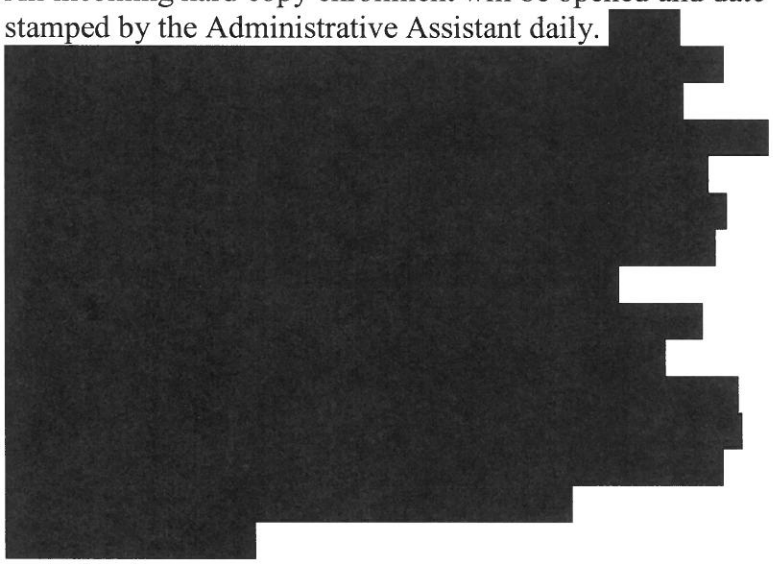
1. We will continue to establish, maintain, and expand our stakeholder relationships across the State;
2. We assure DHHR, BMS, the Medicaid Program, and the MHT Project are represented in the highest manner possible;
3. We help support various stakeholders in achieving their missions and ultimately of improving health outcomes across West Virginia; and
4. We offer proven methods for appropriate statewide field-based outreach and engagement of the stakeholder and provider communities.

4.1.13 Sorting Enrollment Forms and Processing

The Vendor should describe its approach for sorting enrollment forms for processing, identifying enrollees for outreach, researching issues in State systems and identifying enrollment forms that cannot be processed. The Vendor should also propose a process for identifying address discrepancies in State systems.

The customization and deployment of HealthTrack in West Virginia allows us to deliver a tech-savvy and efficient approach to receiving, sorting, and processing enrollment forms as well as researching issues, identifying enrollees for outreach and identifying enrollment forms that cannot be processed. You will see, too, that our approach integrates several quality control and improvement mechanisms such as initial staff review, automated workflow assignment, automatic monitoring of processing timeliness through My Tasks, and PDF linkage of each enrollment form to its case.

All incoming hard copy enrollment will be opened and date stamped by the Administrative Assistant daily.



HealthTrack is the central repository where staff can search for and review previously indexed images.

Staff will be able to see a list of documents sent to and received from a particular enrollee or household and click on any individual item to retrieve a complete image of the document.

After scanning the documents, we will either maintain original documents in separate file folders (filed ID number) for a specified period of time before having them professionally destroyed, or we will have them shredded/destroyed on a routine basis (e.g., monthly or other BMS-desired frequency), whichever is preferred by the State.

On a daily basis, the Call Center Supervisor will be prompted by HealthTrack to check for newly indexed PDF enrollment forms. She will assign these referrals among Benefits Managers and monitor processing timeliness using the My Tasks module of HealthTrack. (See Section 4.3.6.1 for more detail regarding My Tasks.)

For each enrollment form received, the Benefits Manager's first step in the process is to review the form for completeness. If necessary information is missing or discrepancies are identified, we will implement our BMS-approved research and outreach protocols. These include confirming

information in RAPIDS and MMIS, and conducting phone and mail outreach (returning the incomplete form to the enrollee with a notice indicating missing/erroneous information).

In the instance of address discrepancies in MMIS or RAPIDS, we will note these in HealthTrack, attempt to contact the member, and refer them to the Change Center. Additionally, we confirm that the MCO selected is available in their county of residence before processing the enrollment.

If enrollee contact is not possible and the missing or conflicting information is not required for enrollment, the Benefits Manager will enter all provided information into HealthTrack and proceed with processing the enrollment. If contact is not possible and the missing or conflicting information is required for the enrollment to be processed, the enrollment will be flagged in HealthTrack as such, and the enrollee will be auto-assigned if the needed information is not received before the end of the choice period.

Please refer back to Section 4.1.3 for a walk through of how enrollments will be processed in HealthTrack. Targeted outreach to prevent auto-assignment (i.e., HealthTrack's identification of enrollees needing outreach and our outreach approach) was addressed in Section 4.1.10.

4.1.14 Approach for Informing County Offices of Changes in Managed Care or PAAS Programs

The Vendor should include in its strategy an approach for informing all county offices of any chances in the managed care and PAAS programs or processes for enrollment.

Educating and Informing County Offices of Program Changes

We have a strong history of effectively educating and informing county offices about changes in West Virginia's Medicaid programming. Not only did we successfully introduce and garner support for Medicaid managed care in a managed care-resistant West Virginia as the State's first (and only) enrollment broker contractor, but we also educated and supported county offices as West Virginia's continual evolution. From MCOs and PAAS to the Single Rural Option Initiative to Mountain Health Choices and, finally, to the Medicaid managed care as it exists in West Virginia today – we have been there, along side of you. Our phone, mail, and field outreach and education strategies have proven to be effective time and time again. We present an overview of the outreach and education services we provided during the State's 2013 pharmacy expansion as a testimony to validate our approach.

Our Outreach and Education Efforts to Support West Virginia's Pharmacy Expansion

Exhibit 86. Promoting BMS' Pharmacy Expansion



We are proud of our ongoing and coordinated support of BMS' pharmacy expansion and other Medicaid program changes.

On January 8, 2013, we participated in a call with the Contract Monitor and Pharmacy Task Force to discuss how we can assist BMS in promoting the transition of pharmacy benefits to Medicaid Managed Care effective April 2013. It was determined that we would leverage our presence in the field to provide outreach and education for a variety of audiences including prescribing providers, pharmacies, DHHR offices, community partners, etc. In addition, the Call Center staff through the MHT helpline would also provide education and support to consumers and interested parties who had questions about the pharmacy initiative and appropriately direct their call for more information.

Field Support

Field staff (four Benefits Managers supported by the Field Supervisor) were briefed on their education and outreach role for the upcoming expansion of pharmacy benefits to Medicaid Managed Care coverage. Field outreach began on January 9, 2013 with a verbal notification to providers as a heads up. As indicated in the table below, initial outreach efforts by the field staff largely focused on pharmacy providers. As outreach efforts progressed, prescribing providers were included in their visit schedule. The availability of the Prescribing Provider and Pharmacy Fact Sheets for distribution in early March enhanced our ability to more effectively communicate the change to our audience. Additionally, we included the local DHHR offices in our outreach plan. Targeted field efforts continued through Go Live.

Exhibit 87. Field-based Pharmacy Expansion Outreach Visits

Site Type	January 2013	February 2013	March 2013*	Total
Pharmacy Providers	151	153	88	392
Prescribing Providers (PCPs, Specialists, Behavioral Health)	19	123	74	216
Local DHHR offices	9	27	4	40
Total	**179**	**303**	**166**	**648****

**March numbers based on contact sheets entered as of 3/15/13.*
***Contact sheets may include multiple contacts with a single site.*

Other areas of support provided by our field staff included:

- Ongoing promotion of the Pharmacy Expansion webinar held on February 27th and instructions on how to access the archived webinar presentation on the BMS website;
- Distribution of the Prescribing Provider and Pharmacy Provider Fact Sheets;
- Tracking and sharing with BMS the issues and concerns raised by the providers during field visits which provided the State with invaluable insight on how the change is being received and what areas to focus on when compiling the FAQs and other handouts;

- Ongoing outreach to PCPs to ensure that everyone in the provider network was aware of the change;
- Ongoing outreach to pharmacies; and
- Outreach to specialists and behavioral health providers as permitted.

Helpline Support

Helpline staff were initially briefed on the upcoming changes to the pharmacy program and received ongoing updates as the member communication plan unfolded. Staff received copies of the member communication materials sent by each plan, including the initial post card mailings, member letters and pharmacy directories on February 19th and sample membership ID cards as soon as they became available. This ensured that the Benefits Managers were aware of what members were receiving from the MCOs, how to answer questions within their scope of responsibility, and when and where to direct enrollee calls and inquiries in response to the mailings.

Call volume and member inquiries in response to the enrollment packet mailings with the new pharmacy directories was consistent with previous months, indicating that the newly eligible enrollee did not appear to be confused about the inclusion of pharmacy benefits in the MCO's network.

In anticipation of the pharmacy benefit Go-Live date of April 1, 2013, we added a new reason code (i.e., pharmacy benefits) to our software tracking system to track and report the number of pharmacy benefit inquiries received from providers and members through the helpline. This information was shared with the State.

Pharmacy Directories

All three MCOs met their target date of Friday, February 15th for shipment of their pharmacy directories to our Corporate Mail Fulfillment Center. We added the directories to our inventory and updated our mailing processes for the MHT enrollment packets to newly eligible members effective with the February 18th mailing.

We also began inserting the new WV Medicaid Pharmacy Notification letter in each enrollment packet. The letter provided the newly enrolled members with an overview of how the pharmacy program would work.

Enhancing Our Proven Approach: Provider Contact Manager

While our proven field, phone, and mail outreach to County Offices will continue under our purview, as an additional value-added service, we will also incorporate email blast capacity into the Project if approved by BMS. Using our web-based Provider Contact Manager application for email and faxes (described below), we can quickly provide County Offices (as well as any other entities – such as community based organizations – as desired and approved by BMS) with important updates concerning West Virginia's Medicaid programs.

As the only vendor with longstanding ties to the Medicaid community, we are pleased to offer this value-added service to BMS as it:

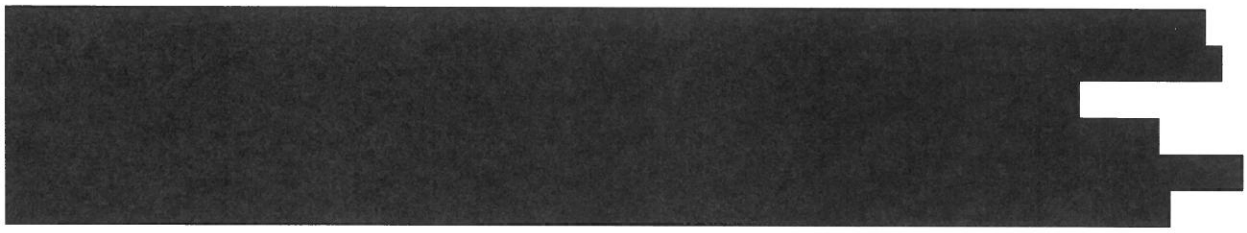
- Serves as an additional mechanism through which BMS can disseminate information quickly;
- Allows BMS to quickly reach partners across the State with no additional administrative burden;
- Bridges the gap in communication between BMS and the CBOs (currently there is no centralized information distribution method to share information); and
- Is a cost-effective solution (e.g., does not rely on expensive printing of materials or mailing costs).

DID YOU KNOW?

As there currently is no centralized distribution method to quickly and efficiently provide community based organizations across the State with programmatic updates, and our Provider Contact Manager will help fill this gap.

While helpful throughout the duration of the contract, we anticipate the Provider Contact Manager (Exhibit 88) will be particularly helpful with regard to sharing information regarding the changes to and impact of program expansion (e.g., to individuals <138% FPL based on the new categories defined under the Affordable Care Act and/or SSI enrollees).

Provider Contact Manager is a Web-based application that allows our Project staff to efficiently communicate with the provider community, whether it is a single provider or a group of providers that fit a certain criteria (e.g., all Providers in a certain county, all OB/GYN providers, etc.). As with all our systems, it will be completely customized and tailored to reach the West Virginia County Office Staff and, if desired, other community based stakeholders. It allows authorized staff to send messages via **fax, email, or both**, as easily as sending an email message.



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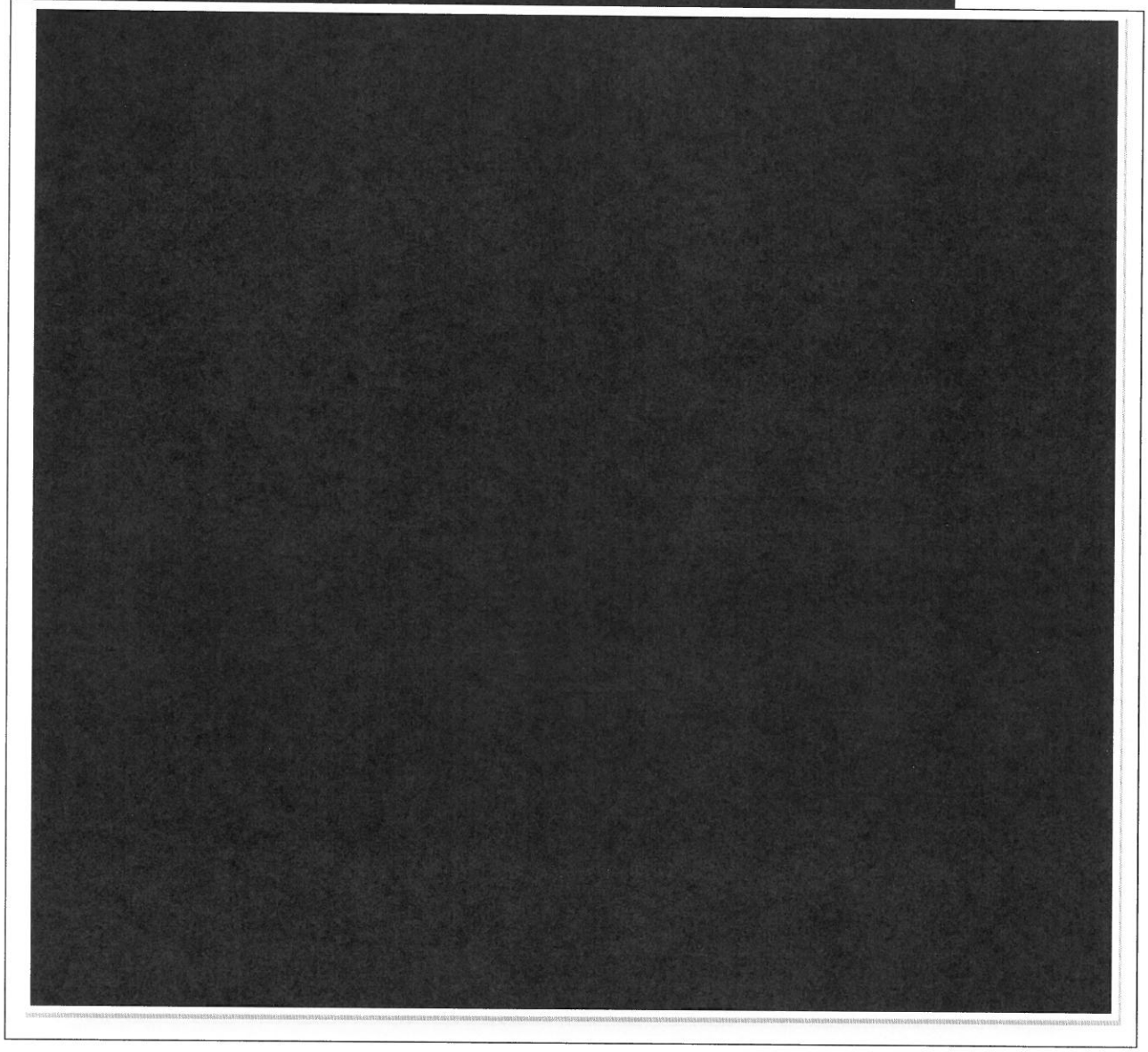

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4.1.15 Process for Providing Field Staff

The Vendor should describe a process for providing additional, highly mobile benefits managers to travel to all fifty-five (55) counties to educate enrollees, providers, agencies, and organizations.

See What WV Partners Say About Us

"Marjorie visited our office to let us know of the implementation and transition of the West Virginia Children's Medicaid Dental Program from traditional Medicaid billing to Scion. She was very helpful in answering any questions our offices had during the initial switch in billing."

- *Kingwood Family Dental*

"Automated Health Systems has supported our work by agreeing to be on the advisory board and making essential decisions about the delivery of our program. More importantly, they have worked with families helping them to understand the choices they have to help them meet their medical needs."

- *Director*
Upper Kanawha Valley Enterprise Community

"Automated Health Systems staff persons have truly been collaborative partners in the Regional Family Resource Network. They are actively involved in task teams, committees, and coalitions in Boone, Kanawha, and Putnam Counties, contributing their expertise as well as learning from others ways to reach out to Medicaid Customers."

- *Director,*
- *Regional Family Resource Network*

"As the West Virginia Enrollment Broker for the Medicaid Managed Care Program, AHS has been very involved within the Jackson County Community and have coordinated their services well within the FRN fold. Their representatives have linked the citizens of the county to those services and networked with the community in a very positive manner."

- *Executive Director*
Jackson County FRN

The success of the managed care model is dependent on the full engagement of enrollees, providers, agencies, and organizations across the state to ensure:

1. Potential enrollees and enrollees have ample choice when selecting a medical home,
2. Potential enrollees and enrollees can receive the care they need, and
3. The partners across the State understand the Project, its goals, and the services offered to the enrollees we jointly serve.

We offer BMS a proven approach to excellent operations across the State achieved through a team of Field Benefits Managers who have:

- Established positive relationships with over 100 community agencies across the State (please refer to Appendix D);
- Earned the praise of countless enrollees, providers, agencies, and organizations across the State;
- Provided ongoing education in the field to providers, agencies, and organizations on ongoing changes to the West Virginia Medicaid Program (e.g., the close-out of the MHC program, the Pharmacy Expansion initiative, the Medicaid expansion, MCO carve-in of dental services, etc.);
- Attended trainings and workshops throughout the State;
- Provided real-time feedback to BMS on emerging issues and concerns expressed by providers; and
- Outreached to over 500 Medicaid dental providers to ensure they were aware of the administrative changes for children's dental services.

We are excited to bring to the Project, a proven, enthusiastic, dedicated team of highly mobile Field Benefits Managers to continue to provide outstanding services across the State and meeting the needs of BMS. Our staffing for outreach and education events across the State is comprised of a Field Supervisor who will directly oversee the work of four Field Benefits Managers.

Field Supervisor

The Field Supervisor provides oversight for Field Benefits Managers who are responsible for informing and educating agencies/potential enrollees and enrollees through broad-based promotional and outreach efforts about West Virginia's Medicaid Managed Care Programs, specifically MHT and PAAS, and facilitating voluntary enrollment into these programs. The Field Supervisor will also be responsible for working with additional populations, including Medicaid expansion, and/or services for future managed care enrollment or benefit expansion at the State's direction. The Field Supervisor ensures maximum levels of voluntary enrollment in participating MCOs among Medicaid potential enrollees and enrollees. This traveling position, reports to the Project Manager, and 100% of her time is devoted to the contract.

The Field Supervisor is required to have a Bachelor's Degree in a related field, and a thorough understanding of BMS/DHHR policies, West Virginia's Medicaid program, MHT, and PAAS, as well as a thorough understanding of state and federal guidelines for managed care and current healthcare delivery issues. Please refer to Appendix J for this position's job description.

In the new contract, Ms. Debbie Hon will continue to serve as the Field Supervisor. She is an experienced health care management professional with over ten years experience specializing in Medicaid operations. She has an extensive background working with field-based Medicaid Enrollment Broker operations in order to maximize the outreach and education efforts to consumers. Having demonstrated a strong aptitude for field and consumer relations as an Outreach and Education Specialist, Ms. Hon was promoted to an Outreach and Education Supervisor in 2013. She has an extensive field-based background to quickly establish and maintain excellent rapport with community resources and ensure partnerships to foster solid relationships with primary stakeholders. Her background with Enrollment Brokering, field operations, and Medicaid will provide a strong foundation for success as the Field Supervisor for the MHT Project in the new contract.

See What WV Partners Say About Ms. Hon:

"Debbie is always very friendly and helpful."
- *Putnam DHHR*

"Thank you so much for helping to make Wayne County Kids Day 2014 a success. I am so glad you participated."
- *Wayne County Schools*

"Material covered very well. It was great to actually learn about the organization/process."
- *Kanawha DHHR*

"Very helpful. Knowledgeable."
- *Boone Memorial Hospital*

Ms. Hon brings a Bachelor of Science from the University of Vermont, training in sign-language, and certification as a Medical Representative. She is fluent in Microsoft Office, and has engaged in numerous community partnership activities, including but not limited to:

- CMR Institute Member,
- Chair of Putnam County Early Childhood Initiative,
- Board Member at Large of Joseph's Tree House,
- Committee Member of Health & Fitness Wayne,
- Committee Member of Jobs & Education Wayne,
- Region 2 Family Centered Practice Trainer,
- Putnam Wellness,
- Putnam Young Child Task Force,

- Board Member Upper Kanawha Valley Starting Points/Parents as Teachers,
- Board Member Mason & Jackson FRNs – Secretary,
- Board Member Mingo FRN,
- Region 2 Our Town Trainer,
- Region 2 Family Youth Engagement Strategies Trainer, and
- Brain Under Construction Zone Trainer.

Ms. Hon's extensive experience, knowledge of MHT and West Virginia's health care program will ensure outstanding outreach and education activities in the new contract. Please refer to Appendix C for Ms. Hon's resume.

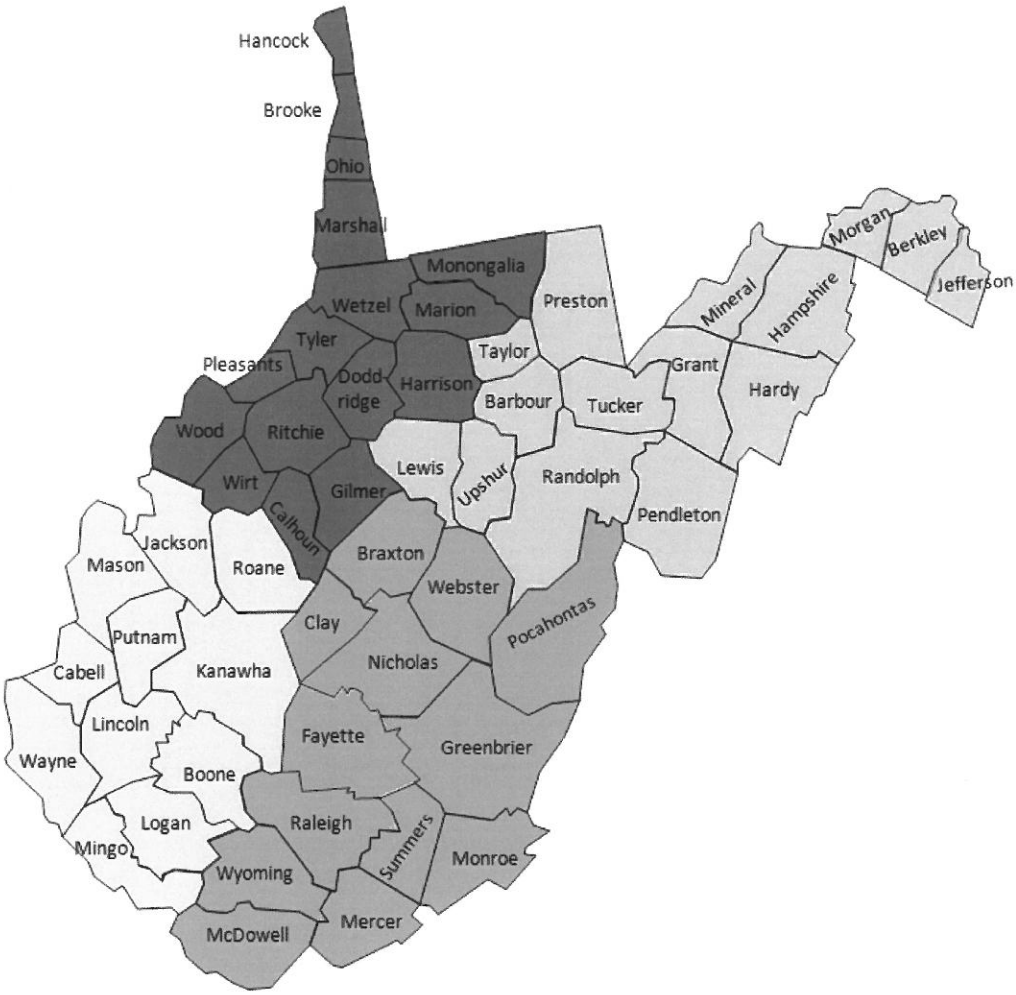
Field Benefits Managers

Outreach and education activities will continue to take place across the State, as provided by our region based Field Benefits Managers. We will continue to employ Field Benefits Managers (4 FTEs), who will each be assigned a region as depicted in Exhibit 89 below. As needed, all Field Benefits Managers have the flexibility to travel outside their region to support additional outreach and education strategies as appropriate.

Please note, if there is a reason to modify our definition of the above territories at any time in the contract, we will do so. We can re-define our regions to align with other West Virginia agencies (e.g., the Department of Health) if so desired.

Within their assigned region, Field Benefits Managers are responsible for informing and educating agencies/potential enrollees and enrollees about West Virginia's Managed Care Medicaid Programs, specifically MHT and PAAS. Field Benefits Managers are responsible for facilitating voluntary enrollment into MHT/PAAS, educating potential enrollees and enrollees/providers/agencies and introducing other new initiatives at the State's direction, including Medicaid expansion and other managed care program expansions. As such, Field Benefits Managers forge relationships with the traditional and non-traditional agencies throughout the State to promote and extend the MHT Project education and enrollment activities. They conduct extensive outreach and educational presentations across the assigned territory and maintain logs of all enrollee interactions in the State's MMIS and HealthTrack. This highly mobile traveling position, reports to the Field Supervisor and 100% of their time is devoted to the contract. (Please refer to Appendix J for this position's job description.)

Exhibit 89. Territories for Field Benefits Managers



To provide coverage in all 55 counties, we will continue to assign Field Benefits Managers to the following regions.

Please note, we supply all Field Benefits Managers as well as the Field Supervisor with laptops and Smart Phones, which allows them to stay in-touch and up-to-date with all Project operations at all times. Cell phone numbers for Field Benefits Managers are provided to community based agencies, partners, and stakeholders, and BMS so they can respond to any issue without delay, and all Project documentation and reporting is completed immediately.
As mentioned, we are excited to offer

DID YOU KNOW?

Our Field Benefits Managers are extensively networked with the West Virginia Medicaid community. With their exclusive focus on enrollment broker work, they are supremely prepared to support the State with any transition or program change it elects to make.

BMS an experienced team of Field Benefits Managers. Please refer to Exhibit 90 for highlights of just two of our experienced Field Benefits Managers.

Exhibit 90. Profiles of Field Benefits Managers

Name	Marjorie Burdick	Teresa Long
Tenure with MHT	10 years	10 years
Territory	Region III	Region IV
Sample Community Partnerships	• Hardy County Family Issues Task Force Board • Barbour County Interagency • Berkeley County Health & Human Collaborative • Grant County Family Issues Task Force • Hardy County Family Issues Task Force • Pendleton County Information Exchange • Preston County Caring Council	• Children's Summit & Collaborative • UniCare Baby Shower • Monroe County Baby Shower • Monroe County Christmas Baskets • Webster County Christmas Store • McDowell Head Start Health Advisory • TLC at the Monroe Board of Education • Appalachian Council Head Start Family Services Advisory Committee Meetings
Compliments Received	"Marjorie is very educated on the information and was able to answer all my questions. Sweet lady!" - *Hahn Medical* "Very glad that we get updated in person. Makes it so much easier for us to explain to our customers." - *Berkley DHHR* "Marjorie is always helpful and always providing us with new information." - *Wellspring Family Medicine* "Ms. Burdick is always accommodating and friendly, explains changes and answers my questions." - *Family Medical Clinic of Jane Lew* "Marjorie is informative and eager to help us with any concerns or questions we may have." - *James Courrier*	"I think Teresa coming around & going from office to office is very helpful. Teresa is very knowledgeable and very nice to work with." - *Lawson Family Dentistry* "Teresa was so helpful and answered some lingering questions concerning the Medicaid changes." - *Harvey Dental Studio* "Teresa did an excellent job in presenting information to our supervisors. She spoke to 26 supervisors who cover 13 counties. We appreciated her speaking to our group." - *Region IV Program Manager, DHHR* "She is reaching out & participating with several events & meetings in our community. I could not ask for a better provider/worker. Teresa was a fantastic addition to the program. She was very helpful & knowledgeable about the Mountain Health Trust Information." - *FRN Director*

4.1.16 Plan for Performing Outreach to Members Who Are Hard to Reach

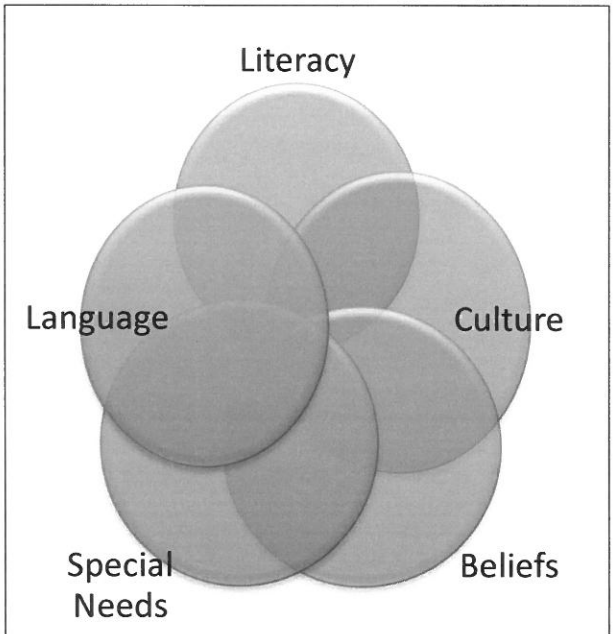
The Vendor should propose a plan for performing outreach to members that, because of housing circumstance, cultural differences, in ability or unwillingness to access information through the county office or community hosted information program or other circumstances, makes an enrollment a challenge.

Comprehensive, Intentional Enrollee Outreach

As documented in the literature and discussed earlier, well-designed, culturally sensitive advocacy, outreach and education to low-income families about managed care is essential. Only when the potential enrollee/enrollee receives an accurate, understandable, culturally sensitive and medically knowledgeable presentation can the benefits of MHT be realized. Enrollees' informed participation largely depends upon the enrollment broker's ability to successfully educate them.

We hope we have effectively conveyed the multiple components of our outreach strategy, all aimed at ensuring presentations are not just accurate, consistent, and objective but also understandable and racially, culturally, and socio-economically sensitive, especially where there are higher percentages of minorities, refugees and immigrants. The introduction of families who may not be familiar with publicly funded programs and may attach some stigma to them adds yet another dimension that must be considered. Further, Project staff must be medically sensitive and take potential enrollees/enrollees' health status and health needs into account.

Exhibit. 91. Factors Impacting Enrollee Education



Our approach addresses the many factors impacting enrollee understanding and ensures Project messaging and education are accessible to our target audiences.

Our Call Center- and Field-based Benefits Managers will continue to be fully trained and prepared to provide culturally competent, medically sensitive, linguistically appropriate, unbiased, and accurate education to potential enrollees and enrollees. Our materials will be low-literacy (written at a 6th grade reading level as determined using the Flesch-Kincaid score), available in alternative formats (for example, audio), and translated into prevalent languages as determined by BMS and us. (Please see Section 4.1.2 Identify Prevalent Non-English Languages.)

Effectively Engaging Hard-to-Reach and Special Needs Enrollees

There are many pieces to the "poverty puzzle" that must be considered when working with low-income families and outreach is more effective if the Project staff fully understand the interaction of these factors and their impact on potential enrollees' and enrollees' lives. These factors not only filter information potential enrollees and enrollees receive, but may also distort or render the messages irrelevant to the targeted individual. We take these complex variables into account by recognizing educational, racial, ethnic and cultural diversity so that our education is understandable and meaningful to those we serve.

Materials for the Project, for example, must be written at an appropriate grade level and must also avoid being race neutral (which fails to promote consumer identity with the subject matter), representative of just one race (which tends to limit their generalizability), or potentially offensive to the intended audience (for example, inattention to Middle Eastern dress codes for women). Each element of the enrollee presentation must address such differences. (Please see Section 4.1.4 for more information on our approach to developing culturally and linguistically appropriate materials.) Additionally, we will continue to provide translation services at no cost to the enrollee, thus mitigating language barriers.

Beliefs also profoundly affect use of health care. Some distrust of organized medicine is increasingly endemic in our society but may be particularly keen in low-income racial and ethnic groups and may be expressed in reliance on home remedies, folk healers and rejection of available "Western" resources. **Especially when cultural and linguistic issues are present, as they may be among refugees and recent immigrants, affiliation with known and trusted local organizations will help establish rapport with enrollees and foster Project objectives.** We will continue to partner with organizations such as these to help promote the objectives of MHT. (Please see Section 4.1.10 for more about our partnership with and support from trusted community groups.)

Other characteristics of the target audience, such as educational level, also shape our enhanced effort. While not perfectly correlated, education roughly translates into literacy. The written materials and visual aids we develop for potential enrollees and enrollees are all written at a 6th grade or lower literacy level. Alternative formats are also available. (Please refer back to Section 4.1.4 for more detail.)

Without an educationally-appropriate presentation that is standardized to promote consistent quality by a flexible "script" and supplemented with easy-to-read materials and message reinforcement through other media, our staff would not be able to make or leave an impression; all aspects of the MHT Project must sensitively accommodate the low literacy and limited facility with English that may characterize some potential enrollees and enrollees. This affects the delivery style and length of interactions as well as the content and format of enrollee materials.

Our staff will continue to be trained on, cognizant of, and skilled in considering these issues and concerns to effectively educate and support MHT's potential enrollees and enrollees. Please see

Exhibit 92 for an overview of the issues facing many hard-to-reach and special needs enrollees and our strategies for overcoming them.

Exhibit 92. Outreach Issues/Concerns of Hard-to-Reach and Special Needs Enrollees

Audience	Considerations	Strategies
Disabled Enrollees	Serving the disabled consumer poses a difficult and ongoing challenge. Often this individual will require a full continuum of care and specialty services over a lifetime.	Interventions must be client-centered and aimed at optimizing functional independence and precluding or slowing the onset of further exacerbations. The "choices" presented to the disabled must afford continuity with a current provider and emphasize coordination of needed services, a team approach to care-giving, numerous high-level support systems and available modifications tailored to changing individual needs. Presentations by our staff must be appropriate for those with communication impairments (for example, available in audio and visual, large-type, and TTY-accessible formats). Websites should be accessible (508 compliant).
Homeless Enrollees	The homeless are often lost on the continuum of healthcare. Their situation, be it temporary or permanent, puts them in a state of flux in which basic human needs often go unmet and decisions about healthcare choices may pale in comparison. Healthcare messages, if heard at all, engender little response, and are can fail to the wayside from the effort needed to "get by" from one day to the next. Outreach and education of the homeless poses a unique dilemma in that information most likely cannot be disseminated via conventional means and locating the consumer becomes the first objective.	Efforts of the Project, therefore, must be geared to those organizations which serve the homeless (i.e., soup kitchens, shelters, walk-in clinics) and/or which provide a conduit to this especially at-risk group. For example, in West Virginia we: • Serve on multiple committees with local shelters (e.g., Mason County Homeless Shelter and others); • Visit the Huntington City Mission and other missions across the state; • Communicate with homeless coordinators in the county school systems; and • Work with Habitat of Humanity when possible and county Housing Authorities at collaborative levels.
Migrant Workers and Refugees	The refugee population presents unique language and cultural challenges, and at times, significant physical and mental health issues of great concern to physical MCOs. Physical needs can range from severe malnutrition, TB and war-related	An understanding of the distinctive features of different cultures is essential. For example, Vietnamese families offer a close-knit support system for newly arriving refugees. Bosnian Serbs, on the other hand, are a proud people who do not readily offer support or help with

Audience	Considerations	Strategies
	injuries requiring basic to complex medical care. There may be emotional and psychological scars that require appropriate intervention that is culturally sensitive. Enrollment issues to be confronted may include fear, skepticism and reserve.	resettlement to incoming families. A multi-lingual approach enhances communication efforts and lessens some of the fear attached to official/government services.
Enrollees with Mental Health and/or Substance Abuse Issues	Special needs intervention is a common denominator here, where enrollees frequently experience overlapping physical and psychosocial concerns. Three-way calls are very useful in these situations, effectively involving the MCO in fostering continuity of care essential to psychiatric and substance abuse treatment. In dealing with consumers, information must be conveyed not only accurately, but also in a sensitive manner; confidentiality is especially essential for this consumer.	In the instance of mental health/drug dependency, it is important to treat the individual holistically, not simply as a collection of symptoms. Three-way calls can be very useful in these situations, effectively involving the MCO in fostering continuity of care essential to psychiatric and substance abuse treatment. Information must be conveyed not only accurately, but also in a sensitive manner. An emphasis on confidentiality is especially essential for this enrollee.
Chronically Ill Enrollees	Serious medical conditions can reflect a concurrent medical and psychosocial complexity due to the chronicity and often poor prognosis involved. This particularly vulnerable group has above-average needs requiring access to specialists, personalized care, immediate response, an integrated delivery system, and alternatives to hospitalization. Adherence to a medical regime and measured decision-making are critical yet difficult elements for individuals often profoundly overwhelmed by the illness itself. The availability of select specialists is a primary consideration in their enrollment decisions, as is the provision of ancillary services, particularly extensive pharmaceutical benefits.	Outreach and education must reflect these concerns, utilizing a level of medical sensitivity that will allow the individual to process the information most effectively and reach the decision best suited to his/her needs. Again, the phone- and field-based Benefits Managers may need to deal with family member, enrollees and other caregivers and assure that MCO choices are explored in a helpful and supportive manner.

4.1.17 Plan for Mailings and Electronic Communications

The Vendor should propose a plan for mailings and electronic communications to MCO/PAAS members The Vendor should be responsible for all member mailings for the managed care and PAAS programs and for coordinating all member mailings with BMS. The cost of materials, printing, and postage for these mailings should be the responsibility of the Vendor. The Vendor should also be responsible for the cost of re-mailings of returned mail, other notices sent on an individual basis and any mailings not done through the system process. The Vendor should advise BMS on the style and content of the mailings and notices.

Experience with Large Scale Mailing Operations

For all of our projects, we have produced materials and generated mass outreach, education, and enrollment mailings; this includes providing all mailing operations required for BMS' MHT program since its inception in 1996.

Our Corporate Mail Fulfillment Center is the mailing hub for nearly all of our contracts. Currently providing comprehensive mail fulfillment services for our West Virginia, Missouri (St. Louis), Ohio, and Wisconsin contracts as well as providing ancillary mail fulfillment support to our Florida and Illinois contracts, our Corporate Mail Fulfillment Center produced and distributed 5,204,833 pieces of mail for these contracts during the past year. With complicated fulfillment requirements where mailings vary due to program, category of assistance, geographic residence, language spoken, etc. and area all mailed according to the contract's standards for timeliness, the more than five million mailings sent by our Corporate Mail Fulfillment Center included a variety of specific mailing types with SLAs for distribution.

Exhibit 93. Our Experience with Large, Complicated Mailings

Contract	Summary of Contract Mailings, by Type	Number Distributed 4/1/11 – 3/31/12
Illinois Health Connect Project	Initial Enrollment Packets – 2 versions Reminder Notices – 2 versions Second Enrollment Packets – 2 versions Confirmation Notices – 2 versions Notification Notices – 2 versions Open Enrollment Notices – 2 versions Appointment Reminders – 2 versions Adult Preventive Care Notices – 2 versions PCP Listings – 1 version IHC Newsletters – 3 versions IHC Panel Rosters – 1 version Provider Profiles – 1 version PCP Surveys – 1 version Provider Bonus Checks – 1 version	3,623,077
Florida Medicaid Reform and Medicaid Options Enrollment Broker Projects	Enrollment Packets – 60 versions MediPass Cards – 23 versions Confirmation Notices – 16 versions Transfer Notices – 136 versions Reminder Notices – 36 versions MediKids Packets – 18 versions	3,318,984
Ohio Medicaid Consumer Hotline Project	Enrollment Packets – 16 versions Reminder Notices – 4 versions Approved Notice – 1 version Rejection Notices – 5 versions Enrollment Applications – 7 versions Brochures – 18 versions Billing Incident Notice – 1 version Reimbursement Notice – 1 version Invoice – 1 version	197,088
St. Louis Gateway to Better Health Project	Initial Enrollment Packet – 1 version	17,680
Mountain Health Trust Project	Enrollment Packets – 12 versions Medicaid Redesign Letters – 2 versions Reminder Notice – 1 version	243,453
Wisconsin Medicaid Managed Care Outreach, Education, and Enrollment Project	Auto-Assignment Notices – 2 versions Reminder Notice – 1 version SSI-Voluntary Notice – 1 version Surveys – 1 version	59,401
		7,459,683 PIECES

Our Florida Enrollment Broker Projects include the most complicated mailings of all our projects – there are 289 different types of mailings including 60 different Enrollment Packets, 136 Transfer Notices, 36 Reminder Notices, 18 MediKids Packets, 23 MediPass Cards, and 16 Confirmation Notices. Mailings are customized to reflect:

- Five different Medicaid managed care programs available to enrollees based on category of assistance, age, special needs (e.g., HIV/AIDS and children with special health care needs), and geography;

- Voluntary versus mandatory enrollment status;
- County of residence; and
- Preferred language (English, Spanish, or Haitian Creole).

The sheer variety of mailings alone is complicated, but the complexity is compounded by the high volume of mailings provided and strict standards for timeliness.

While the above testifies to our corporate expertise in providing complex, high-volume mail fulfillment services and highlights the breadth of letters we generated for just one of our contracts, the narrative below provides more information on HealthTrack's Mail Console, which will be customized and implemented under the new MHT contract.

Provision of Mailing Functions

For the MHT Project, mail fulfillment services will continue to be managed directly by our Corporate Mail Fulfillment Center in Pittsburgh, PA. No mailing activities associated with this Project will be contracted to an outside entity. We are confident the mailing approach we are offering will be successful, as it is the same approach we used to mail 171,445 items of West Virginia mail in 2013 – all within contract standards.

This approach has several benefits:

1. There will be no interruption in the provision of mail fulfillment services. And, continuity of such services will be provided by staff who not only have a thorough understanding of MHT's mailing types and requirements, but who also have demonstrated their ability to meet quality standards for mail fulfillment.
2. BMS benefits from our extensive experience operating large scale mail house operations that include printing, inventory management, and fulfillment services.
3. We retain direct oversight and control over operations, work load, and quality.
4. HealthTrack directly interfaces with mailroom hardware and software. Mailing files will not need to be shared via FTP or other method with an external party, which also limits exposure to a HIPAA breach.

DID YOU KNOW?

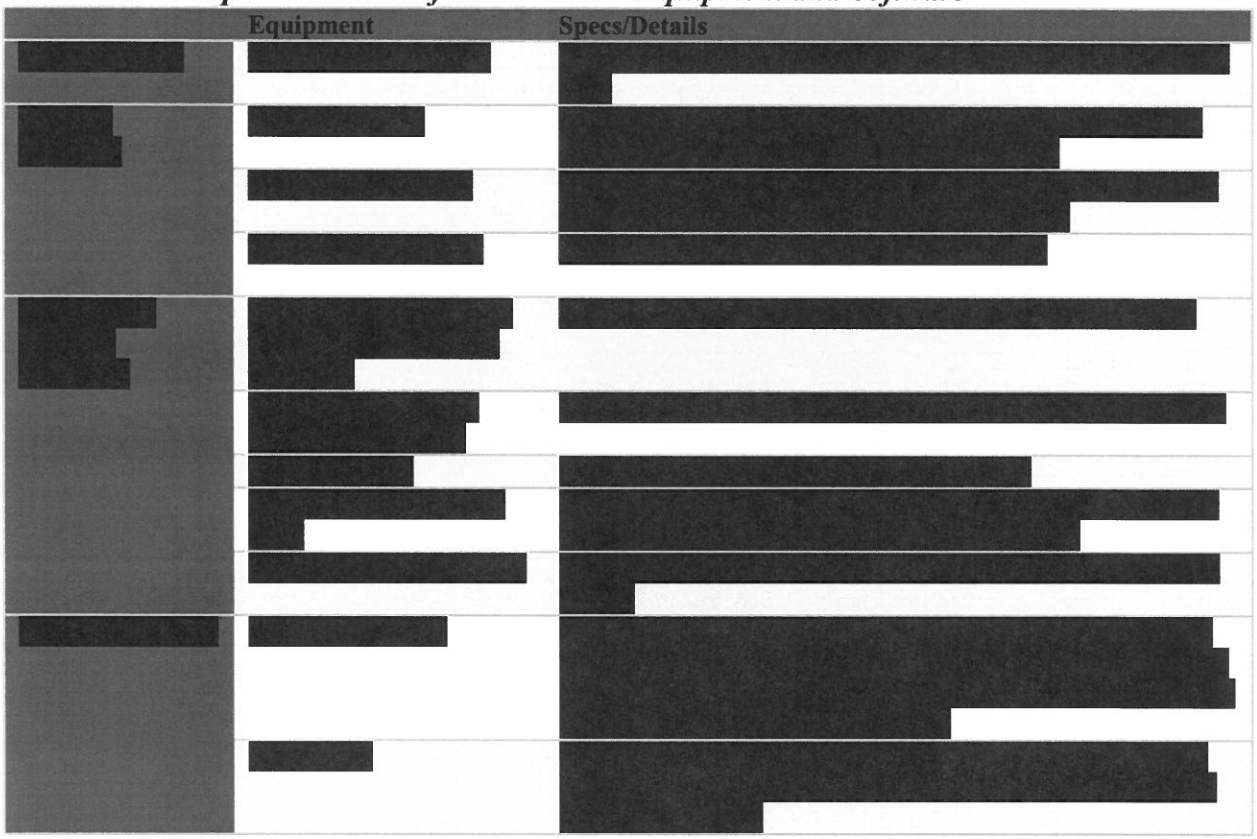
Our Mail Fulfillment Center can support changes in mailings. We worked with BMS on the discontinuation of the provider directories and can add or change new content on mailing files easily – all without a single change order.

5. By maintaining direct communication with IT and project staff, problems and questions can be directly and promptly resolved.
6. Our maintenance agreements with trusted equipment and software vendors ensure timely routine maintenance and swift response times when repair is needed.

Our Corporate Mail Fulfillment Center employs experienced staff who are well practiced in our mail fulfillment workflows, MHT-required mailings, QA standards, and confidentiality policies. The Corporate Mail Fulfillment Center will continue to be overseen by Ms. Susan Sensenich, a highly knowledgeable and proven manager with over 20 years of mail fulfillment and printing experience and 10 years as our Corporate Mail Fulfillment Manager.

All hardware and software needed to meet the mail fulfillment requirements of the MHT contract are on-site and fully functioning. Additionally, we have routine maintenance checks performed on all equipment and service agreements for prompt repair/replacement when needed. Our Mail Fulfillment staff utilize state-of-the-art equipment for preparing mailings (see Exhibit 94), maintain detailed inventories of materials, and utilize the Satori Bulk Mailer system to prepare the mailing and get it out the door within the necessary timeframes.

Exhibit 94. Corporate Mail Fulfillment Center Equipment and Software



Our Mail Fulfillment Center staff look forward to continuing to serve BMS, the MHT Project, and potential enrollees/enrollees.

Ensuring Accuracy of MHT Enrollment Mailings

There are three elements critical to our ability to provide appropriate, accurate, and timely enrollment material mailings:

1. Policies and procedures,
2. State-of-the-art technology, and
3. Quality assurance protocols.

Policies and Procedures

As was already discussed in our response to Section 3.5.3 Enrollment Function and will be fully detailed in our response to Section 3.5.15 Data Systems & Data Requirements, HealthTrack is our proprietary, robust, fully integrated system solution that meets all enrollment broker system needs. We have worked closely with BMS to accurately define and program the policies, procedures and business rules needed to appropriately generate and distribute all enrollment packet mailings according to contract standards for timeliness into our current mailing solution. We will use these same business rules when customizing HealthTrack's Mail Console. The following paragraphs provide an overview of our procedures for ensuring HealthTrack generates enrollment mailings accurately.

All MHT enrollment packets will be sent according to a BMS designated timeline that is programmed into HealthTrack. Prior to generating an enrollment packet to be sent, HealthTrack will check to ensure each potential enrollee meets the following criteria:

1. Is Medicaid eligible,
2. Is MHT eligible,
3. Resides in a West Virginia County,
4. Has a complete address, and
5. Has an address that has not been marked as Returned Mail.

For potential enrollees who have not met all of the above noted criteria, an MHT enrollment packet will not be sent. For potential enrollees who have met all required criteria, HealthTrack will then analyze indicators on the eligibility file we receive from the Fiscal Agent to determine the appropriate package to be sent.

HealthTrack will then batch enrollment packet mailings by job. These jobs are then accessed by our mailroom staff via HealthTrack's Mail Console (described below).

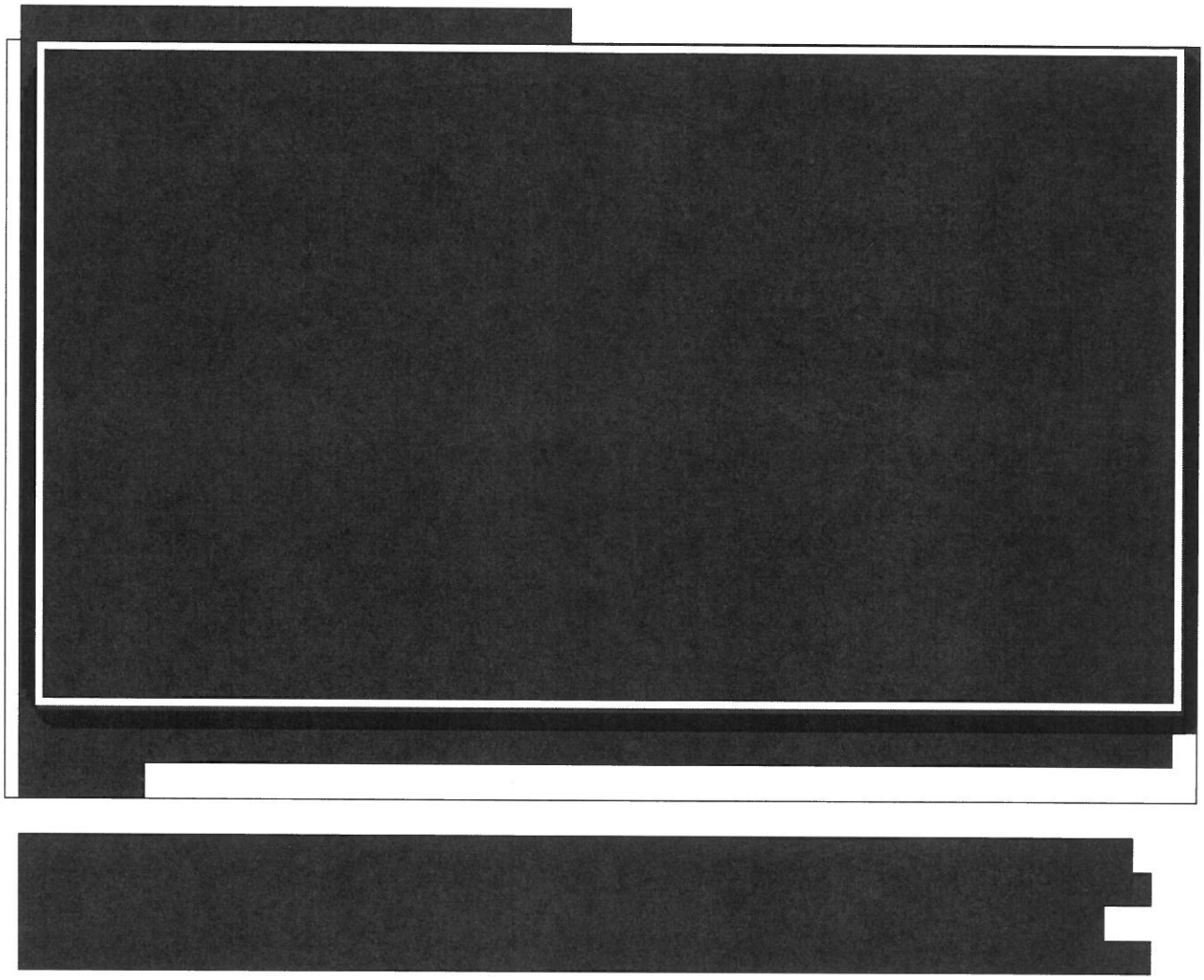
State-of-the-Art Technology

Outgoing Mail

HealthTrack's Mail Console includes a step-by-step guide to process all HealthTrack generated mail. Mailings are selected, prepared, run through Bulk Mailer (if appropriate), printed in PDF and mailed. Mail Console displays the status of each step and includes several quality assurance mechanisms to ensure all files are processed appropriately.

First, once the Mail Console has been opened, the Mail Console Tab launches, which shows two steps:

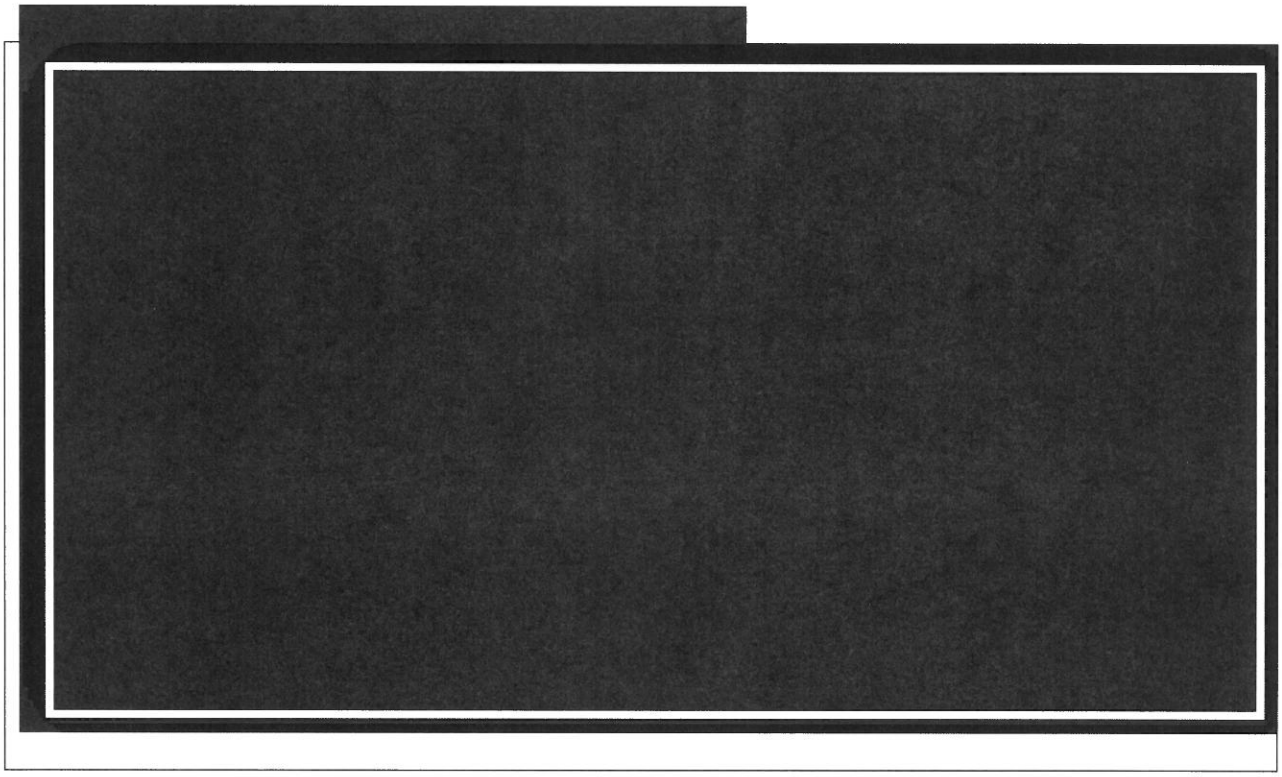
1) Prepare Mailings, and
2) Print Mailings.



[redacted]n the example above the following progress has been indicated:

1. Item #1: NR Confirmation Letter – 3000 MediPass Sleeve (English): HealthTrack generated 1153 records that were sent through Bulk Mail with PDFs successfully created.
2. Item #2: NR Confirmation Letter – 3000 MediPass Sleeve (Spanish): HealthTrack generated 209 records that were sent through Bulk Mail with PDFs successfully created.
3. Item #3: NR Confirmation Letter – 3000 MediPass Sleeve (Creole): HealthTrack generated 3 records that were not sent through Bulk Mail (the volume was insufficient) with PDFs successfully created.

Next, once all items have been created, Mail Fulfillment Center staff use the tab on the right to select the materials that are ready to print.


[redacted]

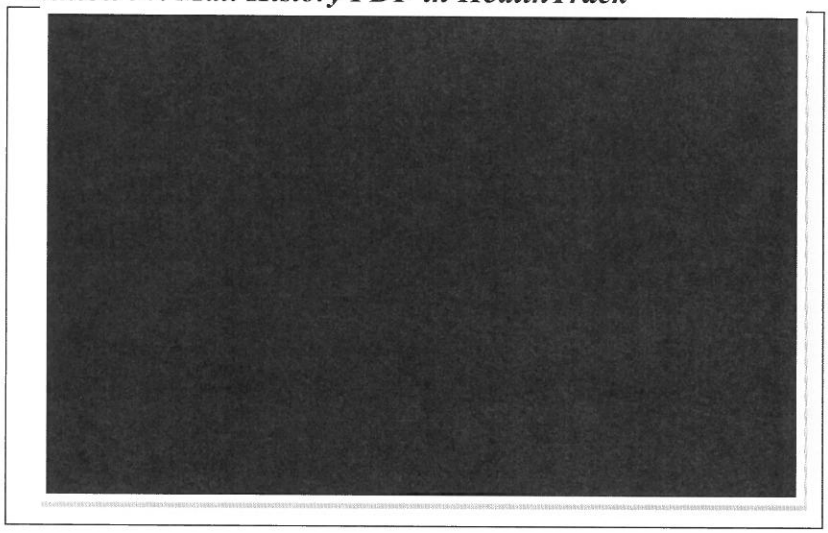
Because printing, stuffing and mailing are accomplished outside of HealthTrack, the user reports the task is completed by clicking a button that marks the file's status. The following steps are taken to print all materials:

1. After the materials have been selected, the file is opened in Adobe Reader and the Mail Fulfillment Center staff reviews the print box and selects "okay."
2. Once the printing is complete, the appropriate materials are selected and marked as printed. A printer icon shows besides the selected print box.

3. Once the final processing is complete, the Mail Fulfillment Center staff clicks "mark sent" that takes the records from "pending" status and makes them "historical."

Mail History

Exhibit 97. Mail History PDF in HealthTrack



Further, a history of all mailings run through the Mail Console can be accessed through the Mail Console history (Exhibit 97). Mailroom staff and management can use this information to track the total number of letters mailed along with the total number of recipients to which the letter's subject applied. A count of the total number of PDF pages is displayed and the screen also allows access to view or reprint all or a part of the PDF.

NCOA and Barcode Technology

Despite these efforts, we recognize that returned mail is a routine part of any large scale project. To that end, we have established procedures for tracking returned mail that will continue to be implemented in our West Virginia office where returned mail is received. Because we will barcode all HealthTrack-generated mailings, the Administrative Assistant will be able to use a barcode scanner to automatically and immediately identify that specific mail within HealthTrack – a quick process that eliminates the need for time consuming data entry. Subsequent outreach tasks (e.g., outbound calls, updated address research, additional mailings, etc.) will be scheduled in HealthTrack, assigned by Project management and supervisory staff, and completed by front-line staff. All actions will be documented in HealthTrack.

Quality Assurance Protocols

Aside from the inherent quality assurance protocols in HealthTrack, we will utilize our current standard of a 5% quality control (QC) check by management staff for all post-production mail jobs. These quality control activities are undertaken to ensure all mail packets are assembled with the correct material, pre-populated items are a match, all mail is properly prepared for acceptance by the United States Postal Service (USPS), and all USPS forms are prepared correctly.

The quality control checker must sign off on all job jackets and note the number of pieces checked for each job. For general mailings (single insert) the QC check will include assuring

that the correct envelope is used, correct postage is affixed, the correct indicia is used, and postal forms are filled out correctly. The address and barcode, if used, must be visible in the window.

For jobs that contain multiple inserts a more thorough inspection is performed. Contents will be pulled out of the mailing envelope to assure correct material is used. If there are multiple types of materials in the job, each section is reviewed for accuracy of material. Envelopes will also be checked to assure correct envelopes and indicia are used and the address and barcode are visible in the window. Once the QC check is completed the job is returned to the Mailroom Clerk to seal the envelopes.

Large jobs that contain multiple pages of varying numbers will be checked before the first pieces of material are placed into envelopes. We will ensure all the correct materials are pulled and ready for use. While the job is being worked, routine spot checks are performed to ensure continuity. We then do one more check of 5% of the job when the job is completed. The job is also checked for the correct postage or indicia used. Envelopes will be checked to ensure the correct envelope is used and that the address and barcode are visible in the window. If errors are identified, the job will be returned to the Clerk who worked on the job to check all the pieces and correct the errors. The job will then be subject to an additional QC check.

Mailing Costs

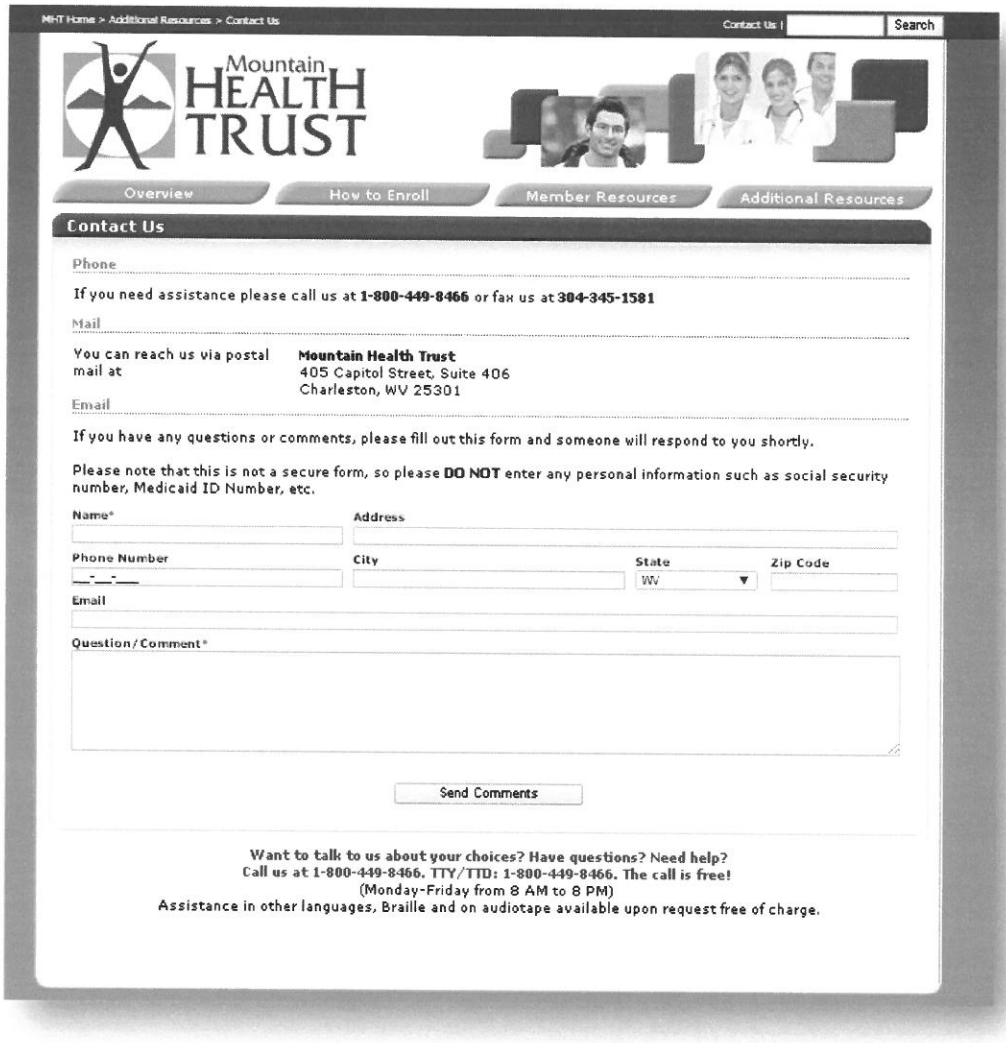
We understand and agree to maintain responsibility for all member mailings for the MHT and PAAS programs and for coordinating all member mailings with BMS. The cost of materials, printing, and postage for these mailings will be our responsibility. The cost of re-mailings of returned mail, other notices sent on an individual basis and any mailings not done through the system process will be our responsibility as well.

Online Contact Us

We have been using email for internal and external communications for many years now. In addition, we have programmed a "Contact Us" feature on the MHT website (see Exhibit 98), and will continue to make this feature available under the new contract. The Contact Us form is an upgrade to simply showing an email address for many reasons:

- Posting an email address online makes it easy to be "harvested" by malicious spammers.
- Consumers may need to copy and paste the email address into their own email program, which is more cumbersome and error-prone.
- Most importantly, email by itself is typically not a secure communication channel. Consumers may be transmitting PHI in an unsecure manner without even realizing it.

Exhibit 98. MHT Contact Us Form



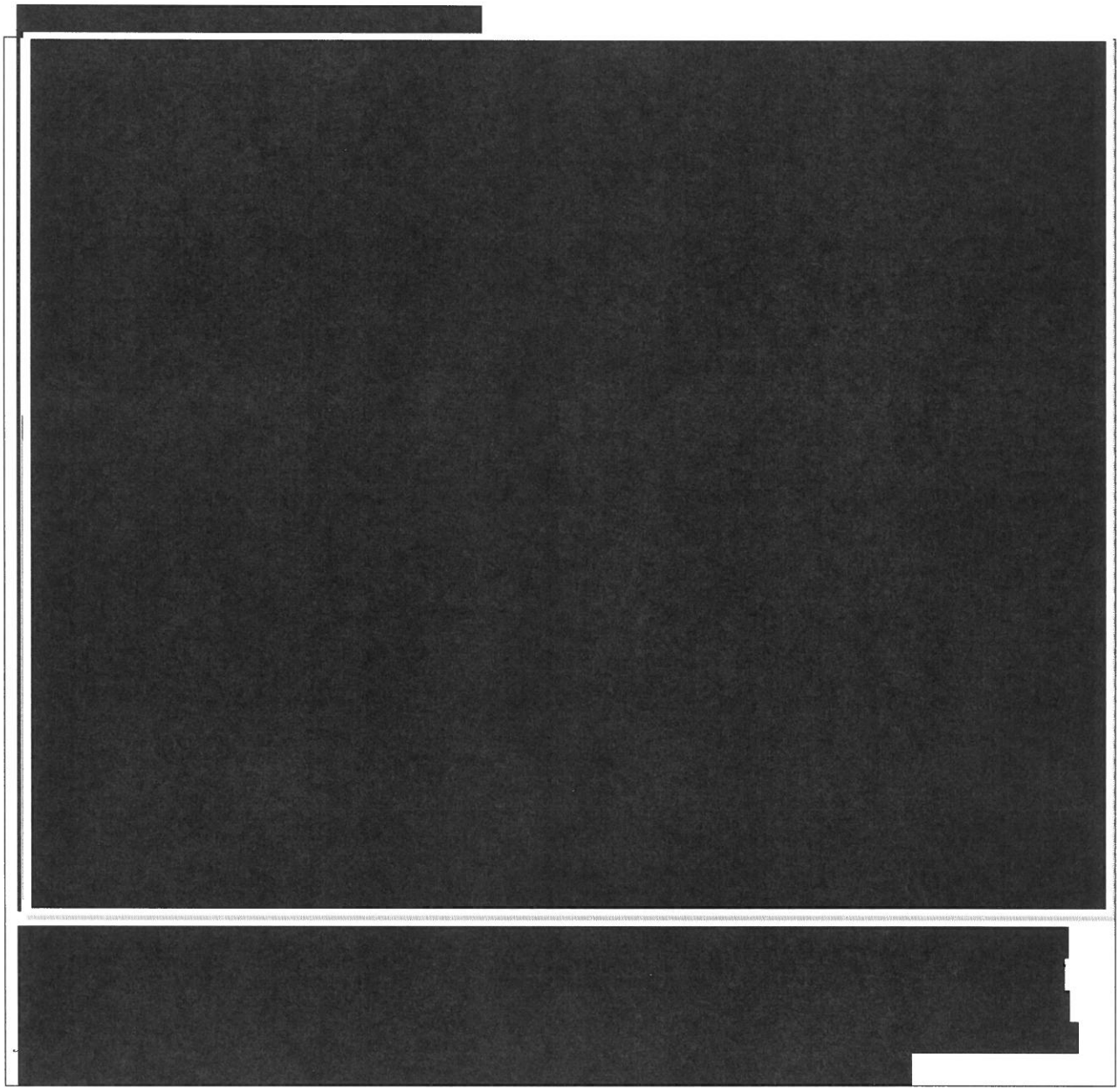
We already offer a Contact Us feature on our MHT website.

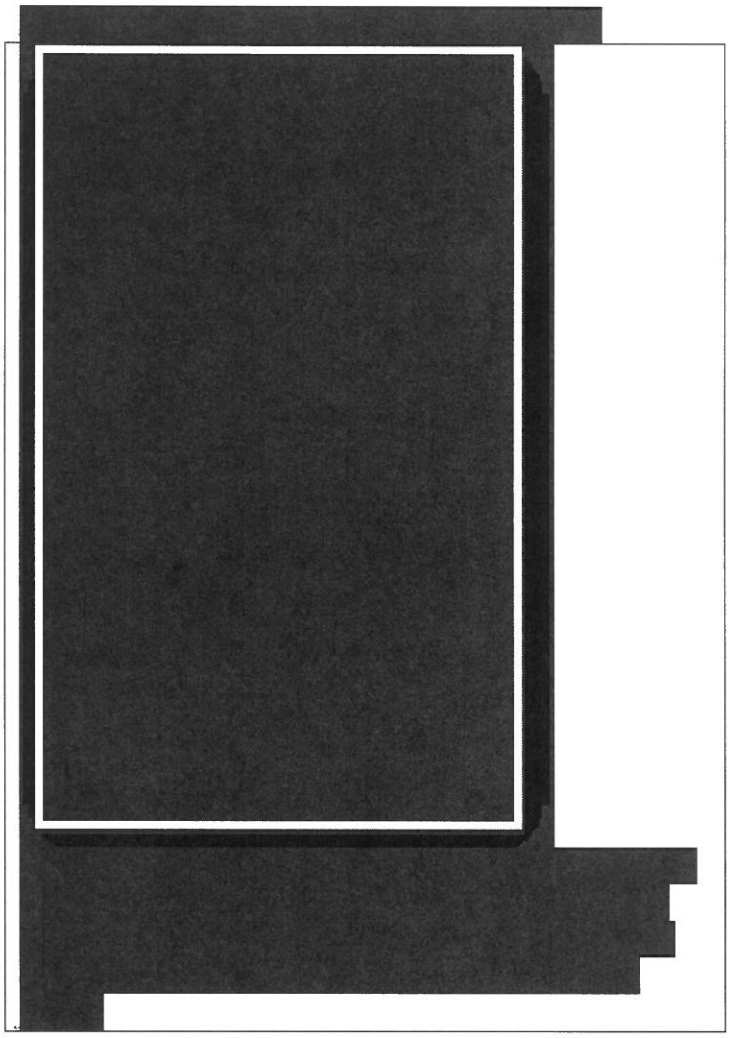
In contrast, our Contact Us form allows several advantages:

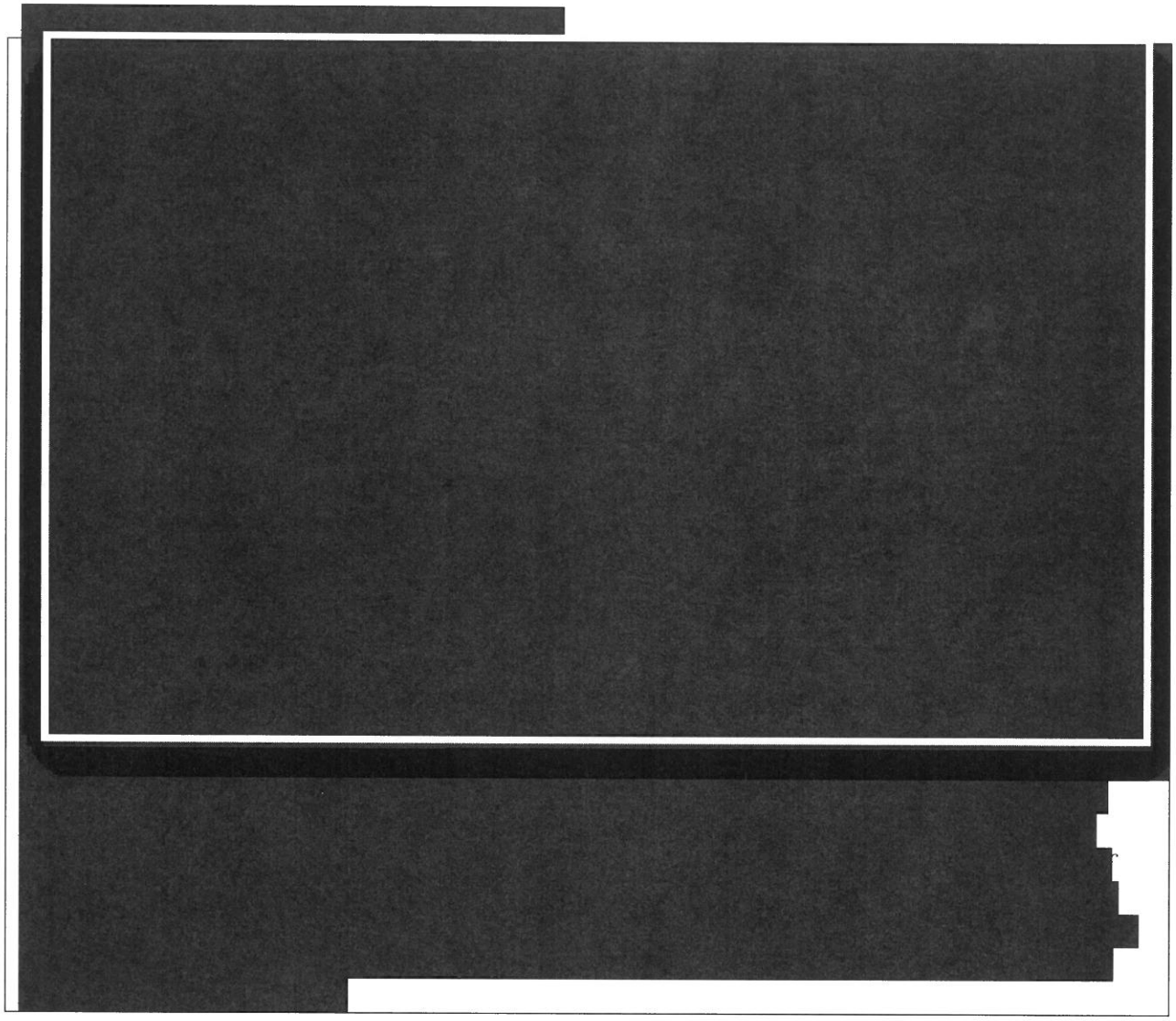
- **Our email address is not published:** therefore spam is unlikely to be received in the inbox.
- **Integrated experience by consumers:** all communications are done on our website, without having to go to another program.
- **Reportable:** We are able to track and report on the timeliness of our responses (since all communications are time-stamped within HealthTrack). All issues are logged in our database and can be reported. We can also add "Issue Type" or other helpful details to capture and report the types of issues we receive via email.

Web Responder – Response Tracking and Reporting

In conjunction with the Online Contact Us form, we have also built a Web Responder tool that is used to respond to consumer inquiries from the Contact Us form. The advantages of using Web Responder over a traditional email client (e.g., Outlook) are that all responses are logged in our database, thus can be tracked and reported easily. Compliance can be calculated easily by comparing the original contact date and response date.







We are pleased to deliver our Contact Us and Web Responder tools in order to best support BMS' initiatives and provide premier customer service.

4.1.18 Designing and Maintaining a Website

The Vendor should include its approach for designing and maintaining an enrollment assistance website available to West Virginia Medicaid beneficiaries for the managed care and PAAS programs. The Vendor should address the type of web accessibility software, the types of information available to beneficiaries, languages supported on the website, frequency of updates to the website, search capabilities, user-friendly provider directives and interactive functionality to facilitate the secure submission of member plan and PCP changes.

Introduction

Both BMS and West Virginia potential enrollees and enrollees need a Project website that provides reputable, unbiased information in an easy-to-use, intuitive format that positively reflects the Medicaid programs as a whole and promotes:

- Informed decision making,
- Healthy behaviors, and
- Appropriate care seeking behaviors.



The website must also be easy to use, intuitive, and accessible to all individuals. Further, while not required in the RFP, we also understand that providers and stakeholders need a Project website that:

- Facilitates an understanding of MHT as well as the West Virginia Medicaid Program as a whole;
- Serves as an accurate source of truth regarding the status of West Virginia's public assistance programming (a particularly critical feature during this dynamic time in the State's healthcare programming);
- Minimizes barriers to MHT program participation; and
- Provides education on pertinent healthcare and programmatic issues.

We bring experience with the design, development, promotion, and maintenance of websites that are engaging and user-friendly for each program we administer. As the current MHT Project Contractor, we have both developed a user-friendly website (available at www.mountainhealthtrust.com) that meets these goals, and voluntarily re-designed it to further enhance the user experience, as described in the response below. It is well-trafficked and has reached a high number of Project enrollees, providers, and stakeholders.

DID YOU KNOW?

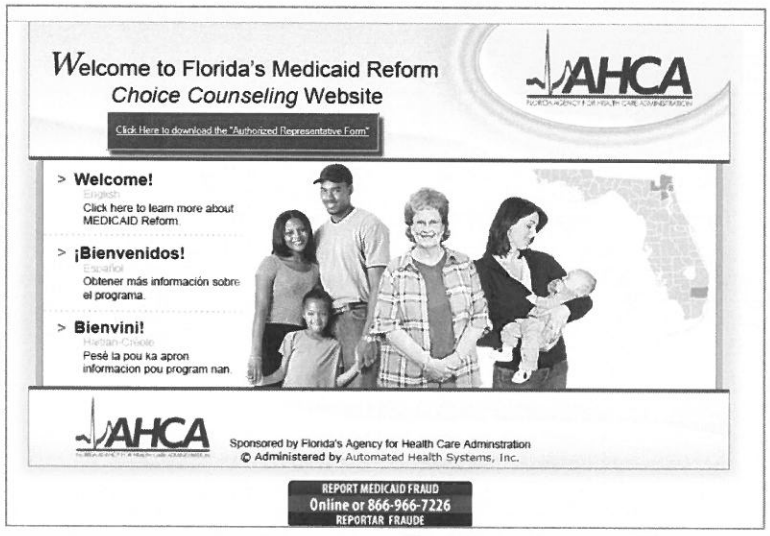
We are offering BMS several enhancements to the MHT website in the new contract, including:

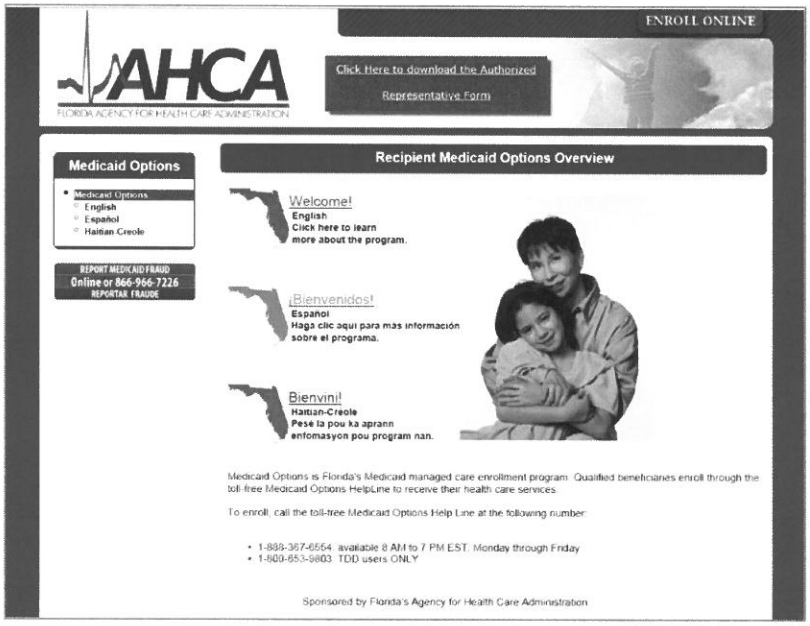
- Blogging,
- Information on healthy habits,
- Resources for providers,
- Calendars, and
- Bulletin board.

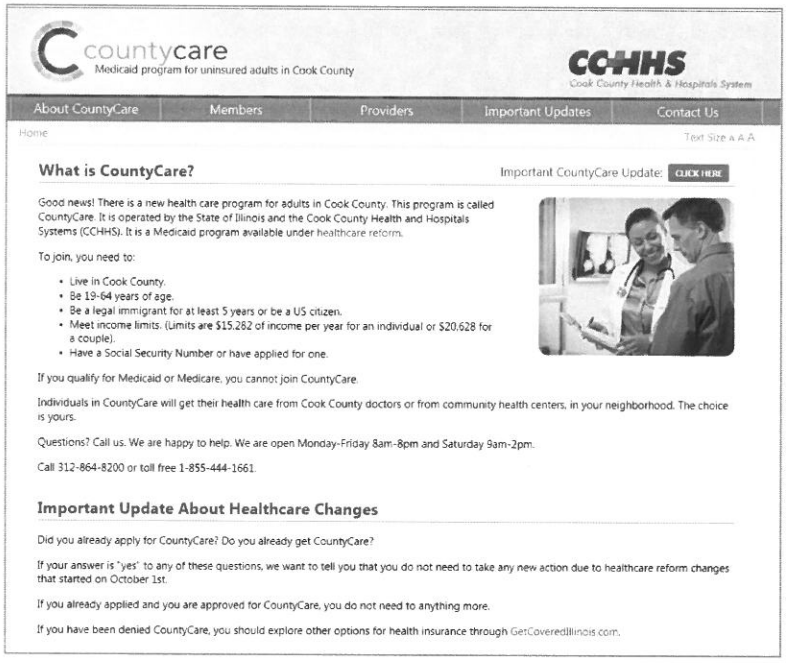
In addition to the current MHT Project website, we have developed and hosted numerous websites for several enrollment, PCCM, Medicaid eligibility, and Hotline Projects that serve populations ranging from 20,000 – 3.3 million eligibles, giving us all the expertise needed to continue to meet BMS' needs throughout the tenure of the contract. Of particular relevance during this period of dramatic changes to West Virginia's public assistance programming, we have widely used Project websites to support transitions to new managed care models, and have often become a trusted source of information for providers, enrollees and stakeholders during periods of Medicaid program change. For example, we provided information on the closure of the MHC Program on our Project website. We are also excited to offer BMS a series of enhancements for the website in the new contract, which are described at the conclusion of this section.

Other websites we have developed or hosted are described in Exhibits 102 and 103.

Exhibit 102. Current AHS Enrollee-Facing Websites

Project and Website	Major Features
Florida Medicaid Reform: www.flmedicaidreform.com 	• Available in English, Spanish, and Haitian-Creole • Secure Online Enrollment • Listing of "What's New in Medicaid Reform" • Website Glossary to assist with understanding relevant terms (e.g., beneficiary, co-payment, lock-in, open enrollment, opt-out, provider service networks, etc.) • Links to Report Medicaid Fraud directly to the Office of Inspector General • Detailed benefit information including definition, limits, exceptions, co-pays, etc. • Provider Searches • Links to Enrollee Materials

Project and Website	Major Features
Florida Medicaid Options www.medicaidoptions.net 	• Available in English, Spanish, and Haitian-Creole • Secure Online Enrollment • Provider Searches • Links to Enrollee Materials • Frequently Asked Questions • Links to Program Resources
Ohio Medicaid Managed Care Enrollment Center www.ohiomh.com 	• Secure Online Enrollment • "What's New" Page • Option to Access a Home Page for each Specific Program Population (i.e., Covered Families and Children and Aged, Blind and Disabled Populations) • Provider Search • Links to Enrollee Materials • Frequently Asked Questions

Project and Website	Major Features
CountyCare www.countycare.com 	• Links to Enrollee Materials • Application Instructions • Links to the CountyCare Provider Portal for Providers • Frequently Asked Questions • Links to Contact Us

countycare
Medicaid program for uninsured adults in Cook County

CCHHS
Cook County Health & Hospitals System

About CountyCare | Members | Providers | Important Updates | Contact Us

Home

Text Size a A A

What is CountyCare?

Important CountyCare Update: CLICK HERE

Good news! There is a new health care program for adults in Cook County. This program is called CountyCare. It is operated by the State of Illinois and the Cook County Health and Hospitals Systems (CCHHS). It is a Medicaid program available under healthcare reform.

To join, you need to:

- Live in Cook County.
- Be 19-64 years of age.
- Be a legal immigrant for at least 5 years or be a US citizen.
- Meet income limits. (Limits are $15,282 of income per year for an individual or $20,628 for a couple).
- Have a Social Security Number or have applied for one.

If you qualify for Medicaid or Medicare, you cannot join CountyCare.

Individuals in CountyCare will get their health care from Cook County doctors or from community health centers, in your neighborhood. The choice is yours.

Questions? Call us. We are happy to help. We are open Monday-Friday 8am-8pm and Saturday 9am-2pm.

Call 312-864-8200 or toll free 1-855-444-1661.

Important Update About Healthcare Changes

Did you already apply for CountyCare? Do you already get CountyCare?

If your answer is "yes" to any of these questions, we want to tell you that you do not need to take any new action due to healthcare reform changes that started on October 1st.

If you already applied and you are approved for CountyCare, you do not need to anything more.

If you have been denied CountyCare, you should explore other options for health insurance through GetCoveredIllinois.com.

We host a multitude of Project websites with a range of features for enrollee, provider, and stakeholder communities to best meet each State's needs.

We also developed a host of websites for previously administered projects that included a wide range of functionalities as described in Exhibit 103.

Exhibit 103. Website Functionality in Previous Projects

Project and Year	Provider Search	Specialty Search	Online Enrollment	Available in Multiple Languages	FAQ	Event Calendar	Quality Resources	Provider Resources
Illinois Client Enrollment Broker (2006-2013)	✓	✓	✓	✓	✓	✓	✓	
Louisiana PCCM and EPSDT (2010-2012)	✓	✓		✓	✓	✓	✓	✓[15]
Pennsylvania PCCM (2006)	✓	✓		✓	✓	✓	✓	✓

[15] Of particular relevance with the Louisiana PCCM and EPSDT Project are the resources we provided on the transition to the BAYOU HEALTH Program (Louisiana's statewide coordinated care program, fully implemented on June 1, 2012).

Standard Features to Enhance User Experience

While a description of the MHT website follows below, we would first like to take a moment to describe the various functionalities and features we routinely provide in all of our websites. Such features include but are not limited to those presented in Exhibit 104 below.

Exhibit 104. Standard Features We Use to Enhance User Experience

Feature	Description
Intuitive Design	• Logically organized, • Use of headings to guide readers to appropriate content,
Sophisticated Search Features	• Provider search functions that allow potential enrollees and enrollees to identify providers of interest based on a variety of parameters (e.g., PCP site name, PCP name, zip code, preferred ages, counties, gender, languages spoken, specialty, etc.), • Available to all users or to a subset with appropriate identifying criteria, based on State preference,
Secure Online Enrollment	• Modules through which enrollees can log-in and change their PCP, • Completely secure,
Links to Project Materials	• Available in a PDF format for easy downloading, • Available in all required languages,
"Contact Us"	• Users can identify an issue or question for assistance within two business days, • Secure,
Web Responder – Response Tracking and Reporting	• Web responder tool for internal use by staff to respond to consumer inquiries in the Contact Us form, • All responses are logged in HealthTrack for tracking and reporting, • Compliance can be easily calculated, • Described in Section 4.1.17,
Available in Multiple Languages	• Available in such languages as Spanish and Creole (please see www.flmedicaidreform.com for an example),

Feature	Description
Key State Taglines	• State-directed content (e.g., information on obtaining additional assistance, receiving materials in alternative formats, contacting the call center for additional assistance, etc.), and
Sophisticated Portals	• Created for specified audiences to log-in and access and/or change pertinent information.

Our Websites are Up-to-the Minute

In the shifting environment of West Virginia's Medicaid programming, it is essential enrollees, providers, and stakeholders can access accurate, current information.

Our Project Manager is responsible for keeping the website up to date. Changes and updates can be made in less than 24 hours – at no additional charge!

Below follows a description of how these features have been applied to the MHT website.

Mountain Health Trust Website

www.mountainhealthtrust.com

We developed a sophisticated and secure website for the MHT program that adheres to all required regulations (e.g., Section 508 [20 U.S.C. 794d] of the Federal Rehabilitation Act, the Web Accessibility Initiative, and Web Content Accessibility Guidelines 2.0. As a testament to our commitment to providing a first-class experience for web users, **we recently completely redesigned the website to make it even more appealing and easy to use**.

When developing the website, we took into account several features to ensure it is user-friendly as well as informative. Such features include but are not limited to:

Overall User Experience

- Structuring the website to provide information for particular audiences in as few clicks as possible. Once users have accessed the website, the most important content is presented to them and available with just one click;
- Launching a mobile-friendly version of the website (please refer to Exhibit 105 below); and
- Ensuring the website is fully up-to-date (**we offer BMS a history of updating the website in two business days of policy or program changes and will continue to do so**).

DID YOU KNOW?

To better provide service to West Virginia's Medicaid community, we voluntarily developed and launched a mobile version of the MHT website – all at no charge to the State.

Exhibit 105. MHT Mobile-Friendly Website



In June 2014, we launched a mobile-friendly version of the MHT website that works on all Smart Phones (e.g., Android, iPhone, and Windows Phone).

User Experience

We designed instant access to the most pertinent reasons users access the website as depicted in Exhibit 106. With a single click of the mouse, users can launch the online enrollment module and access important resources.

Additional factors to enhance the user experience include:

- Linking users to a variety of pertinent information, not only concerning the MHT Project (e.g., MHT brochure, MCO Comparison Charts, etc.), but also on several important resources for Medicaid potential enrollees and enrollees (e.g., DHHR, BMS, inroads, etc.);

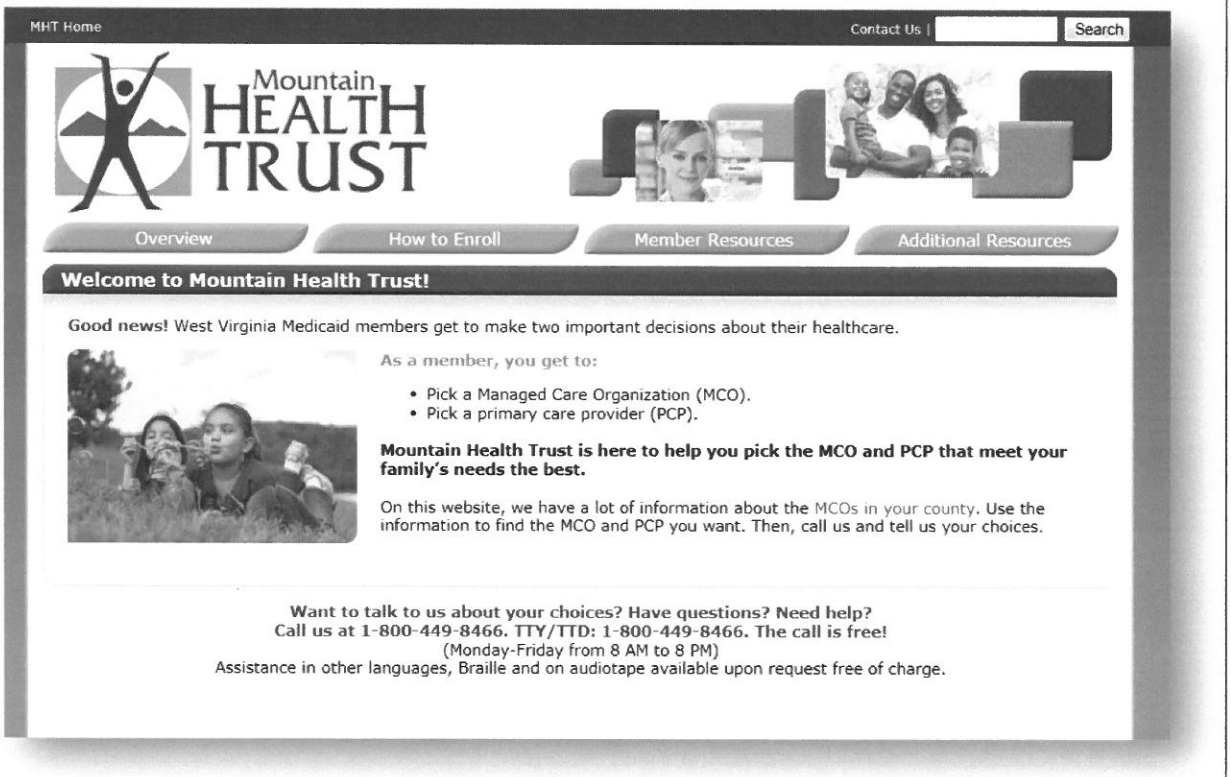
DID YOU KNOW?

We can develop websites in any language specified by the client. If at any time BMS needs us to launch a Spanish version (or any other language) of our website, we have the tools and proven ability to do so.

- Incorporating a FAQ page to provide low-literacy responses to common questions (e.g., what is a Managed Care Organization?);
- Incorporating a Definitions Page to help enrollees understand common health insurance and medical terms (e.g., benefit package, medical home, prior authorization, third party liability);
- Incorporating a privacy statement to alleviate any fears about sharing information over the web (e.g., during online enrollment);
- Incorporating a map function to allow web users to easily identify available MCO/PAAS options in their county; and
- Incorporating a "Contact Us" feature for users to request assistance through the web.
-

Over the course of our contract, we have responded to 100% of web inquiries within two business days!

Exhibit 106. Sample Enrollee Resources Available on the MHT Website



Important tools and resources can be accessed from the MHT homepage.

Provider Search

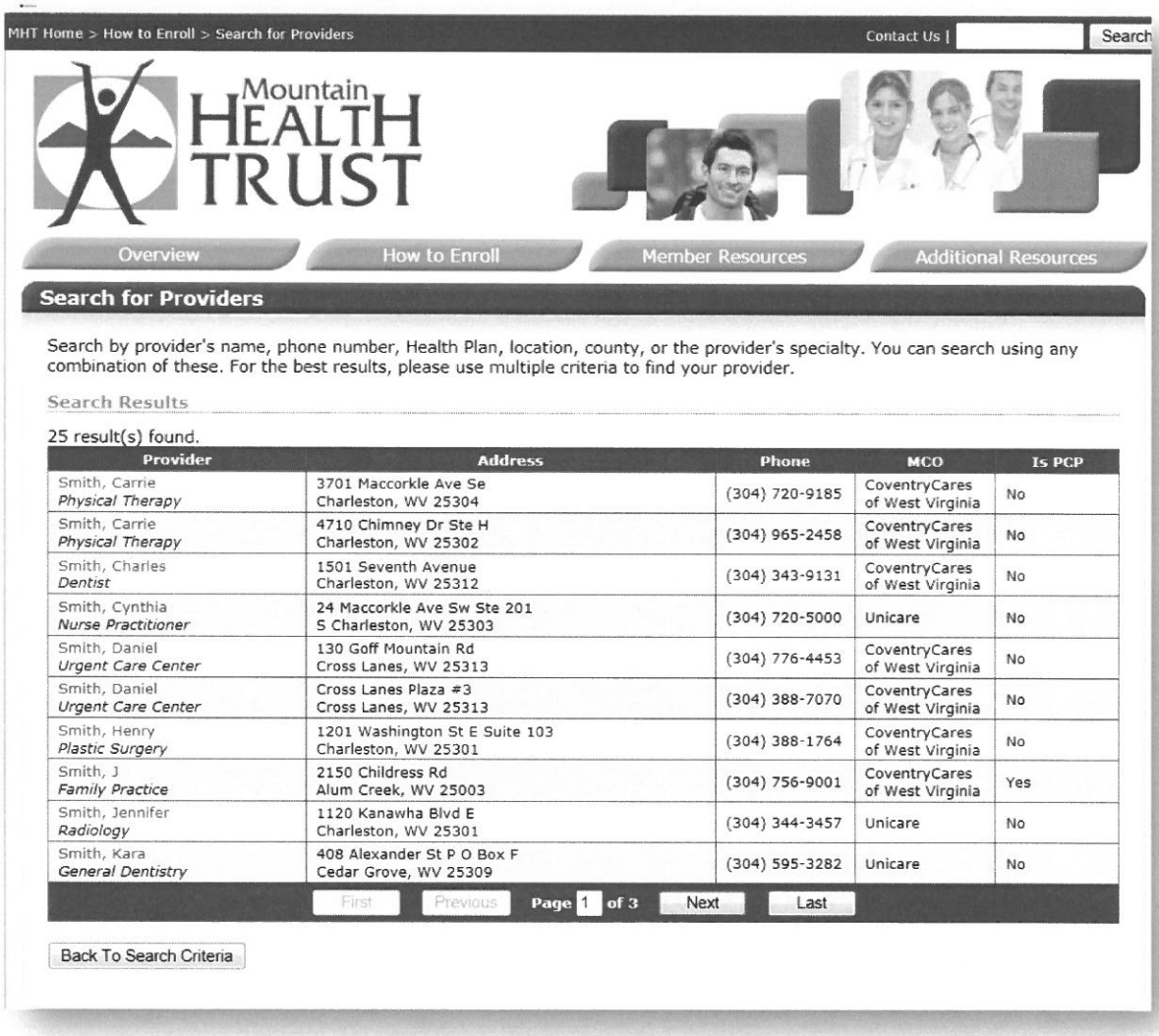
As required in the RFP, the MHT Project website includes comprehensive provider search functionality, which is available as a standalone tool on the website (e.g., any web user can access the provider search – they do not need to be enrolled in West Virginia Medicaid). A description of this search tool follows below in Exhibits 107-109.

Exhibit 107. MHT Provider Search



Users can access the provider search and search by a number of criteria: name, phone, MCO, zip code, county, and specialty.

Exhibit 108. MHT Provider Search



MHT Home > How to Enroll > Search for Providers

Contact Us | Search

Mountain HEALTH TRUST

Overview | How to Enroll | Member Resources | Additional Resources

Search for Providers

Search by provider's name, phone number, Health Plan, location, county, or the provider's specialty. You can search using any combination of these. For the best results, please use multiple criteria to find your provider.

Search Results

25 result(s) found.

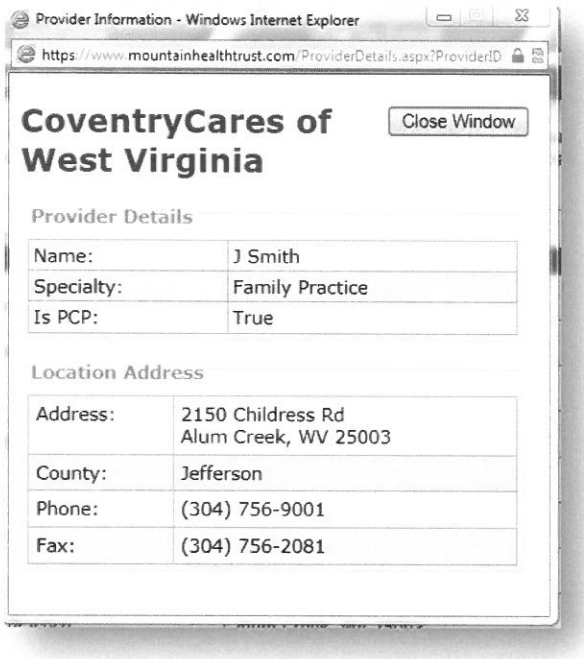
Provider	Address	Phone	MCO	Is PCP
Smith, Carrie *Physical Therapy*	3701 Maccorkle Ave Se Charleston, WV 25304	(304) 720-9185	CoventryCares of West Virginia	No
Smith, Carrie *Physical Therapy*	4710 Chimney Dr Ste H Charleston, WV 25302	(304) 965-2458	CoventryCares of West Virginia	No
Smith, Charles *Dentist*	1501 Seventh Avenue Charleston, WV 25312	(304) 343-9131	CoventryCares of West Virginia	No
Smith, Cynthia *Nurse Practitioner*	24 Maccorkle Ave Sw Ste 201 S Charleston, WV 25303	(304) 720-5000	Unicare	No
Smith, Daniel *Urgent Care Center*	130 Goff Mountain Rd Cross Lanes, WV 25313	(304) 776-4453	CoventryCares of West Virginia	No
Smith, Daniel *Urgent Care Center*	Cross Lanes Plaza #3 Cross Lanes, WV 25313	(304) 388-7070	CoventryCares of West Virginia	No
Smith, Henry *Plastic Surgery*	1201 Washington St E Suite 103 Charleston, WV 25301	(304) 388-1764	CoventryCares of West Virginia	No
Smith, J *Family Practice*	2150 Childress Rd Alum Creek, WV 25003	(304) 756-9001	CoventryCares of West Virginia	Yes
Smith, Jennifer *Radiology*	1120 Kanawha Blvd E Charleston, WV 25301	(304) 344-3457	Unicare	No
Smith, Kara *General Dentistry*	408 Alexander St P O Box F Cedar Grove, WV 25309	(304) 595-3282	Unicare	No

First | Previous | Page 1 of 3 | Next | Last

Back To Search Criteria

In this instance, the user searched by a last name of "Smith" in Kanawha county. The search then generated a list of all providers that met these specifications. As evidenced, the list includes a number of provider specialties – physical therapists, dentists, Nurse Practitioners, Family Practice, Radiology, etc. Please note, at any time, users can opt to go "Back to Search Criteria" to change the search specifications. Users can also elect to restrict the results to just PCPs (please see the previous exhibit for the PCPs Only checkbox).

Exhibit 109. MHT Provider Search



By selecting on a provider, users can view all pertinent details, including participating MCOs, address, county, and phone number.

Online Enrollment

We also incorporated a completely secure online enrollment module into the MHT website. The module, programmed with all BMS business rules, allows enrollees to log-in, search for an appropriate provider, and enroll in their selected MCO.

Exhibit 110. MHT Project Online Enrollment



Our online enrollment module allows potential enrollees to enroll in the MCO of their choice 24/7. The member completes the form (for the purposes of readability, the enrollment form was not displayed in its entirety), provides an electronic signature, and submits the form for processing and enrollment.

Comply with Federal and State Requirements

In the new contract, the Project Manager will continue to collaborate with our corporate IT Department to ensure the Project website includes all RFP required functionality.

We understand the paramount importance of complying with State and Federal guidelines and will continue to ensure the website is compliant. As evidenced in the RFP, it is a major priority and requirement that the MHT website be accessible to all users, particularly individuals with disabilities. We adhere to several major regulations in designing our websites, all of which

contain parameters to ensure web content is accessible, particularly to people with disabilities. Major regulations to which we adhere include but are not limited to:

- Section 508 of the Federal Rehabilitation Act,
- The Web Accessibility Initiative, and
- Web Content Accessibility Guidelines.

We understand and commend the State on their commitment to making information accessible to all users and are intimately familiar with each of these requirements. We have prided ourselves on designing websites that are accessible to all users and meet these stringent standards. Our process for ensuring the MHT will continue to adhere to all federal and state requirements for accessibility standards is built on a multiple step process:

1. **Obtain a Solid Understanding of all Requirements**. All of our Project management, programmers, and developers have read, are familiar with, and have experience developing websites for Medicaid recipients that adhere to various State and federal requirements.

2. **Adhere to all Guidelines**. Because we understand all facets of the requirements, we develop websites to adhere to all guidelines for accessibility. Guidelines for adhering to accessibility are referenced throughout the website development process. Guidelines include guidance for the appropriate coding, markup, page titles, headings, lists, text, colors, images, image maps, sounds, multimedia, animation, links, forms, tables, frames, scripts, embedded objects, downloadable documents, timing, page layout, and alternate accessible versions are carefully followed, as are all other relevant guidelines.

3. **Build Content from Templates**: We develop content from templates that have been proven to meet federal accessibility standards.

4. **Adhere to Checklists when Building Websites**. Many of the requirements include checklists to ensure the guidelines are met. For example, when building websites, we adhere to the Web Content Accessibility Guidelines (WCAG) 2.0 checklist, and at the conclusion of all development activities, verify all items on the checklist are complete. **For the MHT website redesign, we went through all relevant checklists to ensure full compliance.**

5. **Conduct Multiple Reviews**. Websites are scrutinized by multiple audiences prior to their launch. Not only does our Corporate IT Department review each website numerous times, but Project management staff and often front-line staff also conduct multiple reviews for accessibility. In addition to manual user reviews (which is essential to all development), we also utilized specialty software that checks and measures our website's accessibility score. These tools allow us to find problems that may not appear to a regular user, such as issues with style sheets, images, table elements, etc. By using a

combination of automated tools and professional user reviews, we are able to ensure our websites can support all of our target audiences.

6. **Test the Accessibility**: We developed an accessibility assessment, and each web page is tested and modified as needed.

7. **Obtain Feedback**. As mentioned, a key feature on all of our Project websites is a "Contact Us" feature through which users can send Project management staff any question or feedback. All questions and comments received through the Contact Us feature are carefully reviewed, particularly any related to the design, layout or accessibility of the website. We also accept feedback from other parties such as callers, stakeholders, MCOs, etc. Any comment related to these issues is reviewed for consideration and potential improvements are evaluated.

Enhanced Web Offerings

As we advance the technology platform powering MHT, we propose additional enhancements to the website. These include but are not limited to:

- **Blogging**: As an additional value-added service, we are proposing a new blogging feature on our website. With many controls put in place by AHS, the blogging feature will be fully approved by BMS, and all content will be fully controlled.

  To make full advantage of this feature, we will prepare written blogs and submit drafts to BMS for approval prior to posting on the website. The content of the blogs can be directed either to potential enrollees/enrollees to raise awareness of new or existing programs, announce important changes to existing Medicaid programs, promote managed care enrollments, answer frequent questions, and direct potential enrollees/enrollees to existing sources for help. Similarly, the content of blogs can also be created for the provider/managed care plan and CBO community to provide important information related to program updates, announce upcoming changes, provide needed instruction, or communicate changes in policy. BMS will always be welcome to prepare blogs for inclusion on the website; however, to further alleviate burden on the State we are prepared to author all content. Regardless, we will be able to prepare blogs, submit to BMS for approval, and then post the content on our website. Please note, if blogs are to be directed to the potential enrollee/enrollee community, we will adhere to all BMS requirements for written materials (e.g., reading level and language requirements).

  As mentioned, **the blogging environment will be fully controlled**, and we can restrict readers from posting comments altogether, delete inappropriate comments, as well as require all comments to be approved by designated staff prior to being posted publicly. Regardless, consumers with a need to respond to us will be encouraged to use the "Contact Us" feature on our website. This option will close the communication loop, allow for us to research and respond appropriately to the consumer, while at the same time, prevent any inappropriate comments from public display.

- **Information on Healthy Habits**: If BMS is interested, we can program the website to include links on healthy habits (e.g., the West Virginia Tobacco Quitline, etc.).

- **Information for Providers**: As directed by the State, we can incorporate a specific page for providers on the MHT website. On this page we can provide general information on MHT, requirements for participating in PAAS, information concerning providing care for Medicaid potential enrollees/enrollees, relevant program updates as directed by the State, etc.

DID YOU KNOW?

As the only vendor in the country with both enrollment broker and PCCM experience, we are fully prepared to support providers in complying with all PAAS requirements. Our PCCM websites regular include specific content for providers to support them in optimal PCCM participation and delivering quality care.

- **Bulletin Board**: If desired and approved by BMS, we will include a Bulletin Board for providers that links them to up-to-the-minute information concerning MHT and BMS. Such a feature will be especially helpful in providing additional information regarding the Medicaid expansion population (e.g., dates for enrollment, eligibility, etc.).

- **Calendar Feature**: If desired and approved by BMS, we can incorporate a calendar feature of pertinent events (e.g., health fairs, etc.) where our Field Benefits Managers will attend. This will help publicize the event and also provide another avenue for potential enrollee/enrollees and stakeholders to contact us.

- **Incorporate Appropriate Feedback from the Field**: As part of their routine field outreach and activities, Field Benefits Managers will solicit feedback from providers, community based agencies, potential enrollees and enrollees, and Project stakeholders. Any feedback relating to the MHT website will be reviewed by the Project Manager and incorporated into the website as appropriate.

Frequency of Updates

We will make updates to the website on an ongoing basis, particularly as populations expand and the program changes (e.g., as the MCOs expand, the Medicaid expansion population is included, the SSI population is included, etc.). At a minimum, all content will be reviewed annually.

4.1.19 Designing Educational Materials

The vendor should design all educational materials and member content so that they clearly inform members about the programs and possible choices in their area. The Vendor should propose specific content to be included in the educational materials and member content.

It is our hope that Section 4.1.4's description of our approach to materials development effectively conveyed to you our skill for providing potential enrollees with fundamental concepts of care and information that enable them to take action to make the best decision regarding their healthcare. As terminology and concepts related to managed care are frequently confusing, we use six key strategies to facilitate comprehension and support informed decision making by:

1. Using language that is familiar to potential enrollees, or if familiar language is not appropriate, we will provide a framework or context to orient the reader to the information;
2. Providing examples where possible;
3. Reiterating key concepts throughout the material;
4. Supporting with relevant graphics where appropriate;
5. Using checklists and FAQ formats that are easy to read; and
6. Referring potential enrollees to the MHT Call Center or the Project website for further assistance.

Recommended Content for Materials

We are proud to have partnered with BMS in the development and implementation of a variety of materials since MHT's inception. Not only did we work together to create effective materials for introducing and garnering acceptance of MHT to West Virginians – many of whom had no prior managed care experience – but we also established a track record for timely and thoughtfully updated, modified, and/or newly drafted materials as BMS' Medicaid programming evolved and changed over the years.

All MHT materials developed by us are aimed at ensuring potential enrollees and enrollees have the critical information needed in order to make important health care decisions, including voluntarily enrolling in a best fit MCO/PAAS Provider. As such, the materials we provide address the following:

- County-specific MCO/PAAS availability;
- Information specific to each MCO operating in the county (such as benefits covered, service area, contact information, etc.);
- Items to consider when determining the best fit managed care selection;
- The role and benefits of having an MCO and PCP;

- Timeframe for making a voluntary enrollment;
- Auto-assignment;
- Enrollment processes, including routes for enrollment;
- Ability to change MCO and/or PCP at any time for cause;
- Availability of the MHT Call Center and website for additional information and/or help;
- Identifying special health care needs;
- How to access care;
- Availability of oral translation services free of charge for those who do not understand English materials;
- Availability of TTY/TDD services and materials in alternative formats at no cost; and
- Information about program changes as needed (e.g., pharmacy expansion, MCO entry/exit of a county, expansion to new populations, etc.)

As a sign of our dedication to MHT and commitment to the potential enrollees and enrollees we serve, in August of 2012 we worked with BMS on a complete redesign of all MHT materials. Not only were content and language reviewed and modified, but visual appeal (i.e., branding, cohesiveness, format, calls to action, etc.) was considered and improved as well. (Please refer back to Section 4.1.4 a sampling of these redesigned materials.) In fact, the checklist included in enrollment packets was not a BMS-required material. Rather, we identified the need for and benefit of including the checklist and made the recommendation to the State.

As mentioned earlier in our response to Section 4.1.4, while we are quite pleased with the enhanced materials from our redesign, our commitment to continually improving and providing the most accessible, user-friendly, and helpful materials continues. We are happy to revisit the content and design of all MHT materials. And, we will continue to recommend modifications, additions and enhancements to materials under the new enrollment broker contract. For example, as mentioned earlier, with BMS' approval, we are excited to include QR codes on enrollment materials to bolster the helpfulness of MHT's materials. With BMS' approval, enrollment materials (and the MHT website) would be modified to promote and support enrollment via Smart Phone. We are also happy to explore the incorporation of a four-color process for MHT materials, such as the MHT brochure. We are skilled with providing single color plus black materials (such as those currently used for the MHT Project), but we are able to provide full color materials with BMS' approval.

4.1.20 Recommendations for Educating and Engaging Enrollees in High Quality Health Homes

The Vendor should make recommendations for educating and engaging enrollees in high quality health homes and patient centered medical homes.

We commend the State on the exciting initiatives it is taking with regard to health homes as a mechanism to increase patient health and decrease medical costs. We applaud the State for their efforts to work with CMS and SAMHSA to establish a Health Home State Plan Amendment for Medicaid members. We understand the State initially plans to focus on members in a six county region (Wayne, Cabell, Putnam, Kanawha, Raleigh, and Mercer) who suffer from bipolar disorder and may have Hepatitis B or C.

DID YOU KNOW?

Our experience with Primary Care Case Management programs, particularly in the Commonwealth of Pennsylvania where we linked members to medical homes that provided the "whole person approach" to care and achieved over $60 million in cost savings, prepares us well to support Health Home initiatives in West Virginia.

Further, we recognize that Health Homes differ from Patient Centered Medical Homes, which focus on medical care coordination and community referrals, whereas Health Homes focus exclusively on Medicaid by providing care coordinators that work with multiple, cross system providers, including medical providers to facilitate care.[16]

We are prepared to support the Health Homes Initiative as well as any efforts the State undertakes with regard to patient centered medical homes through several routes, as demonstrated in Exhibit 111 on the following page.

First, our Field Benefits Managers can conduct extensive outreach and educational presentations across the State. Presentations will be made to community groups and agencies, and the Health Home Initiative will be presented at various community meetings, board/advisory committee meetings, etc. In addition, Field Benefits Managers will be available to provide education and assistance at ongoing consumer oriented field events (e.g., health fairs, community days, etc.) to any potential enrollee/enrollee who requests additional information about this initiative. As part of our presentations, we will work with BMS to develop appropriate supplemental materials, which may include PowerPoint presentations, Fact Sheets/Tip Sheets, brochures, etc. (Please refer to Section 4.1.4 for information on our materials development process.) As reflected in the text box on the following page, we can supplement ongoing field-based outreach, education, and assistance with webinars, to further extend the information to target audiences.

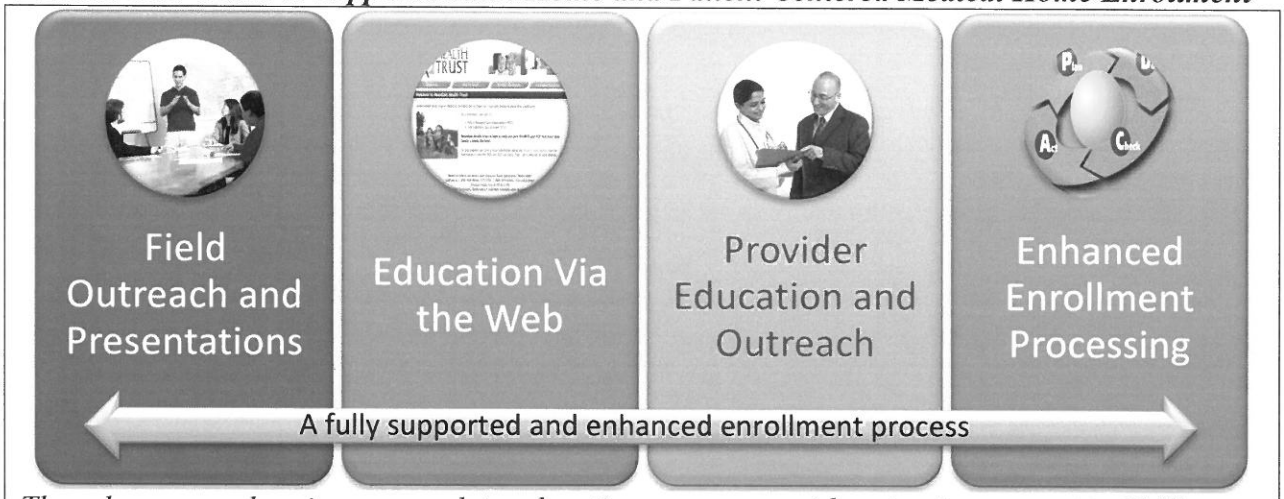
[16] Presentation, Health Homes for Members with Chronic Conditions, by James Becker, Medical Director and Cindy Beane, Deputy Commissioner, BMS.

DID YOU KNOW?

In addition to providing field outreach and presentations across the State, if desired by BMS we can also host webinars to further provide education and assistance. We can archive any webinar to make it available for any audience at any time.

Second, we can post information and updates regarding the Health Homes Initiative on the MHT website. We can target information to potential enrollees/enrollees, providers, and stakeholders, and can also provide links on the website for additional information (e.g., to BMS' Health Home website). Any update, fact sheet, brochure, etc. can be posted to the website, regardless of the author (e.g., regardless if developed by AHS or not). Of note, when needed, we can make updates to the MHT website in less than 24 hours.

Exhibit 111. Plans to Support Health Home and Patient Centered Medical Home Enrollment



Though a comprehensive approach to education, we can provide extensive support to BMS regarding Health Homes and Patient Centered Medical Home enrollment.

Third, our Field Benefits Managers can conduct extensive provider outreach, as directed by BMS. Please note, our Field Benefits Managers have extensive experience supporting the provider community with Medicaid program changes and expansions. Of note, they were particularly instrumental in supporting providers with the Pharmacy Expansion in 2013, and were similarly instrumental in outreaching to over 500 Medicaid dental providers to ensure they were aware of the administrative changes for children's dental services in 2014. Field Benefits Managers can work with providers to ensure they are aware of the Health Home Initiative, and can also target those providers who have submitted applications to ensure they are aware of the MHT Project and MCO enrollment requirements. Please note, no outreach to providers will be conducted without the explicit approval from BMS. In addition, we can also supplement our outreach to providers with blast faxes and emails to quickly disseminate pertinent information to providers across the State. (Please refer to Section 4.1.4 for a description of our blast fax/email approach.)

Last, there are several ways that we can update our enrollment processing to account for health homes and patient centered medical homes. As reflected in the presentation "Health Homes for Members with Chronic Conditions" by James Becker, Medical Director and Cindy Beane, Deputy Commissioner Bureau for Medical Services, we understand the expected enrollment process to be the following:

1. Identification of eligible members through claims review and county of residence,
2. Auto-enrollment to the Health Home covering the member's county or other Health Home if there is a history:
    - Members can opt out at any time,
    - Members can change Health Homes,
    - Health Home must outreach to establish connection with the member,
3. Ongoing enrollments can be initialized by Health Homes or members, and
4. Validation process through BMS contractor.

There are numerous ways in which we can support this process. First, if so desired by BMS, we are fully capable of running the claims review to identify potential eligible members (based on ICD codes or other criteria established by BMS), and we can further stratify these members according to county of residence, so that only those members in the defined six county region are initially identified. (If the Health Homes Initiative expands at any time, we can quickly expand or adapt this process at any time based on changing BMS rules.)

Second, as described in detail in Sections 4.3.6.4 and 4.3.6.5, we have extensive experience conducting auto-assignments, and can:

- Conduct auto-assignments based on county, or
- Review the member's claims history to determine if the member has an existing relationship with a Health Home.

Our experience sharing auto-assignment information with the State and its partners equips us to notify all appropriate parties of any auto-assignments via file transfer (or any other transmission method if directed by the State).

Third, if the member wishes to change their Health Homes, we will be happy to process the change. Our phone number can be distributed to members and they can contact us to process the change. We will record all changes in HealthTrack (including reasons for change) and provide full documentation to BMS as part of our monthly reports.

Last, we can also implement the validation process as directed by BMS. We can update our workflows and systems to accommodate this process. (Please note, while this section extensively references Health Homes, the same approach will be used with regard to Patient Centered Medical Homes.)

There are several key features in our approach to providing outreach and education regarding enrollment into high-quality Health Homes that directly benefits BMS and the enrollees it serves:

Exhibit 112. Features and Benefits of Approach to Enrollment into Health Homes

Feature	Benefit
Our Benefits Managers are well-networked throughout the State.	• We are able to quickly provide education and outreach throughout the State. • We are able to target our efforts to partners and stakeholders who most directly serve the target audience. • We can supplement out in-person events with webinars to further reach our target audience.
Our website is well trafficked and well-recognized.	• The Mountain Health Trust website is already a recognized resource in the managed care community, and will be able to provide extensive information to a wide audience – all in a very cost-effective manner.
We have longstanding relationships with providers throughout the State.	• We can provide targeted education to providers to encourage participation in Health Homes. • We can ensure providers are equipped to spread the message and make appropriate referrals. • We can supplement our provider outreach and education with cost-effective fax and email blasts.
We can quickly implement any enrollment process needed.	• We can draft, receive approval for, train staff, and integrate comprehensive, updated scripts into HealthTrack quickly. • Our systems are designed with inherent flexibility so we can update our systems and auto-assignment processing quickly. • Our systems are designed to integrate with any system needed, so we can accommodate any other system in the process. • We are experienced with claims analysis (and include claims analysis in our auto-assignment processing in other states) and can easily assume any extraction or analysis pertaining to claims. • We can make numerous adjustments to our enrollment processing algorithm as needed – all without a change order – to accommodate changes in the process as the program matures.

Feature	Benefit
We have an established, well recognized call center	• We can quickly implement scripting to answer calls from potential enrollees/enrollees, providers, stakeholders, etc. • HealthTrack will fully document and track all calls related to these initiatives for reporting to BMS. • We can supplement our efforts with any telephonic outreach needed.

4.2 Plan for Creating a Telephone Unit

The Vendor should propose a plan for creating and operating a telephone unit. Such responsibilities of the telephone unit should be to complete the enrollment of members into the MCO of their choice of PAAS ; answer enrollment questions regarding the MHT and PAAS programs asked by Medicaid members, providers, and the general community; settle complaints when possible; provide information on covered services; and complete research as requested by BMS. Types of calls could include but not necessarily be limited to:

AHS' response to addressing each of the items specified in Section 4.2 is provided in this section. These items include:

4.2.1 Enrolling enrollees into the MCO or PAAS PCP of his or her choice;

4.2.1 Enrolling newborns into the mother's county-appropriate choice of MCO or PAAS provider;

4.2.3 Assisting enrollees in transferring from one (1) MCO to another, from an MCO to PAAS, from PAAS to an MCO and from one (1) PAAS PCP to another;

4.2.4 Processing exemption requests using BMS developed criteria;

4.2.5 Assessing any unique health care needs to ensure appropriate enrollment;

4.2.6 Identifying and, if possible, maintaining existing enrollee/provider relationships;

4.2.7 Explaining the options available to individuals depending upon their place of residence;

4.2.8 Explaining the health benefit coverage;

4.2.9 Providing specific information about each MCO and PAAS option such as the network of providers (e.g., physicians, hospitals) and the extent of new enrollees being accepted;

4.2.10 Documenting reasons for changes in MCO and/or PAAS enrollment and including change information in monthly reports to BMS;

4.2.11 Explaining Medicaid covered services and freedom of choice for access to family planning services;

4.2.12 Referring enrollees to the correct human service agency if calls are received that are outside the scope of the managed care programs;

4.2.13 Triaging enrollee calls to service representatives and medical hotlines when necessary;

4.2.14 The development of operational procedures, manuals, forms and reports necessary for the operation of the telephone unit;

4.2.15 The Vendor's approach to staffing the telephone unit and training personnel on all relevant issues on an ongoing basis;

4.2.16 Procedures to ensure that telephone operators treat all callers with dignity and respect the callers' need for privacy;

4.2.17 Procedures for providing access to oral translation services;

4.2.18 The Vendor should address in its proposal how it plans to provide special services necessary to accommodate Medicaid members;

4.2.19 The plan should include procedures for identifying individuals with special health needs through health assessments conducted as part of the enrollment process;

4.2.20 The Vendor should propose a Quality Assurance Plan to assure that all telephone functions meet their own internal standards;

4.2.21 The Vendor should establish, maintain and operate an office within fifteen (15) miles of the city limits of Charleston, West Virginia.

Introduction

Outreach and education to Medicaid consumers over the phone has been a mainstay of our consumer relations efforts since 1986 and is utilized in all of our current contracts. When our flagship EPSDT effort was favorably reviewed by HCFA (now CMS) in 1987, 1992, and 1995, our phone outreach was one of the four areas where exemplary practices were noted. Since those reviews, our approach to call center administration has continued to evolve as new technologies and additional best practices are developed.

Using advanced telephone systems and techniques, our telephone workers handle outreach, education, application assistance, and enrollment for a variety of health programs (enrollment broker, PCCM, EPSDT, SCHIP, and Medicaid consumer hotline efforts), comprehensive health assessments, care coordination, linkages to medical homes, complaint resolution, and even appointment scheduling and referral to needed services (such as disease management, transportation, dental care, child care, etc.), all by phone.

We currently operate statewide call centers for West Virginia, Illinois, Ohio, Florida, North Dakota, and Wisconsin, and additional call

See What WV Callers Say about Us:

"Marjorie is very educated on the information and was able to answer all my questions. Sweet lady!"

"Giselle was very, very helpful. She clarified things in a way that I could understand. She was very good! I used to work in a call center and know the difficulties around it. Giselle was easy to understand and made sure I understood everything before we finished the call. She went above and beyond!"

"Michelle was very nice. She answered all my questions, was patient with me, and very friendly."

"I was calling because I wanted to let a supervisor know how helpful Lisa was. Lisa did a great job of explaining the enrollment process and assisting me."

centers for St. Louis, Missouri and Cook County, Illinois. We will draw upon our 25 years of call center management experience to ensure the MHT Project Call Center is equipped and staffed to effectively meet the needs of BMS and West Virginia potential enrollees, enrollees, and Project stakeholders.

We will continue to operate a high-quality, user-friendly call center for the MHT Project that meets or exceeds all program requirements. Leveraging our West Virginia-specific and corporate expertise in call center operations, integrating proven telecommunication and computer systems, and employing a robust approach to training, monitoring, and continual improvement, we guarantee continued high performance and caller satisfaction.

4.2.1 Enrolling Enrollees into the MCO or PAAS PCP

Enrolling enrollees into the MCO or PAAS PAP of his or her choice.

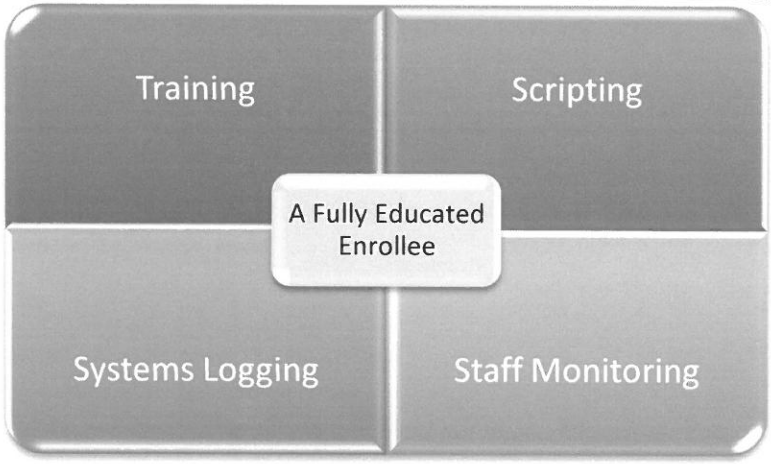
We are well versed in processing all enrollments into the MCO or PAAS PCP of an enrollee's choice. We process approximately 25,000 enrollments per year for the State of West Virginia, and nearly half of these enrollments are completed over the phone. As a complete description of our enrollment process is provided in Section 4.1.1, below follows a summary of our telephonic enrollment processes.

DID YOU KNOW?

In 2013, we processed 23,590 MCO and PAAS enrollments for West Virginia.

In order to ensure our staff correctly provide the telephonic choice counseling and enrollment services, we adhere to a four step approach, detailed in Exhibit 113.

Exhibit 113. Approach to Choice Counseling and Telephonic Enrollments



Through a comprehensive approach to enrollment, we ensure our staff provide outstanding services resulting in fully satisfied enrollees.

First, we provide all staff with extensive training on not just the enrollment process and choices available, but also the West Virginia Medicaid program as a whole, customer service tips and techniques, HIPAA, etc. (Please refer to Section 4.2.15 for a complete description of our training modules.)

Second, as described in Section 4.1.3, we provide staff with scripting to guide them through all interactions with callers. Scripting allows staff to correctly and concisely respond to callers needs with the appropriate language and literacy levels. Staff are provided with scripting to both provide choice counseling services (e.g., identifying MCO options in their county, identifying in which MCOs the enrollee's desired PCP participates, etc.) as well as to provide callers with information regarding the actual enrollment (e.g., effective dates, process for changing MCOs, etc.).

[redacted]

[redacted]

Last, we monitor all staff to verify all staff are providing all services in accordance with our standards (e.g., all staff follow scripts, use an appropriate tone of voice, follow guidelines for customer service, correctly logged all details, etc.) For additional details on our Quality Assurance Plan, please refer to 4.2.20.

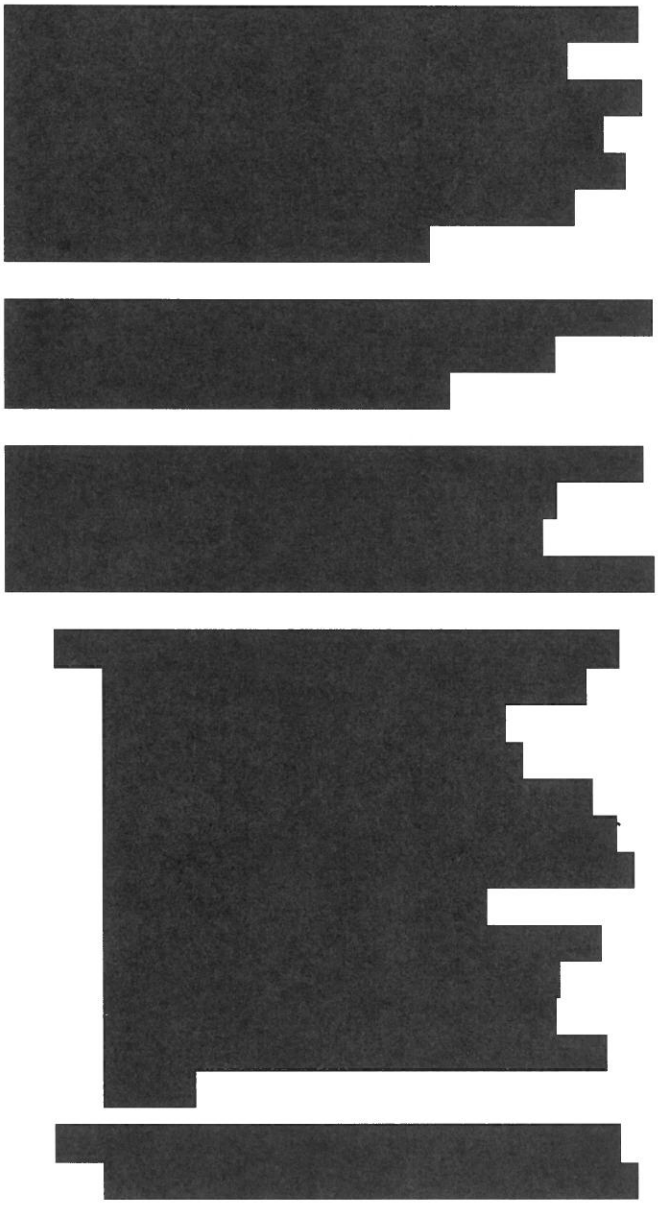
Again, we are confident this approach is successful, as it has enabled us to process over 20,000 enrollments each year for the past several years. As our change rates in this Project are historically low, average 1-2%, we can be assured that we have, in fact, enrolled enrollees into the MCO or PAAS PCP of their choice.

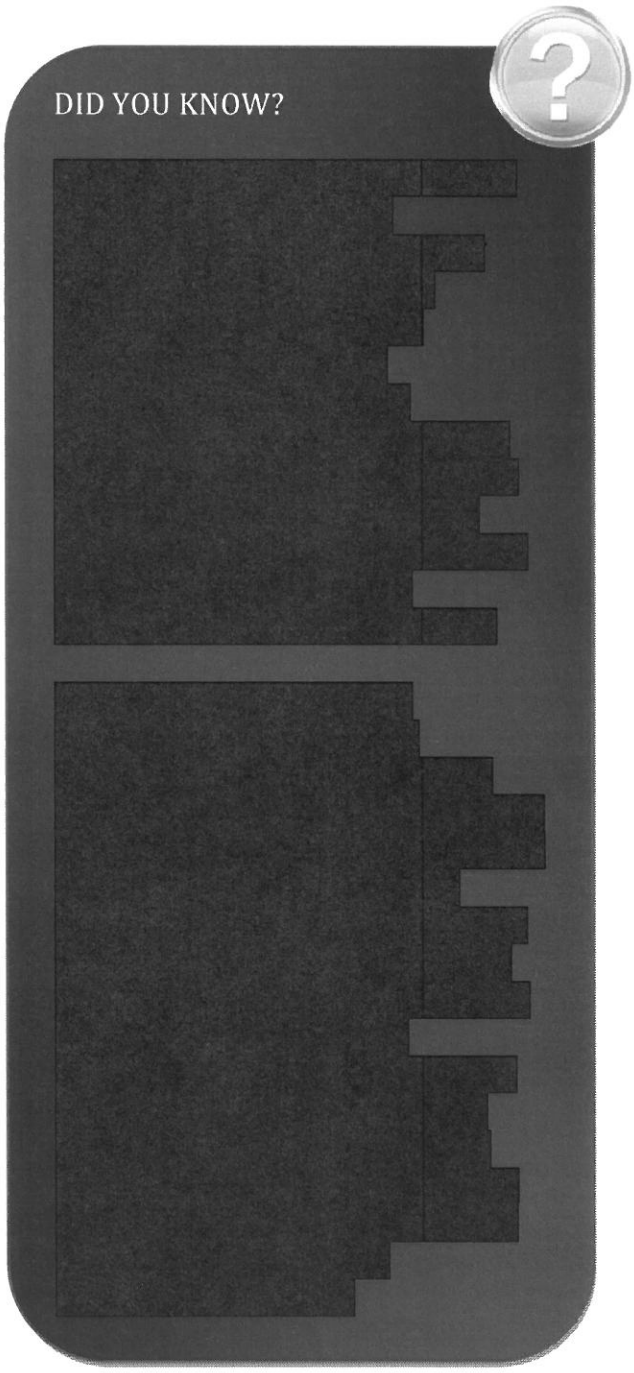
4.2.2 Enrolling Newborns

Enrolling newborns into the mother's county-appropriate choice of MCO or PAAS provider.

We are committed to processing newborn enrollment forms promptly so that newborns can receive the care and services needed at this critical time in their lives. To do this, we use the information provided by the MCOs on the Newborn Enrollment Forms and/or Weekly Newborn Eligibility file.

Our proven process for enrolling newborns into MCOs is described below:

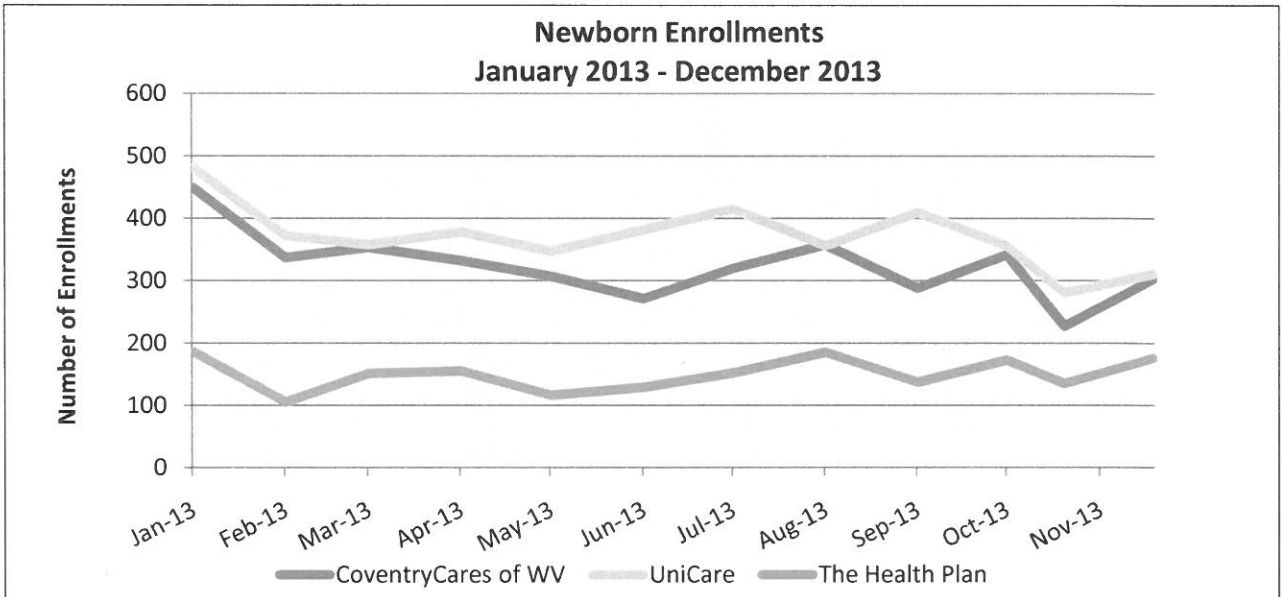




[redacted]

Please note, we send all newborns on the weekly eligibility file an enrollment packet. Currently, we do not conduct targeted outreach for PAAS-eligible newborns. We use outbound dialing campaigns and send a reminder letter to promote a voluntary selection. If the PAAS newborn does not respond to the enrollment packet and other outreach initiatives, we auto-assign the newborn to the MCO. In the new contract, we will be willing to work with BMS to determine if there are any other special outreach activities we can initiate to prompt a voluntary selection.

Exhibit 114. 2013 Newborn Enrollments



We have used this time tested approach to process thousands of newborn enrollments each year.

In addition, we wish to note that our newborn enrollment process is fully flexible. It can be used to accommodate any changes in timelines (e.g., if BMS elects to change the timing auto-assignments are run, or if eligibility files will be sent to us more frequently, etc.), or any other changes initiated by BMS. Further, it is also fully scalable, and will be able to respond to increasing enrollments if needed.

We will continue to work with BMS to ensure this time-tested approach, which as demonstrated in Exhibit 114, has been successfully used to process thousands of newborn enrollments, continues to meet the State's evolving needs.

4.2.3 Assist with Transferring

Assisting enrollees in transferring from one (1) MCO to another, from an MCO to PAAS, from PAAS to an MCO and from one (1) PAAS PCP to another.

We offer BMS a proven approach to assisting enrollees in transferring from one MCO to another, from an MCO to a PAAS provider, from a PAAS provider to an MCO, and from one PAAS provider to another. We respond to requests for enrollment changes received through:

- Calls to the helpline,
- Mailed enrollment forms,
- Forms completed on the MHT website.

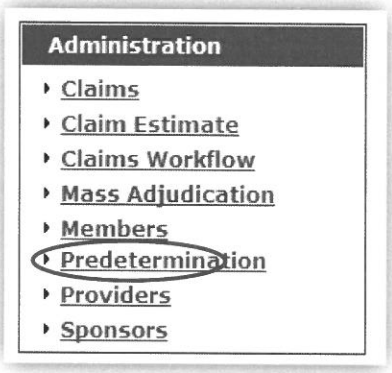
Our process for completing enrollment transfers from one MCO to another is described below.

DID YOU KNOW?

While we have a comprehensive approach to assisting enrollees in transferring among MCOs and PAAS PCPs, our change rates are less than 1-2%, indicating enrollees are satisfied with the choice counseling services they received.

Benefits Managers log into MMIS and select the Member module from the MMIS homepage (Exhibit 115). They then use the 'Member Search' function to locate a member, searching based on partial name, MCO ID, social security number, or date of birth. Once the information is entered in the 'Member Search' field, Benefits Managers click 'Search' and select the name of the member to be enrolled in the search results field to bring up the member's case.

Exhibit 115. Member Module from MMIS Homepage



We are already familiar with using the MMIS screens to process enrollment changes.

Benefits Managers verify all identifying information as part of our adherence to all confidentiality requirements. Please note, enrollees must provide information; at no point do our staff provide information for the caller to verify. If the caller cannot verify the identity, the Benefits Manager asks if there is anything else they can do (e.g., provide general education), and asks the caller to call back once they have complete information. Pending successful verification, our staff then ask the enrollee the name of the MCO/PCP desired, and click on the Provider tab and click the radio button of the current enrollment. If the enrollee needs additional choice counseling assistance, the Benefits Managers explain the MCOs/PAAS PCPs available in their county, and, in the new contract, will also offer the Choice Driver tools (described in Section 4.1.6) to assist enrollees with selecting a new MCO or PAAS PCP.

Upon identification of the selected MCO or PAAS PCP, Benefits Managers then select "Terminate" and enter the termination date based on the current cutoff. This date is the last day of the month prior to any new enrollment being effective the first of the following month. Please note:

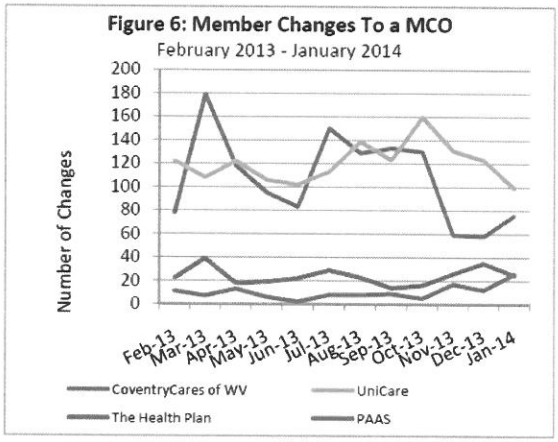
a. If an enrollment form or phone call from an enrollee comes in before cutoff and the enrollee has already been automatically assigned effective the first of next month delete the automatic assignment span and create a new span showing the 'choice'.
b. Benefits Managers delete the automatic assignment span even if it is the same as the choice the member has indicated on the form or call.
c. On the contact sheet, Benefits Managers indicate that the 'AD' span was deleted and a 'C' span was entered.

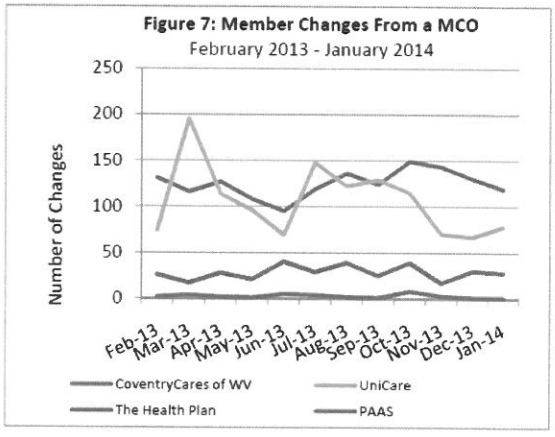
After logging all termination date information, Benefits Managers select 'Plan Switch' then select 'Update'; and enter the new enrollment information.

In this manner, all information is logged in both MMIS and our internal system, which provides BMS, the Fiscal Agent, and eventually the MCOs with comprehensive data needed to understand all plan changes. Please note, all plan changes are included as part of our monthly reports and also provided with a rolling 12 months of data each month, as reflected in Exhibit 116.

Exhibit 116. MCO Changes Reported Each Month

Exhibit 7: Enrollment Changes – January 2014								
	'To' CC of WV	'From' CC of WV	'To' The Health Plan	'From' The Health Plan	'To' UniCare	'From' UniCare	'To' PAAS	'From' PAAS
Week 1	12	27	8	3	18	15	7	0
Week 2	13	21	4	5	13	11	7	0
Week 3	12	13	1	3	12	10	1	0
Week 4	39	58	12	17	56	42	11	1
Total Changes	**76**	**119**	**25**	**28**	**99**	**78**	**26**	**1**





Our proven process for assisting enrollees with MCO and PAAS PCP changes results in comprehensive reporting to BMS.

4.2.4 Exemption Requests

Processing exemption requests using BMS developed criteria.

We processed exemptions for many years; however, currently as the MCOs are required to work with the provider if s/he is not enrolled with the MCO, there are very few instances when we currently need to process exemptions. Possible scenarios where we many need to process exemptions in the MHT Project include instances of terminal illness, disruption in care, hardships, or other instances as defined by the State.

We have the ability to quickly process any exemption requested, and our proposed exemption process as described below in Exhibit 117.

DID YOU KNOW?

We currently process thousands of exemptions in our Florida and Ohio Enrollment Broker Projects, and have the tools and operational workflows to process any exemption in any timeframe required.

Exhibit 117. Proposed Exemption Processes



Enrollee Initiated

- Contact Provider
- Request Provider fax letter to us stating the reason the patient should be granted an exemption
- Complete the Exemption Request Form
- Submit the provider documentation and Exemption Request Form to DHHR for Approval
- Enter the Member Attribute Exemption Note in MMIS



State Initiated

- Enter the Member MMIS

Our proposed exemption process demonstrates we understand the steps needed to process exemptions regardless if they are initiated by the enrollee or State.

As referenced above, we have incorporated an Exemption Form into the process to allow DHHR to consistently track exemption requests and appropriately approve or disapprove. Items included in the Exemption Request Form are items to be completed by the State and us.

Exhibit 118. Items Included in the Exemption Form

Items to be Completed by AHS	Items to be Completed by the State
• Name • Recipient Number • Address • Benefits Manager's Signature • Supervisor's Signature • Project Manager's Signature	• State Official's Signature • Check Box for Granted or Denied • Explanation for Denial

In the new contract, as we will move to HealthTrack (discussed fully in Section 4.3.6.1), all information associated with exemptions will be integrated into the Case Screen (also discussed in Section 4.3.6.1) for easy reference. If so desired by the State, we can use mouse hover technology so that should Benefits Managers need to see the reason for an exemption, all they need to do is hover over the exemption, and the details will appear.

We are confident this approach to exemptions will meet BMS' ongoing needs, as:

1. It is built from BMS policy,
2. It entails appropriate flexibility – any step, form, or procedure in the process can be easily changed so we continue to meet BMS' needs at any point during the contract, and
3. It includes appropriate documentation to allow for comprehensive case counseling and tracking by both BMS and AHS.

4.2.5 Assessing Unique Health Care Needs

Assessing any unique health care needs to ensure appropriate enrollment.



DID YOU KNOW?

We currently conduct a Health Needs Assessment as part of telephonic enrollments. The Health Needs Assessment includes three brief questions, which allows us to identify health needs without taking up too much of the callers' time.

Appropriately identifying health care needs is to incorporate into the enrollment process is imperative. Not only does identifying health care needs lead to greater satisfaction with an MCO or PAAS PCP, but it also has the potential to increase health outcomes, as those needs are more likely to receive appropriate care.

We have integrated a comprehensive Health Needs Assessment into the enrollment process. The Health Needs Assessment identifies the following: health conditions such as asthma, diabetes, or a heart condition, interest in smoking cessation resources, and pregnancy.

In the new contract, we will ensure all health care needs are documented in HealthTrack, and the information is also provided to the Fiscal Agent via whatever method is preferred by the State.

For telephonic enrollments, Benefits Managers will continue to adhere to the process detailed on in Exhibit 119 on the following page. (A sample Enrollment Form that includes Health Needs Assessment is included in Section 4.1.1).

In addition to adhering to this process, there are three primary avenues through which we will enhance our service to individuals with special needs in the new contract:

1. Sensitivity Training,
2. Specially Trained Staff, and
3. Use of the Choice Drivers to Ensure Continuity of Care.

Sensitivity Training

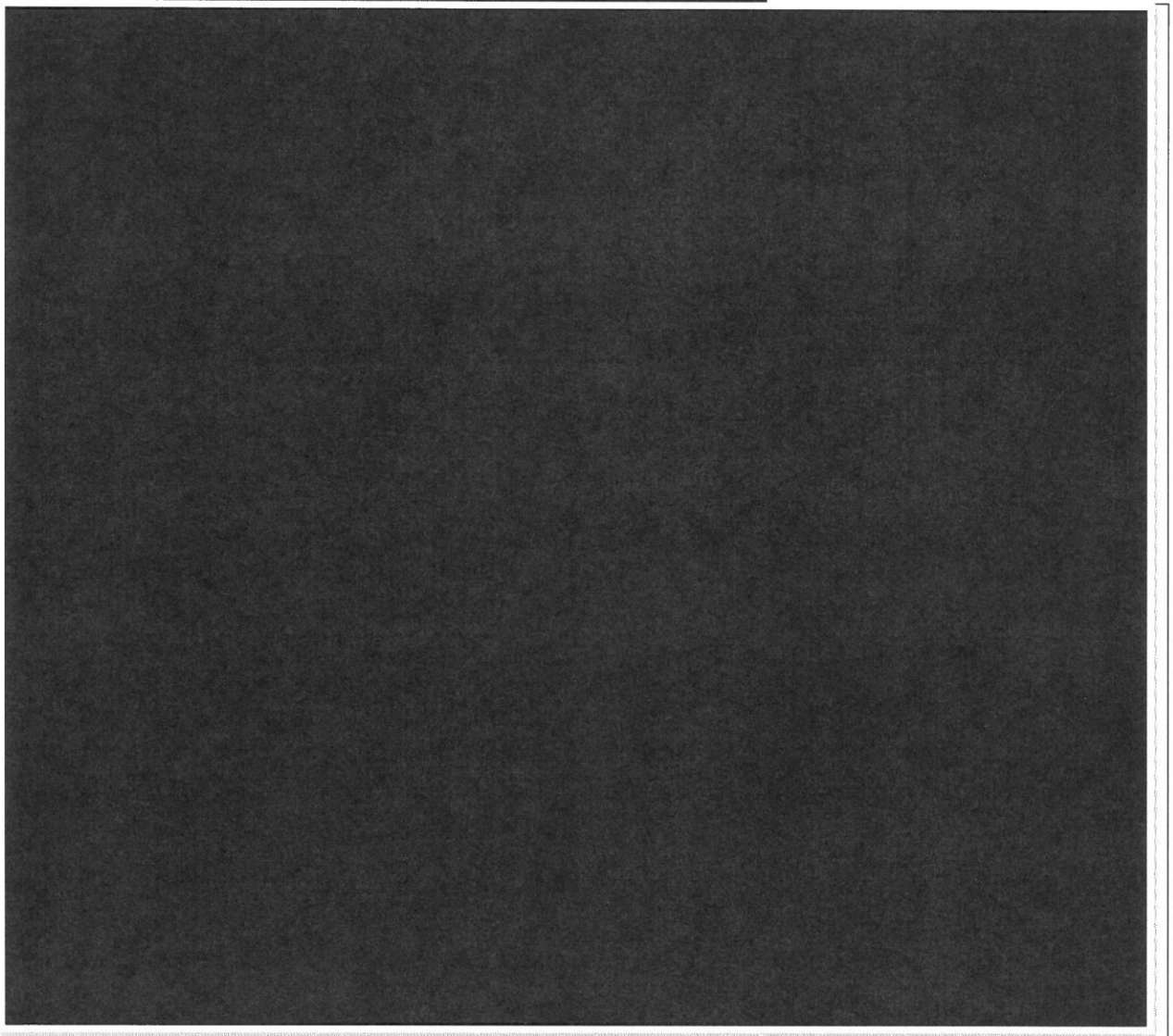
First, we will develop and implement a sensitivity training module into our routine ongoing trainings. The module will emphasize the importance of remaining, neutral, compassionate, and nonjudgmental when conducting the health needs assessment, as many potential enrollees/ enrollees may have feelings of embarrassment about revealing health needs.

Specially Trained Staff

Second, we will provide the Call Center Supervisor with special training on providing counseling to enrollees/potential enrollees with complex health needs. As our Supervisor, Ms. Veronica James, introduced in Section 4.1.15 brings a background at DHHR where she provided support

in corresponding with recipients detailing their medical records, she brings an understanding of the sensitivity needed to serve those with complex health needs. Call Center Benefits Managers who need additional identifying health conditions will be able to refer the calls to her.

[redacted]



Using this process, we ensure unique health care needs are identified and factored into the enrollment selection.

[redacted]

[redacted]

[redacted], factor them into the enrollment selection to ensure continuity of care.

During calendar year 2013, we completed over 17,000 Health Needs Assessments that identified several important conditions, as detailed below in Exhibit 120.

Exhibit 120. 2013 Health Needs Assessments

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Asthma	63	40	65	55	56	64	88	69	64	90	94	95	843
Diabetes	11	10	10	8	12	16	15	13	16	23	11	35	180
Heart Condition	24	20	30	20	20	22	17	17	20	29	40	34	293
Newborn	1,116	812	867	870	770	788	897	900	837	873	649	787	10,166
Smoker	159	124	143	126	107	127	112	140	150	178	327	361	2,054
Planned Surgery	21	13	12	12	9	15	12	14	4	19	16	15	162
Pregnancy	265	194	229	210	194	221	259	222	168	206	131	154	2,453
Smokeless Tobacco	5	11	13	7	11	7	7	9	8	5	33	37	153
Other	86	73	105	86	80	88	109	99	78	121	134	163	1,222
Total	***1,750***	***1,297***	***1,474***	***1,394***	***1,259***	***1,348***	***1,516***	***1,483***	***1,345***	***1,544***	***1,435***	***1,681***	***17,526***

Our approach to Health Needs Assessments has enabled us to identify nearly 20,000 important health conditions.

In the new contract we will work closely with BMS and the MCOs to determine if there are any potential revisions to the Health Needs Assessment that will prepare the MCOs to better provide quality care. Our goal in any such communication with BMS and the MCOs will be to ensure we collect all pertinent information for the State and MCOs, but also to do so in a way that minimizes the burden placed on the potential enrollee.

4.2.6 Enrollee/Provider Relationships

Identifying and, if possible, maintaining existing enrollee/provider relationships.

We recognize the importance of maintaining enrollee/provider relationships to the extent possible and desired. In fact, because we understood the criticality of the enrollee/PCP relationship, we incorporated the PCP Choice Driver as a major tool into HealthTrack (described in detail in Section 4.1.6), which is by far the dominant choice driver used in enrollment selections.

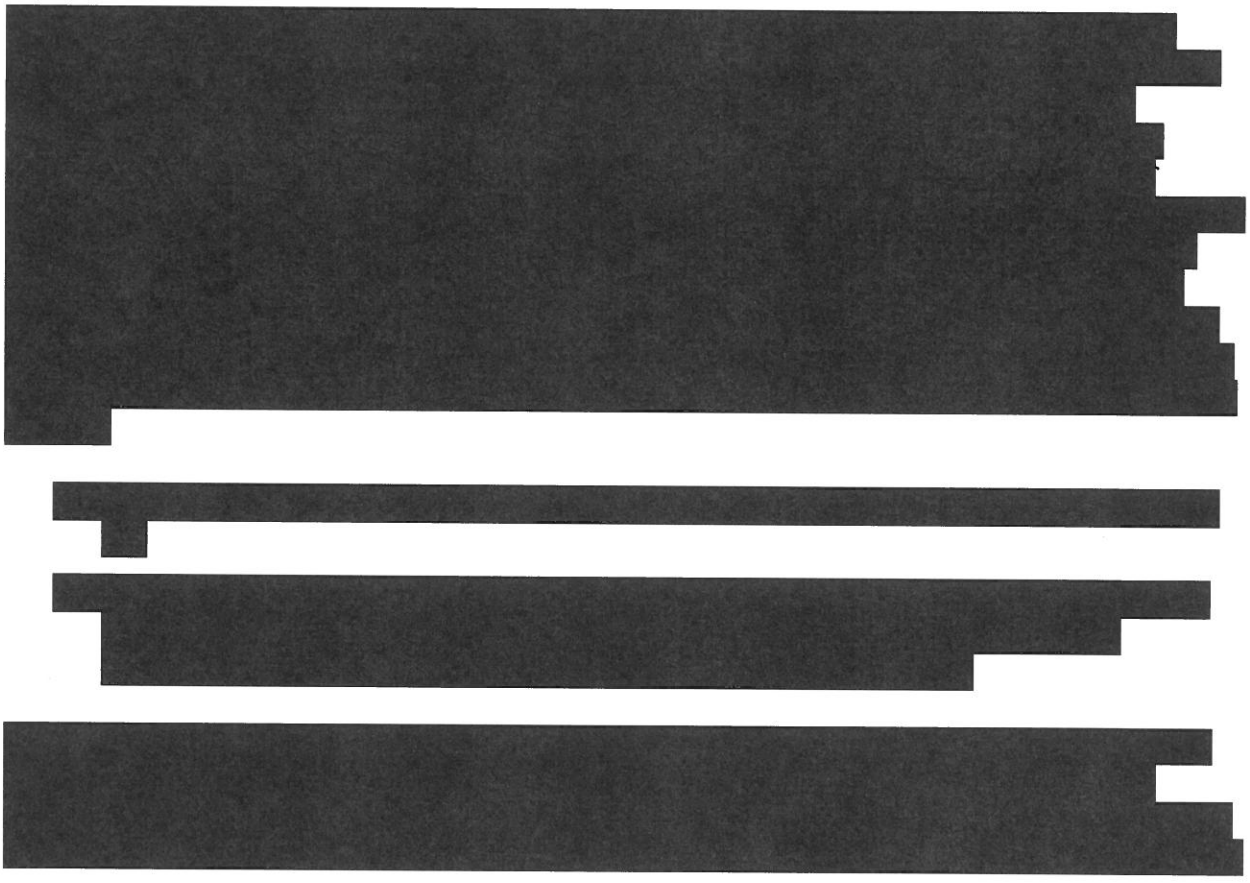
DID YOU KNOW?

We have tools and scripting in place to ensure we maintain not only enrollee/PCP relationships but also enrollee/specialist relationships, and existing hospital relationships.

Our approach to ensuring enrollee/provider relationships are identified and maintained is based on a two-fold approach:

1. HealthTrack, and
2. Scripting.

HealthTrack



[redacted]

Scripting

We developed scripting to support the preservation of the enrollee/PCP relationship by incorporating the following questions into our scripts:

1. A Primary Care Provider will monitor your health, treat minor health problems and refer you to a specialist. Do you know the name of a PCP you would like to see?
2. I see that (doctor name) is participating in (name of MCOs). Would you like to enroll in (name of MCOs) or is there anything else that you would like to look at before you make a decision?
3. What is the name of your specialist? I can look to see which MCOs they are participating with.
4. I see that (specialist name) is participating with (name of MCOs). Would you like to enroll with (name of MCOs) or is there anything else you would like to look at before you make a decision?
5. Which Hospital or Clinic would you like to use for your care? I can look to see which MCOs they are participating with.
6. I see that (hospital name) is participating with (name of MCOs). Are you ready to make a selection?

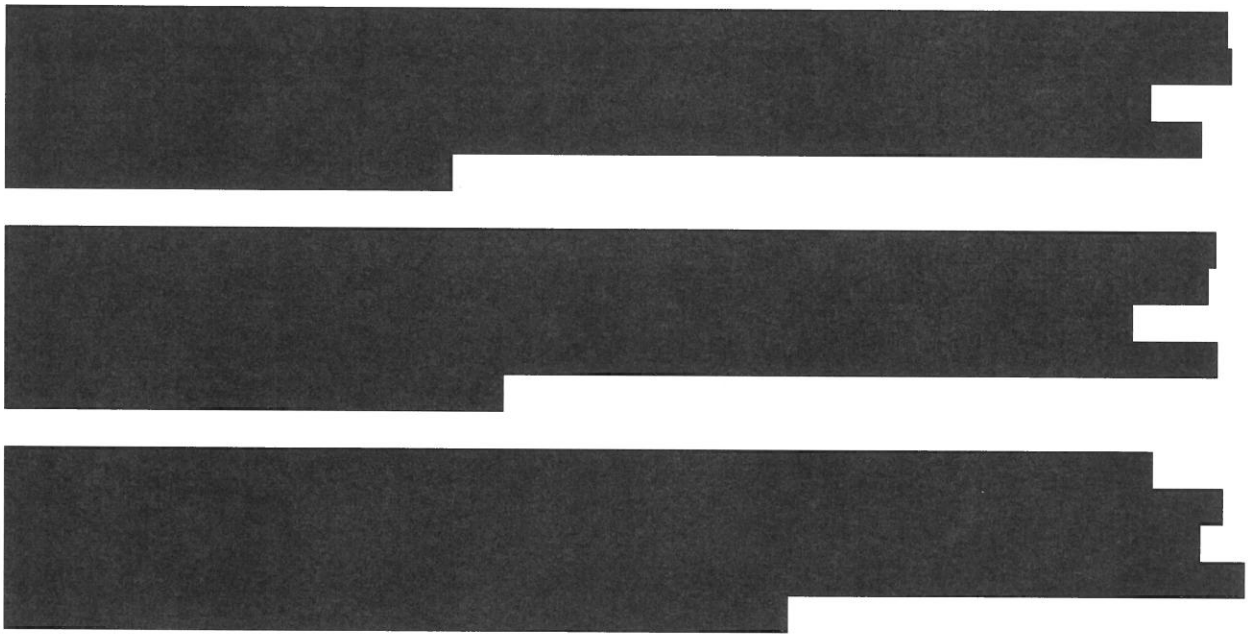
As mentioned, our approach to identifying and maintaining existing enrollee/provider relationships exceeds the requirements of the RFP by ensuring where possible, we also preserve specialist and hospital relationships. Further, all scripting is below a 6th grade reading level and already BMS-approved.

[redacted]

4.2.7 Options Based on Place of Residence

Explaining the options available to individuals depending on their place of residence.

One of the first elements in our scripting is to state the MCOs available in the caller's county. (Please note, we also make this information available in our enrollment packets as well as available on the MHT website.) In the new contract, there are numerous ways this component will be enahnced.



If the MCO options in the counties changes (e.g., a new MCO enters or expands its region, or an existing MCO leaves), we can immediately update our materials and resources so that updated information is instantly available to callers. Our Benefits Managers will be alerted to the situation in advance so they are prepared to answer any caller questions.

As reflected in Firm and Staff Qualifications and Experience, we have supported over 65 MCO expansions/changes in nearly every county in West Virginia during our current contract (i.e., from 2007-present). We will bring this same commitment to prompt response times to the new contract, and will ensure HealthTrack always includes the most up-to-date information concerning MCO participation in each county. Of note, as reflected in the text box, we are actively preparing for The Health Plan's coming expansion.

DID YOU KNOW?

We are already preparing for the expansion of The Health Plan (THP) into Grant, Hampshire, Hardy, Jefferson, Logan, Mason, Mineral, Mingo, Morgan, Nicholas, Pendleton, Raleigh and Summers counties to ensure we provide all callers with accurate information concerning the areas served by THP.

4.2.8 Explaining Health Benefit Coverage

Explaining the health benefit coverage.

We are well prepared to explain the health benefit coverage to potential enrollees/enrollees. Further, we can accommodate multiple benefit packages if needed. For example, presently the Medicaid expansion population is enrolled in an Alternative Benefit Plan; however, they may elect to opt out to be enrolled in the Traditional Medicaid Plan. If the Medicaid expansion population is rolled into the MHT Project, we will be able to provide counseling and assistance on understanding the coverage of both benefit packages.

DID YOU KNOW?

Through our work with the CountyCare and Gateway to Better Health Projects, we have been on the forefront of helping the Medicaid expansion population transition in and out of programs and delivery systems. We have an unmatched understanding of the unique blend of both Medicaid and ACA coverage options, which prepares us well to explain health benefit coverage options to this population if they are included in MHT.

Our approach to explaining health benefit coverage is based on:

1. Receiving files of benefit coverage and loading into HealthTrack,
2. Developing enrollment materials: if needed, we will develop new plan comparision charts, tip sheets, and enrollment forms to highlight the various benefits,
3. Developing scripting: we will develop scripting on the various benefit packages. Of note, as part of our scripting, we will implement a glossary, which we have found is often helpful in clarifying benefit terms that may be confusing (e.g., copay, deductible, managed care organization, etc.),
4. Receiving BMS approval for all scripting and then incorporating scripting into HealthTrack, and
5. Placing supporting materials on the MHT website for easy reference by enrollees.

To demonstrate one example of how we have supported various benefit packages, we illustrate the Florida Medicaid Reform Program, where MCOs had the option of offering enhanced benefits. Below is an example of the scripting we integrated into this Project to help enrollees understand and consider the various benefits offered.

"Health plans can offer some different benefits and some of these benefits may be more important to you than others. Since everyone doesn't have the same healthcare needs, plans can now offer different levels of coverage. All plans must offer the same benefits, but they can decide how much of the service to cover. Health plans are also offering extra services, and some of these may be important to you. Which benefits are most important to you?"

"As a reminder, children and pregnant women do not have co-pays or plan limits. Some of the health plans are offering some extra services, and some of these may be important benefits for you and your family. Which benefits are most important to you?"

"Did you take a look at the health plan's benefits to make sure they meet all of your healthcare needs? I just want to make sure you know that there are other plans in your area and they may have different limits on the services offered. Also, everyone in the family doesn't have to be in the same health plan. We can take some time to compare your options, if you like."

Key benefits of this scripting are that it empowers the enrollee to:

1. Select an MCO based on a comprehensive view of their healthcare needs,
2. Select the most applicable benefits to their healthcare needs, and
3. Consider all family members' needs in the decision making process.

In the new contract, we will work with BMS and the MCOs to obtain files of their benefit coverage. Discussions with potential enrollees/enrollees concerning benefit coverage will algin with our discussions of Medicaid covered services, discussed in Section 4.2.11.

In addition to explaining health benefits, please note that the Choice Drivers Tools (detailed in Section 4.1.6) can be customized to allow for extra benefits to help identify the MCO that best meets the needs of the callers. For example, in the Florida Medicaid Reform Project, each MCO had their own drug list, that included different prior authorizations (or no prirorizations) and copay requirements. We developed a comprehensive Preferred Drug List Choice Driver that allowed a Benefits Manager to work with an enrollee to identify various medications (including various coverage options based on generic, brand equivalent, etc.). In this manner we not only promote continuity of care, but we also promote continuity of ongoing treatment regimens **and** help enrollees better prepare for costs.

DID YOU KNOW?

If needed, we can modify and customize the Choice Drivers to identify any extra benefits offered by the MCOs.

In addition to the Preferred Drug List Choice Driver in HealthTrack, we also supplemented our scripting to prepare Benefits Managers to respond to varying questions concerning coverage of prescription medications.

As mentioned, if needed, we can work with BMS on the customization of all Choice Drivers and scripting to accommodate varying levels of benefit coverage. Further, we understand BMS is looking to achieve an integrated delivery system, consisting of behavioral, physical, dental, and pharmacy services. As the State moves closer to this integrated model, we will update our scripting as well as HealthTrack to accurately reflect information concerning benefit coverage for all components of healthcare that will eventually be covered. Part of our messaging to enrollees will be to ensure they understand how to access all services (e.g., behavioral and dental) through the MCOs.

4.2.9 Specific Information About MCO and PAAS Options

Providing specific information about each MCO and PAAS option such as the network of providers (e.g., physicians, hospitals) and the extent of new enrollees being accepted.

DID YOU KNOW?

As BMS and the MCOs work to make the information available to us concerning the network of providers and the extent of new enrollees accepted, we can accommodate any information transfer, in any format, at any time.

As evidenced throughout our proposal, we are offering BMS HealthTrack, our enhanced healthcare administration system, through which we will provide sophisticated PCP, specialist, and hospital searches allowing us to easily provide specific information about each MCO and PAAS option.

While fully described in Section 4.1.6, a brief description of our provider and hosptial searches follows.

[redacted]

For PAAS providers, the MMIS Provider Screen displays "accepting new paients" (yes or no). If the PAAS provider is not accepting new patients and the enrollee is requesting the closed provider, the Benefits Manager can further offer another PAAS provider or have the enrollee contact the provider by phone to see if s/he will accept the enrollee. Please note, if needed, we can conduct warm transfers or remain on the line during these calls to provide further assistance. If the provider agrees to accept the enrollee, we accept the aproval by phone and click on "Ignore New Assign" in MMIS, and are able to enroll the enrollee with the provider.

Additionally, for written enrollments the PAAS Enrollment Packet includes a "Doctor's Approval Form." The enrollee can have the provider complete the form and either the enrollee or provider can send it to us or fax it to the MHT Call Center. We will then process the PAAS enrollment.

4.2.10 Documenting Reasons for Changes

Documenting reasons for changes in MCO and/or PAAS enrollment and including change information in monthly reports to BMS.

We currently document all reasons for changes in MCO and/or PAAS enrollments for all enrollees who elect to change their MCO or PAAS selection. These results are then included on our monthly report. The reports include both the total number of MCO or PAAS enrollment changes as well as the information broken out:

- By week,
- According to MCO or PAAS (e.g., number of changes to The Health Plan and the number of changes from The Health Plan, etc.), and
- The most common reasons cited for enrollment changes.

DID YOU KNOW?

We not only report the reasons for changes in MCO or PAAS selection in our monthly reports to BMS, but we also trend this information for the previous 12 months.

Information concerning enrollment changes are provided in table and graphical format. Further, each monthly report provides a rolling 12 months of data, for easy trending of enrollment changes. Please refer to Exhibits 121-123 for samples of information included in our monthly reports.

Exhibit 121. Change Information Included in Monthly Reports

Exhibit 7: Enrollment Changes – December 2013								
	'To' CC of WV	'From' CC of WV	'To' The Health Plan	'From' The Health Plan	'To' UniCare	'From' UniCare	'To' PAAS	'From' PAAS
Week 1	18	28	10	5	26	23	2	0
Week 2	10	41	9	5	37	17	3	0
Week 3	2	41	11	13	42	20	4	0
Week 4	26	20	5	7	18	7	3	1
Total Changes	**56**	**130**	**35**	**30**	**123**	**67**	**12**	**0**

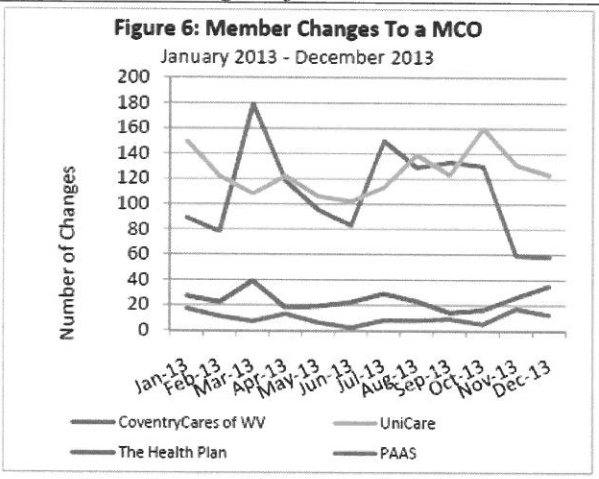
We provide detailed information concerning the number of changes to and from each MCO and PAAS.

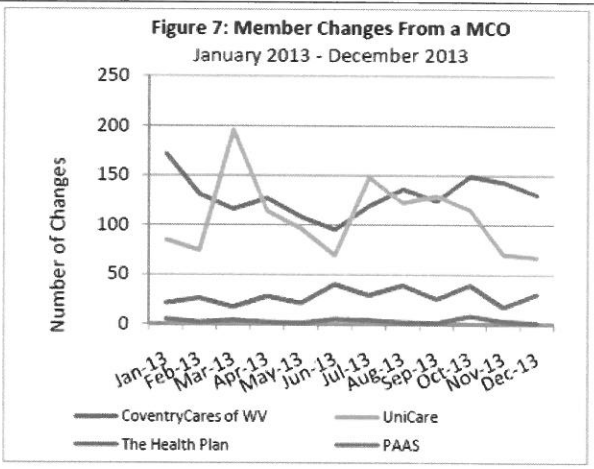
Exhibit 122. Change Information Included in Monthly Reports

Exhibit 8: Top Reasons for Enrollment Change from Plan – Dec 2013				
	CC of WV	The Health Plan	PAAS	UniCare
Provider Not in Plan	90	9	1	42
Doctor Recommended	15	2	0	2
Auto-Assigned	17	12	0	10
Written Enrollments	5	2	0	8

Each month, we provide BMS with the most common reasons for enrollment changes. The most common reason continues to be lack of provider participation.

Exhibit 123. Change Information Included in Monthly Reports





By graphing information over the past 12 months, we help BMS fully understand trends in enrollment changes.

4.2.11 Explaining Medicaid Covered Services

Explaining Medicaid covered services and freedom of choice for access to family planning services.

Our discussions of all Medicaid covered services and freedom of choice for access to family planning services will follow from BMS-provided materials. We will use the following information on Medicaid covered services (provided by DHHR as part of the Your Guide to West Virginia Medicaid, most recently updated in May 2014) to guide all discussions on what services are covered by what plan.

Exhibit124. Medicaid Covered Services

Benefit	Traditional Medicaid Plan		Mountain Health Bridge Plan Alternative Benefit Plan (ABP) (Expansion Plan)	
	Covered	Service Limits	Covered	Service Limits
Pharmacy Care Office Visits	X		X	
Specialty care	X		X	
Podiatry	X		X	
Chiropractic	X		X	Limit of 24 treatments per year. An additional 6 treatments per year can be authorized if OT and PT services have not been utilized in combination with this service.
Diagnostic X-Ray	X		X	
Outpatient Hospital Services	X		X	
Hospice	X		X	
Nursing Home	X		Not Covered	
Emergency Room Outpatient Hospital Services	X		X	
Emergency Transportation/ Ambulance	X		X	
Inpatient Hospital Care	X		X	
Hospital Inpatient/Maternity	X		X	
Outpatient/Maternity	X		X	
Rehabilitative Psychiatric Treatment	X		X	
Inpatient Psychiatric Hospital	X		X	
Prescription Drugs	X		X	
Physical Therapy	X	20 visits per year (combined PT and OT, additional authorization requried	X	30 visits per year for Habilitative and Rehabilitative services (combined PT and OT)

		over limit)		
Occupational Therapy	X	20 visits per year (combined PT and OT, additional authorization required over limit)	X	30 visits per year for Habilitiative and Rehabilitative services (combined PT and OT)
Speech Therapy	X		X	Habilitiative and Rehabilitative services
Cardia Rehabilitation	X		X	
Pulmonary Rehabilitation	X		X	
Durable Medical Equipment	X		X	
Orthotics and Prosthetics	X		X	
Home Health	X	60 visits per year (additional authorization required over limit)	X	100 visits per year
Inpatient Rehabilitation Hospital Services	X		X	
Laboratory Services and Testing	X		X	
Diabetes Education	X		X	
Early Periodic Screening, Diagnosis and Treatment	X		X	
Famiily Planning Services and Supplies	X		X	
Nutritional Counseling	X		X	
Tobacco Cessation	X		X	
Non-Emergency Medical Transport (NEMT)	X		X	
Personal Care Services	X		Not covered	

All information surrounding Medicaid-covered services will be based on DHHR/BMS provided information.

We will provide all education accurately, based on plan and eligibility group. (For example, scripting will ensure pregnant women, children under age 21, and Native American and Alaska Natives are aware they do not have any copays). We will further supplement our scripting to include relevant details related to out-of-state Medicaid coverage. Of note, in the new contract, all scripting and benefit coverage charts will be loaded into HealthTrack for easy access, reference and discussion by Benefits Managers.

Additionally, as referenced earlier in Section 4.2.8, we will also work to ensure potential enrollees/enrollees understand all services that are covered in the managed care model, which will be particularly critical as BMS moves towards the integrated healthcare model (e.g., behavioral, physical, dental, and pharmacy) anticipated by the State. Further, part of our message will be to assist potential enrollees/enrollees with not only understanding what services

are covered but also how to access all services through the MCOs. We will work closely with BMS throughout the development of all scripting related to these elements.
With regard to family planning, we will ensure our scripting includes pertinent details related to family planning. Pending approval and discussion with BMS, elements pertaining to family planning services will include:

- Freedom of choice,
- Exemption of co-pays, and
- Information concerning free/low cost access to family planning through the West Virginia Family Planning Program.

4.2.12 Referring to the Correct Human Service Agency

Referring enrollees to the correct human service agency if calls are received that are outside the scope of the managed care programs.

There are numerous reasons why enrollees may need to be referred to an additional human service agency. For example, enrollees often call with questions on the following topics, which warrant referrals to other agencies:

- Benefits,
- Biling issues,
- Dental issues,
- Eligibility issues,
- Third Party Liability (TPL),
- Changing PCP (if enrolled in an MCO),
- Demographic updates,
- Assistance locating a specialist,
- Durable Medical Equipment,
- Governemnt/legal offices,
- Lock-in program,
- Transportation assistance,
- Pharmacy issues,
- Deductibles/co-pays
- Prior Authorization, and
- Spenddown.



Our approach to ensuring we correctly refer callers is based on three components:

1. Phone system,
2. Call handling guidelines, and
3. Resource Directory.

First, all of our call centers have the capacity to transfer calls to other helplines and the MHT Call Center is no different. We are fully capable of conducting all transfers, and warm transfers, as needed. Transfers may be initiated to MCO Member Services, local DHHR offices, etc. Naturally, our telephone system is also capable of conducting transfers to any other number

needed. Of note, when needed, we will offer warm transfers to further improve the customer service we deliver.

Second, we have Call Handling Guidelines, which Benefits Managers use to identify the nature of calls and also to identify when calls are outside the scope of the MHT Project. They then follow the appropriate protocol to make the referral. Please note, when making referrals, Benefits Managers offer to transfer the call and also provide the phone number of the referral agency for the caller's reference.

Last, we have developed an extensive Resource Directory to which we can refer callers. The Resource Directory includes not only the phone numbers for common referral agencies, but also a statewide listing of relevant health and human service providers to further provide assistance and education. Common agencies we refer callers to include but are not limited to:

- MCO Member Services,
- Molina Customer Service,
- Medicaid Client Services,
- DHHR Change Center,
- TPL Unit,
- Member's PCP,
- Local DHHR Offices, and
- WVMI Prior Authorization Helpline.

In the new contract, all referrals will be tracked in HealthTrack and available for reporting, either on an ad hoc basis or for inclusion in our monthly reports.

4.2.13 "Triaging" Enrollee Calls

"Triaging" enrollee calls to service representatives and medical hotlines when necessary, and resolving complaints and acting as troubleshooter and enrollee "ombudsman" for enrollees in the program.

Our approach to triaging enrollee calls is based on 4 components:

1. Commitment to "Delighting the Customer",
2. Conducting Referrals,
3. Processing Complaints, and
4. Troubleshooting Enrollee Issues.

Commitment to Delighting the Customer

We understand that as the actions of the MHT Project administrator ultimately reflect on DHHR, BMS, and the Medicaid program in general, it is critical for the contractor to provide outstanding services to every enrollee, every time. It is part of our commitment to excellent service to go beyond customer's expectations by "delighting" the customer, which involves going beyond the expectations of satisfied customers and addressing their unmet and, perhaps even unspoken, needs in a proactive manner.

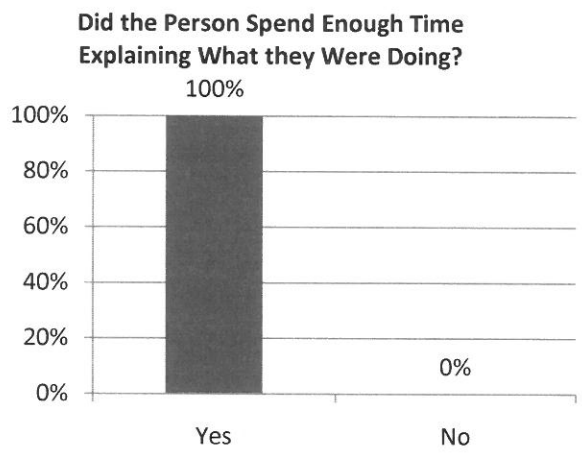
- A **satisfied customer** is one whose issue we have addressed or whose problem we have solved.
- A **delighted customer** is one whose issue we have addressed or whose problem we have solved but in a sensitive and confidential manner that dignified the customer and exceeded expectations.

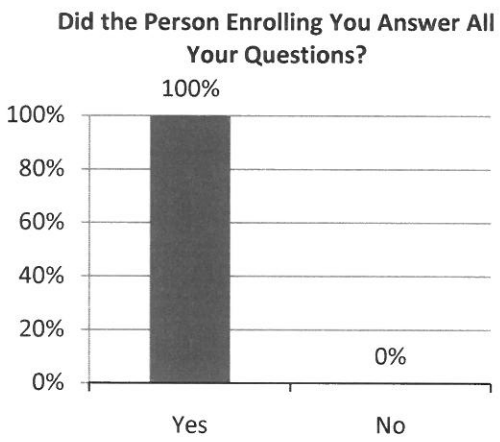
We have found that there are various ways to delight the customer. We will continue to delight potential enrollees and enrollees by:

- Treating the customer's call as top priority;
- Taking time to explain why things are done as they are, not just reciting the law; and
- Not transferring to someone unavailable to take the call (leaving the caller with merely a voicemail system).

A testament to our commitment to "delighting the customer" is found in our satisfaction surveys, which as demonstrated on the following page in Exhibit 125, reveal high marks with our services. (Please refer to Section 4.2.20 for a complete description of our approach to satisfaction surveys as part of our Quality Assurance Plan.)

Exhibit 125. Satisfaction Survey Results





Callers to the MHT Call Center feel that we meet all their needs.

Conducting Referrals

During phone interactions, Benefits Managers triage calls to determine when immediate help is needed. Appropriate referral information to various resources and medical hotlines and education are provided. (Please note, in the event of medical emergencies, Benefits Managers instruct the callers to hang up and call 911.) Benefits Managers follow the process for making referrals described in the previous section.

Processing Complaints

We are pleased to offer BMS a comprehensive approach for complaints. One of the key features of our approach to complaints is our effort to work with callers in a calm manner to resolve their issue before it becomes a formal complaint. Oftentimes, a sympathetic tone combined with accurate education can resolve a complaint. Please refer to Section 4.3.4 for a comprehensive description of our approach to complaints.

Please note, while we pride ourselves on our low-literacy scripts, our education is designed to be empowering. In no way do we ever want callers to feel that we are "talking down" to them. In fact, see what one caller had to say about our Benefits Manager:

"I really appreciated her help. She never made me feel rushed. Never made me feel dumb."

Troubleshoot Enrollee Concerns

Our approach to troubleshooting enrollee concerns is based on two elements:

1. Enrollee Education, and
2. Customer Service.

First, we provide low-literacy phone based education on the area of the enrollee's concern. Often enrollees are frustrated by terms or conditions they do not understand, and providing education and information in easy-to-understand language helps to clarify the misconception.

Second, as mentioned in the introduction to this question, we pride ourselves on providing consistently outstanding customer service. Our approach to doing so is to treat callers with compassion and to make them feel as if they have been heard, and their concerns are respected and taken seriously. Our Benefits Managers receive extensive training on customer service (described in detail in Section 4.2.15) and are also trained to "function as an ombudsman" for enrollees. In fact, serving as an "ombudsman" for enrollees is even a part of their job description (please refer to Appendix J for job descriptions).

4.2.14 Operational Procedures

The development of operational procedures, manuals, forms and reports necessary for the operation of the telephone unit.

Operational Procedures



Policies and procedures are essential not only to coordinate efficient and organized work efforts and ensure tasks are completed in a timely manner in accordance with contractual requirements, but more importantly to ensure potential enrollees and enrollees are provided with a first-class customer experience that represents the BMS programs we will serve throughout the Project. Throughout our corporate history, in all of our contracts, we have developed comprehensive Policies and Procedures Manuals that ensure compliance with all contract specifications, adherence to all SLAs, and achievement of performance standards. We have developed Policies and Procedures Manuals to address all components of Call Center, Enrollment Broker, PCCM, Eligibility, SCHIP and Vaccines for Children contracts. In fact, these soft and hard copy manuals serve as the "textbook" for training and the source for staff's desk-top reference and are updated as changes occur. Highly comprehensive, our Policy and Procedure manuals cover all facets of the Project, including but not limited to:

- Workflows and scripts for the provision of required functions (including time frames for completion of the function)
    - Mailings and mailroom quality control activities
    - Call processes (in- and out-bound)
    - Transfers (for example, to the MCOs)
    - Enrollment/disenrollment, plan change activities
    - Data management (includes data entry, quality assurance, archiving data, etc.)
    - Outreach activities (for example, outbound mailings, out-bound outreach calls, in-person sessions, etc.)
    - Plan changes
    - Exception requests
    - Managed care transition of membership
    - Measuring participant satisfaction
    - Complaints
    - Fraud and abuse detection
    - Reporting

  - Quality activities
- Roles and responsibilities of staff
  - Job descriptions
  - Reporting structures
  - Training responsibilities
- Key stakeholders and community resources (brief descriptions and contact information with embedded links for electronic viewing)
- Protocols and procedures for all staff in terms of:
  - Corporate personnel policies (for example, HIPAA/confidentiality, security, FMLA, use of company property, etc.).

Policies and procedures are very comprehensive, and include the following sections: purpose, scope, policy, procedure, submission date, revision date, and approval date. When needed, we include definitions to ensure thorough understanding.

For the new MHT Project, we will analyze all facets of the new contract and its scope of work as well as the policies and procedures already in place under the current operation. We will identify which of the already existing policies and procedures are transferrable, which ones need to be modified, and which ones need to be completely developed (we anticipate that with the inclusion of HealthTrack, several policies and procedures will need to be updated). Any policy and procedure that has been drafted or altered in any way will be submitted to BMS for approval. All changes identified and requested by BMS will also be promptly made and the manual will be re-submitted for final approval.

If there are any changes to the managed care programs during the tenure of the contract (e.g., the SSI or Medicaid expansion populations are included), we will develop and/or incorporate new policies and procedures as needed and appropriate. We will follow a seven step approach to ensuring all new policies and procedures meet the needs of BMS, and ultimately the Program's participants. The process is described below.

The Project Manager will:

1. Research and review all pertinent information (e.g., service areas impacted, populations affected, effective dates, etc.);
2. Draft proposed changes and submit to project staff for review;
3. Incorporate relevant feedback from project staff;
4. Submit the draft policies and procedures to BMS for approval;
5. Ensure feedback from BMS is incorporated into the policies and procedures and resubmit for approval;

6. Update the electronic Policies and Procedures Manual and produce hard copies for distribution; and
7. Schedule, coordinate, and oversee targeted training on the changes.

The Project Manager will continue to review the Policies and Procedures Manual on an annual basis, and any resulting changes and updates will be forwarded to the State for review and written approval. Additionally, as needed, we make pertinent updates to the Policies and Procedures Manual throughout the contract period. Updates to policies and procedures can stem from several events, such as release of new information from State agencies, changes to existing laws and regulations, or the implementation of new programs. As part of each policy and procedure we will maintain a complete revision history including documentation of dates and approvals.

As technology has evolved and allows for enhanced efficiencies, we have put enhanced, user-friendly tools and resources at our staff's fingertips. Policies and Procedures Manuals are now made available to staff in an electronic, indexed format, allowing staff to easily and efficiently search and locate the information they need online.

Please refer to Appendix K for sample policies and procedures. All of our policies and procedures submitted as samples are from our current MHT Project and demonstrate our understanding of overall Project operations and our commitment to providing services in accordance with contract requirements. We have selected the following sample policies and procedures to demonstrate various competencies we bring to the Project.

Exhibit 126. Sample Call Center Policies and Procedures

Policy and Procedure	Contents
Enrollment Changes	Addresses the full scope of processing enrollments, enrollment changes, and PAAS PCP enrollments and changes.
Interpretive Services	Addresses the methods needed to provide excellent services to callers with speech or vision impairments.
Provider Directory Requests	Addresses the Benefits Managers responsibilities to log and promptly respond to requests for provider directories.

With comprehensive policies and procedures in place, we are well prepared to continue to operate all aspects of the MHT Project.

There are numerous benefits to our policies and procedures, which include but are not limited to the fact that they:

- Are already in place and will result in a minimal burden on BMS with regard to review and approval during the implementation period;
- Document all facets of Project operations;
- Have allowed us to earn high marks of enrollee praise and numerous enrollee compliments;

- Allow us to minimize complaints by providing consistent, standardized interactions in accordance with BMS specifications across all aspects of the Project;
- Ensure *all* participants are reached and appropriately counseled regarding enrollment options (e.g., persons with special needs, persons with alternate language needs, hearing impaired individuals, etc.); and
- Align with all performance standards and contract requirements.

Forms

We have already developed all forms required to operate the project. These include but are not limited to:

- Quality Assurance Surveys,
- Call Monitoring Forms and Standards,
- Scripts, and
- Confidentiality Guidelines.

As described for policies and procedures, all forms currently used in the project will be reviewed and appropriately modified during the contract implementation period. Through this review, we will determine if there are any new forms that need to be developed during the Project and will ensure all operations continue to meet BMS' needs.

Reports

We are pleased to offer BMS a comprehensive and enhanced approach to reports. Please refer to Section 4.3.7 for a detailed description of our approach to reports for this Project.

4.2.15 Staffing Telephone Unit and Training Personnel

The Vendor's approach to staffing the telephone unit and training personnel on all relevant issues on an ongoing basis. The staff operating the telephone unit should be responsible for responding to a variety of phone calls from members (e.g., disenrollment, exemptions, choice counseling, covered services).

To increase the readability of this item, our response begins with a description of our approach to staffing the call center, followed by a description of our training methods.

Staffing the Telephone Unit

While a complete description of our approach to determine the appropriate size of our staff is discussed in Section 4.4, we would like to highlight a few features of this approach that are particularly relevant to the MHT Project, particularly given the possibility of program and population expansions during the contract. First, when determining the number of staff, we carefully evaluate a number of factors including but not limited to:

DID YOU KNOW?

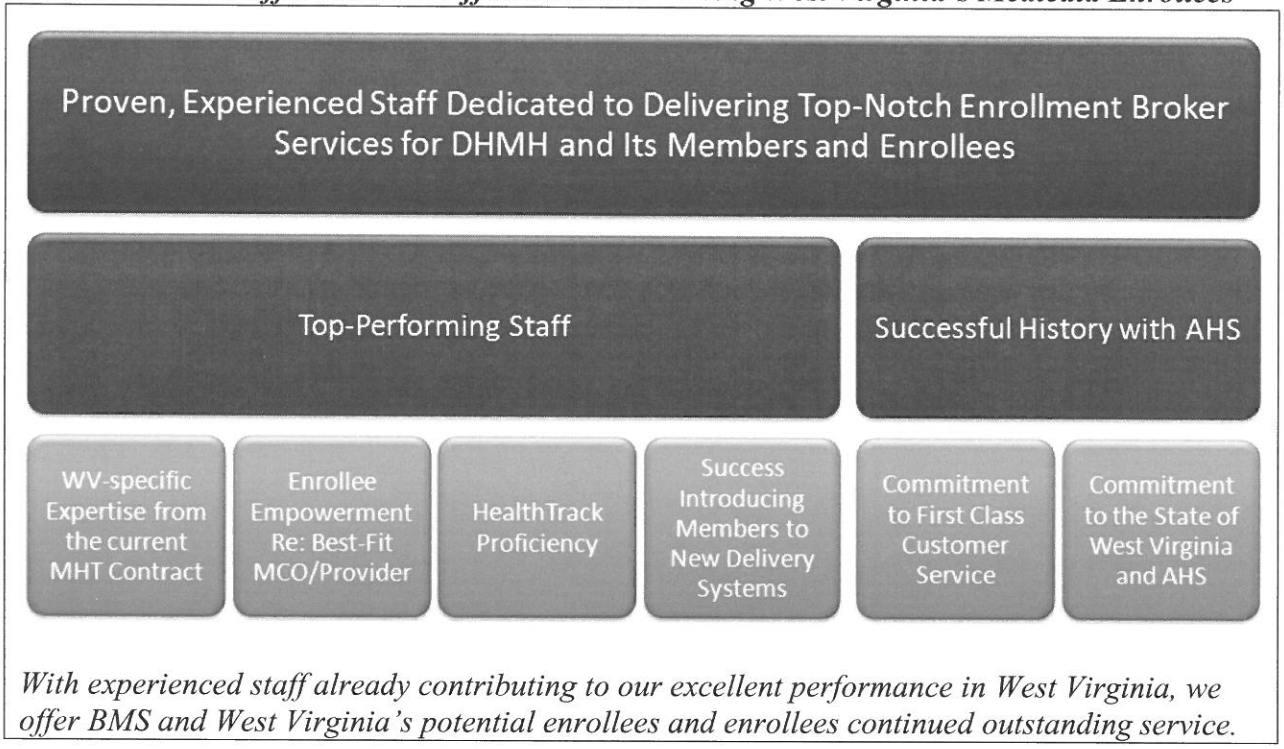
All our Project staff bring a proven experience serving enrollees in both an MCO and a PCCM environment – giving them experience with the full breadth of the managed care environment in WV – something no other bidder can offer.

- **The workload and structure/organization of our current staff**. While we are proud of our ability to organize our staff into logical units, our first approach when determining staffing models for a new program/expansion is always to determine if we can save the State valuable dollars by incorporating additional tasks into current staff's workflows. We look for ways where we can leverage efficiencies (including coordinating with our IT Department as necessary), and implement necessary protocols and procedures when doing so is appropriate to ensure that service delivery is not compromised;
- **Relevant population data** (e.g., population size, relevant program factors such as mandatory vs. voluntary, magnitude of differences related to how care is currently obtained vs. how it will be obtained in the new model, etc.). Of note, we understand that when new programs are implemented, there may be circumstances when BMS simply does not have such data available. In these instances we leverage our corporate experience with similar programs and/or populations, and incorporate as many features to make our staffing plans as flexible as possible (e.g., use of part-time staff, suspending time away from phones for trainings and/or meetings, incorporating temporary staff who can be called on to assist, etc.). We also understand that as new programs are implemented, not only are call volumes higher, but talk times are frequently higher as well, and we plan for both of these scenarios.

Our Proven, Experienced Staff will Continue to Serve West Virginians

As the current contractor for the MHT Project, we already employ all of the proven, dedicated, and trained Call Center Benefits Managers needed to continue serving BMS, potential enrollees/enrollees, and Project stakeholders.

Exhibit 127. We Offer Proven Staff to Continue Serving West Virginia's Medicaid Enrollees



With experienced staff already contributing to our excellent performance in West Virginia, we offer BMS and West Virginia's potential enrollees and enrollees continued outstanding service.

These supervisory, and customer service professionals not only have a proven, successful tenure with us and a history of service to the State of West Virginia and its Medicaid potential enrollees and enrollees, but also offer:

- A demonstrated commitment to providing first-class customer service;
- Extensive knowledge of West Virginia's Medicaid and related programming;
- Experience helping potential enrollees/enrollees determine and enroll with a best fit MCO and/or PAAS PCP as well as providing look-ups and information on specialists;
- Demonstrated ability to effectively educate and support potential enrollees and enrollees regardless of their special needs;
- Experience responding to several MCO expansions; and
- Experience educating and successfully introducing potential enrollees and enrollees to new delivery systems (a skill set that will be critical if West Virginia elects to implement additional managed care programs).

These staff are on-board, excited to continue serving West Virginia's Medicaid potential enrollees and enrollees, and will be able to mentor any external staff hired by AHS (when such additional staff are needed). Below, we feature three members of our dedicated call center staff.

Exhibit 128. Meet Some of Our Dedicated Staff

	Years of Service	Current Position	Biography
Ms. Veronica James (fully introduced later in this section)	15 years	Call Center Supervisor	Having started with AHS as a Benefits Manager and then being promoted to the Supervisor position, Ms. James is a shining example of our commitment to investing in and growing the careers of our top performing staff. She uses her Benefits Manager experience and in-depth program knowledge to coach and provide on-the-floor leadership to Benefits Managers.
Ms. Jan Thompson	9 years	Benefits Manager	With nine years' experience for the MHT Project, Ms. Thompson brings a deep understanding of West Virginia's Medicaid programs and its history of managed care. Ms. Thompson is particularly skilled in communicating with and appropriately serving enrollees with special needs, and is dedicated to ensuring special needs enrollees are provided with and understand all critical information for their selection of an MCO/PCP that is able to best meet their often complicated needs. She shares her passion for enrollee education and empowerment with Benefits Managers by assisting with staff training and providing on-the-floor coaching.
Ms. Lisa Crider	6 years	Benefits Manager	Ms. Crider started with AHS as a Benefits Manager six years ago. While Ms. Crider has extensive program knowledge, proficiency in all MHT Call Center operations, and continually earned stellar quality scores, she is also sincerely compassionate and has the innate ability to quickly build a true rapport with callers. Always willing to share her passion for customer service with newer staff, she often makes herself available for newly hired staff to shadow and receive coaching from her.

These dedicated staff and others like them are excited to continue representing West Virginia's Medicaid programs and serving its potential enrollees and enrollees.

During a recent audit, AHS was praised for our high retention.

AHS should continue to be commended for the competency of its program(s) and staff. AHS has many strengths including tenured, dedicated staff that works well as a team and has a strong work ethic.

- Quality Compliance Auditor

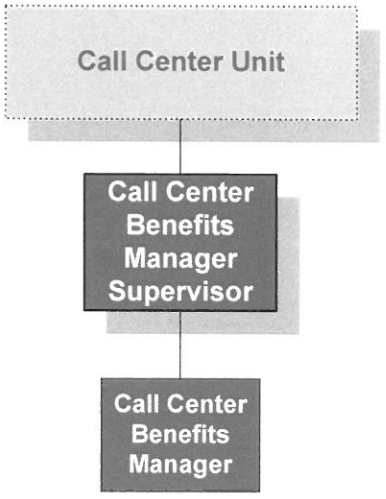
We have a demonstrated ability to retain staff, which reflects our continuous investment in this most valuable resource. We benefit from this high retention in several ways. We:

- Maintain a strong knowledge repository;
- Have low administrative costs associated with staff replacement[20] and lost productivity;
- Have low costs associated with training;
- Maintain quality customer service;
- Profit from high morale and teamwork, fostered through shared work activities; and
- Help employees develop their jobs into career paths.

MHT Call Center Staff

The MHT Project's Call Center Unit includes staff who provide call center outreach, education, and enrollment services for the Project. Because this Section specifically requests that bidders address call center staffing, our discussion here only focuses on the organization, qualifications, and responsibilities of those staff. Full details of our plans for staffing all aspects of the MHT Project are included in our upcoming response to Section 4.4.

Exhibit 129. Call Center



The MHT Project's Call Center Unit are overseen by a single Supervisor to ensure seamless coordination of efforts.

Call Center Supervisor

The Call Center Supervisor is responsible for directly overseeing all MHT call center operations. With support from the Project Manager, the Supervisor ensures that all call center staff are fully trained and prepared to deliver understandable, unbiased, and appropriate phone-based

[20]The cost of replacing lost talent has been estimated to range from 70 to 200 percent of that employee's annual salary. Kaye, Beverly, and Barbara Jordan-Evans. "Retention: Tag, You're It!" *Training and Development.* April 2000.

choice counseling, enrollment services, and ancillary support to potential enrollees and enrollees during inbound and outbound calls.

The Supervisor will play a critical role in the operation, enhancement, and continued success of the MHT Project. Because our proposed Supervisor, Ms. Veronica James, is currently serving the project and will therefore be available to serve the MHT Project immediately upon contract award, she will play a critical part of our Implementation Team. She will work closely with the Project Manager and our Senior Management Team to ensure that all call center enhancements introduced under the new MHT contract (e.g., customization of the new HealthTrack, installation of enhanced monitoring software, etc.) meet expectations and operational/performance needs. She will also work closely with the Project Manager and our Senior Management Team to review and update (as needed) training programs and materials.

During the ongoing operation of the MHT Project, the Supervisor will monitor the call center and individual staff's performance to ensure the call center operates efficiently and effectively, and that staff provide complete, personalized, high-quality phone-based service. This position's primary responsibilities include ensuring optimal productivity in providing education, choice counseling, enrollment activities, referral services, and first-class customer service to West Virginia's Medicaid potential enrollees and enrollees. In addition to performing as a Benefits Manager, the Supervisor directly supervises the Benefits Managers and empowers them to perform optimally. Additionally, the Supervisor coordinates the newborn enrollment process, ensuring newborns are enrolled following State policy, and responds to difficult customer complaints and issues. This position reports all activities, trends, and concerns (and recommended solutions, as appropriate) to the Project Manager.

The Supervisor will also be responsible for the assignment of work via My Tasks among subordinate Call Center staff using HealthTrack's My Tasks module (please refer to Section 4.3.6.1 for more information on My Tasks), monitoring day-to-day operations, evaluating call accounting telephone reports, and assisting the Project Manager with implementing targeted phone-based outreach activities and call campaigns.

The Supervisor is required to have a previous supervisory experience with a strong customer service focus. Previous call center and proven management experience are also required. A thorough understanding of BMS' policies, state and federal Medicaid guidelines, and managed care delivery systems is preferred. Two years of experience with health and human services as well as an Associate's Degree are preferred.

The Supervisor must be an articulate professional with the ability to understand, plan and evaluate phone-based MHT activities. She must be able to effectively lead, motivate, and coordinate the work of Benefits Managers and monitor call center activities according to the MHT Project's QA Plan (please refer to Section 4.2.20 for a description of our QA Plan). In turn, she must be able to accurately assess and report on performance, identify areas for improvement, develop enhancements to Call Center Unit operations and training, and implement approved enhancements. (Please refer to Appendix J for this position's job description.)

We are confident Ms. Veronica James will continue to thrive in this role. She has served the MHT Project since 1999, and has spent the last eleven years in the Supervisor position. She sets a culture of commitment to excellent customer service, which is evident in the numerous accomplishments she has attained in this position, including but not limited to:

DID YOU KNOW?

Ms. Veronica James has been with the MHT Project for 15 years, and has performed in the Supervisor role for 11 years, giving her unmatched experience providing these services.

- Maintained an abandonment rate significantly under the Project's SLA (our average abandonment rate for 2013 was 3.05%, which is considerably less than our SLA of 10%);
- Maintained an average hold time of mere seconds (our average was 0:07 for 2013);
- Ensured the processing of over 10,000 newborn enrollments each year was in accordance with BMS policy;
- Provided education and training to staff on ongoing initiatives (e.g., the close-out of the Mountain Health Choices Program, the Pharmacy Expansion, etc.);
- Performed monitoring on all Benefits Managers and provided with real-time feedback and training to ensure optimal quality and performance;
- Ensured emerging issues and feedback were tracked and reported to BMS;
- Ensured all scripting was up-to-date and current; and
- Ensured continuous attainment of all call center-related SLAs over the course of the contract.

See What WV Callers Say About our Benefits Managers:

"She clarified things in a way I could understand."

"Lisa did a great job of explaining the enrollment process and assisting me."

"She was very friendly."

In addition to working with AHS, Ms. James previous worked with the PAAS Program at DHHR, where she processed PAAS enrollments and PCP change requests for enrollees. In addition to this relevant experience, Ms. James holds a word processing certificate and is fluent in Microsoft Office, HealthTrack, AVAYA, and the CCR module. Please refer to Appendix C for Ms. James' resume.

Benefits Managers

Benefits Managers are responsible for providing outreach, education, and enrollment services to potential enrollees and enrollees. All Benefits Managers' interactions with callers will be provided in a timely, unbiased manner, in the caller's preferred language (via AHS' bilingual staff, Corporate Translation Unit and Language Line Services) and in accordance with the Project's policies and procedures.

We prefer the Call Center Benefits Managers have an Associate's degree, but the equivalent in job-related experience is acceptable. A minimum of two years' experience working in a call center and/or a health and human services position with consumer contact is required. Benefits Managers must consistently demonstrate exceptional interpersonal skills and a professional phone manner. They must be able to work under pressure, relate to a broad range of callers, and demonstrate cultural sensitivity. Bi-lingual language skills are a plus. (Please refer to Appendix J for this position's job description.)

We offer the State a talented team of Benefits Managers, who have worked as a team to achieve an impressive list of accomplishments that demonstrates their commitment to customer service, meeting the needs of BMS, and providing excellent service to potential enrollees/enrollees. These include but are not limited to:

- Supported callers who had questions about the pharmacy initiative and appropriately directed their calls for more information through our call center;
- Provided direction to the Medicaid expansion members for help with their questions on Medicaid eligibility and covered service effective with the January 1, 2014 start date;
- Provided Medicaid expansion callers with links to helpline resources to assist with co-pay and coverage questions;
- Exceeded all call center SLAs (e.g., blocked call rate, hold time, abandonment rate, etc.) each month; and
- Responded to a 76% increase in call volume in January 2014, due in part to adults who received coverage through Medicaid expansion effective January 1, 2014, while still maintaining impressive statistics (e.g., abandonment rate of 2.45% and hold time of only 10 seconds).

DID YOU KNOW?

Even when our call volume increased by 76% in January 2014, we still maintained an abandonment rate of 2.45% and an average hold time of 0:10.

We bring to BMS a team of experience Benefits Managers, all of whom have served the Project for at least one year. This longevity provides us with a strong knowledge repository to continue serving BMS' Medicaid potential enrollees and enrollees. Our staff are committed to serving potential enrollees and enrollees, bring an unmatched understanding of BMS, the State's Medicaid Programming, and the MHT and PAAS PCP enrollment and change processes.

Telephone Unit Training

Given the tradition of excellence BMS has experienced associated with the MHT Project (the Project has received rave reviews from callers, stakeholders, and has helped control costs by supporting enrollees in their enrollment with an MCO), it is imperative that the Contractor

operate the MHT Project in the best possible manner. Again, given the expansion of managed care populations served by the project, representing the MHT Project in a professional, unbiased, culturally sensitive manner not only supports high levels of enrollee satisfaction, but also a positive and successful experience with any new program implemented by BMS. Clearly a key factor in the Contractor's ability to do this is their ability to provide highly trained staff to the State. We are proud to provide BMS with a training program that will continue to meet the needs of the State.

Exhibit 130. Proven Approach to Training



Our approach to training ensures staff are equipped to perform job duties, empowered to cultivate a deeper knowledge-base, and assisted with furthering their education.

We hope that we have conveyed our understanding that attainment of the Project's objectives substantially depends on the capabilities of our front-line employees, and our commitment to providing training plans so that these objectives can be achieved. As a result, key ingredients of our approach to quality performance are:

- A structured initial orientation and training period that includes overarching project and position-specific instruction;
- Ongoing staff development ("refreshers" held bi-monthly, updates as warranted, and routine staff discussions about experiences and problems facilitated weekly by

management staff) and remedial training (instituted whenever prompted by monitoring); and

- Continuing education opportunities to keep staff interest and motivation levels high.

Each of these is briefly addressed in Exhibit 130 (above) and discussed in detail later in this Section.

Preparation of Training Materials for BMS' Approval

In an environment as dynamic and fluctuating as State Medicaid, BMS needs a vendor who can accurately provide potential enrollees and enrollees with timely, pertinent information needed to obtain quality healthcare. As such, we are committed to providing all training materials to BMS with ample time for review so that BMS may have confidence in our ability to meet the aforementioned objectives. We understand all training materials and relevant updates throughout the duration of the contract are to be reviewed and approved by BMS prior to the implementation of any such training materials. At a minimum, items to be included in our training curriculum and program include:



- **Training Agenda**: The Training Agenda will include the dates, times and locations for each training session, broken out by module.
- **Training Materials**: All training materials, including handouts, the Policies and Procedures Manual, PowerPoint presentations/slides, manuals, etc. will be included for review and approval.

Please note that the training agenda and training materials will include both those materials needed for the initial orientation as well as all materials developed for ongoing refresher trainings. The content of materials (described in the pages to follow) will reflect not only detailed information related to BMS and DHHR, the MHT Project and the programs it serves, but also all relevant processes and policies. Further, the materials submitted will include the content of the training modules as well as the educational objectives upon which they are based. As described below, we carefully construct each module around a series of objectives, which allows us not only to appropriately direct the content, but also clearly evaluate staff's attainment of each objective.

To ensure we are compliant in meeting these deadlines, all tasks related to training materials, development, and submission for approval will be included in our Implementation Plan (please refer to Appendix L for a draft plan) and will be tracked throughout the implementation period to ensure they are completed on time.

Additionally, we will maintain documentation to confirm our internal training, including curriculum, schedules and attendance. Should at any point during the course of the contract, BMS desire to see such documentation, we will promptly provide for review.

Initial Training/Orientation

Any new staff hired during the contract will complete a two-week initial training/orientation program. This will be offered under the auspices of our Corporate and key project management staff. While our staff will be in charge of these sessions, DHHR/BMS personnel, and other key stakeholders may be invited to serve as faculty in the initial training (as well as the ongoing staff development sessions). Such opportunities not only build collaborative relationships, but also increase BMS' confidence in our abilities.

Because some external candidates will be hired to serve the MHT Project on an ongoing basis, we provide a comprehensive two-week new hire training and orientation to these staff. This training introduces and welcomes new staff to AHS. It also addresses critical information, operational processes, customer service skills, systems training and other modules needed to successfully serve the MHT Project. However, all such training is provided at an appropriate pace so that staff are best able to learn the vast program information provided and hone essential systems and customer service skills.

While extensive training is provided on all relevant topics, the primary goal of all training is to ensure Project staff are equipped to provide excellent customer service that meets BMS' needs and provides potential enrollees and enrollees with unbiased education and assistance in the enrollment, disenrollment and change process. These items, other project-specific information, and standard corporate training information, are fully integrated into our training as described in Exhibit 131.

Exhibit 131. Training Curriculum Topics

The MHT Project. Several modules summarize West Virginia's Medicaid programs, particularly the MHT and PAAS Programs. The sessions also address history of the State's Medicaid programming, program-specific eligibility criteria and the populations served, and the participating MCOs. In addition to understanding the roles of BMS and AHS in this Project, staff also learn about Medicaid (Federal and State) and managed care. BMS' goals, mission and structure of the managed care program is addressed. Our approach is to involve DHHR, BMS and other program staff in this segment, inviting guest speakers to answer questions and provide opportunities for staff in the various efforts to meet their counterparts.

Program- and Position-specific Education. After staff have received overarching training regarding the MHT Project and its Medicaid managed care programming, specific training is provided in various "break-out sessions" so that staff are presented with and have more opportunity to process more detailed information specific to each trainee's position. (For example, breakout sessions are held for Call Center Benefits Managers and Field Benefits Managers.)

HIPAA 101. Although the importance of maintaining confidentiality is integrated throughout the various training modules, this module reinforces the importance of protecting all information with which staff are trusted. HIPAA and the HITECH Act are discussed. Staff become more familiar and comfortable with relevant terminology. Policies and procedures to ensure information is protected and kept confidential are presented, as are repercussions for breaches. At the close of this module, staff sign and return a confidentiality statement to AHS.

Quality and the Customer. Staff learn the definition of "quality" and begin to understand the concept that a customer is anyone who interacts with people within our organization. This module reviews the elements of good customer service (Reliability, Responsiveness, Empathy, Tangibles, and Assurance) and the cycle of improvement (Define, Measure, Analyze, Improve and Control) for use in managing their daily work. They also have the opportunity to explore specific ways they can provide customers with excellent service in their specific roles.

Collaborative Work Skills (Interpersonal and Team). This module provides a framework for communicating with employees both internal and external to our organization. It discusses the essentials of building relationships, conducting effective meetings, and constructively approaching and resolving conflict situations. Principles of stress management are addressed to help staff remain calm and well organized when working.

Embracing Difference (Diversity). This module heightens awareness and appreciation of differences among coworkers and Enrollees/Potential Enrollees by making staff aware of their own prejudices and apply the "Platinum Rule", i.e., treating others the way **they** want to be treated, instead of the way **we** want to be treated. It also addresses strategies and factors to consider in relating to people with other values, languages, cultures, disabilities or experiences. As available, guest speakers from local agencies who represent our enrollee populations may be invited to share their insights and expertise with staff. We similarly provide training on remaining calm and delivering excellent customer service in difficult situations.

Special Needs Populations. We provide staff with an understanding of various special needs populations, including homeless and homebound individuals, and persons with physical, sensory and/or cognitive disabilities. Methods to best serve these individuals are provided as well as the importance of additional factors (including the role of health care needs and chronic illnesses) that may need to be considered in making a best fit MCO and provider selection.

Health Literacy. Through this module, staff learn the definition of health literacy and how it factors into the enrollment process. Staff learn how to promote understanding of Medicaid delivery systems and enrollment-related concepts such as MCO and provider selection and navigating the healthcare system, in a culturally competent, sensitive manner.

Enrollment Process. Several modules cover the details of the enrollment process for MHT enrollees, including time frames, requirements, scripting, internal controls, and reporting. Enrollment in special circumstances (e.g., foster children) and factoring in enrollee health care needs is also discussed. The role of third party liability is explained and discussed in this module as well. Member outreach and enrollment materials, including the health needs assessments, are

provided and discussed in detail. Particular emphasis is given to the role of objectivity and staff understand they are never to recommend one MCO over another. Scripts and call flows are fully addressed as part of these topics.

Enrollment Systems. Provided in conjunction with the Enrollment Process module, several sessions address hands-on mastery of HealthTrack. For the new contract, this will include using the Choice Drivers and logging all activities in HealthTrack. It also provides instructions on all other HealthTrack related features such as using My Tasks, Case Tasks, accessing mailing history, etc. Explanations of using relevant State systems (e.g., MMIS and RAPIDS), the various screens and data field requirements are provided as are the basics of word processing and spreadsheet applications. Staff are provided with ample opportunities for hands-on practice with the HealthTrack system in order to perfect their skills.

Phone and Communications Systems. Participants are given hands on opportunities to explore the full features of the phone system, including call transfers and referrals, hold features, TTY and accessing AHS' Internal Translation Unit and Language Line Services.

Processing Complaints. This module will provide an explanation of procedures to resolve and process complaints. Staff will be provided with an explanation of how to work with enrollees who have complaints (including techniques to speak with callers who are angry), processes to forward complaints as appropriate (i.e., to the MCOs as needed), and using the HealthTrack complaint module to document all complaints.

Other topics as required.

Please refer to Appendix M for sample training modules currently incorporated into the Project. Again, in the new contract, we will revisit all training materials and make appropriate modifications (e.g., documenting all Project operations in HealthTrack) as needed. All new materials will be resubmitted to BMS for approval.

Training Provided during Staff's Initial Weeks Taking Calls

Once the initial training is complete and staff have passed the assessment (discussed later in this section), staff members are still supplied with additional support to complement and reinforce content learned during training. The Project Manager and Supervisor are available to answer any questions that arise, monitor performance and provide feedback to improve performance as necessary and appropriate.

In fact, the Supervisor is responsible for providing answers to questions and mentoring to newly hired staff on an ongoing basis. When new staff are trained and seated at their stations, they are carefully positioned to have close proximity experienced staff. This positioning also gives the Supervisor an additional vantage point of being able to observe the activity and progress of new staff.

Ongoing Training

The major purpose underlying our Ongoing and In-service Refresher Trainings is to keep job performance, skill and interest levels high; data from Project monitoring and employee evaluations are used to shape these trainings and maintain their relevance to ongoing quality improvement efforts. Therefore, these sessions feature presentations by Corporate and Human Resources staff, Project management staff and/or guests, and are conducted bi-monthly. In conjunction with shorter ad hoc and periodic meetings, these trainings provide all staff with the most current Project information. As we are committed to enhancing staff's cultural competency, health literacy, and knowledge of the communities served, we supplement the trainings described above by offering staff the opportunity to attend appropriate presentations in the community. As with all initial training materials, ongoing training materials and refresher training materials (including changes to materials) will be submitted to BMS for approval prior to use.

Our ongoing training is broken out into three separate components:

1. Quality Improvement Training,
2. Certification Component, and
3. Routine Ongoing Training.

Quality Improvement Training

To continue to keep quality high, all staff will be closely monitored. (For additional details on our approach to monitoring, please see Section 4.2.20.) Monitoring will address several areas including customer service components (e.g., used the proper greeting, offered language line/interpreter services, correctly assessed the caller's needs and offered assistance appropriately, thanked the caller for calling, etc.), and enrollment/PCP processing (e.g., correctly followed scripts in HealthTrack, appropriately processed MCO and PCP selections, etc.). All monitoring will be documented and for any area where staff members are deficient, supplemental training will be provided to correct the deficiency.

To ensure consistency of supplemental training to improve quality performance, we will develop a series of standard training modules/presentations that reinforce key concepts for each area of the quality improvement monitoring. Training will be conducted in either individualized or group sessions, as appropriate, and will occur within five days of the completion of the monitoring. Employees will be provided with an opportunity to ask questions and seek clarification on any items that were missed. From there, as mentioned in our QA Plan, staff will be monitored more frequently to ensure deficiencies have been corrected.

Certification Component

To motivate staff and supply the job enrichment that supports retention, we have also developed and implemented in-house, Project-specific Certification Components for Call Center staff as part of the ongoing development of our workforce that we will employ for Benefits Managers.

The Project-specific Certification Component, to be refined under the auspices of State, corporate, and Project management staff, rewards these essential staff and helps them obtain a deeper understanding of Project information and commitment to quality customer service.

Exhibit 132. Certification Component Overview*

	Basic Level	Intermediate Level	Advanced Level
Definition	Basic knowledge of Project protocols	More in-depth understanding of Project protocols and standards	Evidence of ability to critically analyze complicated enrollee/potential enrollee interactions and assist management to meet or exceed Project standards
***(potential)* Standard/ Measurement for Certification**	• Completion of Basic Training modules as evidenced by the 'Basic Training Checklist' in personnel file • Basic Level Test - passing score of 90% or above**	• Completion of 6-8 week Friday seminar classes • Passing score on Intermediate Level Test - (% TBA)	• 11 months of Project experience • Passing Score on Advanced Test • Evidence of at least 3 of 6 'Leadership Skills' • 6 months of achieving successful Call Center standards
Documentation	Certificate of Achievement	Certificate of Achievement	Framed Certificate of Achievement
Training provided at this level	All-staff trainings and Q&A seminars	Tailored topical training seminars as announced	Advanced seminars with outside speakers on relevant topics of interest
Role of Call Center staff at this level	Share responsibility for maintaining queue and work to better personal statistics	Share responsibility for maintaining queue; assist in new staff orientation and offer suggestions to enhance operations	Share responsibility for maintaining queue and act as a mentor with staff
***(potential)* HR Classification**	Benefits Manager 1	Benefits Manager 2	Benefits Manager 3
Other		Seasoned staff (employed 6+ months) may test out of this level if desired	Other 'perks' TBA

* A Project-specific Certification Program will be developed under the auspices of Department, Corporate, and Project management staff.

** Continued employment will be contingent upon successful test completion by 3rd attempt.

The Certification Component consists of three nested units and is to be implemented incrementally – providing staff the opportunity to train, test and become certified at "Basic," "Intermediate," and "Advanced" levels, as shown in Exhibit 132. Certification Component Overview. This is an approach we have implemented in our other contracts to motivate and keep our best employees; it has proved very worthwhile and demonstrates our commitment to promoting Project staff while fostering continual growth and learning throughout their tenure with us.

Aside from Project-specific trainings, our Human Resources Department requires front-line staff to attend mandatory and "elective" in-house training sessions via our Professional Development Series. Course credits are awarded for successful completion of each training session; staff are required to earn six credits per year. While four credits are earned by completing mandatory programs, the remaining credit balance is earned by participating in elective sessions. Offering elective sessions allows staff to customize training to their own interests, needs, etc.

AHS staff are encouraged to continue their education outside of our in-house training initiatives. After one year of employment, all staff are eligible to receive an educational stipend (AHS' Tuition Assistance Program), to off-set the cost of taking academic courses. In order to qualify for tuition assistance, a course must be directly related to the position currently held by an employee or to a position to which that employee may reasonably aspire. Staff may be reimbursed for courses which are not job related when the course is required in either an undergraduate or graduate degree in a job-related field.

Routine Ongoing Training

Routine ongoing trainings are provided on both a quarterly and monthly basis. Such trainings foster team building, allow the staff to celebrate joint accomplishments and be updated on new initiatives and relevant topics. Geared to all staff, we follow the same approach of carefully building training modules around structured objectives and provide high quality materials for routine trainings.

Also, for any new program or population that is incorporated into the program, we will develop and deliver appropriate training. For example, if the Medicaid expansion population is incorporated into MHT, we will provide training on the eligibility criteria as well as the delivery system that is currently in place (i.e., fee-for-service), so our staff are able to help new Medicaid eligibles understand how to access care in the managed care environment relative to the fee-for-service environment. As another example, as shown on the following page, in 2013, we contributed to the development of the "Fast Facts" handout to help staff understand the pharmacy transition to managed care and conducted training sessions so our staff were equipped to help enrollees, providers, and stakeholders with their pharmacy-related questions.



DID YOU KNOW?

Our staff have already started providing assistance to the Medicaid expansion population – we provide resources and referrals to help answer their questions concerning benefits, coverage, and application procedures.

Exhibit 133. "Fast Facts" Handout

Prescribing Providers

Mountain HEALTH TRUST

Fast Facts for Prescribing Providers on the Pharmacy Transition to Managed Care

Effective April 1, 2013, West Virginia Mountain Health Trust members will begin receiving their pharmacy benefits through their managed care organization (MCO). As the MCOs currently handle the majority of the program's offered benefits, this change should ensure access to needed prescriptions and improve coordination of health care for members.

All providers, including out-of-network providers, will need to ask members for an MCO identification card to verify Medicaid and MCO enrollment. Members will not be responsible for any copayments.

Overview of Changes

Same as Under FFS	Changes from FFS
Payment and Billing	
▪ All MCOs support e-prescribing	▪ Each MCO has their own established procedures for electronic processing of claims
Benefit Coverage	
▪ MCOs will follow all drug selections including preferred/non-preferred statuses and criteria on the State's Preferred Drug List (PDL)* ▪ Beneficiaries will continue to access the following services through the fee-for-service Medicaid program: o Non-emergency transportation o Long-term care o Behavioral health (except prescriptions) o Children's dental ▪ Members enrolled in the Adult Basic Benefits Package will be limited to four prescriptions per month with some exceptions (see individual MCO plan description) ▪ Hemophilia medications will continue to be covered under Fee-for-Service	▪ MCOs may implement their own policies for prescribing drugs not on the State's PDL
Accessing Services	
▪ Mail order pharmacies will not be utilized ▪ Pharmacies will be required to dispense emergency 3 day prescription supplies in accordance with the Federal regulation	▪ MCOs will use their own pharmacy lock-in programs based on their own criteria ▪ For the first the 90 days after implementation, the MCOs will be required to provide any previously approved prescriptions

* The PDL is available at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pdl.aspx

By providing staff with easy-to-use handouts and ongoing training and collaborating with various partners (i.e., the Lewin Group) to develop them, we prepare staff and stakeholders to continuously respond to BMS' emerging needs and program changes.

Appropriate specialized training modules will be developed throughout the contract (e.g., on the inclusion of the SSI population, etc.).

Delivering Training

Training is supplemented with a handbook of valuable information and resources. All training materials are carefully developed and scrutinized to ensure they:

- Are easy to read,
- Include ample white space,
- Do not contain distracting colors, and
- Use graphics appropriately.

Geared to the adult learner, active strategies are key; even the didactic sessions are highly interactive and the educational process becomes even more dynamic as the training proceeds. For example, while PowerPoint presentations are used in many modules and included in the training manual, they are supplemented with discussions, and question and answer sessions.

Further, as content is absorbed by the employees, phone/computer competency is developed through exercises utilizing a library of screens and the HealthTrack application. Training progresses to the actual application and practice of computer skills in the training environment of HealthTrack. The training culminates in video-taped role playing using the scripts, HealthTrack application, and the skills learned for in- and out-bound calls and individual/group interactions. The "textbook" for training and the source for their desk-top reference, updated as changes occur, is our Policies and Procedures Manual, encompassing all aspects of training.

We Have Creative Training Strategies

- Particularly during busy implementation periods we have found there is tremendous value in offering 15 minute "mini" training sessions at the start of each day. These sessions:
  - Reinforce key concepts,
  - Address common questions,
  - Begin the day on a positive note, and
  - Foster team building.
- We have also ended training days with fun and engaging games to review critical concepts. Of note, "Jeopardy" and "Who Wants to be a Millionaire" are staff favorites.

Ensuring the Quality of Training

The importance of quality staff performance is introduced to all staff even before they are hired; sharing highly specific job descriptions is part of the interview process. Once hired, the rationale behind optimal job performance and ongoing evaluation by management personnel is presented to new staff during their initial orientation. Guided by our tested curriculum, initial training familiarizes newly-hired employees with AHS, ensures all staff understand the goals of the Project, and provides hands-

on, position-specific training including "quality" customer service and programmatic information.

As mentioned earlier, all modules are designed to ensure the appropriate topics are covered and are developed around a series of objectives. We build objectives around 'SMART' principles, which ensures modules and objectives are:

> **S**pecific: We ensure the criteria are clearly spelled-out and identify what percent of participants must meet the criteria and how they must demonstrate it has been met. For example, an objective of "Participants will understand the enrollment process" is too vague to assess.
>
> **M**easureable: We ensure the criteria can be measured. The example above provides no criteria that could be measured.
>
> **A**chievable: We ensure that based on our experience, the participants can feasibly achieve the objective.
>
> **R**ealistic: We ensure that it is realistic to expect participants to meet the stated objective based on the training methodology and time allocated. For example, it is not realistic to expect training participants to correctly process an enrollment in HealthTrack after only seeing screenshots and not having time to practice in a test environment.
>
> **T**ime-Specific: We ensure the time is clearly specified. For example, will participants be required to demonstrate a skill at the end of the session or at the end of the entire two-week orientation?

For each module we carefully craft a series of objectives based on these principles (approximately three to five objectives for each module), which then serve as the basis for the evaluation criteria at the end of the module. While hardly a comprehensive list, sample objectives for the Enrollment Systems module are provided below:

> **Objective 1**: At the conclusion of the session, 100% of training participants will be able to successfully demonstrate all actions necessary to log a call in HealthTrack.
>
> **Objective 2**: At the conclusion of the session, 100% of training participants will be able to successfully demonstrate all actions necessary to process a PAAS PCP enrollment in HealthTrack and MMIS.
>
> **Objective 3**: At the conclusion of the session, 100% of training participants will be able to successfully demonstrate all actions necessary to process a Health Plan change in HealthTrack and MMIS.

By building the training modules around a series of objectives, we also benefit from having an unbiased, objective basis to determine employees' understanding and mastery of the skills for

each module. Because we use these objectives as the foundation for evaluation at the conclusion of every module and address deficiencies at that time, not merely at the end of the entire training, we ensure that at the conclusion of the initial training, staff are fully prepared to be successful in their post-training evaluation (described in the following pages). Based on staff's attainment of each objective, should additional training be needed to more fully address a topic (either at the individual or group level), such training is provided at that point in time, which prevents staff from growing further behind when information is presented that builds on the topic that was not understood.

Assessing Staff Readiness Post-Orientation

We use both formal and informal mechanisms to assess employees' readiness during the orientation period. Informal mechanisms will occur throughout the training and will include such items as:

- **Discussions Concerning Covered Material**: Simply taking the time to speak with employees during the training about the topics that have been addressed, their interpretations of the material and their comfort level with the items presented, provides trainers with the opportunity to identify areas where additional training is needed;

- **Question and Answer Sessions**: Conducting question and answer sessions at the conclusion of modules provides the trainers with an opportunity to identify areas where staff clearly understand the information presented and those where additional clarification is needed;

- **Role Play Sessions**: Towards the end of training, participants are placed in groups and participate in a variety of role-play scenarios. Such scenarios allow participants to demonstrate good customer service skills and practice adhering to a script while completing all necessary tasks in HealthTrack. Not only will the sample "enrollee" (i.e., the participant playing the role of the enrollee) provide feedback to the employee, but the Project Manager and Supervisor will also be available to provide additional feedback – both positive and constructive; and

- **Games**: While commonly used as a fun tool to review critical concepts, playing games such as 'Jeopardy' or 'Who Wants to be a Millionaire?', also helps the Project Manager identify topics where additional training or review may be needed.

We Have Experience with Post Test Assessments

As part of the Florida Medicaid Reform Enrollment Broker Project, we coordinated the certification of all Choice Counseling Specialists with Florida State University, who is responsible for administering the certification assessment to all Call Center and field staff.

While none of these mechanisms is a test in and of itself, each provides an opportunity for the trainer to gauge

participant understanding and make modifications, review critical material, conduct additional sessions as needed – prior to the conclusion of the orientation. By doing so we not only ensure employees are fully prepared to perform their jobs, but we also ensure a high percentage of participants pass the final post-test assessment on the first try.

We also use a formal post-test assessment to determine staff readiness in the new contract. Earlier in this section, we mentioned that modules in the new contract are built around learning objectives. These objectives will serve as the basis for the final post-test assessment. The post-test assessment will include two parts:

1. Written exam, and
2. Successful demonstration of HealthTrack and MMIS proficiency.

The written exam will be highly comprehensive and cover all learning objectives and topics presented in each module. We will use a variety of assessment strategies in the post-test assessment (e.g., multiple choice, fill-in-the blank, etc.). Separate from the written assessment is a practical test where participants are required to demonstrate their proficiency with HealthTrack and MMIS. As part of this practical exam, we will create various scenarios pertaining to enrollments, Plan changes, disenrollments, etc. that participants will be responsible for processing correctly in a training environment of HealthTrack. The history within HealthTrack's training environment can then be accessed so participants can see what items were missed. In addition, data can be summarized so the trainer can identify common elements that were missed among the class and conduct additional trainings if needed. Such feedback is particularly helpful for the trainer, who may elect to make future modifications to the training based on post-assessment results. All participants must meet 80% to pass the post-test assessment. Participants who do not meet the 80% threshold will be given an additional opportunity to take the post-test assessment.

4.2.16 Dignity and Respect for Callers' Need for Privacy

Procedures to ensure that telephone operators treat all callers with dignity and respect the callers' need for privacy.

We offer BMS a comprehensive approach to ensuring Benefits Managers treat each call with dignity, respect, and privacy protection. Our approach to doing so is comprised of the following components:

1. Customer Service Training,
2. Confidentiality Guidelines, and
3. Approach to HIPAA.

DID YOU KNOW?

We developed a "Confidentiality Guidelines Tip Sheet" that we regularly review with staff as part of our ongoing training.

Customer Service Training

In the previous section we discussed in detail our comprehensive approach to training, which is designed to train staff on not only all program and systems knowledge, but all provide staff with the tools and techniques they need to deliver outstanding customer service in order to ensure all callers are treated with dignity. Critical modules of our training approach are described below in Exhibit 134 (please refer to Section 4.2.15 for a comprehensive discussion of our training programs). These topics are also discussed on an annual basis as part of our ongoing refresher training.

Exhibit 134. Customer Service Training

Module	Summary
Quality and the Customer	The elements of good customer service (reliability, responsiveness, empathy, tangibles, and assurance) are discussed.
Embracing Diversity	The awareness and appreciation of differences is stressed. Staff also learn the golden rule of customer service (i.e., treating customers the way they want to be treated, not the way we want to treat them).
Special Needs Populations	The various needs of special needs populations are discussed as are methods to best serve these individuals.

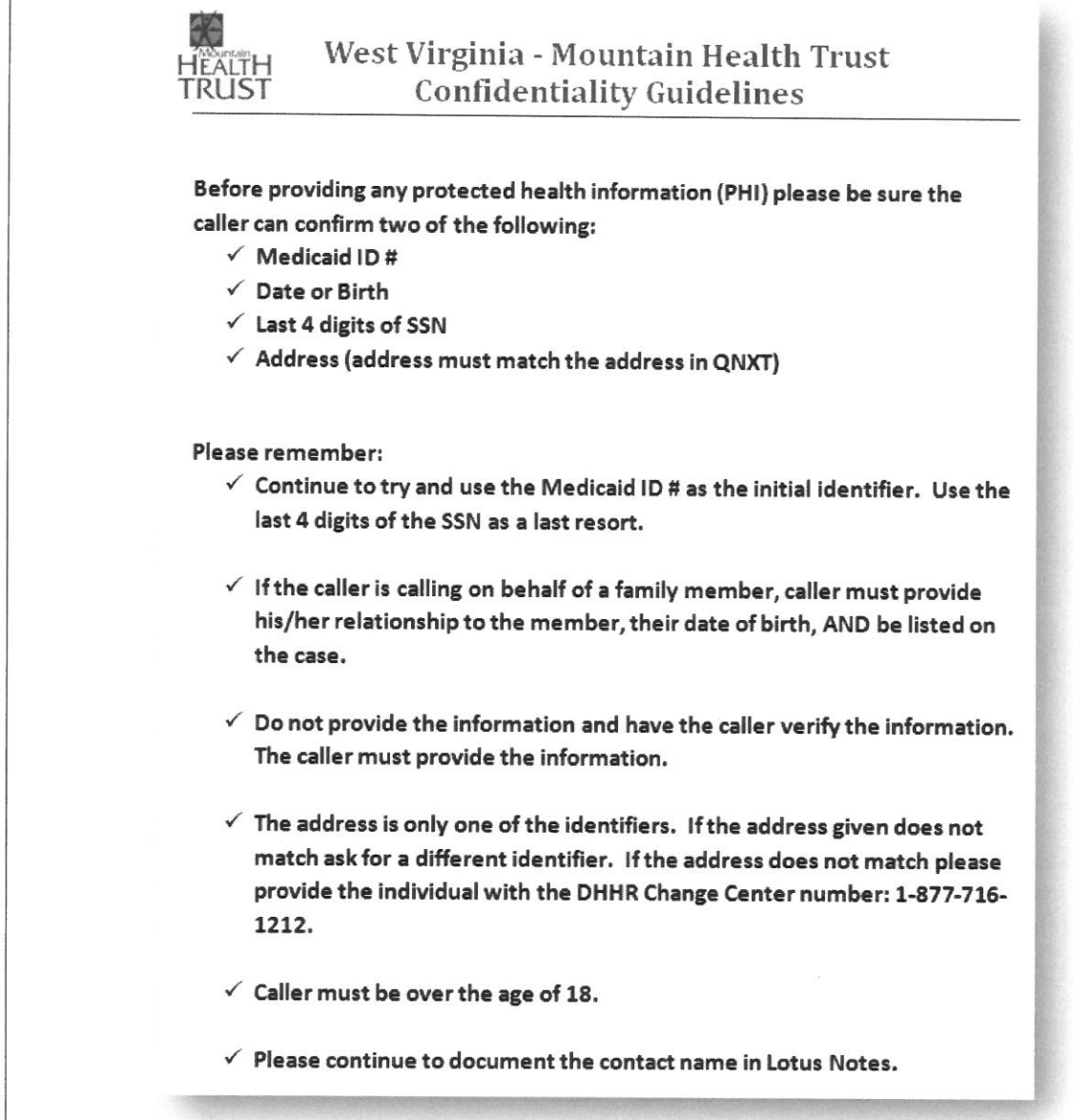
We provide regular training to equip our staff to treat each call with dignity and respect.

Confidentiality Guidelines

We have developed Confidentiality Guidelines (described below in Exhibit 135) and have integrated them into Project operations. We regularly review and update our Confidentiality Guidelines – in fact, they were updated in March of this year! All staff are trained to adhere to these guidelines. Briefly, all staff are instructed that no protected health information can be released without the caller providing at least two of the following:

- Medicaid ID Number,
- Date of Birth,
- Last four digits of the Social Security Number, and
- Address that matches the address in MMIS.

Exhibit 135. Confidentiality Guidelines



Mountain HEALTH TRUST

West Virginia - Mountain Health Trust
Confidentiality Guidelines

Before providing any protected health information (PHI) please be sure the caller can confirm two of the following:

- ✓ **Medicaid ID #**
- ✓ **Date or Birth**
- ✓ **Last 4 digits of SSN**
- ✓ **Address (address must match the address in QNXT)**

Please remember:

- ✓ **Continue to try and use the Medicaid ID # as the initial identifier. Use the last 4 digits of the SSN as a last resort.**
- ✓ **If the caller is calling on behalf of a family member, caller must provide his/her relationship to the member, their date of birth, AND be listed on the case.**
- ✓ **Do not provide the information and have the caller verify the information. The caller must provide the information.**
- ✓ **The address is only one of the identifiers. If the address given does not match ask for a different identifier. If the address does not match please provide the individual with the DHHR Change Center number: 1-877-716-1212.**
- ✓ **Caller must be over the age of 18.**
- ✓ **Please continue to document the contact name in Lotus Notes.**

We have implemented Confidentiality Guidelines into Project operations and trained staff to adhere to them during every call. These Guidelines will be revised and updated in the new contract (e.g., information will be documented in HealthTrack, not Lotus Notes).

We will revisit these guidelines in the new contract to ensure they are in alignment with all operations (e.g., appropriate documentation in HealthTrack, etc.).

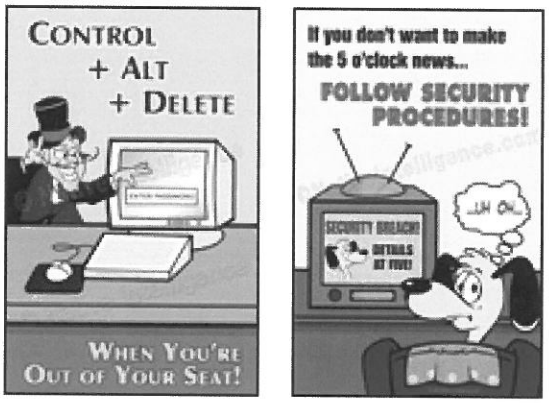
Approach to HIPAA

We further bring to the Project a robust approach to ensuring adherence to all HIPAA requirements, which ensures we protect enrollee confidentiality through all aspects of Project operations. We recognize the importance of our work and the data to which we have access. Our systems design as well as policies and procedures reflect the significance that we place on information security and integrity. Further, the HIPAA Privacy and Security Rules provide protection for all personal health information held by covered entities (BMS) and their Business Associates, of which we are one. As such, we ensure that its data systems and policies and procedures adhere to both federal, BMS, and State requirements as they relate to the security, integrity, and confidentiality of Protected Health Information (PHI).

We understand that HealthTrack must protect the confidentiality of all information. We would like to provide BMS with a description of our plan to ensure the operation of all aspects of the MHT Project are performed in accordance with State and federal regulations and guidelines related to security and confidentiality and meet all privacy and security requirements of HIPAA regulations. We have always complied with all State and federal regulations and guidelines related to security, confidentiality, and HIPAA regulations, and will continue to do so.

HIPAA Compliance

Exhibit 136. HIPAA Compliance Posters



We post friendly reminders throughout our offices to remind our staff to protect PHI.

For the MHT Project, we will comply with all applicable requirements of Public Law 104-191, the Health Insurance Portability and Accountability Act and all subsections in the fulfillment of our duties in the administration of the Project. We have developed corporate wide privacy and security policies that apply to all of its current contracts. All of our employees are required to complete a HIPAA training module that covers the privacy and security rule requirements and the specific policies and procedures that must be followed by AHS employees. In addition to initial training, HIPAA/privacy trainings also occur on an ongoing basis (annually at a minimum) and are part of our corporate culture. Articles pertaining to privacy protection are regularly published in AHS' corporate newsletter, and posters promoting HIPAA compliance and privacy protection are displayed throughout Project offices.

We recognize that all information we collect or have access to is considered confidential under both state and federal statutes. Further, there are specific confidentiality, privacy and security requirements concerning Protected Health Information (PHI) contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Balanced Budget Act of 1997, and the HITECH Act of 2009. We agree to abide by all such requirements in the operation of the MHT Project, and assure BMS that all staff will receive training on these issues. Additionally, all members of our team will ensure that any personal electronic device that captures and saves any information (for example, personal computers, palm pilots, copy machines, etc.) will not be used for this Project or will have all files deleted and/or erased prior to their disposal (meeting all HITECH data destruction standards), or any other disposition as may be required.[21]

To demonstrate our support of these critical principles, the overarching statement of our privacy policy is included herein:

"It is the policy of AHS to regard any data containing individually identifiable information obtained from any source, and in any format to be confidential, and should, therefore, be used only for the purpose(s) for which they were obtained. Further, it is AHS' policy to maintain such individually identifiable information in a secure environment that limits unauthorized access to these data to the maximum extent possible."

Also, our employees must understand and agree that in the performance of their job duties, and after employment at AHS, they must hold in confidence all medical, social, enrollee or other company business related information. All information contained in any state database is confidential and should not be divulged to or discussed with friends, co-workers, family, etc. An employee assigned a special task, assignment, or project must keep all information regarding that project confidential. In addition to project-related information, employees should be respectful, and refrain from discussing (i.e., with outside parties) any business or personal conversations that may be overheard or witnessed between co-workers and/or management. Employees may use a company owned computer terminal and/or laptop only for the specific authorized functions associated with the performance of their job duties.

Due to concerns over privacy, confidentiality, security, and sensitivity, use of the photographic capabilities of personal camera and video cellular telephones is prohibited at AHS worksites. Use of this technology is also prohibited while an employee is conducting official AHS business away from an AHS facility. This policy does not forbid normal voice use of cellular phones; however it prohibits the use of camera-related technology while in AHS work settings.

Further, in accordance with any Business Associate Agreements as defined in 45 CFR Subpart A §160.103 Definitions of the HIPAA Privacy Rule, we will not disclose, or cause to be disclosed, Protected Health Information (PHI) obtained from any individual in the course of carrying out its day to day activities to any person or entity, unless for treatment or payment activities of other

[21] Please note, no PHI is ever stored locally on any desktop or laptop computer.

covered entities or other health care providers, and for certain health care operations for other covered entities. Further, any PHI disclosed to a covered entity must be limited to the minimum necessary to accomplish the intended purpose.

To comply with the requirements of this section and the specifics contained therein, we will employ a combination of management oversight, documentation, and specific policies and procedures related to meeting the specific requirements of applicable law. We routinely perform background checks on new hires. Further, all employees are required to read and sign a confidentiality agreement pertaining to the maintenance of confidentiality and security of all project information, and that any inappropriate disclosure of or false claims made about such information will result in dismissal and possible legal action.

We are particularly sensitive to the necessity of maintaining confidentiality of any and all information associated with a given project. To that end we have signed Business Associate Agreements (BAAs) with every state in which we do business, including West Virginia.

Much of our approach to protecting the confidentiality of data and adhering to all HIPAA and HITECH requirements is established through the following measures:

- System Controls for Information Integrity,
- Audit Trails,
- Access Management,
- Prevention of Unauthorized Access through,
    - Policies and Procedures,
    - Physical Security,
    - Network Security
    - Laptop Security
    - Application-Level Security,
    - Staff Monitoring, and
- Robust Approach to Dealing with a Breach.

4.2.17 Oral Translation Services

Procedures for providing access to oral translation services that can be used to answer questions and provide information to enrollees who do not understand English.

Approach to Providing Translation Services

To assure the Project's messages are correctly received, we employ personnel and procedures to accommodate participants who speak languages other than English or Spanish. Resources for these callers are currently available (and will continue to be available) for the MHT Project. These resources will be provided at no cost to the caller and will be provided "on demand." That is, the caller will be connected to the resource immediately upon identification of need and will not be required to make a separate telephone call. Using two approaches, we ensure all contacts with callers will be conducted in a language understood by the caller.

We have a strong history of hiring bilingual operators across all our Projects; we currently have bilingual operators who provide services in:

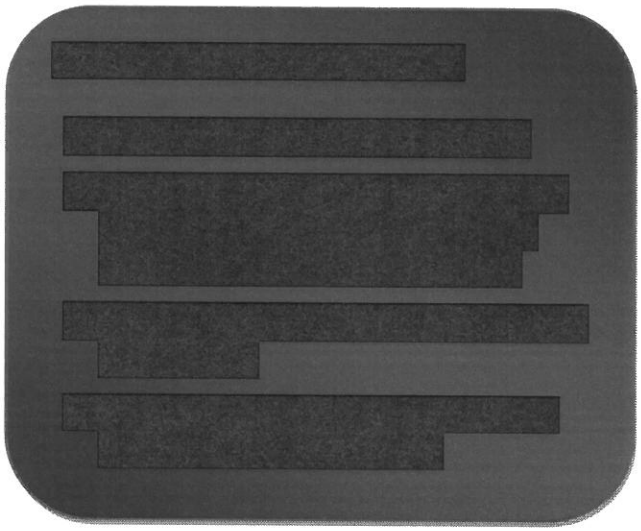
- Amharic
- Arabic
- Cantonese
- Creole
- French
- Hmong
- Mandarin
- Polish
- Russian
- Spanish
- Tigrigna
- Vietnamese

- For non-English-speaking callers, our bilingual Benefits Managers will assist callers speaking several other languages. Please note, we have always been committed to providing bilingual Benefits Managers to serve the MHT Project, even though we were not contractually obligated to do so. We look forward to continuing this tradition in the new contract and providing bilingual services through bilingual Benefits Managers.
- For those who need assistance in other languages not spoken by a bilingual Benefits Manager, [redacted] or Language Line Services (formerly operated by AT&T), which provides interpretation for 170 languages.

[redacted]

With regard to meeting the needs of the non-English speaking population, we go several steps beyond what may be expected of a vendor. As highlighted in the text box, we have a strong history of hiring bilingual staff, and will provide a Spanish-speaking Benefits Manager. We will actively seek out bi-lingual Benefits Managers where possible.

[redacted]



[redacted]

[redacted]

Further, we assure that **information is presented to consumers in a manner that recognizes ethnic diversity and is sensitive to cultural differences.** Again, our staff training plan includes a strong cultural competency component. We have known for some time the importance of this competency, and have made every effort to assure that our staff are proficient in this area. In our approach, our understanding of two principal challenges (culturally relevant and educationally appropriate presentations) guides our decisions about the selection of Project staff, their training, the content of potential enrollee/enrollee interactions and the process of outreaching and assisting callers. For additional information regarding staff training, please refer to Section 4.2.15.

Our approach not only allows us to meet all potential enrollee/enrollee needs in a cost effective manner, but it is fully compliant with all Federal guidelines and ensures no individual under the age of 18 delivers interpretation assistance.

4.2.18 Special Services to Accommodate Medicaid Members

The Vendor should address in its proposal how it plans to provide special services necessary to accommodate Medicaid members. Special services may include, but not be limited to teletypewriter (TTY) line translation services, assistance for the blind/literacy challenged, and program fact sheets in different languages for prevalent non-English members as defined in 42 CFR 438.10 (c).

In order to meet the goals of the Project, BMS needs a vendor who can provide high quality services to all potential enrollees and enrollees served by the Project in order to:

- Ensure a "best-fit" MCO or PAAS PCP selection that meets the needs of the enrollees on the case;
- Promote satisfaction with the MHT Project;
- Promote satisfaction with the Medicaid program in general;
- Provide a low change rate;
- Ensure the enrollee is enrolled with an MCO or PAAS PCP that is well-prepared to meet their needs; and
- Promote optimal health outcomes.

We are proud of our ability to help BMS meet these goals. Our approach to providing special services involves the following three elements:

1. Services to the hearing-impaired,
2. Services for the visually impaired, and
3. Program fact sheets in various languages.

Services for the Hearing-Impaired

In the new MHT contract, we will continue to use a two-fold approach to serve hearing-impaired callers. First, we will continue to make TDD/TYY services available to any caller needing this service. Second, we will continue to provide assistance to hearing impaired callers via Relay services.

We currently provide assistance to hearing-impaired callers via TDD/TTY devices in our West Virginia, Illinois, Florida, and Ohio Projects. Relay services, however, are available through all of our contracts, including MHT. **We have found that hearing impaired callers often prefer using Relay Services and we are pleased to be able to provide assistance in the manner that is most helpful and beneficial to them.** The benefits of using Relay Services are:



DID YOU KNOW?

Our two-fold approach to providing services to the hearing-impaired (comprised of TTY and Relay Services) exceeds the requirements of the RFP.

- There are a variety of options the Call Center can use depending on the callers' needs (e.g., voice users, voice carryover, speech to speech, ACSII, and Telebraille),
- The MHT Call Center staff is empowered to manage the call in real time at the moment it comes through the queue by conferencing with the Relay Service.
- The Relay Service has training on how to manage the call and can guide both the caller and the call center staff through the call more efficiently,
- All calls are confidential by federal law, and
- Hearing impaired callers are familiar with using the Relay Service.

Regardless of the method chosen by the caller or Relay Services, we will continue to provide education, counseling, and enrollment assistance that best meet callers' needs. As with all services, no cost associated with the TDD/TYY or Relay Services will ever be passed on to any caller.

Services for the Visually Impaired

For the vision-impaired, we will continue to offer assistance and support via the Call Center, and will offer recorded information on a CD to any caller who requests it. Additionally, we will place audio recordings on the MHT website as well as links to print copies of narratives for families/friends to access if interested. Our audio recordings adhere to key principles for enhancing comprehension. Specifically, we:

- Provide an interesting introduction in order to retain the listener's interest,
- Break information into small segments to avoid one long monotone recording,
- Modulate the narrator's tone in a subtle and professional manner and also avoid overly dramatic readings,
- Ensure the narrator speaks in a clear voice,
- Ensure no background noise can be detected, and
- Avoid unnecessary/distracting sound effects.

Program Fact Sheets in Various Languages

As described in detail in Section 4.1.2, we will continue to monitor the language usage across the State of West Virginia to identify prevalent non-English languages, and will provide a comprehensive approach to providing Project communications in prevalent non-English languages, including via our internal Translation Unit and Language Line services (described in previous section), as well as providing program fact sheets in multiple languages. We



DID YOU KNOW?

In addition to developing program fact sheets in multiple languages, we have developed Project websites in multiple languages, too!

offer BMS extensive experience providing high-quality Project materials in multiple languages. In fact, through our multi-state experience, we have developed program information sheets in:

- English,
- Spanish,
- Vietnamese, and
- Haitian Creole.

We can make such translations available through the mail, field, and Project website. Of note, if the need arises and BMS is interested, we can make our entire Project website available in any prevalent non-English language. Please refer to Section 4.1.2 for a detailed description of our approach to providing translations to any Project material.

4.2.19 Identifying Individuals with Special Health Needs

The plan should include procedures for identifying individuals with special health needs through health assessments conducted as part of the enrollment process. In addition to identification strategies proposed by the Vendor, the Vendor should ask enrollees to indicate whether they have a special health care need. The Vendor should review health assessment forms and enter information on medical conditions, physician preferences or potential health problems within the Medicaid Management Information System (MMIS) and their own data system. It is anticipated that this data, along with a copy of the health assessment form, be forwarded to the MCOs by BMS's fiscal agent.

We provided a detailed description of our approach to identifying individuals with special health needs through health assessments in Section 4.2.5. Briefly, we include health assessments through all enrollment routes:

1. Mailed: Health assessments are included as part of the enrollment form,
2. Phone: Benefits Managers review the health assessment with all callers making an enrollment, and
3. Web: The health assessment is included as part of the online enrollment module.

In the new contract, the results of all health assessments will be documented in HealthTrack, and we will continue to provide the results to the Fiscal Agent. Or, if BMS would prefer, we can also send the information both to the Fiscal Agent as well as directly to the MCOs. Of note, as mentioned repeatedly throughout our proposal, we can provide this information in any format in any timeframe desired by BMS and the MCOs.

Please note, for the health assessment included as part of the enrollment form (discussed in Section 4.1.4) is very easy to complete. The form matches our color scheme (black and white with a green accent color) and includes ample space to write. In addition, our enrollment materials checklist (also discussed in Section 4.1.4) prompts the potential enrollee to complete the form prior to mailing in the enrollment selection.

As mentioned in Section 4.2.5, we are offering several enhancements to our identification of individuals with special needs. Of note, for Benefits Managers providing telephonic assistance, we will provide sensitivity training to support them in working with callers to identify special health needs. When needed, Benefits Managers can also refer callers to the Supervisor for additional assistance. Last, and perhaps most exciting, we will be offering Choice Drivers, most notably our PCP, Specialist and Hospital Searches (described in detail in Section 4.1.6), which allow us to take the next step in preserving provider/enrollee or hospital/enrollee relationships in order to assure continuity of care. (These tools allow an enrollee to identify as many PCPs, Specialists or Hospitals of interest and determine the MCO that best meets their needs.) We feel these tools will be of particular assistance to the SSI population, who frequently present with multiple, complex health conditions that need to be factored into the enrollment process.

Similar to the mailed enrollment form, the web-based health enrollment is easy-to-use (and follows word-for-word the questions on the enrollment from) and users are provided with prompts to promote completion.

Please refer to Section 4.2.5 for a complete description of our approach to health assessments.

4.2.20 Quality Assurance Plan

The Vendor should propose a Quality Assurance Plan to assure that all telephone functions meet their own internal standards, subject to BMS approval. As part of this plan, the Vendor should propose promptness and quality standards (e.g., percent of telephone calls answered within four (4) rings, maximum number of calls per operator in a queue, wait time in the queue, rate of abandoned/dropped calls).

To address all required content in this section, we first begin with our approach to quality (including our QA Plan) followed by our proposed standards for the MHT Project.

Approach to Quality

We have mentioned throughout our proposal that we are dedicated to delivering quality services to our clients and the potential enrollees/enrollees we serve. Our approach to supporting the ongoing review and implementation of programmatic enhancements through quality monitoring and improvement activities is summarized in the pages to follow.

To assure and continually enhance performance levels in pursuit of excellence, we have developed a Quality Assurance (QA) Plan that addresses all oversight of Project operations and in the new contract, we will revisit this plan and resubmit it to BMS for approval. Looking inward, our evaluation will:

- Describe our circular internal monitoring process,
- Reflect our internal monitoring timeframe,
- Identify responsible staff,
- Cite assessment mechanisms, and
- Explain the process of feedback to institute Project improvements.

These activities serve as the backbone of sound Project management and control by:

- **Establishing performance standards that are process-oriented** (based on working backwards from Project objectives, performance standards and desired outcomes) and broadly utilized (for example, in the recruitment, initial training and ongoing development of our employees);
- Assessing adherence to these processes and progress toward outcomes via ongoing and comprehensive **monitoring at the level of the individual worker and the Project overall**; and
- **Noting and acting upon deviations (positive and negative)** through feedback to staff; the former are supported through tangible and intangible rewards (recognition, raises, promotions, etc.) and an internal **corrective action plan** (incorporating root cause

analysis, determining and then implementing the best way to address the problem/prevent reoccurrence) is set in motion to address the latter.

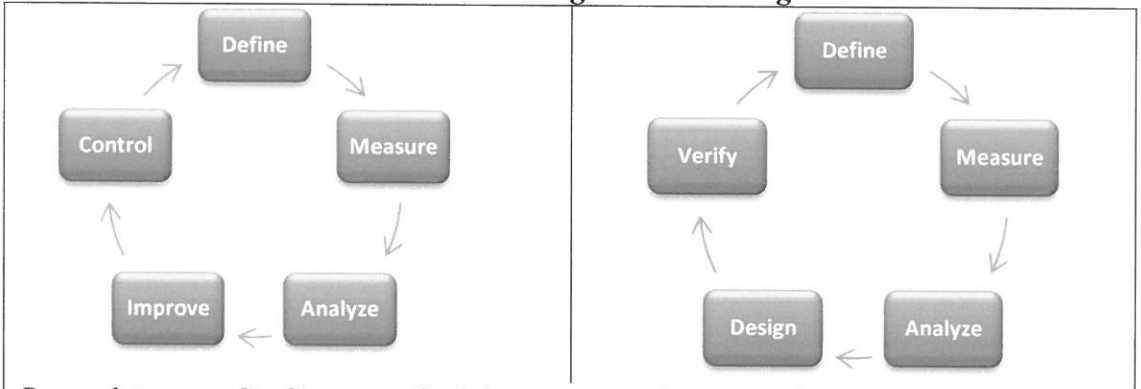
The backbone of our QA Plan is our multifaceted monitoring strategy to **ensure that we meet or exceed performance standards** noted throughout the text of this proposal and discussed at the end of this question. These monitoring activities will also serve as an early warning system so that any problem can be detected and promptly (and permanently) corrected. Any significant deficiency will be conveyed immediately to BMS, followed summarily by the submission of a Corrective Action Plan; in that document, we will describe the situation, its impact, and the steps being taken and/or proposed to effectively address it and prevent reoccurrence.

While the overall responsibility for internal monitoring will lie with the Project Manager, **bringing the plan to life will be a shared responsibility Project-wide**. Project tasks will be understood and effectively carried out by all of our staff in their interactions with our broad target audiences – enrollees, potential enrollees, providers, MCOs, Project stakeholders, etc. – resulting in meeting or exceeding Project objectives and mandated performance objectives.

Overall Approach to Quality

Our approach to quality uses a combination of best practices learned from our nearly 30 year history operating healthcare projects to serve health care consumers blended with established, structured processes designed to yield efficiency and quality operations across all levels of the Project. The structured processes that comprise the second portion of our approach to quality are based on the proven Six Sigma methodology, which involves the implementation of a measurement based strategy that focuses on process improvement and variation reduction through the application of the DMAIC Cycle and the DMADV Cycle:

Exhibit 138. DMAIC and DMADV Six Sigma Methodologies



By applying two Six Sigma methodologies, we realize several important benefits to the Project such as improved customer loyalty, data based decision making, systematic problem solving and employee motivation.

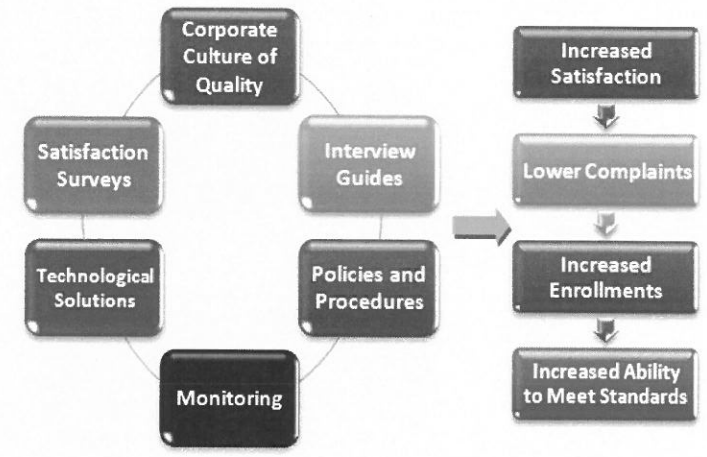
1. **DMAIC**: The DMAIC process (define, measure, analyze, improve, control) is an improvement system for existing processes falling below specification and looking for incremental improvement.

2. **DMADV**: The DMADV process (define, measure, analyze, design, verify) is an improvement system used to develop new process or products at Six Sigma quality levels. It can also be employed if a current process requires more than just incremental improvement.

There are numerous, documented benefits to the Six Sigma methodology, including but not limited to:

- Enhanced enrollee focus,
- Improved enrollee loyalty,
- Lowered waste/decreased inefficiencies,
- Data based, objective decisions,
- Operational efficiency and time management,
- Sustained gains in improvements,
- Increased employee motivation,
- Increased measurements according to BMS' needs,
- Enhanced coordination between departments, and
- Reduced caller complaints.

Exhibit 139. Multi-Faceted Approach to Quality Services



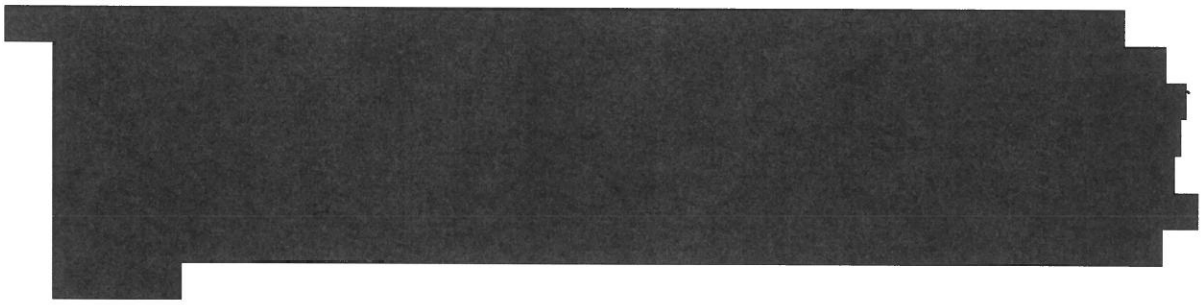
Our multifaceted approach to quality services results in numerous benefits to BMS and the enrollees we serve.

In addition to the Six Sigma approaches described above, our incorporation of best practices internally learned from our corporate history also include the following as components of our quality approach:

1. **Corporate Culture of Quality**: We have mentioned throughout our proposal that as a corporation, we are dedicated to quality. This is not a value that is merely on paper; rather it is a company-wide commitment to strive to achieve the best performance possible. Quality is celebrated in all of our projects: staff are recognized for achievement of outstanding monitoring scores, and staff jointly celebrate accomplishments related to meeting service level agreements and standards.
2. **Satisfaction Surveys**: As required by the RFP and as mentioned earlier in our proposal, we strongly believe in satisfaction surveys and the value they bring to quality operations.

We incorporate satisfaction surveys into all of our projects (regardless if we are contractually required to do so or not) as a mechanism to identify areas of improvement and measure our progress towards achieving the desired improvement levels. Our approach to satisfaction surveys for this Project is detailed later in this section.

3. **Emphasis on Scripting**: We have extensive experience developing scripts, and in doing so, we ensure scripting is thorough, in accordance with client expectations, written at an appropriate literacy level, accurate, and meets callers' needs. All staff are provided with extensive emphasis on training with regards to scripting and are heavily monitored to ensure they adhere to scripting requirements.
4. **Standard Operating Procedures**: All aspects of our operations are supported by sound operational policies and procedures that provide clear direction on efficient workflow processes.
5. **Monitoring:** Our Monitoring Approach (described below) allows for the identification of areas of improvement, directs staff to the correct training, provides supportive methods for improvement, and allows management/supervisory staff to identify errors early.



The benefits of this combined approach to quality include but are not limited to:

1. **Incorporation of a Structured Approach and Clearly Defined Steps**: Our approach ensures that all monitoring activities are clearly defined and the personnel responsible for each level of quality activities (as well as the quality activities for which they are responsible) are clearly identified;
2. **Use of a Proven Approach**: While the documentation on the success of the Six Sigma approach is well established, our overall performance and continuous adherence to performance levels and service level agreements speaks for itself. We have used this methodology to implement, operate, and improve several statewide call centers throughout the country that have provided comprehensive assistance to millions of callers needing help obtaining coverage and accessing appropriate healthcare;
3. **Incorporation of Established Parameters**: Our quality goals are not poorly defined (e.g., "operate at a high level"), but rather include the specific metrics that define achievement in each category. In providing such levels of specification, we collect the data to verify performance is indeed occurring according to specifications;
4. **Customization to the Needs of Each Project**: Our approach is neither rigid nor ill-aligned with the needs of the Project. The flexibility involved in the approach to quality

allows BMS to have maximum impact on the operations and levels of success of the Project; and

5. **Incorporation of Several Tools and Processes**: There are numerous tools, described below, that are incorporated into our processes, such as quality monitoring reports, policies and procedures, workflows, training modules, etc.

In the following pages, we describe how this overall approach will be applied to the MHT Project.

Our established Quality Assurance Plan addresses the quality oversight of all Project operations, including through the call center. Authored primarily by the Project Manager, the overall goals of the Quality Assurance Plan are to:

1. Provide the best possible customer service experience for potential enrollees and enrollees through processes that support continuous quality improvement. These include:
    - Monitoring performance through trending and analysis of quality activities against performance goals,
    - Implementing interventions to promote achievement of goals,
    - Measuring and analyzing the effectiveness of improvement actions, and
    - Continuously re-evaluating the goals and interventions used;
2. Ensure the accurate and timely response of all inquiries regardless of the communication channel;
3. Analyze performance that does not meet expectations to identify causes of errors and develop and implement strategies to eliminate those errors;
4. Measure customer satisfaction and implement effective interventions to address areas of dissatisfaction; and
5. Ensure effective coordination of QA activities with all appropriate stakeholder groups.

All responsibilities, frequencies, and persons responsible will be clearly identified in the Quality Assurance Plan. Further, all quality-related reporting will occur in concert with routine, ongoing reporting to BMS.

Components of Our Quality Assurance Plan

There are multiple components to our Quality Assurance Plan:

1. Policies and Procedures,
2. Training,
3. Call Center Monitoring,
4. Data Analysis,
5. Satisfaction Surveys,
6. Complaint Processing, and
7. Corrective Disciplinary Action Follow-Up Monitoring.

Policies and Procedures

As mentioned, policies and procedures will underlie all operational workflows in the MHT Project, and monitoring activities are no different. Standard operating procedures are provided to all employees during their orientation and will also be made available online via integration into HealthTrack, which allows:

- Staff to easily search for the correct information without having to shuffle through heavy binders of papers;
- Management/supervisors to update policies and procedures and disseminate the information immediately;
- Us to save considerable costs on paper; and
- The Project Manager to easily share policies and procedures with BMS for approval.

As indicated, policies and procedures will be reviewed on an annual basis (the dates of all reviews will be included in the policy/procedure), and will be submitted to BMS for approval prior to implementation. Policies and procedures related to monitoring will also be included in our QA Plan that will also be submitted to BMS for approval. Please refer to Section 4.2.14 for a complete description of our approach to policies and procedures.

Training

Training is a fundamental component of our approach to ensuring quality services. As a full description of our approach to training is provided in Section 4.2.15, the narrative below focuses on training as related to monitoring/quality activities and is focused on three types of training:

1. New Hire Training,
2. Quality Improvement Training, and
3. Quarterly Refresher Training.

New Hire Training

New Hire Training is conducted for approximately two weeks and consists of a comprehensive course of didactic study on all aspects of the operations. As part of the training, New Hires will spend time shadowing seasoned staff, which allows for:

- Increased comprehension,
- Increased application of skills,
- Increased preparation,
- Reinforcement of learning, and
- Prompt answers to questions.

Training also allows for ample time for hands-on practice using the Project systems combined with extensive role play activities to provide New Hires with not only the technical, programmatic, and customer service skills they need to aptly perform their jobs, but also the confidence to do so with efficiency and accuracy. **As a result, our New Hires are better prepared on Day One to provide callers with first-class customer service and achieve service level requirements.**

New Hires will be monitored more heavily during their initial 90 day orientation period. After their initial training period, the Supervisor will monitor calls regularly for New Hire Benefits Managers, coaching them on the best methods to assist callers and evaluating their ability in their new positions. Further, New Hire Benefits Managers will be strategically situated in the call center with close proximity to high-performing experienced staff to facilitate additional mentoring and high performance.

Quality Improvement Training

All staff who do not meet the requirements outlined as part of our monitoring policy are required to attend Quality Improvement Training that month as part of their Action Plan. Quality Improvement Training is designed to provide updated training in areas where the Benefits Manager scored poorly on their monitoring evaluation form. The training reinforces requirements of phone monitoring.

The Project Manager will conduct a Quality Improvement Training class every month for those individuals who do not meet the designated thresholds. Quality Improvement Training lasts approximately 30-45 minutes and consists of a PowerPoint presentation, hands-on practice, and

an evaluation test. Benefits Managers who do not pass the evaluation test will be required to re-take the Quality Improvement Training module.

The benefits of such targeted training are documented in a recent Gallup study and include:

- 50% lower turnover among staff,
- 27% greater profitability,
- 56% higher loyalty, and
- 10-20% lower average handle time.

Quarterly Refresher Training

As mentioned in Section 4.2.15, we routinely conduct regular refresher training for all staff. During quarterly refresher trainings, we will reinforce pertinent customer service and quality metrics when we convene with the entire Project staff during quarterly trainings. These creative-themed, interactive training classes will reaffirm the quality approach all staff should take in their day-to-day activities and the principles they should carry through each call.

Call Center Monitoring

Evaluation Form

Monitoring staff performance is the backbone of our quality approach. In order to ensure we effectively monitor Project staff for all elements critical to successful performance, we first develop an Evaluation Form. Elements included on the Evaluation Form include the Benefits Manager's name, evaluator, date of call, indication if the call was inbound/outbound, and specific elements for monitoring.

Our current Evaluation Form includes the following categories:

Exhibit 140. Current Evaluation Form

Criteria	Explanation
Customer Service	
Greeted caller appropriately	Benefits Manager welcomed the caller to the MHT helpline, identified her first name and asked how she can assist the caller.
Satisfied confidentiality requirements.	Verified at least two identifiers before releasing any information relative to the case (name, DOB, recipient number, or last 4 digits of SSN).

Criteria	Explanation
Used proper tone of voice.	Benefits Manager: • Was polite (please, thank you), professional (demonstrating the skills to do the job), and empathetic (considerate), • Did not use slang or jargon, and • Maintained a pleasant tone of voice.
Used proper holding procedures.	Benefits Manager: • Asked the caller permission before placing him/her on hold, • **Thanked the caller for holding when getting back on line**, • **Did not use mute in lieu of hold**, • Advised caller that the wait would be no longer than one minute, and • Checked with the caller within the minute if the wait time was longer.
Good interaction with the caller – good listening skills.	Benefits Manager: • Was responsive and attentive to the caller, • Kept the conversation active and with a good flow, • Made sure that the caller understood the information provided, • Allowed caller to make decisions at their own pace, and • Handled angry/stressed callers with patience and compassion.
Closed the call appropriately.	Before closing or referring the caller to another helpline for assistance, the Benefits Manager asked the caller: Have I answered all of your questions today? **Is there anything else that I can help you with?**

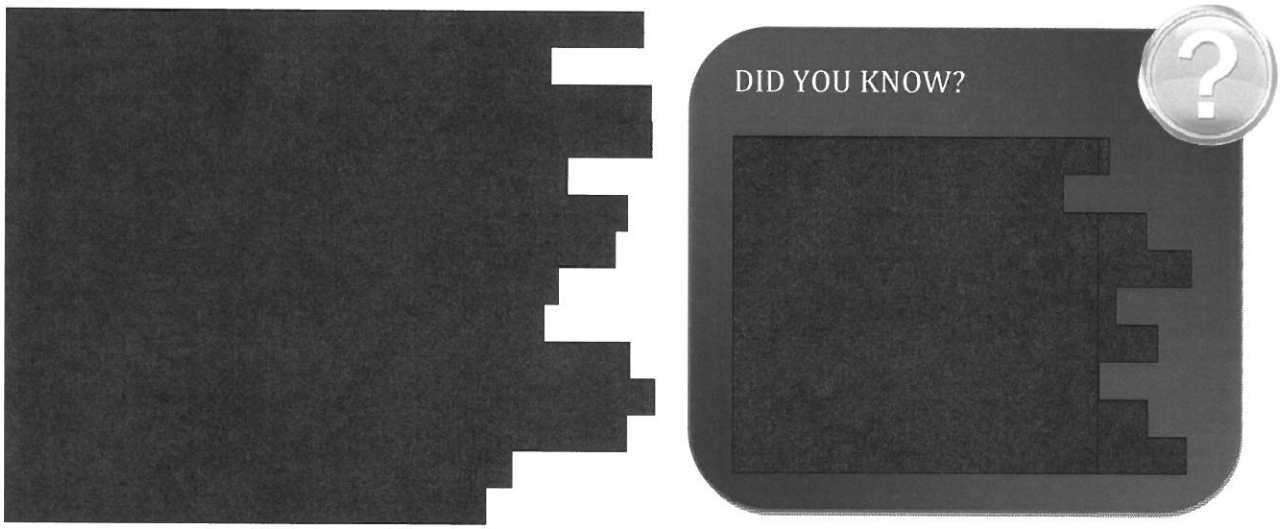
Criteria	Explanation
Call Flow	
Determined reason for the call.	Benefits Manager: • Asked probing questions to identify caller's needs, • Actively listened to caller's responses before providing assistance with enrollment, plan change, prior authorization issues, among others, and • Referred the caller to another helpline if it was determined that the needs of the caller were not within the scope of the MHT helpline.
Verified member information/other members in case.	Benefits Manager: • Utilized MMIS to verify information from the caller before providing assistance, • Accessed RAPIDS if there were questions or issues regarding the member or case, • Documented the call and actions, and • Asked the caller if there were any other members on the case.
Explained program features for Mountain Health Trust or PAAS program features and options.	Benefits Manager: • Properly explained each program and described the medical home concept, and • Remained neutral while informing the member of options in his/her county.
Attempted to enroll with MCO or Health PAAS.	Benefits Manager: • Asked if member received enrollment packet in the mail. If yes, Benefits Manager offered to enroll member over the phone. If enrollment packet was not received, Benefits Manager offered to review information over the phone and process the enrollment, • Also offered to mail another enrollment packet out if the caller did not wish to enroll at this time, and • For callers requesting assistance to complete their enrollment online through the MHT website, Benefits Manager walked the member through the steps or offered to process the enrollment through the Helpline.

Criteria	Explanation
Completed health needs assessment.	Benefits Manager asked member to describe any health concerns and documented appropriately the health needs assessment responses in Lotus Notes and MMIS if enrolling in MHT.
Asked for other insurance (if appropriate).	Benefits Manager: • Asked member if she/he hand any other insurance. If the other insurance was not found in MMIS, Benefits Manager entered the information in a contact sheet and completed the TPL form, and • Referred the member to the TPL Unit if the insurance listed in MMIS was no longer correct.
Reviewed enrollment effective date/ membership card.	Benefits Manager: • Explained when the effective date would be for the plan/PCP assignment, • Reviewed the concept of a medical home, • Explained that the member would receive a wallet size membership card from the plan/PAAS and that the member must take the membership card and their monthly medical card to the doctor or pharmacy.
Referred member appropriately.	Benefits Manager provided phone numbers and contact information for other helplines and services including the DHHR Change Center, MCOs for covered services; BMS for other insurance; Molina for claims information; 211 for other resources; etc.
Documentation	
Completed MHT enrollment in MMIS.	Benefits Manager completed enrollment in MHT in MMIS by enrolling the member in their plan of choice; entering the PCP; confirming effective date; completing the health needs assessment, etc.
Created 'contact sheet' in Lotus Notes.	The Benefits Manager: • Documented all interactions that occurred with the member by creating a contact sheet in Lotus Notes, • Confirmed that the information entered in Lotus Notes matched what was entered in MMIS for the member(s).
Accurately notated the case.	The Benefits Manager accurately documents the call in Lotus Notes and if needed, added comments.
Verified MCO selection for enrollments.	The Benefits Manager's documentation in MMIS matches what is in Lotus Notes.

Criteria	Explanation
Generated request for mailing.	The Benefits Manager documented the request from the member for the MHT enrollment packet (or hard copy of the MCO and/or PAAS directories).
Utilized RAPIDS and MMIS systems appropriately.	The Benefits Manager appropriately navigated screens correctly to confirm eligibility, enter plan choice and PCP selection, and pended enrollments when appropriate.
Call Handling	
Identified caller's needs.	Benefits Manager: • Demonstrated good listening skills, • Asked appropriate questions to identify caller's needs and actively listened to caller's responses, • Was able to quickly determine whether a hand-off/referral to another agency or program was appropriate.
Treated caller with courtesy and respect.	Benefits Manager: • Diffused anger and calm a disgruntled caller; • Verified an understanding of their request for assistance; • Assessed literacy skills to ensure that the caller was able to understand the information; • Used appropriate terminology to convey program information; and • Utilized the Translation Unit, Language Line or TTY/Relay Services as appropriate.
Provided complete and accurate information.	Benefits Manager: • Followed approved guidelines when assisting the caller, • Covered all aspects of program services, and • Provided accurate information to affect a "one call resolution" for the caller whenever feasible.
Asked caller if s/he had any additional questions.	Benefits Manager appropriately closed the session by asking the caller if s/he had any additional questions. Also took the opportunity to offer enrollment assistance to other eligible family members on the case.
Provided additional contact/referral information.	Benefits Manager transferred or referred the caller when required to do so by the call handling guidelines regardless of his/her ability to handle the call.

Our comprehensive Evaluation Form ensures we measure all standards of service.

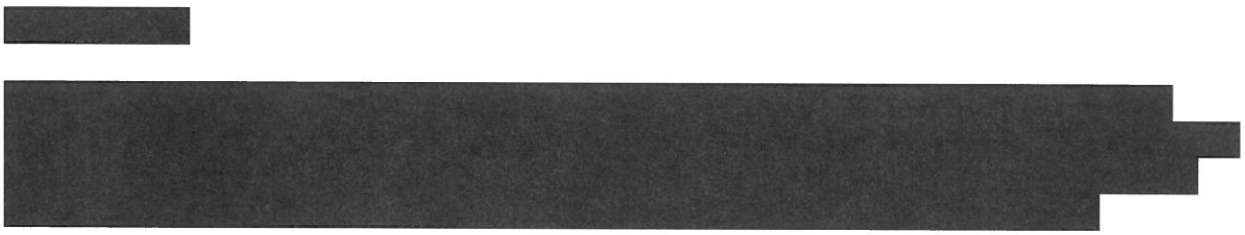
For the new MHT Project, we will appropriately modify the Evaluation Form in consultation with BMS and ensure it accurately reflects all updated processes, most notably all documentation will be recorded in HealthTrack rather than Lotus Notes.



Monitoring Process

For the MHT Project, the Supervisor will have primary responsibility for monitoring Benefits Managers, with oversight provided by the Project Manager. Each Benefits Manager will have a minimum of four calls monitored per month. The Supervisor will use the CCR system to discretely listen to calls (please refer to Section 4.2.21 for a description of CCR). The Supervisor will be responsible for completing all elements on the Evaluation Form, and will discuss the results of the monitoring with the Benefits Manager.

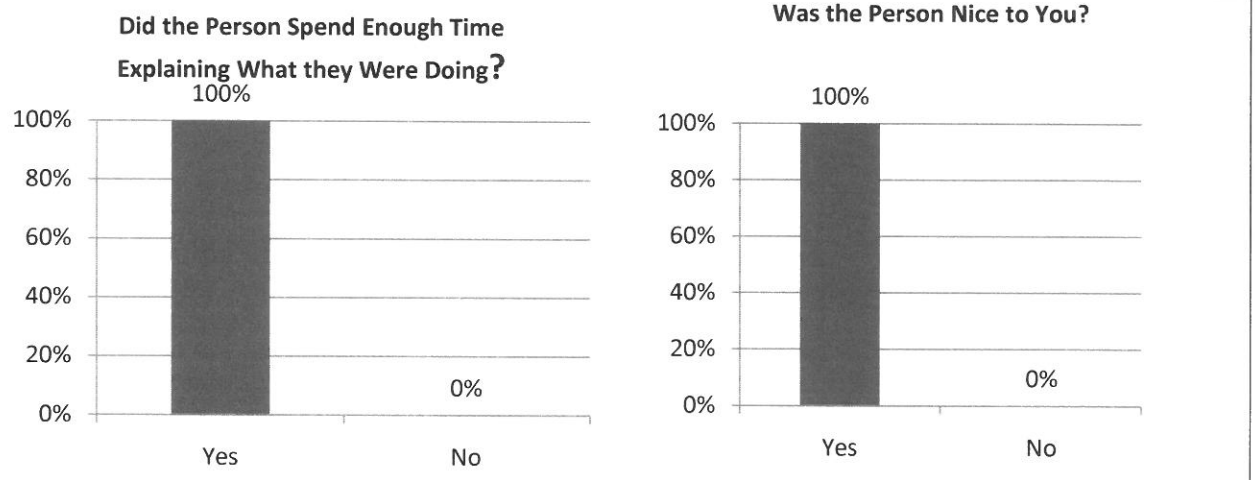
Staff members who are out of compliance as designated by their total score or low score on individual elements with heavy weighting (e.g., customer service elements) will receive the appropriate corrective action, which will be specified in the standard operating procedures. Corrective actions may include: ongoing refresher trainings, mentoring, and disciplinary action if the breach in quality is severe enough to warrant such actions. Again, our policies and procedures will clearly delineate the scores and areas of evaluation that will trigger appropriate corrective actions. In this way, we effectively ensure Benefits Managers receive the appropriate training and corrective support they need to make the change early and permanently.



Satisfaction Surveys

Satisfaction surveys are an essential component in our quality improvement toolbox. We have a long history of maintaining high levels of customer satisfaction and we are committed to working with BMS to continue to measure callers' satisfaction with our services.
We have incorporated a satisfaction survey into our operations to date, and as evidenced in Exhibit 141 below, results are overwhelmingly positive.

Exhibit 141. Satisfaction Survey Results



Results from our satisfaction surveys are overwhelmingly positive.

Our current satisfaction survey is designed to minimize the burden on respondents. It includes five brief questions, answered yes/no, to determine enrollees' satisfaction with our services. The questions are:

1. Did you enroll over the phone?
2. Was the person nice to you?
3. Did the person spend enough time explaining what they were doing?
4. Did the person enrolling you answer all your questions?
5. Do you have any additional questions?

With regard to survey development, when developing the survey, we incorporated several features into our surveys that not only reflect best practices and solid research principles, but engaged the participant. We:

- Formulated our objectives first and then develop questions,
- Included an introduction with the survey and an estimate of how long it will take to complete,

- Thank participants for their time,
- Surveyed a representative sample that assess adequate numbers of respondents in key groups (e.g., gender, age groups, geographic location, etc.),
- Use a statistically valid sample, and
- Wrote all questions at an appropriate literacy level.

Exhibit 142. Techniques to Support Survey Development

Survey Development Step	Techniques	Result
Step 1. Developing	• Use simple questions based on stated objectives, • Include clear, concise options.	Survey respondents have an increased understanding of the items asked and less confusion when answering questions.
[redacted]	[redacted]	[redacted]
Step 3. Sorting	• Electronically record data, • Complete descriptive and statistical analyses.	We can easily analyze data and drill down accordingly.
Step 4. Reporting	• Include descriptive narrative, • Include summary overview, • Highlight key findings, • Detail specific areas of interest.	Our reports are thorough and clearly communicate all needed information to the client.

Through careful attention to sound research principles, we increase the value of survey information.

We will continue to report all results BMS as directed and will include recommendations for improvements. Based on recommendations for suggested improvements (and any indications of caller dissatisfaction that is controllable by AHS), we will develop Action Plans to ensure we continuously offer potential enrollees and enrollees the best service possible.

Based on the results of satisfaction surveys, we identify specific target areas we would like to improve. From there, we determine the specific actions we feel will best address the target area. Items are very specific – we do not use global actions like "retrain staff." Rather, we focus on the interventions as much as possible (e.g., "Provide all staff with a two hour customer service training on November 15, 2014). Each action item is also tied to at least one outcome the Project Manager will continuously monitor to ensure we are indeed improving our performance. If our performance does not improve after a reasonable amount of time, we will identify additional action steps that are more effective in terms of achieving the desired outcome. We will review

all Action Plans with BMS prior to implementation, and will report on a regular basis to BMS on progress and improvements made.

Complaint Processing

As we are dedicated to providing first-class customer services and supporting positive relationships with enrollees/potential enrollees, we are also dedicated to accepting, processing and resolving complaints in a professional manner. We will carefully review data from all complaints to determine if they are indicative of larger issues that we can address (e.g., through modifications in workflows, enhancements to scripting, refresher trainings, etc.). For a detailed description of our complaint processing approach, please refer to Section 4.3.4.

Corrective Disciplinary Action Follow-Up

When a Benefits Manager receives a corrective disciplinary action (CDA) related to work quality on the phones, the Supervisor may require as part of the corrective action plan to increase the phone monitoring and/or side-by-side training for a set period of time to track improvement. The Supervisor will be responsible for the appropriate monitoring.

The Supervisor will complete the phone monitoring as requested, utilizing the Evaluation Form according to the monitoring procedures documented above.

When the increased phone monitoring for the corrective action plan is complete, or when areas of further need for improvement are found, the Supervisor will consult with the Project Manager regarding the next steps and further communication with the employee.

Performance Standards

As part of our commitment to quality, we propose the following performance standards:

1. Less than 3% of Telephone Calls Receive a Busy Signal,
2. 95% of Telephone Calls Answered within Four Rings,
3. 2 Calls Per Operator Per Queue,
4. Less than 3 Minute Wait Time in Queue, and
5. 7% Abandonment Rate.

Below follows a discussion of our approach to meeting each of the performance standards.

Performance Standard #1: Ensure Less than 3% of Calls Receive a Busy Signal

In Section 4.2.21, we describe our phone system, which is configured to ensure that 100% of calls are answered (and 0% of calls receive a busy signal). The success of our system speaks for itself through the performance of the MHT Call Center, where throughout our nearly 20 year

tenure with the Project, not one call has ever received a busy signal, even during times of increased call volumes resulting from program expansion, mass mailings, etc. Exhibit 143 demonstrates our track record of ensuring no calls get a busy signal.

Exhibit 143. Experience Ensuring Less than 3% of Calls Receive a Busy Signal

Month	Number of Calls	% Calls Receiving a Busy Signal
January 2013	1,927	0%
February 2013	1,745	0%
March 20313	2,102	0%
April 2013	2,308	0%
May 2013	1,661	0%
June 2013	1,793	0%

Our technology allows us to consistently ensure no calls ever receive a busy signal.

Performance Standard #2: Answer 95% of Calls within 4 Rings

Our proposed phone system, which, as mentioned, is engineered for 0% incoming blockage so that 100% of all calls are answered within three rings – a measure more aggressive than our proposed standard of four rings. This is a standard approach for us; regardless of the contract measure, we always set the phone system to answer calls in a metric more aggressive than our contract standard, which is another layer of protection to ensure we meet this measure.

Performance Standard #3: Maximum 2 Calls per Operator per Queue

We engineer our phone system to accommodate a maximum of two calls per operator in the queue, which given the call volume in West Virginia, is more than ample. In fact, during our tenure as the MHT Contractor, we have never experienced a period when we have had two calls per operator in the queue.

Of note, our proposed telecommunications platform is fully scalable to accommodate varying population and program expansions. If at any time the Project will expand (e.g., the Medicaid expansion population is incorporated), we may need to add additional staff or telephone lines. If needed, we can quickly acquire and install additional phone lines to accommodate the additional call volume without compromising service. We feel this approach is most beneficial to BMS' needs – we do not need to pay for additional phone lines that we are not using, but when needed, we can immediately acquire and install new lines to meet the changing demands of the Project.

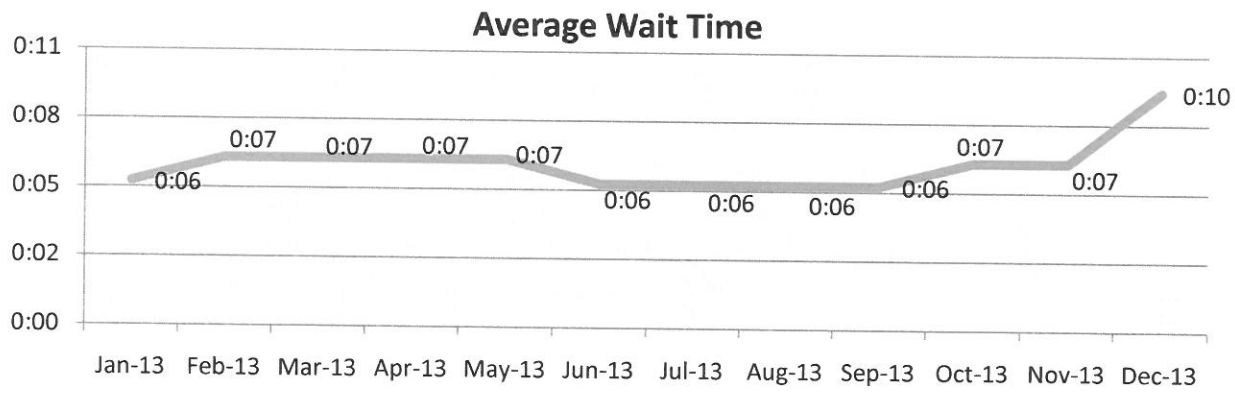
Performance Standard #4: Less than 3 Minute Wait Time in Queue

A detailed description of our phone system is provided in Section 4.2.21. Two critical features of this phone system relevant to this item include the Automatic Call Distribution (ACD) and the auto-attendant features. The ACD routes calls on the toll-free line to the next available Benefits Manager, thereby providing prompt service and minimizing the chances of losing a caller by allowing for a short average wait time in queue. The second critical feature of the phone system

is the auto-attendant feature, which ensures all calls will be answered within three rings and no incoming calls will get a busy signal.

We hold ourselves accountable for superior performance, and we are proud of our established record of impressive performance statistics, including low wait times. Our consistent performance with this measure for the MHT Project is demonstrated below in Exhibit 144. Of note, **during the past year, our average wait-time has never been higher than 10 seconds – an amount that dramatically exceeds the proposed performance standard**!

Exhibit 144. Experience Providing Consistently Low Wait Time



Our performance in West Virginia far exceeds the performance standard of ensuring the average wait time after the initial automatic voice pick-up is less than three minutes.

This same commitment to providing prompt, courteous, accurate education and service via the phone will continue under our continuing administration of the contract.

Performance Standard #5: Less than 7% Abandonment Rate

We have mentioned that we share BMS' goal of ensuring callers are provided with a first-class customer service experience, and one way we demonstrate this is through our consistent performance. We have a proven track record of keeping abandoned call rates under the 5% benchmark. **For the MHT Project, we have consistently maintained abandonment rates under 4% - a in fact, for nearly all months of the year our abandonment rates are even better, often at only 2-3%.**

Using a combination of live abandonment rate monitoring and daily/monthly statistical reporting, we manage our resources to assure the maximum number of callers reach a Benefits Manager or opt out of a busy queue to leave a voicemail message requesting a return call or a mailing. In addition, we also monitor the average time-to-abandon to determine if this time is shorter or longer than the average hold time. For example, within one of our statewide contracts, we found callers routinely disconnected sooner than the 90 second maximum allowed hold time, with an average time to severance of 52 seconds. In setting our internal goals for abandonment rates, we used this rate as our maximum average hold time in lieu of the higher contract standard to assure

we met the five percent abandonment rate goal. We will continue to supplement our abandonment rate monitoring with this time-to-abandon analysis to ensure our response time performance, and understand that calls abandoned within 30 seconds after entering the queue will not be counted in the abandonment rate.

Further, in times of higher than normal call center volume, we will ensure call center performance metrics are not compromised by maintaining adequate staffing using any of the following three methods:

1. We track and analyze calls on an hourly, daily, weekly and monthly basis, allowing us to forecast and plan accordingly. **Of note, after 18 years of administering the MHT Project, we have a thorough understanding of seasonal trends, something that no other bidder can bring to the Project;**

2. We plan our staffing schedules accordingly to ensure an adequate number of operators are available during busy times; and

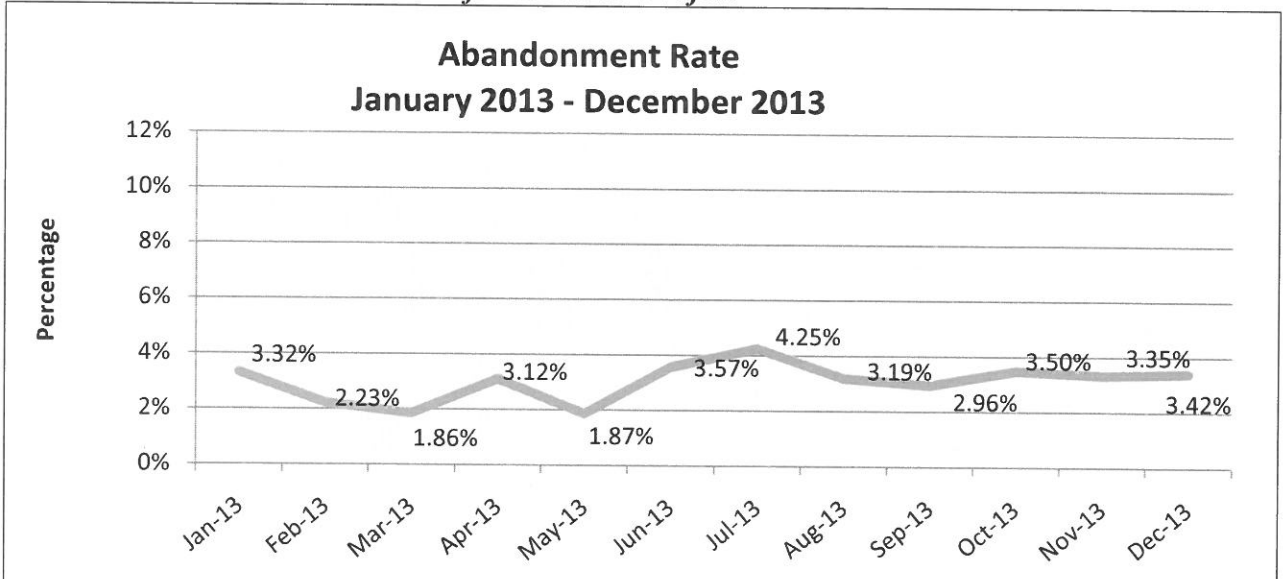
3. When warranted, we make adjustments as they occur throughout the day. If needed, we will suspend time away from the phones for meetings and/or trainings. We will also call part-time and temporary staff for additional assistance.

DID YOU KNOW?

After 18 years of administering the MHT Project, we have a thorough understanding of seasonal trends in call volume.

We would like to again demonstrate that our low abandonment rates in West Virginia are a consistent marker of our service.

Exhibit 145. Abandonment Rates for the MHT Project



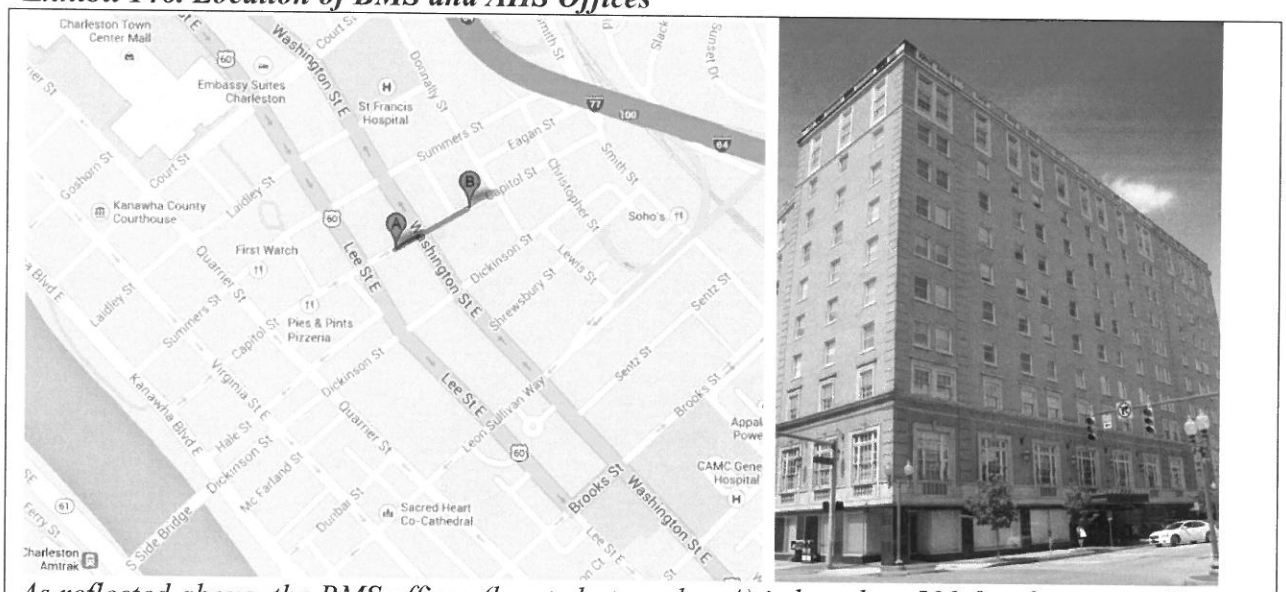
We have a proven ability to meet all abandonment rate standards for the MHT Project.

4.2.21 Maintain an Office within Charleston

The Vendor should establish, maintain and operate an office within fifteen (15) miles of the city limits of Charleston, West Virginia (Charleston). The Vendor should administer telephone support (as described in Section 4.3) from that location or an additional location within fifteen (15) miles of the city limits of Charleston.

We will operate the MHT Project from our established office located at 405 Capitol Street, Suite 406, Charleston, WV, which is less than 500 feet from BMS' office.

Exhibit 146. Location of BMS and AHS Offices



As reflected above, the BMS offices (located at marker A) is less than 500 feet from our office (located at marker B and depicted in the photograph to the right).

We will continue to operate the Project's call center from our current office in Charleston, WV. As is our current policy, the call center will continue to be staffed with Benefits Managers dedicated 100% of the MHT Project (please refer to 4.2.15 for a description of our approach to staffing the call center). [redacted]

Exhibit 147. Benefits of Charleston-based Call Center

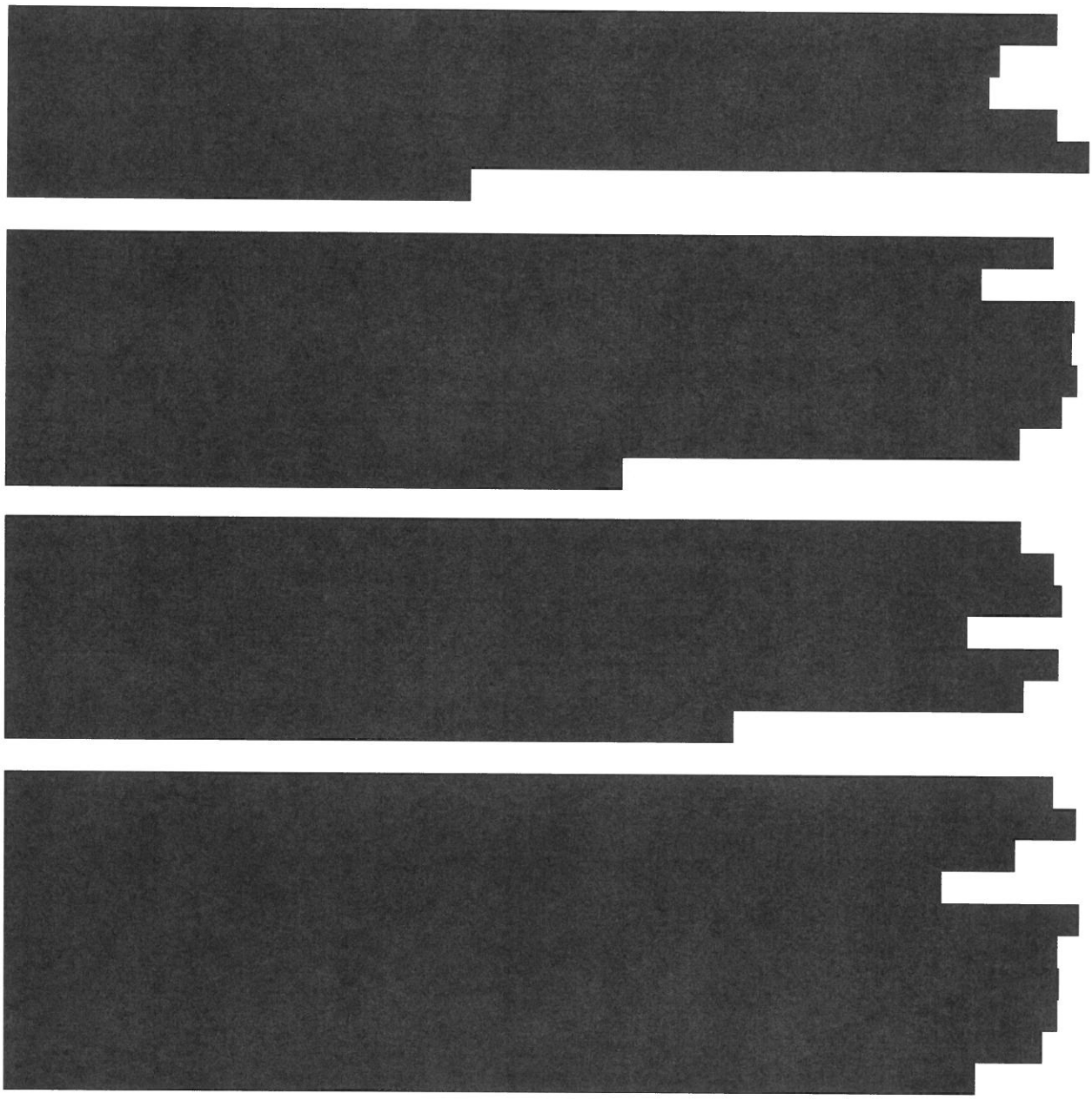
Feature	Benefit
The facilities are already in place.	Our call center in Charleston is already in place and we can leverage additional adjacent space to accommodate any expansions in managed care without requiring expensive build-out or renovations – savings we can pass on to the State.
Phone system installation is complete.	[redacted]
Trained, knowledgeable staff is retained.	**MHT staff are already trained, in-place, committed to the Project, and providing services to West Virginia's potential enrollees and enrollees.** Our staff are already familiar with West Virginia Medicaid, managed care, the workings of the phone system, and our policies and procedures, and have earned rave reviews from MHT callers. As a result, we will enjoy lowered costs associated with recruitment and training (again, savings that we can pass on to the State) and demonstrate our commitment to retaining staff and helping them develop their career paths.
Charleston facilities are unlikely to be affected in a natural disaster.	Our Charleston office is unlikely to be affected during natural disasters such as hurricanes and tornados, allowing us to offer increased service to potential enrollees and enrollees at times when it may be needed most (i.e., an emergency situation).
The Charleston office is not part of a larger "corporate call center."	Our Charleston office maintains its own call center where Benefits Managers and Project staff are dedicated 100% to the Project. At no time will any Benefits Manager or other Project staff ever be required to devote time to any other project.
We retain jobs in West Virginia and provide an economic benefit to the State.	By housing all Project staff in West Virginia, and recruiting for positions from the State, we support the West Virginia economy and provides direct economic benefits to the State.

Our Charleston office offers BMS, potential enrollees, and enrollees outstanding services and several benefits including cost savings, a low-risk implementation, and economic benefits to the State.

Below follows a description of our proposed call center operation that will be conducted through our Charleston office.

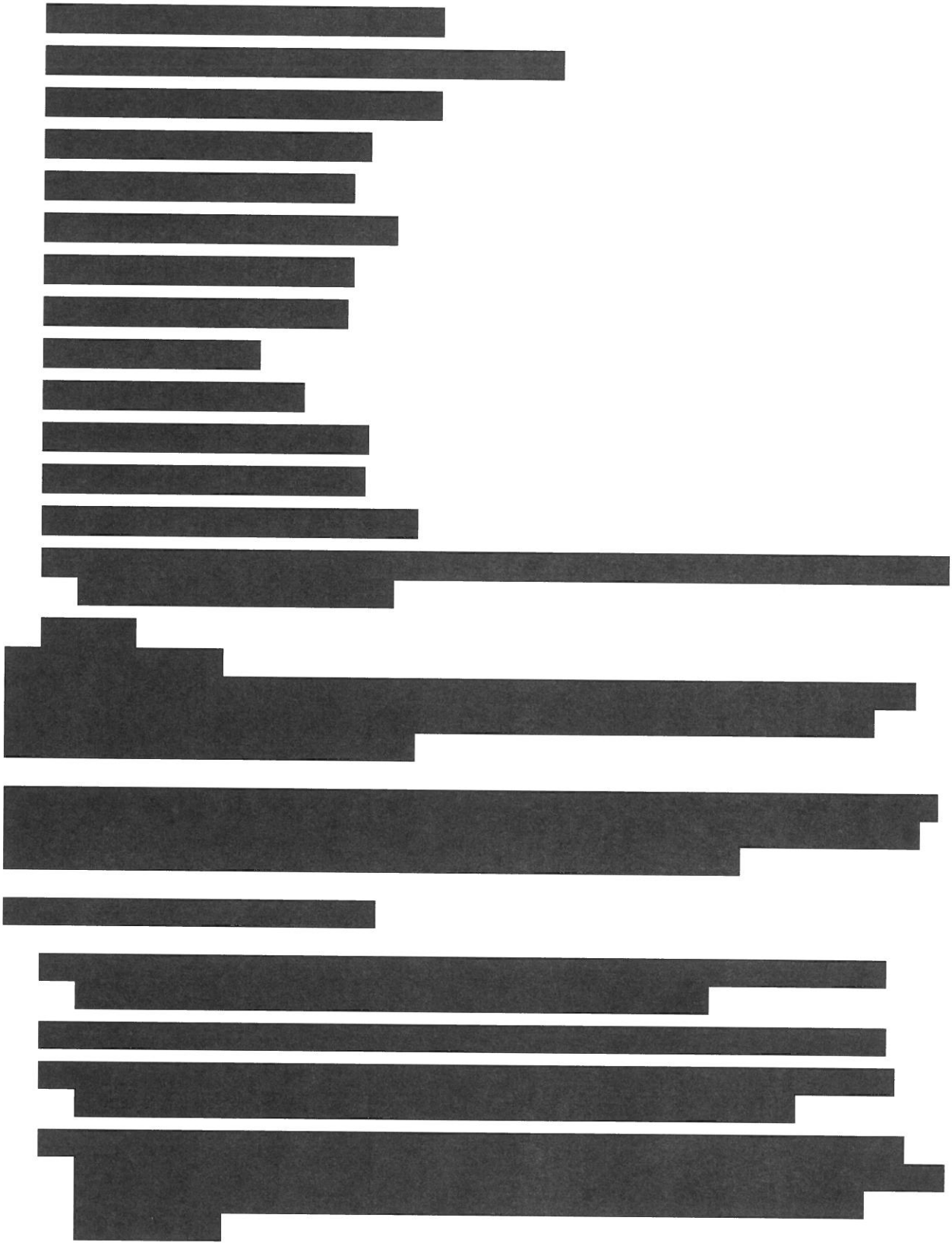
Overview of Proposed Phone System

The following text provides a detailed overview of our proposed telecommunications equipment and software for our MHT Call Center. As mentioned, all telecommunications equipment is already installed, fully operational, and currently being used to provide services to thousands of West Virginia callers. We are fully capable of providing all telephone support for the MHT Project. Our proposed solution meets or exceeds the requirements of the RFP and BMS.



[23] These are the current hours of operation for the MHT Call Center. If BMS desires new hours, we will work with the State to modify our operation.

[redacted]



[redacted]

Call Center Reporting Capabilities

We will utilize the [redacted] to produce all of the necessary daily, weekly, monthly, quarterly, annual, and ad hoc reports. This software provides a sophisticated management support and extensive reporting mechanism for call centers of all sizes[redacted] a comprehensive set of real-time and historical reports on virtually every aspect of our operation and permits easy customization.

Highly comprehensive, [redacted] reporting capabilities include but are not limited to the following:

- The number of incoming calls by day/week/month by each operator;
- The number of telephone calls received by all operators by day/week/month;
- The average number of calls handled by day/week/month by each operator;
- The average number of calls handled by all operators by day/week/month;
- The number and average number of hours of use by each operator by day/week/month;
- The number and average number of hours of use by all operators by day/week/month.
- The number of calls receiving busy signals;
- The average time until there is a response from the automated voice response system;
- The number of calls that reach the automated voice response system;
- The number of calls that are abandoned during the wait in queue for interaction with a Benefits Manager;
- The number of calls that reach Benefits Managers;
- The average and maximum time spent in queue for all calls;
- The identity of the Benefits Manager taking the call;
- Availability and occupancy;
- The average and maximum talk time;
- The average and maximum time for calls that are placed on hold;
- The number of calls that are abandoned while on hold;
- The daily percentage of abandoned calls; and
- Peak call times and days.

While our proposed telephony system ensures that callers are dealt with promptly and provides information on the data items required in the RFP (e.g., number of calls answered, average talk time, number of calls abandoned, etc.), a second component documents call-specific data, tracks ongoing and completed tasks, and provides users access to a host of online tools to effectively and efficiently accomplish their assigned duties. As mentioned, we will employ HealthTrack to accomplish the numerous tasks related to the administration of the MHT Project (please refer to Section 4.3.6.1 for a comprehensive description of HealthTrack). Built with advanced enrollment broker and call center functionality, HealthTrack's primary function is to log, track, and report on all contacts with potential enrollees, enrollees, and any other interested parties as well as handle referral activities, and generate extensive reports.

Thus, by using these two systems we will be fully capable of exceeding the reporting requirements as set forth in the RFP. Additional information on our approach to reporting is provided in Section 4.3.7.

4.3 Plan for Systems Development and Ongoing Communication with BMS and the MCOs

The Vendor should propose a plan for systems development and ongoing communication with BMS and the MCOs. This plan should address the Vendor's process for:

AHS' response to addressing each of the items specified in Section 4.3 is provided below. These items include:

4.3.1 Maintaining direct, ongoing communication with BMS regarding the Vendor's activities and working closely to assure accomplishment of the enrollment goals and objectives;

4.3.2 Meeting with the MCOs after contract award and on an ongoing basis, as necessary to obtain detailed information about each individual operation;

4.3.3 Providing training and technical assistance to all designated DHHR and BMS staff;

4.3.4 Forwarding any complaints concerning its staff to BMS with an explanation;

4.3.5 Notifying BMS on a case-by-case basis, of any discrepancies found on the enrollment form;

4.3.6 The Vendor's proposal should specify its approach for implementing and performing the systems development tasks listed below:

- 4.3.6.1 Establish and maintain databases and systems to support the enrollment operation;
- 4.3.6.2 Work with BMS to learn the data entry screens within the MMIS;
- 4.3.6.3 Work with BMS and the fiscal agent to identify any modifications needed;
- 4.3.6.4 Work with BMS staff in refining the default auto-assignment algorithm;
- 4.3.6.5 Work with BMS staff in supporting any additional auto-assignment strategies;

4.3.7 The Vendor should provide BMS with a monthly snapshot of key activities. A sample reported should be provided to BMS that may include some or all of the following elements:

- 4.3.7.1 Number and type of enrollee mailings related to the MHT program;
- 4.3.7.2 Per outreach effort, the number of enrollees mailed to or contacted through electronic methods along with the reason for the mailing or contact;

4.3.7.3 The total number of newborn enrollments;

4.3.7.4 The total number of enrollments per month;

4.3.7.5 The auto-assignment rate per month;

4.3.7.6 The number of defaulted enrollments per month;

4.3.7.7 The number of choice enrollments per month;

4.3.7.8 The number of changes in existing enrollment and reason for change per month;

4.3.7.9 The number and percentage of choice enrollments that are processed accurately within two business days of receipt;

4.3.7.10 Problems reported by counties or providers and the number and types of questions asked;

4.3.7.11 Number and type of complaints about marketing methods or discrepancies in enrollment materials;

4.3.7.12 Number and type of complaints about the Vendor;

4.3.7.13 Number of enrollees in the various benefit packages by eligibility groups;

4.3.7.14 Enrollment activities by county, program, and MCO;

4.3.7.15 Telephone activities, including:

4.3.7.16 Number of days the telephone unit was operational;

4.3.7.17 Number of telephone calls received by all operators and by each operator per day, per week and per month;

4.3.7.18 Total number of telephone calls answered regarding enrollment into the managed care programs by all operators and by each operator;

4.3.7.19 Number of calls abandoned and abandonment rate by all operators and by each operator per day, per week, and per month;

4.3.720 Number of calls in the queue at peak times;

4.3.7.21 Average wait time for calls in queue per operator;

4.3.7.22 Number of calls resulting in information generated to BMS's Third Party Liability (TPL) unit;

4.3.7.23 Active time and inactive time for each operator's line; and

4.3.7.24 Log of requests for presentations for stakeholders.

4.3.1 Maintaining Direct Communication with BMS

Maintaining direct, ongoing communication with BMS regarding the Vendor's activities and working closely to assure accomplishment of the enrollment goals and objectives.

We offer BMS a robust approach to ensuring direct, ongoing communication with BMS and DHHR, which includes not only direct communication with our Project staff, but also our Senior Management Team, including our CEO and Director of Information Technology. We are proud to have offered BMS direct access to our Senior Management Team throughout the course of our tenure in West Virginia, and are excited to continue these relationships in the new contract.

DID YOU KNOW?

We offer BMS direct access to both our Project staff *and* our corporate Senior Management Team.

Direct Communication with Project Staff

We offer direct communication with our Project staff using three major routes:

1. **Meetings**: Our Project staff are available to participate in any meetings at any time desired by the State. We can attend meetings in person, either at our facilities or at BMS offices, or we can host meetings via webinars to eliminate any travel.
2. **Email**: All Project staff are all assigned an AHS email account, which will continue to be a major vehicle for communication. Email addresses will continue to be shared with BMS staff.
3. **Phone**: All Project staff are available via our Charleston office phone lines. Further, our field staff and management team are also provided with Smart Phones so they can be reached by BMS staff at any time. Smart Phones further allow staff to not just be available for phone calls, but also to immediately respond to emails and address any urgent issues that arise without delay.

Further, our Field Benefits Managers will continue to be available to make presentations and outreach efforts on behalf of BMS, if so desired by the State. We have always appreciated the opportunity to conduct presentations on behalf of BMS – for example, in 2013, we assisted with the creation of the DHHR PowerPoint presentation for the fall provider workshops and then presented the information on behalf of DHHR.

Throughout the course of our tenure in West Virginia, our Project staff have worked with BMS on countless issues to jointly identify and resolve issues. Recent examples of this work are included in Exhibit 148 below.

Exhibit 148. Recent Communications with BMS

Issue Shared with BMS	Date
Provided real-time feedback to BMS on emerging issues and concerns expressed by providers, pharmacies, and consumers during the Weekly Pharmacy Expansion Meetings.	2013
Assisted with the creation of the DHHR PowerPoint presentation for the fall provider workshops, and presented the information at each of the sessions on behalf of DHHR	2013
Supported the MHC Phase Out	2013
Oh behalf of DHHR, presented the MHT Medicaid Expansion PowerPoint presentation at the OFS Supervisors' Conference in Bridgeport	2013
Attended the weekly Children's Dental Implementation meetings, provided real-time feedback on issues and concerns expressed by the dental providers during our outreach visits	2013
Created a draft DHHR Tip Sheet (at the request of DHHR) that describes the MHT enrollment process and effective dates for newly enrolled Medicaid members, members who lose and regain Medicaid eligibility, and MHT members who want to change their MCO.	2014

Through regular communication, we have supported new BMS initiatives and supplied BMS with timely information to resolve issues.

Direct Communication with Senior Management Team

Unique among many vendors, we also offer BMS direct access to our corporate Senior Management Team. Of note, our CEO, Director of Information Technology, Director of Human Resources Training and Development, and Telecommunications Manager are all just a phone call away. Naturally, all members of our Senior Management Team can also be accessed via email. And, particularly during the implementation period of the new contract, these staff will travel to Charleston and coordinate the implementation of new Project enhancements.

All communications, both with Project staff and the Senior Management Team will continue throughout the lifecycle of the Project.

As part of these communications, we will be available to:

- Determine enrollment goals,
- Identify barriers to achieving enrollment goals and develop action steps,
- Monitor progress towards achieving goals, and
- Implement any desired program enhancements.

Through honest, continual communications, we will be able to fully support BMS in achieving not only its enrollment goals, but desired enrollee experience for the Project.

4.3.2 Meeting with the MCOs After Contract Award

Meeting with the MCOs after contract award an on an ongoing basis, as necessary to obtain detailed information about each individual operation.

As the State's longstanding enrollment broker, we are already intimately familiar with the operations of the MCOs. In fact, during our tenure in West Virginia, we have supported numerous MCO implementations, expansions, and changes in their programming. For example, in 2013, we made modifications to our enrollment materials to support the MCO expansion into Boone, Braxton, Clay, Kanawha, Roane, and Pocahontas counties.

We currently have positive relationships with each of the MCOs participating in Mountain Health Trust, which we have established through the same types of ongoing communication described in Section 4.3.1 (i.e., phone, email, and in-person communications). We make ourselves routinely available to MCOs (we have even attended The Health Plan (THP) provider seminar on behalf of the MHT program as an invited guest), and, if needed, upon contract award, we will re-solidify each of our contacts and update our understanding of their operations. As with now, we will ensure MCOs are aware of our roles and responsibilities.

The ultimate goal of all communications with the MCOs is to ensure that together we administer a high quality Medicaid managed care program that meets the needs of BMS and the potential enrollees/enrollees it serves.

DID YOU KNOW?

In 2014, we supported the expansion of The Health Plan (THP) into Lincoln and Putnam counties by:

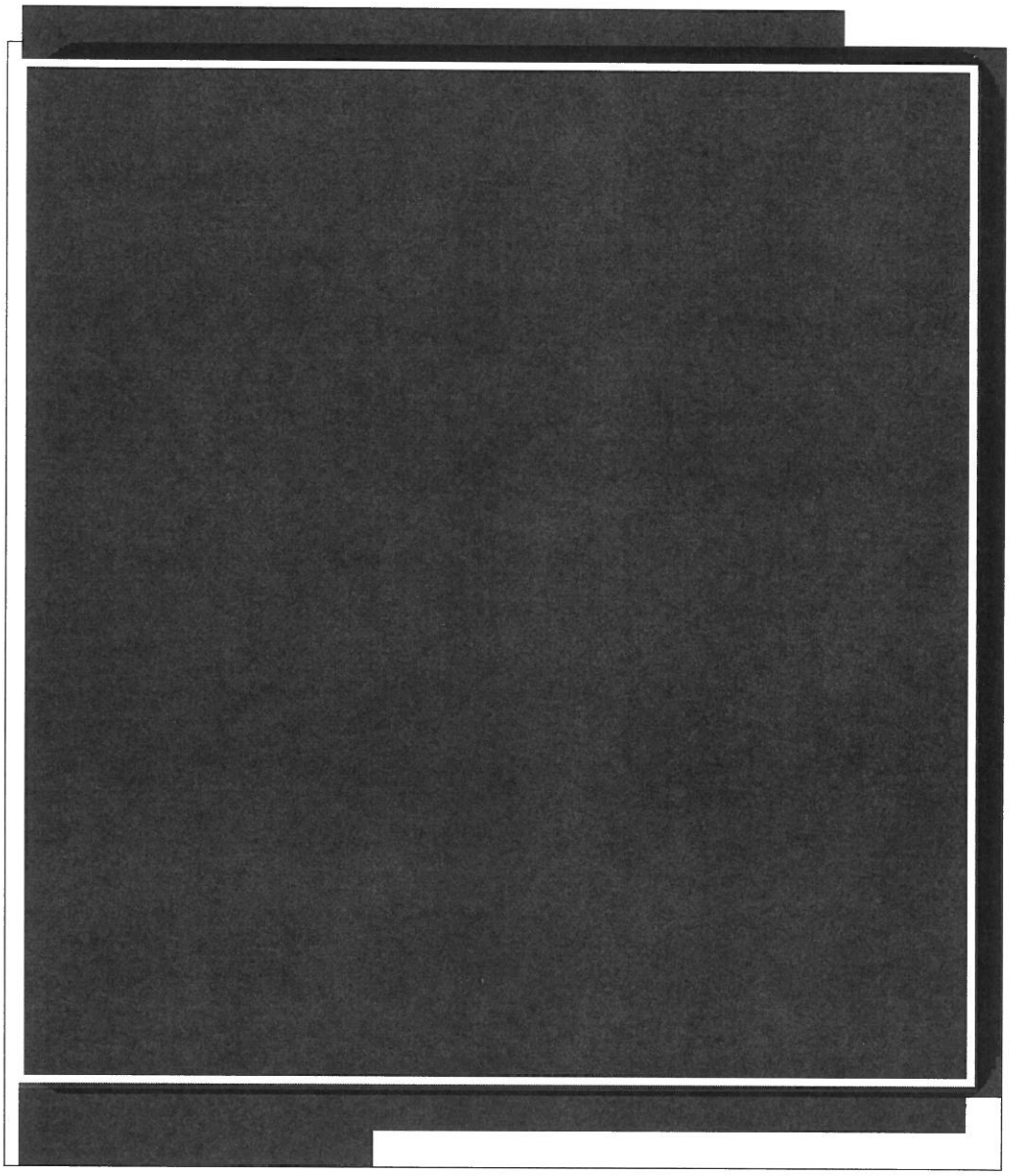
- Mailing the notification letter,
- Updating the MHT website plan options maps,
- Reconfiguring the mailing phases for the counties to include THP plan brochure in the newly eligible enrollment packets,
- Updating helpline and field staff on the effective dates for choice and auto-assignment, and
- Educating providers, pharmacies, agencies, DHHR offices, consumer groups and advocates about the MCO expansion.

This expansion is just a single snapshot of the countless changes we have supported during our tenure with West Virginia.

4.3.3 Technical Assistance

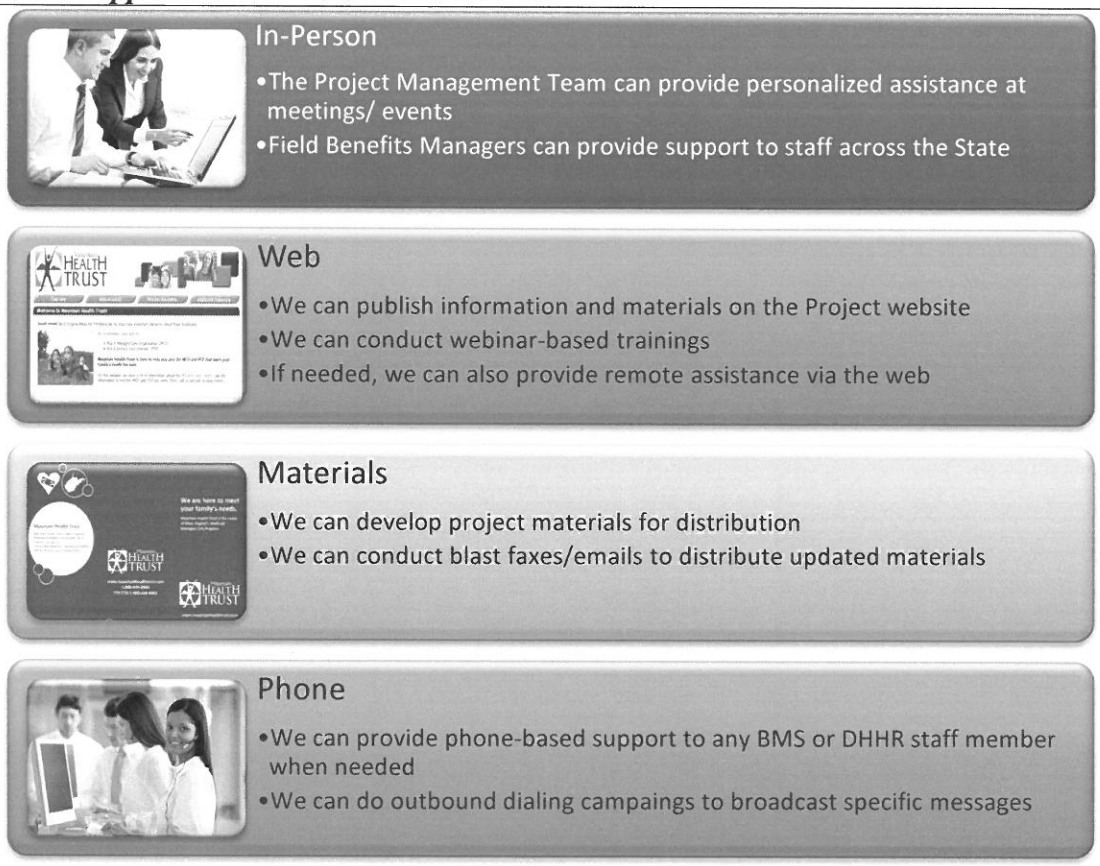
Providing training and technical assistance to all designated DHHR and BMS staff and their contractors participating in this project during the duration of the contract.

We are committed to providing DHHR and BMS staff with multiple forms of needed assistance in a timely manner. For example, in early 2014, at the request of DHHR we created a draft MHT Tip Sheet that describes the MHT enrollment process and effective dates for newly enrolled Medicaid members, members who lose and regain Medicaid eligibility, and MHT members who want to change their MCO. The Tip Sheet (provided on in Exhibit 149) was designed as a training tool to help DHHR workers understand when an enrollment is effective based on monthly cut-off dates.



Our approach to offering technical assistance is three-fold, as demonstrated below in Exhibit 150.

Exhibit 150. Approach to Technical Assistance



Our multi-component approach to providing technical assistance assures DHHR and BMS that we will be continuously available to provide the support needed in a timely manner.

First, our Project Manager or any member of the Project Management Team can provide personalized assistance at any meetings or events. Field staff are available to provide in-person assistance and support at locations across the State.

Second, we can provide updated information and/or support on the Project website. This may include posting updated materials/training guides on the Project website, or providing new information as part of the "Additional Resources Tab." We are also able to provide trainings to designed DHHR or BMS staff using webinars. In our Illinois Health Connect Project we commonly use webinars to provide training to stakeholder and provider audiences, demonstrating that we have the skills, and technical resources to incorporate high-quality training

DID YOU KNOW?

Providers can earn Continuing Medical Education (CME) credits by attending our webinars in Illinois.

webinars if so desired by DHHR. Sample webinars conducted as part of our Illinois Health Connect Project include but are not limited to:

- Paying Attention: Looking at ADD/ADHD,
- Be an HPV Vaccine Advocate,
- Responding to the New Lead Reference Level,
- Food Allergies,
- BMS Billing for Encounter Rate Clinics,
- Billing for Practitioners, and
- Many more.

[redacted]

Third, we can develop a host of training materials. Such training materials may include tip sheets (please see Exhibit 149 earlier for an example), PowerPoint presentations, or FAQs. As referenced in Section 4.2.15, we place great pride in our training materials, and training materials developed for DHHR or BMS staff will be no different. We will pay the same careful attention to font size, visual imagines, white space, etc. to ensure training materials and guides are high quality, and easy for staff to use. **Of note, in our Florida Enrollment Broker Project, we have successfully trained the State staff, including headquarters and regional assistance offices, to use HealthTrack for all enrollment functions.** We provided State staff with their own user manual to ensure they had the needed information about their specific functions and responsibilities at their fingertips.

"Theresa did an excellent job in presenting information to our supervisors. She spoke to 26 supervisors who cover 13 counties. We appreciated her speaking to our group."

--Region IV Program Manager

[redacted]

Last, as is standard for us, State staff are welcome to contact us via the phone at any time for any assistance needed. We can further implement outbound dialing campaigns to make pertinent announcements to a wide audience.

4.3.4 Forward Complaints to BMS

Forwarding any complaints concerning its staff to BMS with an explanation. Serious or repeated complaints about any staff person may result in a recommendation for removal of the staff member.

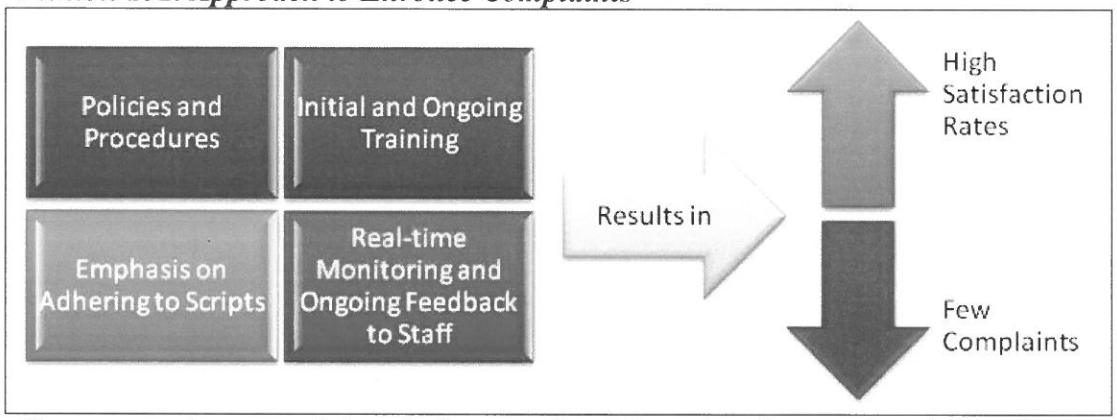
We are excited to offer HealthTrack to BMS as a significant enhancement to our information technology platform (please refer to Section 4.3.6 for a comprehensive description). HealthTrack includes a robust complaint tracking module that will greatly assist in tracking all Project-related complaints, including any complaints lodged against our staff. Below follows a description of our overall approach to complaints, followed by a description of how HealthTrack will be used to log complaints and forward all appropriate complaints (including any complaints against our staff) to BMS. We understand that serious or repeated complaints about any of our staff may result in BMS' recommendations to terminate the staff member.



We are dedicated to accepting, processing and resolving complaints in a professional manner. **Our approach to handling complaints is not only built around taking timely and appropriate action once a complaint has been lodged, but also preventing complaints from arising in the first place to the extent possible** by incorporating four key principles (see Exhibit 151. Approach to Enrollee Complaints):

1. Detailed policies and procedures for all aspects of the Project result in consistency across all staff members;
2. Initial and ongoing training allows staff to provide high caliber services;
3. The importance of adhering to scripts is emphasized and promotes accuracy of service delivery; and
4. Ongoing feedback to staff fosters the provision of excellent service at every level.

Exhibit 151. Approach to Enrollee Complaints



Our approach to complaints, built around a philosophy of prevention, is based on regular training, adherence to call scripts and real time monitoring. As a result, we experience high rates of enrollee satisfaction.

First, policies and procedures facilitate the consistent and timely resolution of complaints and ensure appropriate, thorough documentation for tracking and reporting (details regarding our process and capability to log, track and report on complaints are included below).

Second, we provide extensive initial and ongoing training related to complaints. Our training emphasizes our staff's role in providing information and assistance to program callers (or their legal representatives) as they consider registering a complaint or grievance, and stress that AHS staff must never act as the consumer's legal counsel or representative.

Third, as mentioned, our front-line staff follow scripts and are monitored to ensure they follow scripts during every interaction with every caller. Scripts include the most up-to-date information needed (please refer to Section 4.1.1 for a comprehensive discussion of scripts).

Last, as described extensively in Section 4.1.20, we closely monitor staff to ensure that not only are they following scripts, but they also deliver information that is complete, concise, clear and correct.

In addition, management staff monitors Project data that is collected and recorded. Any issues noted with staff performance are addressed, either through mentoring programs, further trainings, or when needed, corrective action plans.

There will be instances when a caller wishes to file a complaint. As was noted above, our staff will follow our BMS-approved scripting to solicit pertinent information about the nature of the complaint including (but not limited to) the complaint reason, source, affected party, targeted party and other relevant details. Staff will use relevant information gathered regarding the nature of the complaint and in accordance with BMS-approved

We have a proven track record using gentle, persuasive skills to encourage the most difficult callers to talk and work with us in getting complaints and grievances addressed.

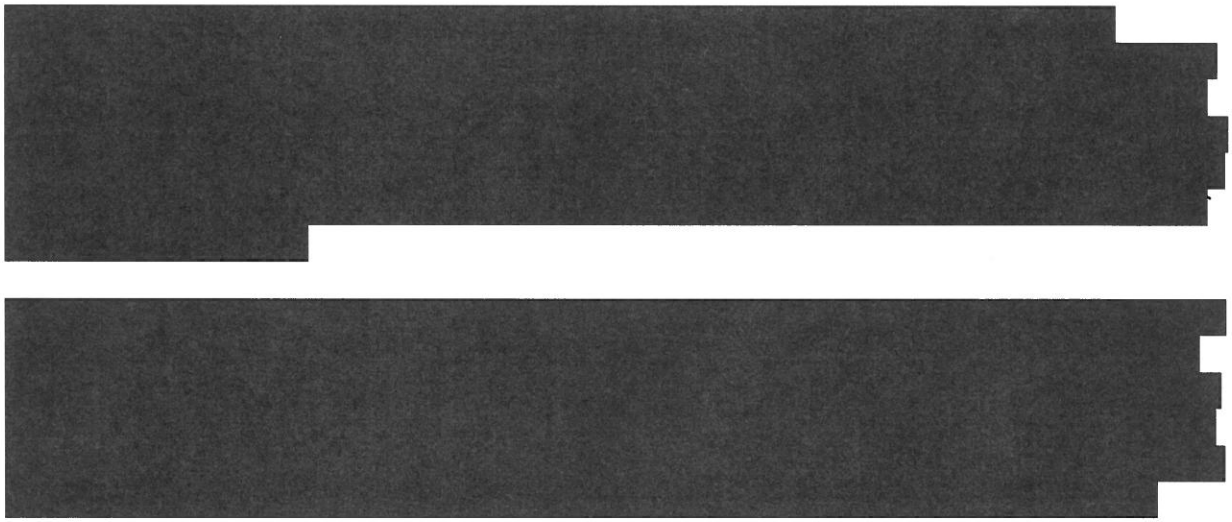
complaint resolution procedures, staff will determine whether or not the complaint can be resolved directly by AHS or should be referred according to procedure.

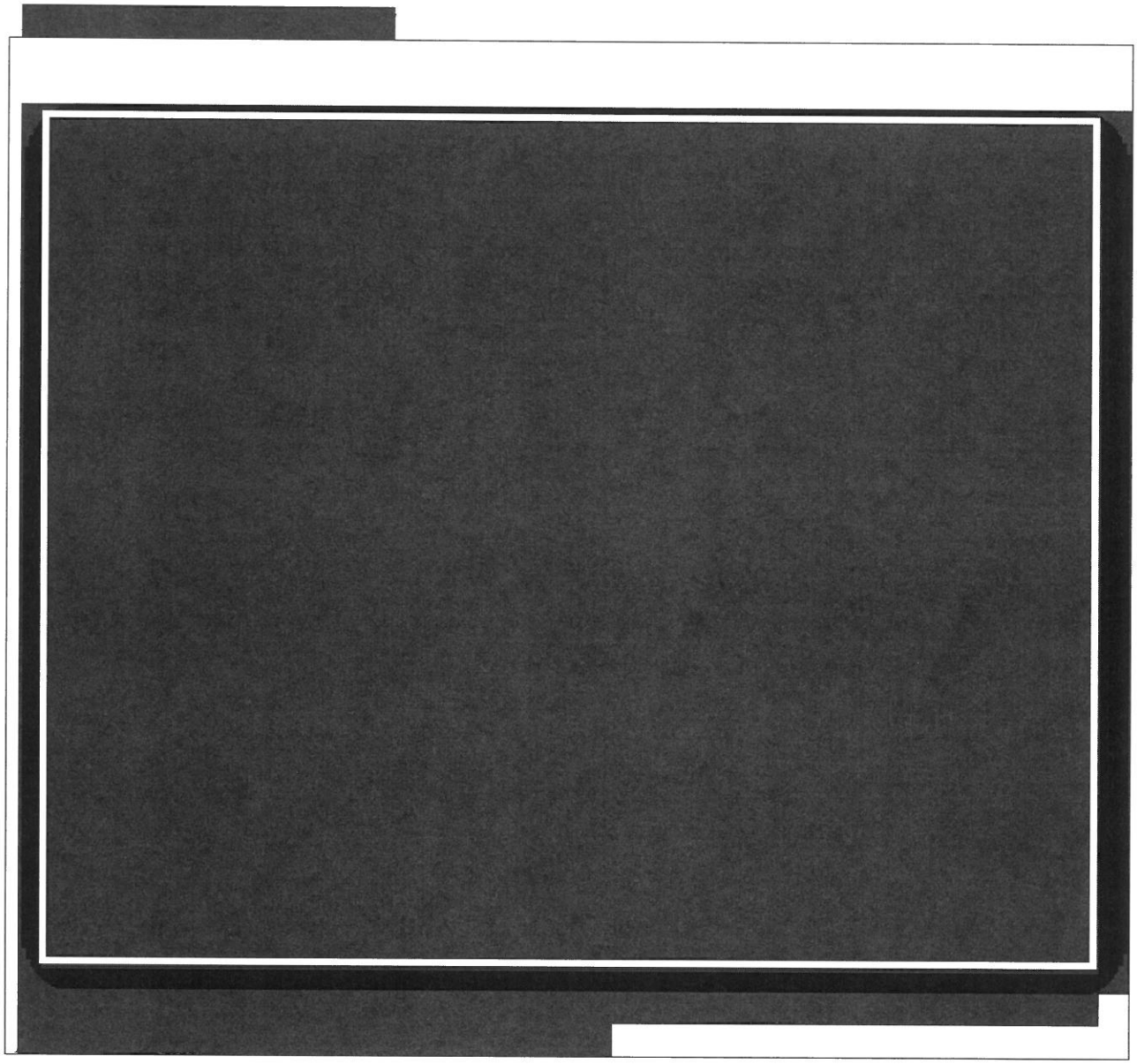
To streamline the resolution of all complaints, our staff will talk with callers who have raised concerns and appropriately assist them in the resolution or filing of a complaint or grievance; every effort will be made to secure satisfactory closure at the time of the call. **If treated in a courteous and empathetic way, we have found that most individuals are responsive to our efforts on their behalf – resulting in the prompt resolution of even the most contentious issues.**

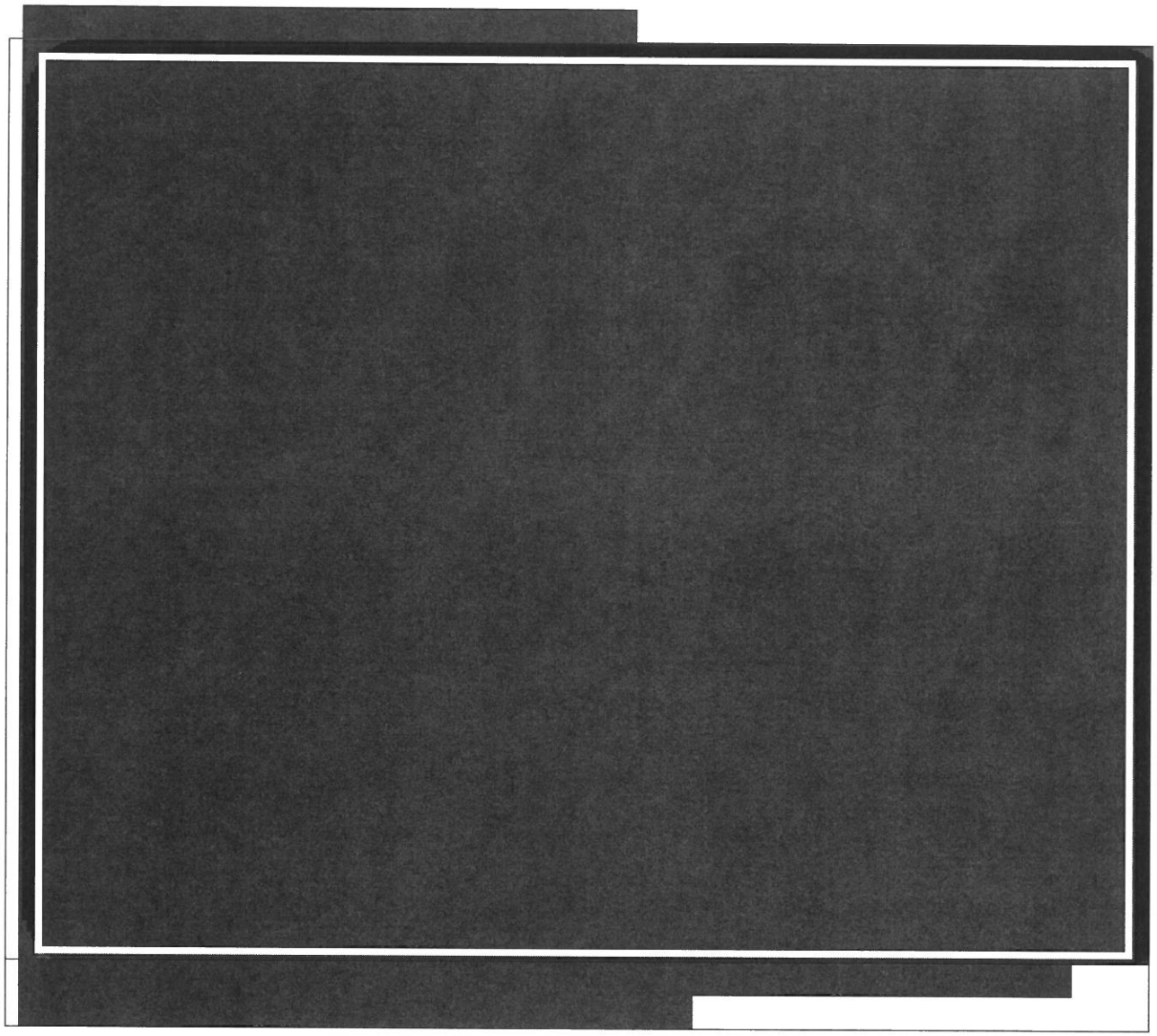
If it is determined that the complaint is one that can be resolved by AHS, staff will:

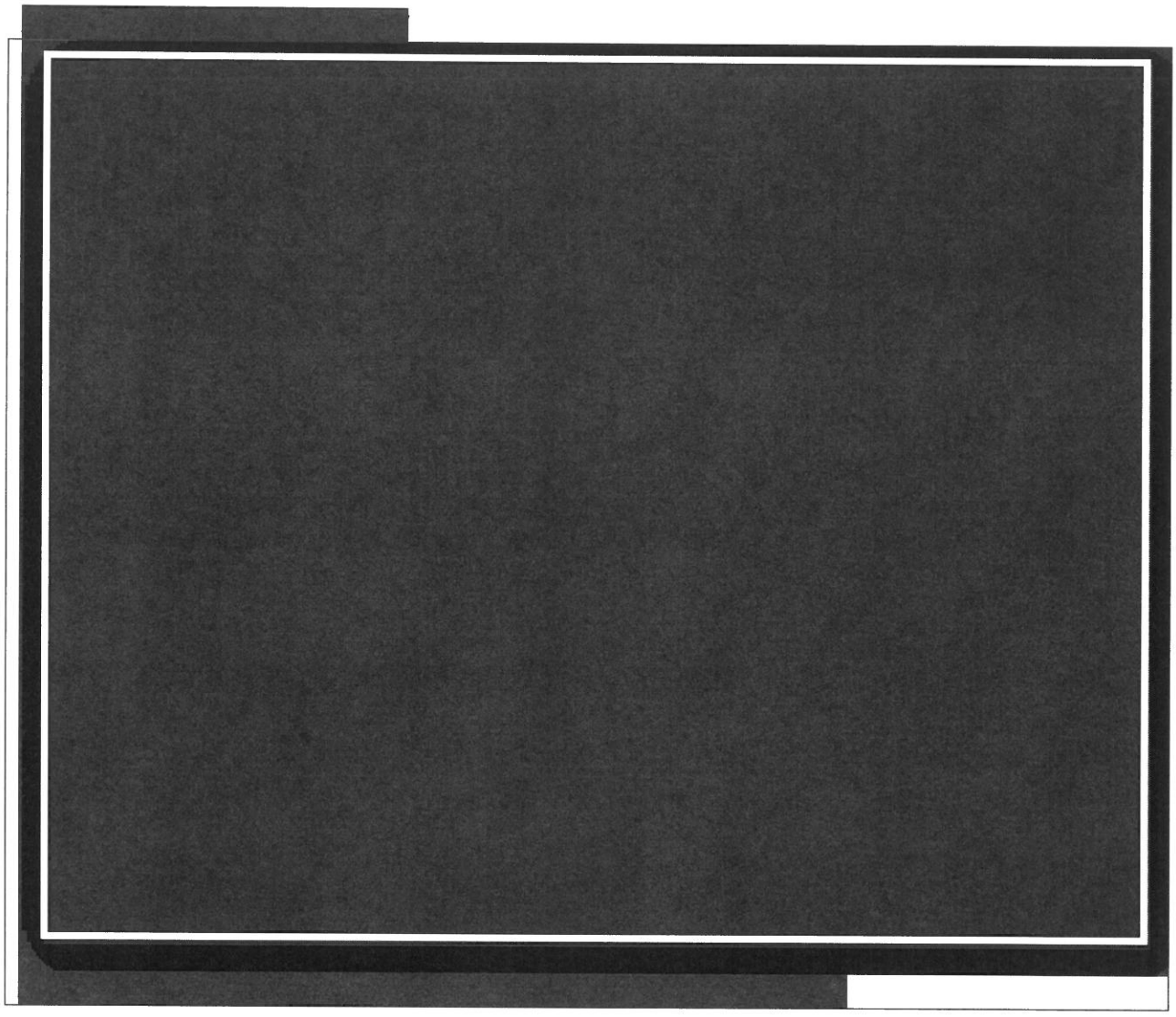
1. Discuss the problem and the potential resolution with the caller;
2. Take the necessary steps to resolve the problem;
3. Verify with the consumer that they are satisfied with the resolution; and
4. Record the resolution including any referrals made in HealthTrack's Complaint Tracking Module.

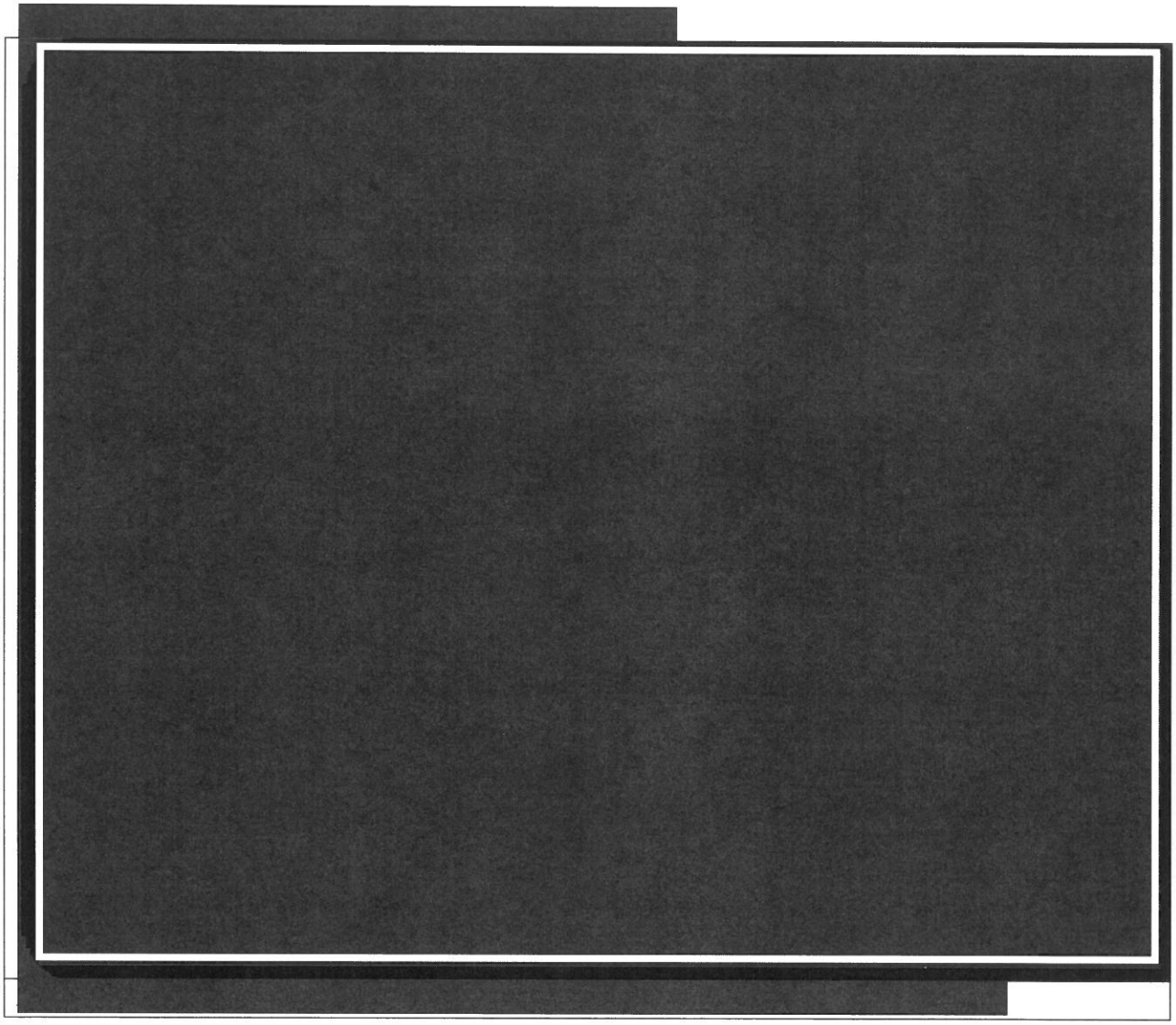
HealthTrack includes robust, integrated complaint logging, tracking, follow-up, and reporting capabilities. The following paragraphs describe how this process will be integrated into the MHT Project.

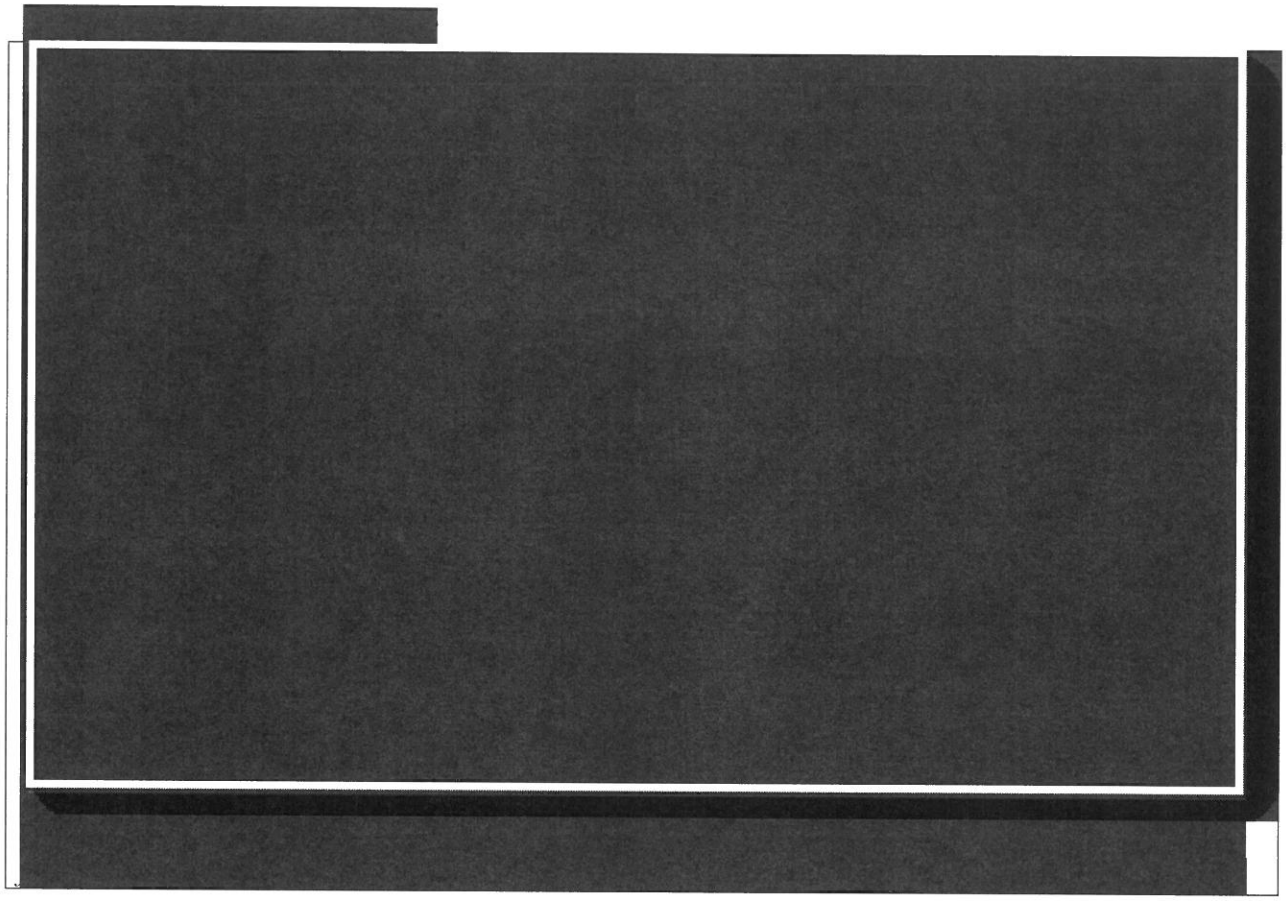


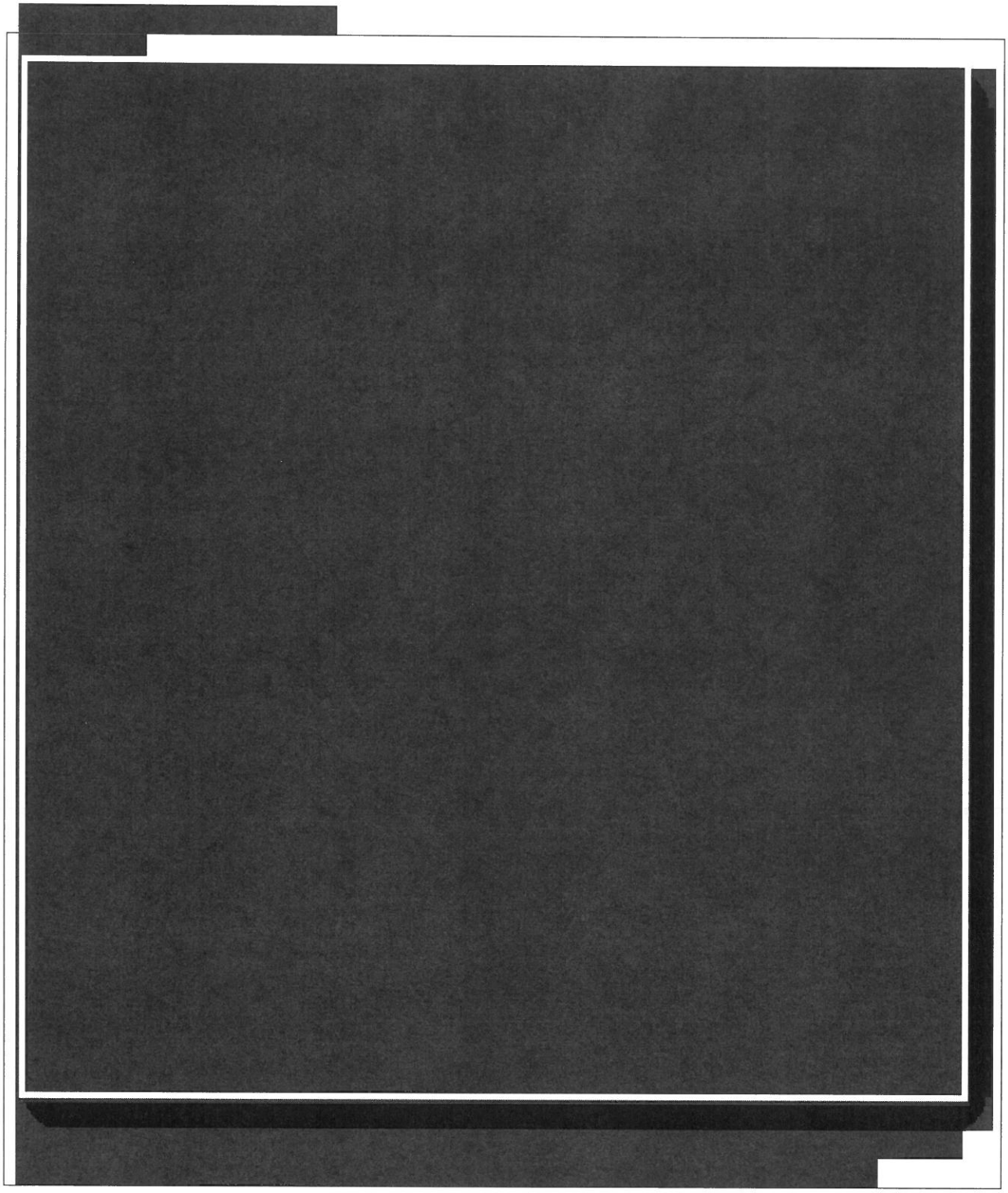












We will work with BMS to determine the steps and actions they will need to take with regard to complaints for the MHT Project. Further, we will also work with BMS to incorporate relevant status indicators into the complaints (e.g., open, closed, pended, etc.).

[redacted]

Please note, as requested, in order to address all issues in a timely manner, we will promptly and fully research all complaints and will notify the party of the results and actions taken to resolve the issue.

4.3.5 Discrepancies on Enrollment Forms

Notifying BMS, on a case-by-case basis, of any discrepancies found on the enrollment form such as, but not limited to, name spelling, date of birth, number of family members in the home, returned mail which indicates the Medicaid eligible has moved, etc., for resolution. Any discrepancy found on the enrollment form should be tracked and reported to BMS monthly via electronic file.

For discrepancies identified, the Vendor should work with BMS to reconcile the monthly list of enrollees for each MCO, which may require extensive research. The vendor should monitor report from the fiscal agent and alert BMS regarding any discrepancies.

The Vendor should be alert to possible discrepancies between approved materials and actual practices as may be reported by members. Any discrepancies discovered should be documented and forwarded to BMS for disposition.

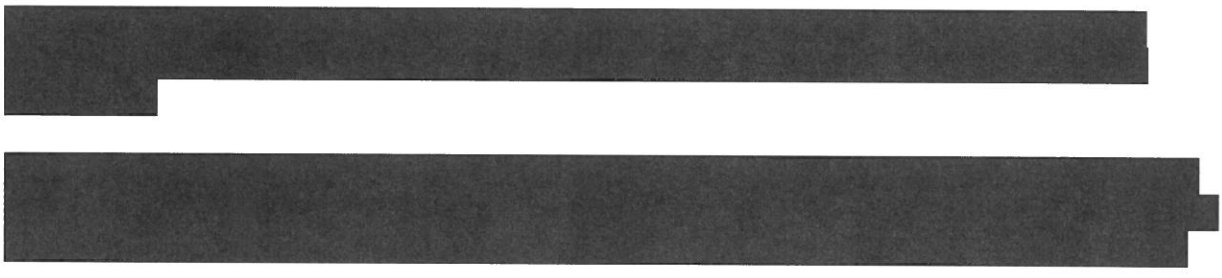
DID YOU KNOW?

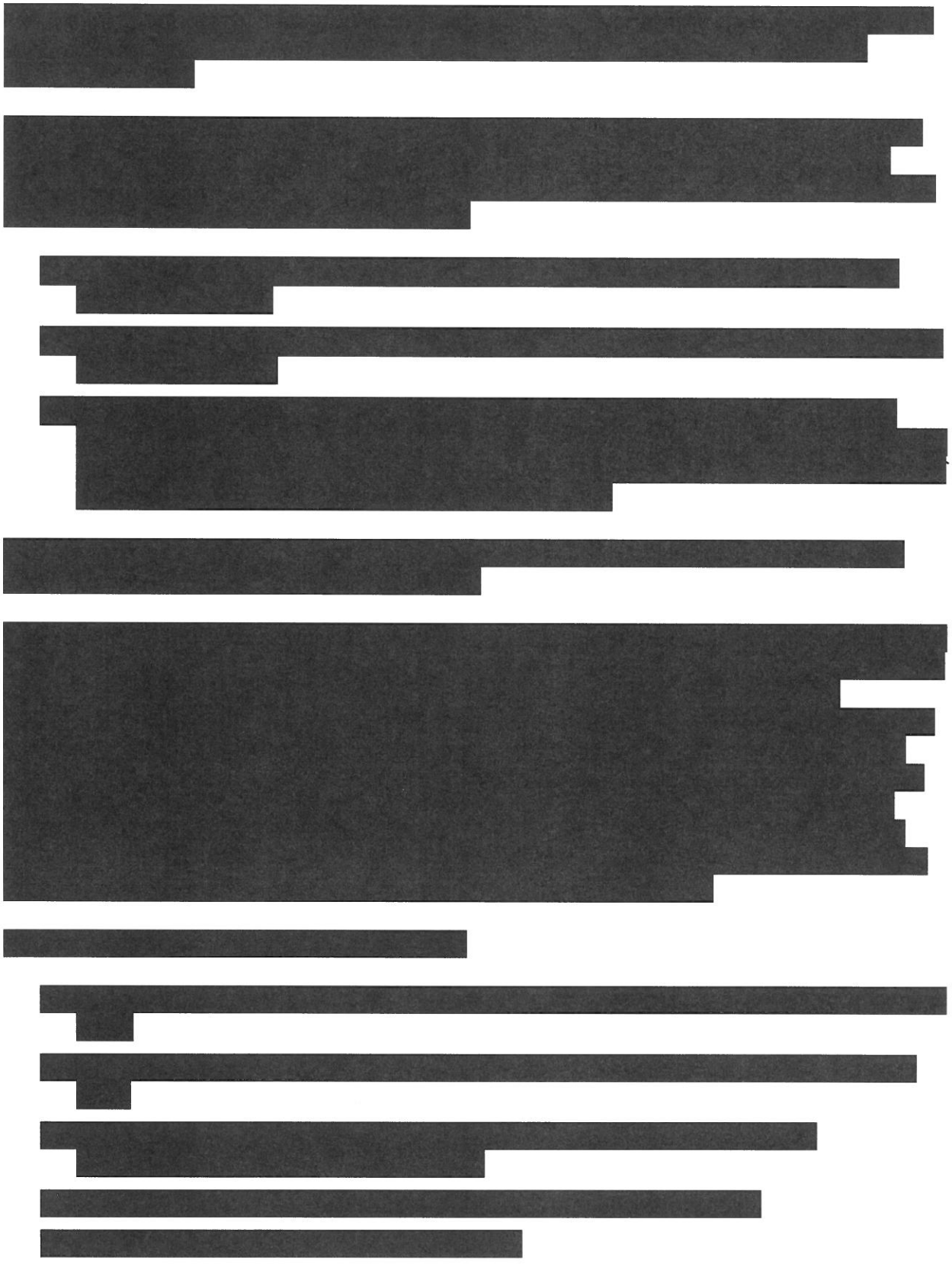
Because our staff are already trained and familiar with all the systems (i.e., RAPIDS and MMIS) required for the Project, they are well positioned to research all discrepancies.

As described extensively in Section 4.3.6 below, we are offering BMS an enhanced IT solution, HealthTrack. One of the many advantages of HealthTrack is that it will allow us to easily identify and log all discrepancies found on the enrollment form (e.g., name spelling, date of birth, number of family members in the home, returned mail that indicates the Medicaid eligible has moved, etc.). Further, we can program HealthTrack to automatically email designated BMS contacts any instance when this occurs.

Because these discrepancies will be tracked in HealthTrack, we can also include them on any monthly reports submitted to BMS if so preferred by the State. They will also be included in the monthly file submitted to BMS. (We will work with BMS on the format to use in the monthly file.)

The Project Manager will update the Policy and Procedure for researching discrepancies and will train staff on all approved protocols. Because our staff is already familiar with the MMIS and RAPIDS systems, they are well poised to assume these research responsibilities. The Project Manager will also develop and receive approval for scripting for Benefits Managers to use when contacting an enrollee to clarify any discrepancies.





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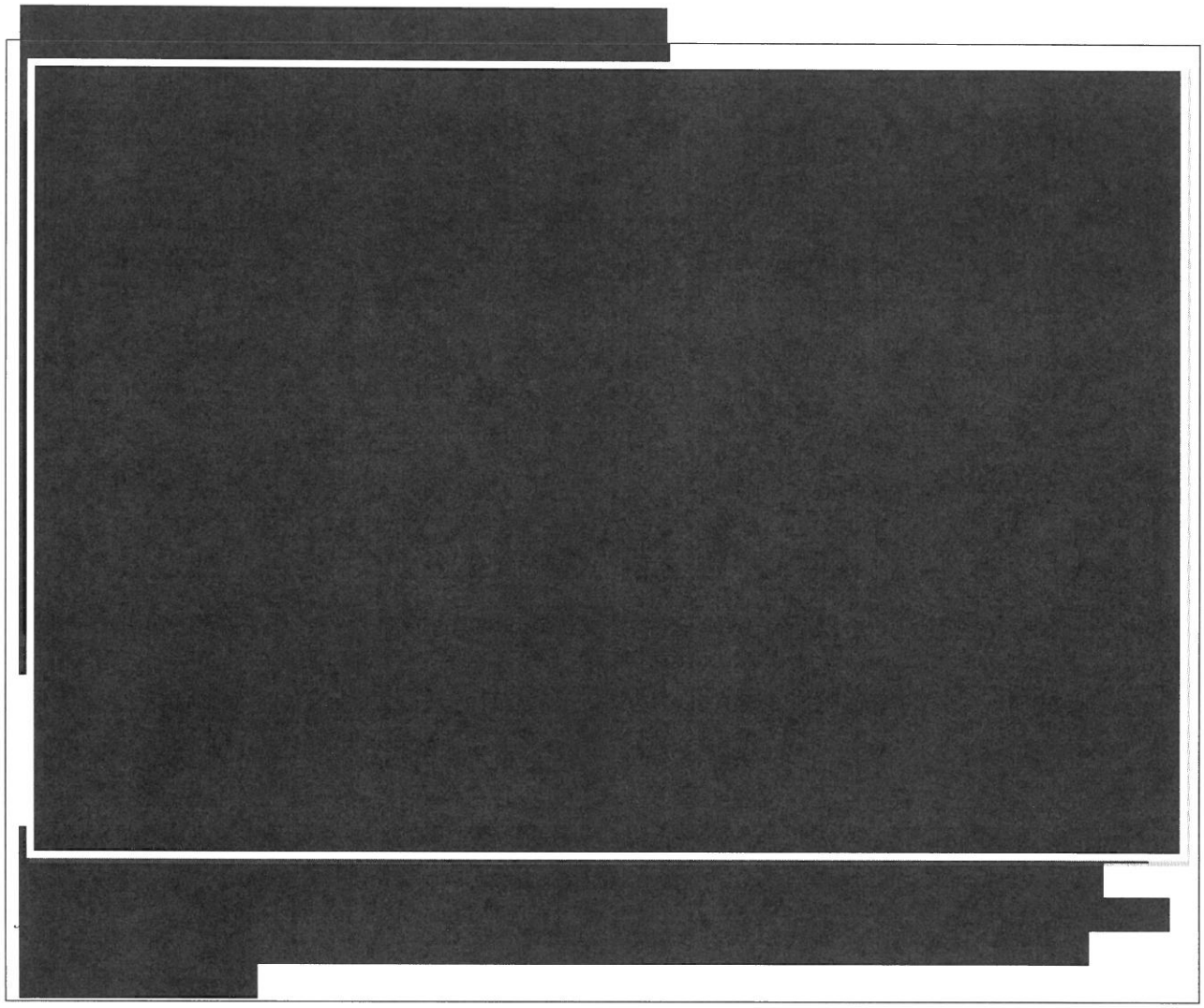
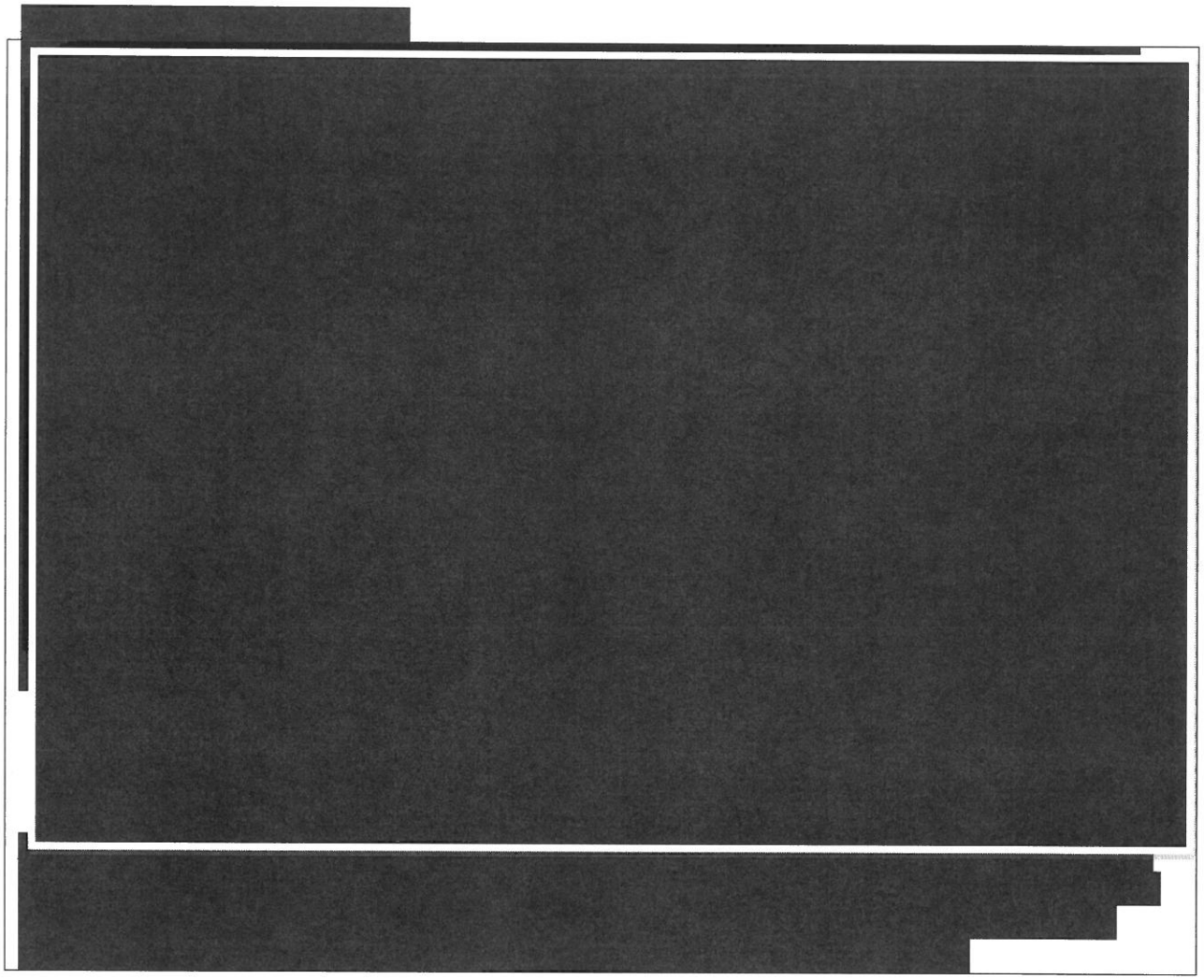




4.3.6 Implementing and Performing Systems Development

The Vendor's proposal should specify its approach for implementing and performing the systems development tasks listed below:

4.3.6.1 Establish and maintain databases and systems to support the enrollment operation

As the current MHT contractor, we already have all of the hardware, software, systems interface/connectivity, and other requirements for continued operation of the MHT Project in place. **We are already fully prepared and equipped to seamlessly continue our service to BMS, DHHR, potential enrollees, enrollees, and the MCOs as West Virginia's MHT Contractor.**

However, as highlighted throughout our proposal, "business as usual" is not our proposition. The most significant upgrade we propose under the new MHT contract is the full customization of our most recent iteration of HealthTrack – a deliverable that we will have fully tested and deployed prior to the operational Go-Live of the new MHT contract. **The upcoming contract and any potential expansion of MHT activities provide BMS and AHS the perfect opportunity to bring our operational excellence and customer service to the next level.**

Given the longstanding success of the MHT Project and West Virginia's managed care programming, BMS needs a contractor who provides an Information Technology system that will:

- Support and enhance the continual provision of customer service assistance in response to myriad inbound inquiries;
- Continue the State's tradition of successfully processing managed care enrollments for potential enrollees and enrollees and, when so requested, SSI population and Medicaid expansion population;
- Be fully flexible and able to easily adapt to changing business rules;
- Allow for an easy interface with the State and MCOs;
- Support the State in its advancement of MITA maturity;
- Be able to expand and respond and adapt to any changes resulting from the Affordable Care Act;
- Support the continual delivery of our numerous value-added services;



DID YOU KNOW?

We are able to integrate with any system. In 2007 when the State transitioned to a new MMIS vendor, we seamlessly interfaced with the new vendor, supported all transition activities, and continued offering potential enrollees and enrollees uninterrupted services.

- Respond to changes in the managed care landscape as MCOs come and expand into additional regions; and
- Support the collection of data (as desired and appropriate) into the State's Data Warehouse.

As evidenced from the narrative to follow, we are pleased to be such a vendor, and not only bring the skills needed to perform these functions with ease, but also a successful track record of smooth information technology system implementations that surpasses the expectations of the States with whom we contract and facilitates service delivery improvements. To demonstrate a few examples of such accomplishments, we offer the following highlights of how we have supported similar objectives:

- In 2006, we handled the expansion from the original 15 county mandatory managed care service area in Ohio to an 88 county statewide effort supporting over a million Medicaid eligibles. While the geographic expansion was occurring, we also assumed the enrollment of the ABD population to MCOs. Our IT Department made all programming changes necessary for all Project Units (e.g., Call Center, Field Operations, and Mailings) to handle the transition.
- In 2010, in addition to the 1.2 million Medicaid managed care consumers we already served in Illinois, we enhanced HealthTrack and all related systems to accommodate the Integrated Care Program serving an additional 40,000 AABD eligibles at the request of the State.
- In 2011 we expanded our enrollment broker operations from the five county service area for Medicaid Reform into the 62 remaining Medicaid Options counties in the State of Florida. As part of this expansion, we made the programming changes necessary to accommodate the three million additional consumers, MCOs, vastly different program requirements including eligibility and enrollment processing changes, mailings (the expansion required over 50 different letters in three different languages) and operational changes. We execute a similar expansion in 2014 that required significant updates to all our systems.
- In Illinois, throughout the duration of our ICEB contract (2006-2012), we expanded geographically and provided services for additional MCOs. The initial Project focused on the Cook County area, and by the end of 2007, we expanded to the southern regions (the counties included Washington, Williamson, St. Clair, Perry, Randolph, Madison, and Jackson). By the end of 2008 as Meridian provided services in the Northwest/Central regions, we began serving Scott, Rock Island, Pike, Mercer, Henry, Brown, and Adams counties. When Harmony Health Plan moved into Kane County in 2010, we began providing services in that county as well. Last, in 2011 we expanded into Lee and McHenry counties.
- In 2008, in Illinois we demonstrated our capability to quickly and easily accommodate the introduction of a new MCO, as we did with the introduction of Meridian Health Plan. For this implementation, we held our first meeting with the State on September 5, 2008

and completed all our required tasks by September 26, 2008 for the anticipated start date of October 6, 2008.[24] IT-related tasks included but were not limited to updating the Project website to include information about Meridian Health Plan, updating enrollee materials and posting these on our website, updating the provider search function, updating the online enrollment materials, generating/updating appropriate reports, and modifying HealthTrack as needed.

Through our 18 year history with Enrollment Broker Contracts (particularly our nearly 20 years in West Virginia), we understand that the Information Technology System for the Project must include intuitive and user-friendly interfaces needed for Benefits Managers to provide accurate and consistent answers to Medicaid-related inquiries, effective counseling, and log all call activities/enrollment functions. Further, the IT system must also include robust back-end processes to interface with State systems and share and transmit data with BMS and the MCOs, and be fully compliant with all HIPAA and HITECH Act requirements. As a result, we are pleased to offer our most recent and robust iteration of HealthTrack.

We are excited to offer the HealthTrack at this time, as it:

- Mirrors the State's commitment to advancing technology and MITA maturity;
- Demonstrates our commitment to advancing our technological capacities and staying on the cutting-edge;
- Has been successfully developed, tested and deployed in other large statewide Medicaid contracts;
- Supports BMS' need to achieve cost efficiencies by streamlining staff workflows and providing numerous tools at Benefits Managers' fingertips;
- Supports the easy accommodation of new managed care programming, enrollee populations, and customized business rules.

We are not offering BMS a prototype Information Technology System. Rather, HealthTrack has been fully tested, developed, and deployed in other large statewide Medicaid contracts. As a result, BMS does not need to worry about encountering unforeseen problems with the system during the implementation period, and we can assure BMS with complete confidence no services or operations will be disrupted.

While we have mentioned that HealthTrack has already been successfully developed and deployed in other contracts (and has earned rave reviews from end users and State staff alike), it will still be *fully* customized to meet the needs of the MHT Project. It is a hallmark of AHS to truly understand all of BMS' needs and make all programmatic changes needed. As we have proven time and again with our customers, we will develop systems to meet BMS' needs and support new initiatives. This is not a process we take lightly.

[24] The actual start date was October 27, 2008.

In less than a month, we designed, developed and launched the first ever online enrollment application for the State of Florida. (The previous enrollment broker contractor was unable to launch online enrollment.) Our application allows an enrollee to log-in securely, become educated on the program and available MCOs, search through the provider database and select/change MCOs and PCPs. Not only that, but consumers can enroll in English, Spanish or Creole. According to Interim Secretary Elizabeth Dudek, "By providing an opportunity for recipients to enroll online, they have the opportunity to make the best decisions for themselves and their families when it is convenient for them."

To provide BMS with a full discussion of our data systems for the MHT Project and our ability to exceed BMS' data systems requirements, the following response is organized as follows:

- Plan to Customize HealthTrack, and
- Plan to Help West Virginia Advance Its MITA Maturity Level.

Plan to Customize HealthTrack for the MHT Project

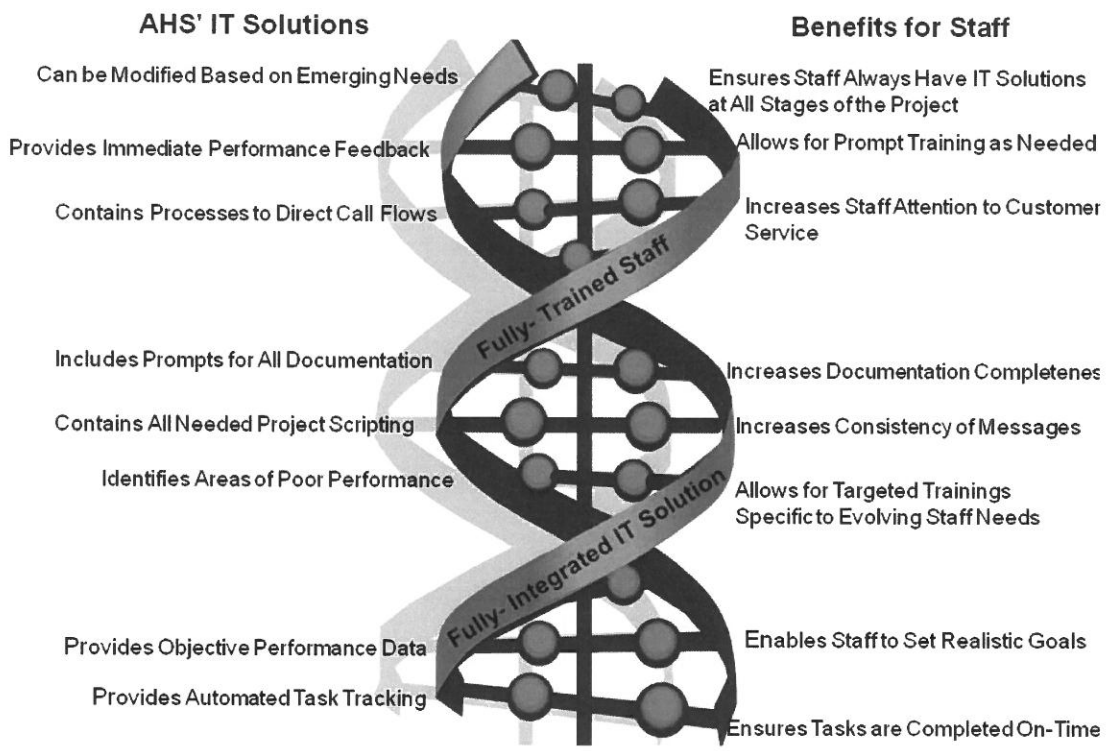
While the current system has served the MHT Project well both in terms of functionality and adaptability, we recognize that there are now newer and better alternatives available. Advancements in both hardware and software technologies have been developed that have become the new mainstream and industry standards. As we have expanded our customer base and technical capacity over the last several years, we have incorporated new technologies and approaches to the design, development and implementation of the call center and enrollment broker contracts we manage.

DID YOU KNOW?

If BMS changes the process for conducting file transfers at any time during the Project (e.g., file formats, timeliness of transfers, file exchange partners, etc.), we can accommodate these changes – all without a change order!

We should note that much of the success of our IT systems is through our approach to marrying technology with the "human touch," as both are integral components and cannot function alone. Our IT systems are built to support and augment staff work tasks and are developed with real user input to assure they fully support staff in completing their tasks. As a result, BMS benefits from an efficient IT solution that meets all the requirements stated in the RFP and ensures consumers still receive personalized services of the highest quality. The benefits of this approach are depicted below in Exhibit 160.

Exhibit 160. Benefits of Approach to Integrating Technology with Staff Needs



By marrying technology with staffing, we provide additional benefits to staff, the State and West Virginia's potential enrollees/enrollees.

Before we provide a description of HealthTrack, we wish to stress that all current processes (e.g., file transfers, enrollment processes, mailing functions, etc.) will continue as they do now. **The transition to HealthTrack will not jeopardize in any way, current established policies and procedures for interfacing with BMS, reporting, and ongoing program activities.** What it will do is position us to be better able to accommodate any changes resulting from West Virginia's MITA maturity efforts, changes in managed care programming/managed care expansions, the Affordable Health Care Act, and other requirements BMS may need or wish to make within the Medicaid Program. In fact, we assure BMS that during the implementation period, all existing systems and processes will function normally and not be impacted while we customize HealthTrack for BMS.

[redacted]

[redacted]

[redacted]

Our Florida client has been so impressed with our technical capabilities, specifically HealthTrack that they requested for all their local county offices to be able to access AHS' system instead of the enrollment information system they were previously using.

[redacted]

[redacted]

[redacted]

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DID YOU KNOW?

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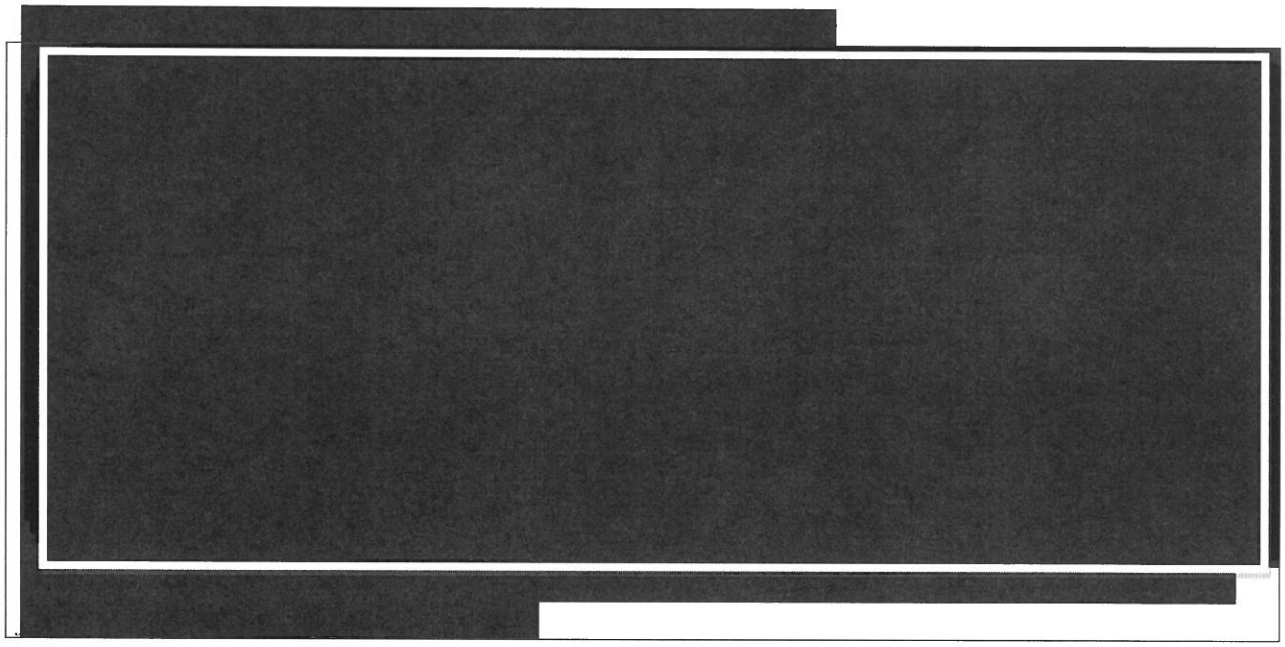

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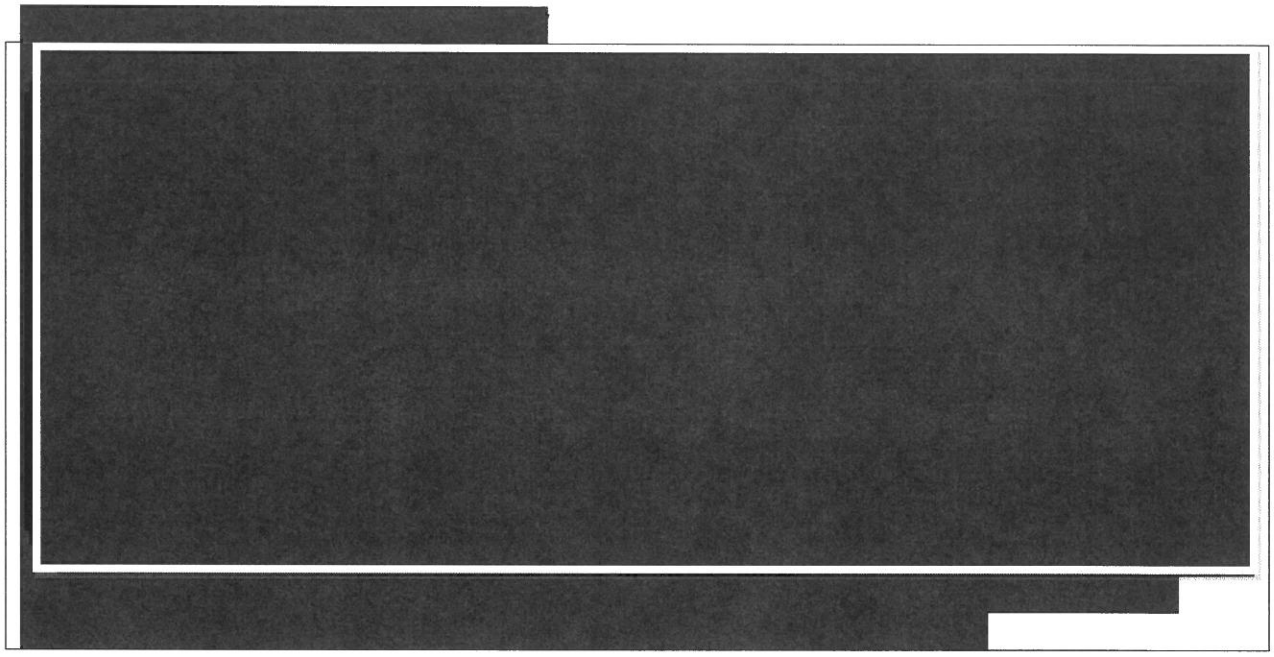

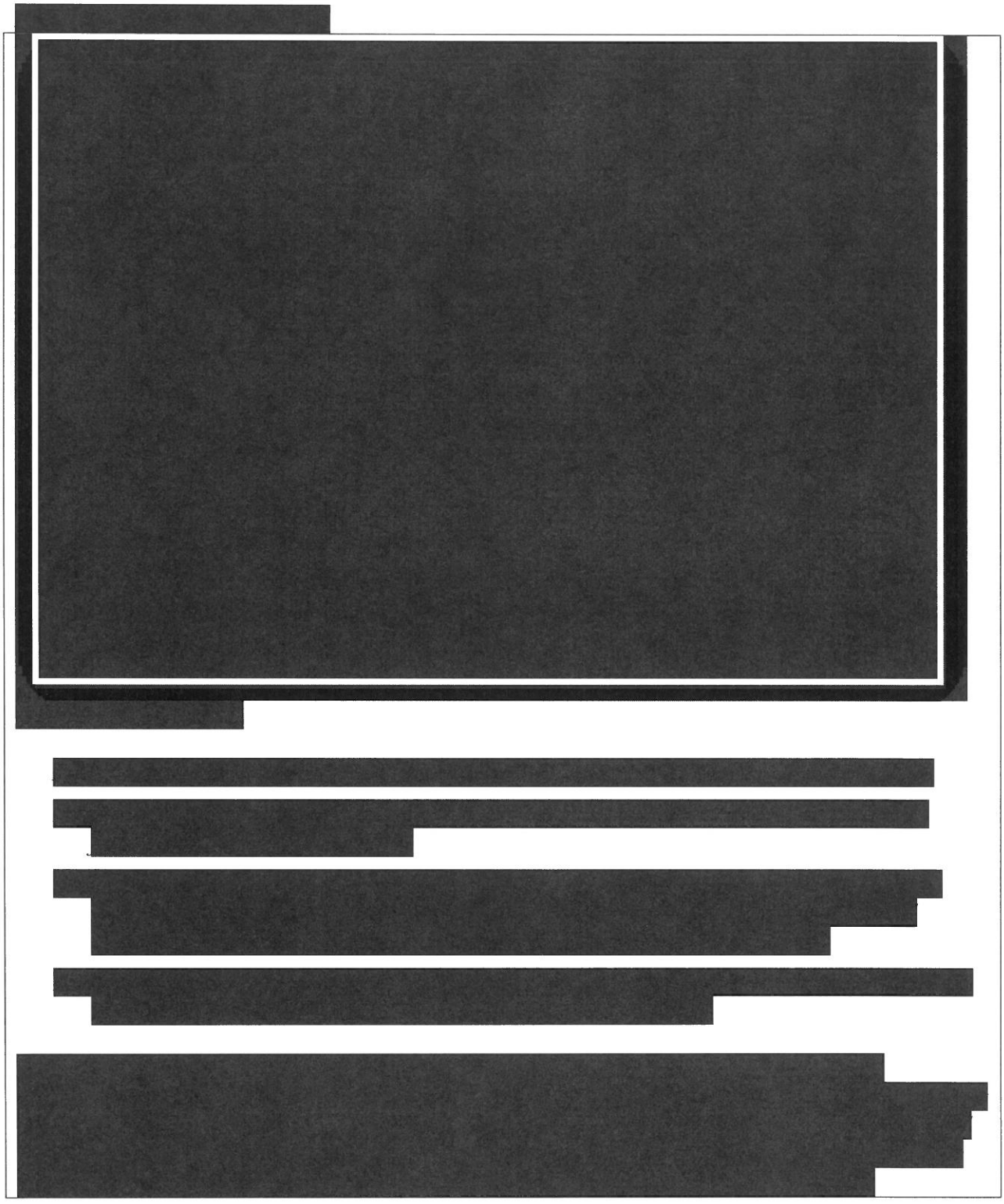

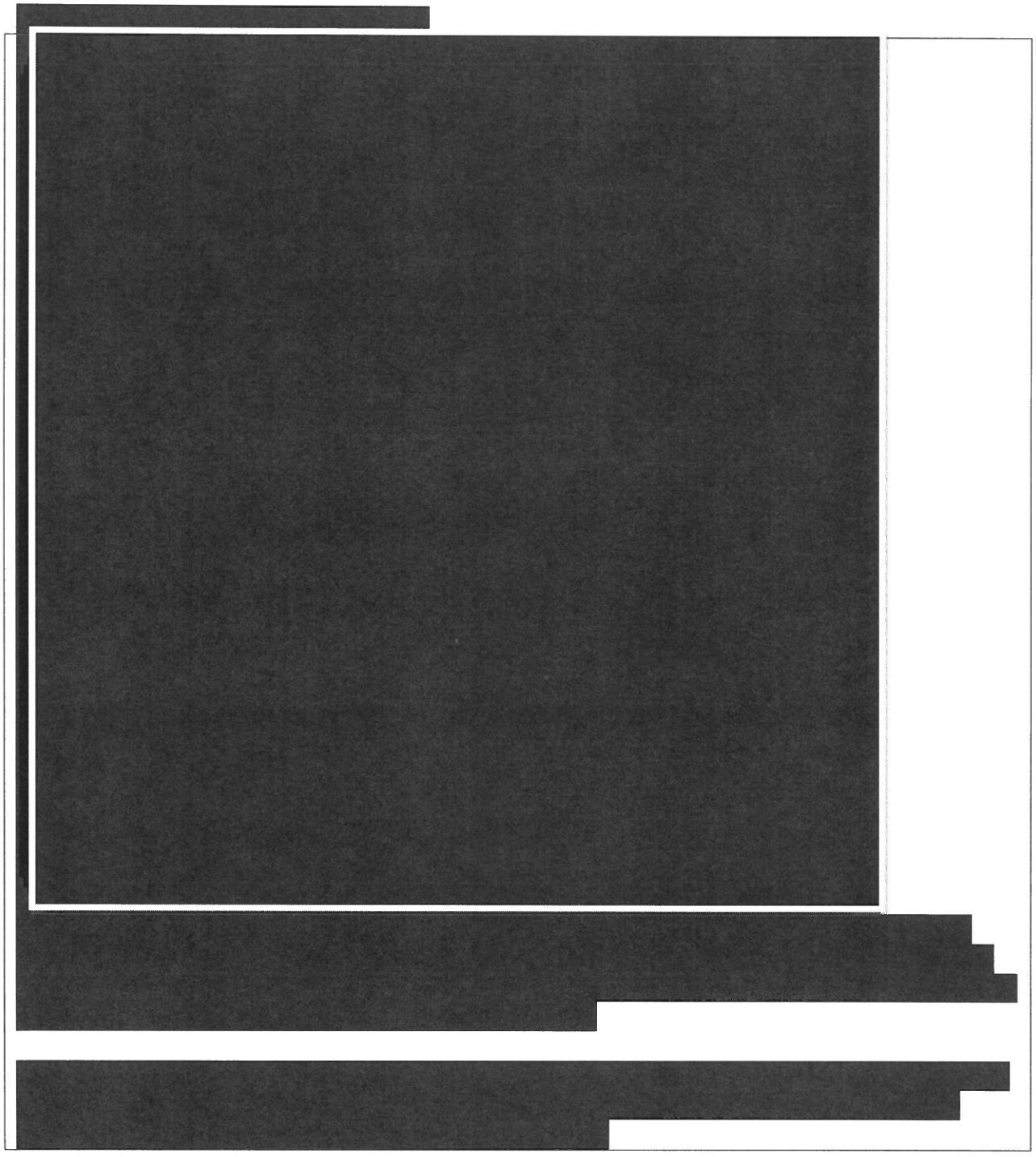

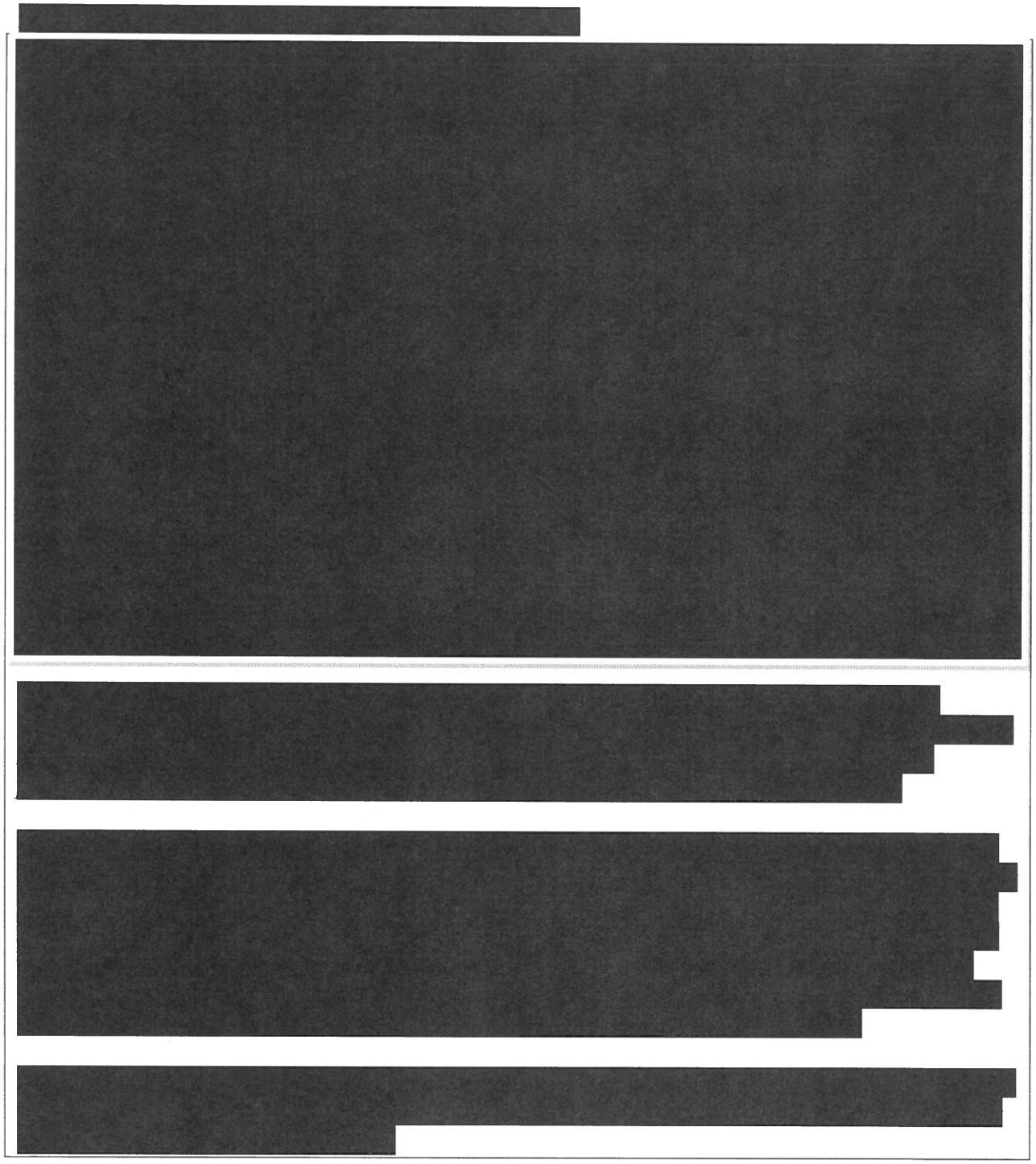

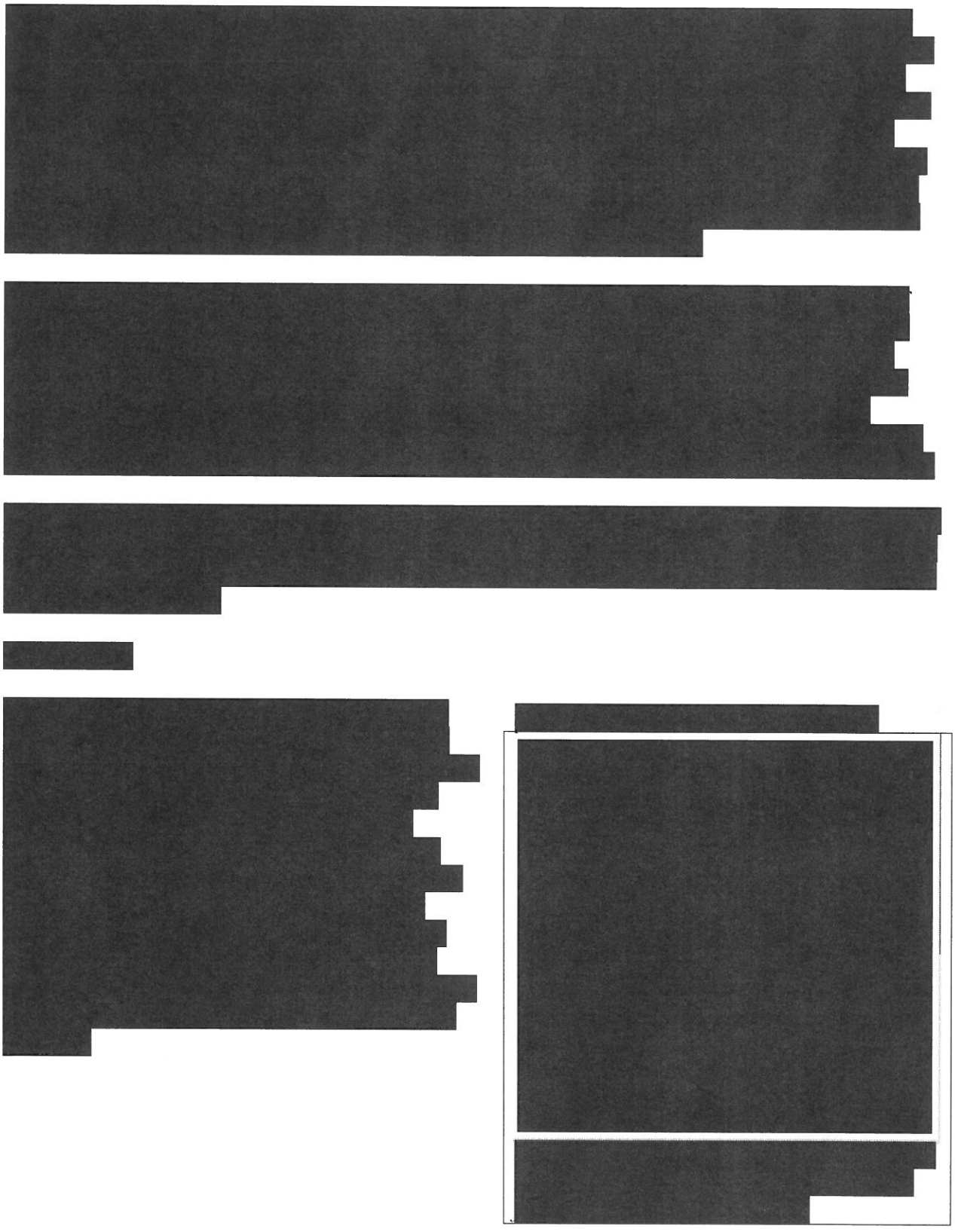

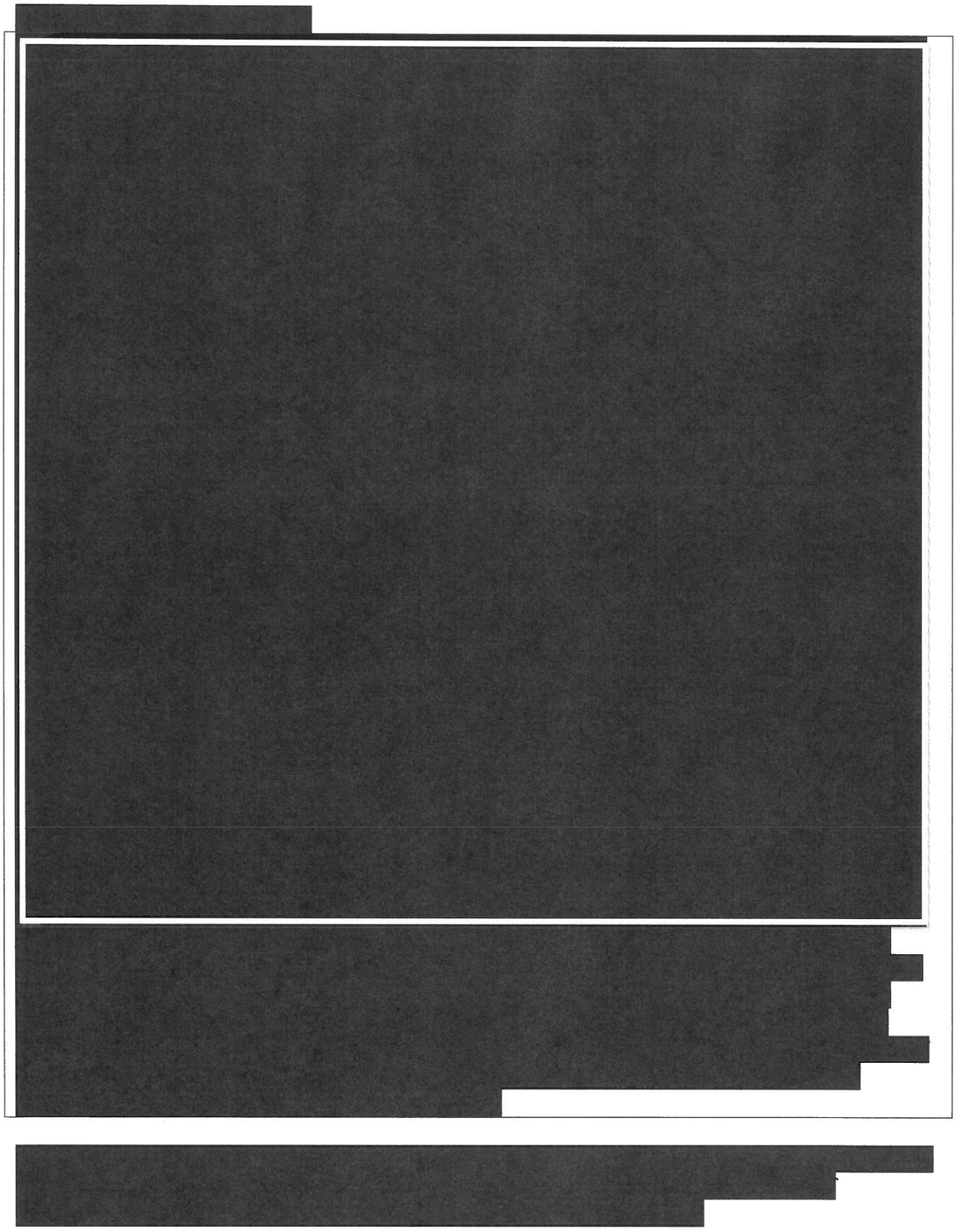

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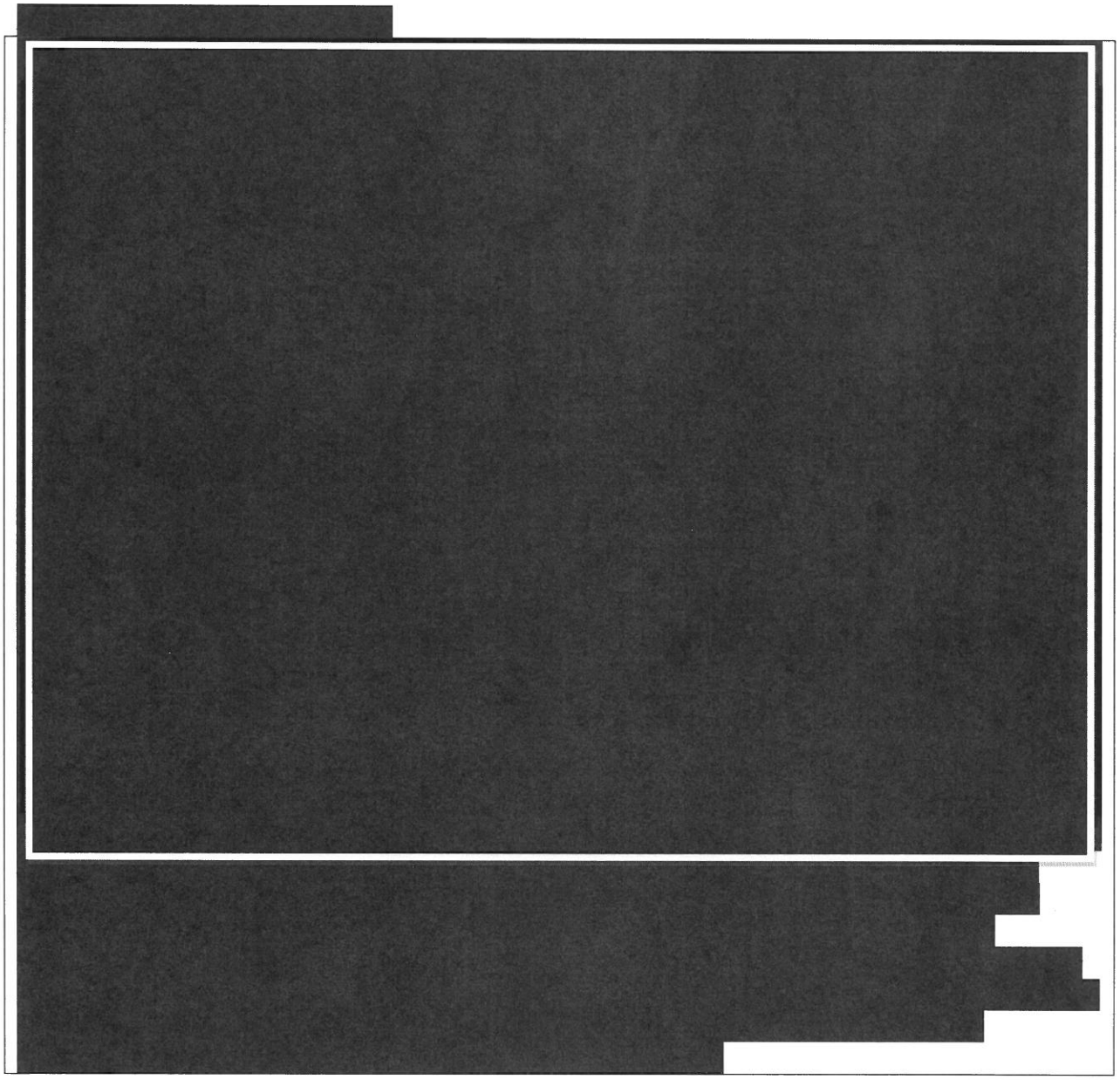
[25] Please note, the list of call reasons will be appropriately customized according to BMS specifications.

[redacted]



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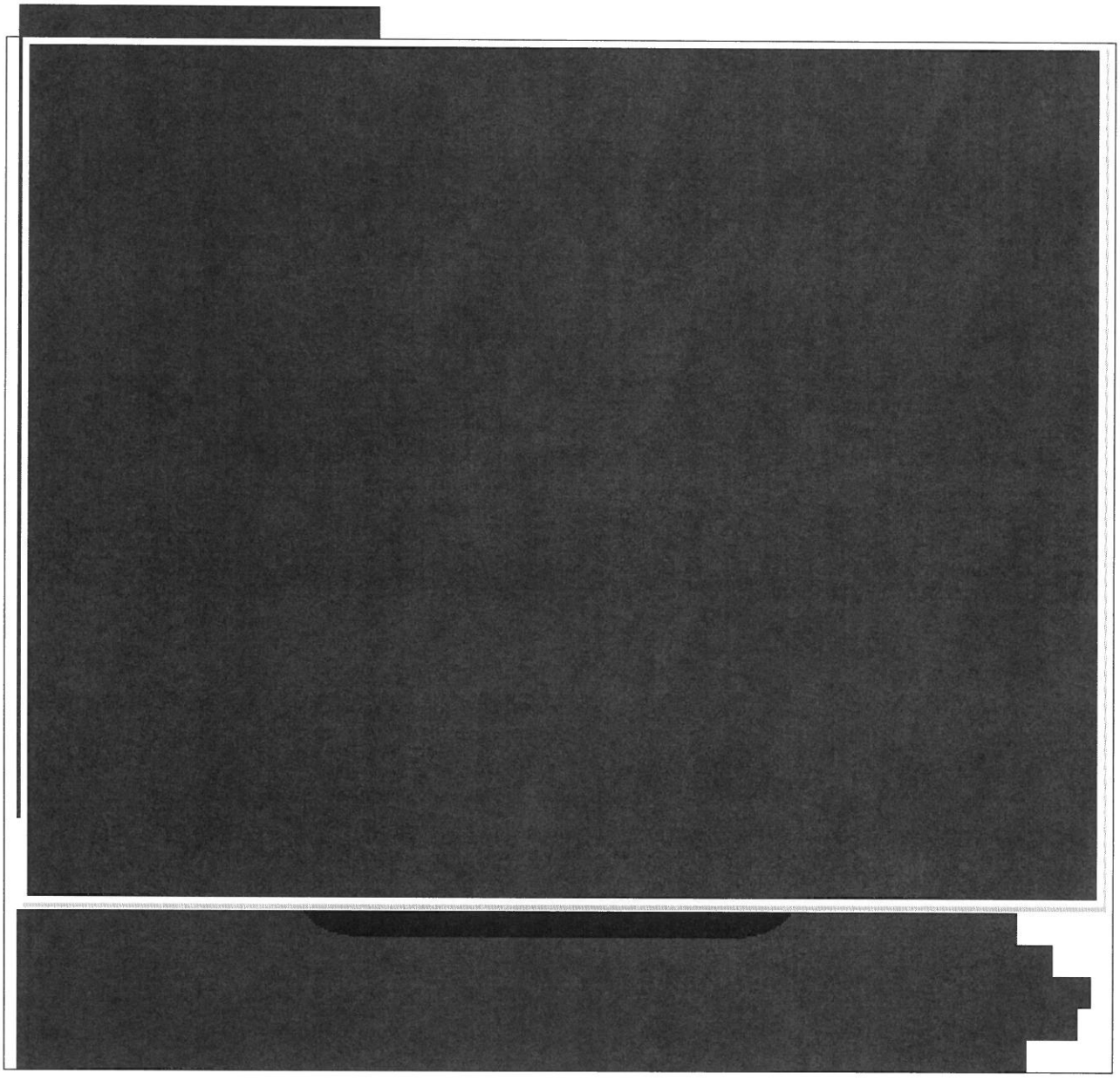

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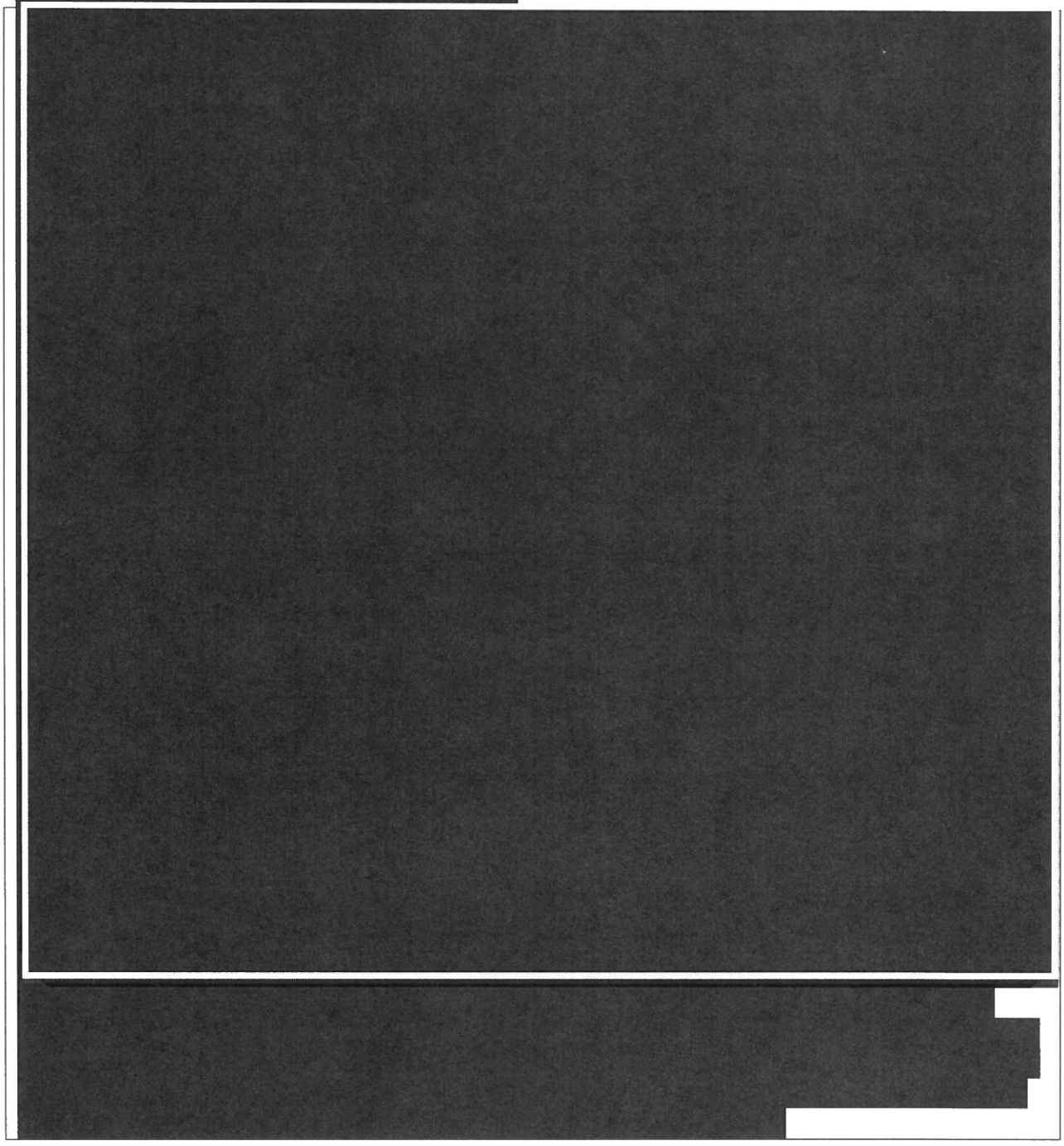

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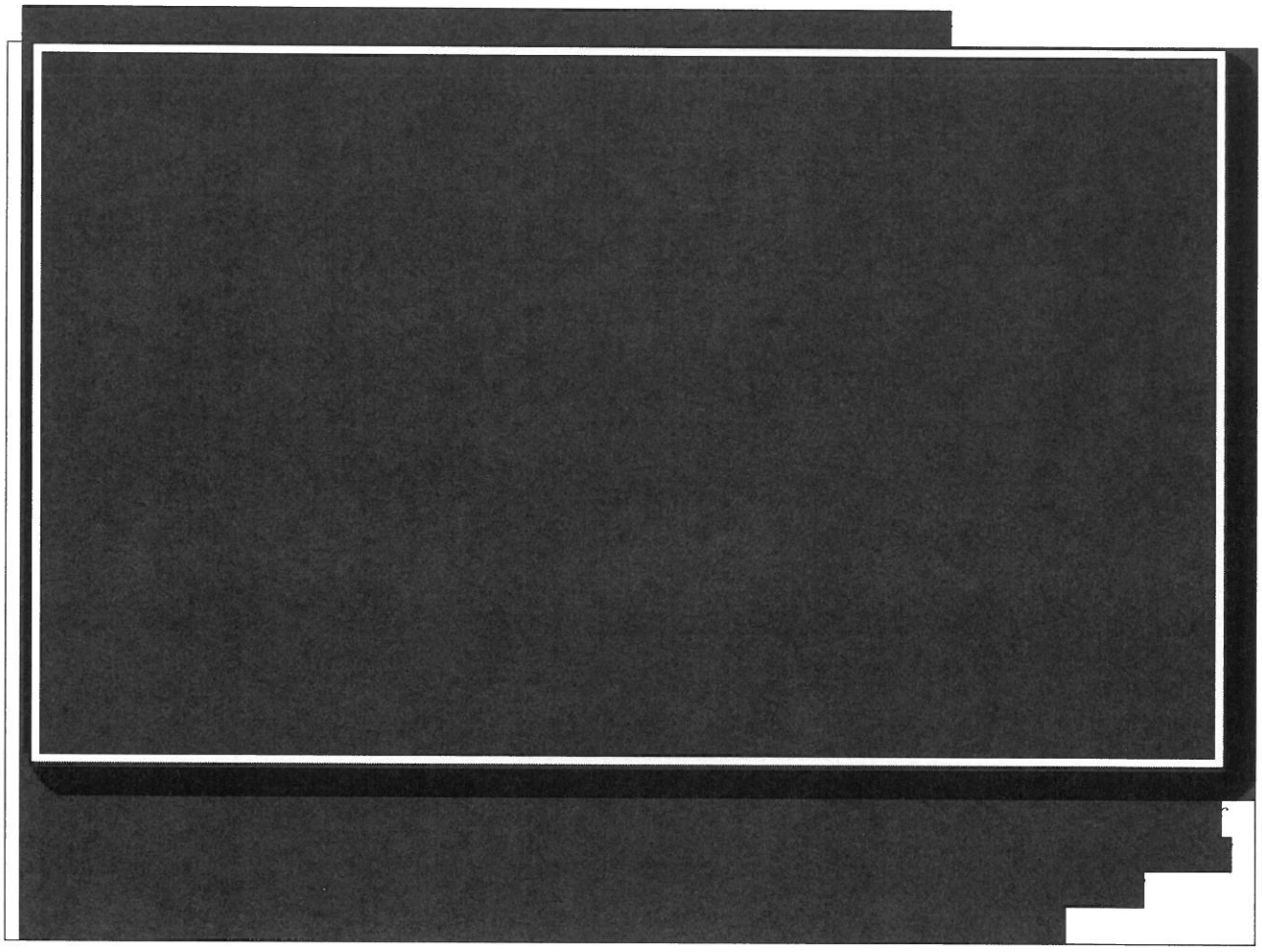


HealthTrack Improves Quality and Efficiency

We have noted in the narrative above that HealthTrack has excellent call logging and coding functionalities. As part of our ongoing continuous quality improvement efforts, we have recently updated our call logging functionality to address specific needs of the Ohio Medicaid Consumer Hotline as part of the Ohio-specific iteration of HealthTrack. In the Ohio Medicaid Consumer Hotline literally every second counts (even though we routinely exceed our contract ceiling for inbound call volumes by as much as 10-30%, we still meet strict standards for talk time and abandonment rates), and we recognized that by improving the system, we would not only help increase user efficiency, productivity, and accuracy, but would we also help improve customer service. We will give this same attention to the needs of the MHT Project.

As we have mentioned extensively throughout our proposal and this section in particular, the description provided above details an overview of HealthTrack; all requirements and details specific to the MHT Project will be customized to meet the needs of BMS. We are excited to offer this solution to BMS; as indicated in Exhibit 172 below we have carefully designed it to include several features that will result in demonstrated benefits to the State.

Exhibit 172. HealthTrack Offers BMS Several Benefits

Feature	Benefit	Proof
HealthTrack was designed to have user-friendly, intuitive interfaces.	• Enhanced staff satisfaction, and • Improved staff efficiency.	Our Florida client requested HealthTrack for their State headquarters and county workers instead of the system they were currently using.
HealthTrack includes tools to streamline Benefits Manager workflows.	Tools such as scripting, case tasks, My Tasks and Enrollment Wizards, ensure staff address all facets of operations efficiently, preventing unnecessary callbacks and follow-up calls.	The My Tasks and Case Tasks features are programmed in accordance to contractual specifications and have assisted our Florida Project in meeting all SLAs since Day One of the Project.
HealthTrack easily integrates with other systems.	• Reduced/eliminated need for dual-data entry, and • Faster talk times and customer service delivery.	We used HealthTrack to successfully interface with Louisiana's and Ohio's MMIS system, allowing staff to integrate and perform lookups and updates quickly and intuitively. Most of the time there is no need for dual data entry, allowing us to better serve our customers.
HealthTrack was designed to be fully flexible.	We can quickly respond to changes in business rules, changes in the Medicaid managed care landscape and quickly respond to new responsibilities and initiatives.	We were able to appropriately update HealthTrack in response to the contract expansion in Florida to assume an addition three million eligibles over a 62 non-Reform county area, including updating mailings, enrollment requirements, and operational changes.
All tools are fully integrated into HealthTrack.	• Benefits Managers do not need to toggle back and forth between applications, and • We do not experience data issues due to files that are out of sync.	Key tools including search functions, provider and specialist directories, resource directories, and even a preferred drug list, have already been incorporated into HealthTrack.
HealthTrack includes several automated processes.	• Data errors are reduced due to measures to protect data integrity ensure correct value input, and • HealthTrack's My Tasks module supports SLA adherence.	We have met all SLAs since Day One in our Florida Enrollment Broker Project.
HealthTrack is fully tested.	We are able to offer BMS a low-risk implementation.	HealthTrack has successfully processed over a million enrollments for our projects, along with managing several million case loads.
HealthTrack includes User Management and Permissions Management Tools.	HealthTrack is fully secure and users are not permitted to perform functions outside their role.	We have never had a breach of confidentiality.
HealthTrack is supported by a comprehensive Information Technology System architecture.	The hardware and software portfolio, LAN and WAN, and workstations selected by us are designed to ensure a high level of availability and meet the needs for future growth.	We have greater than 99% uptime on all of our Projects.

Feature	Benefit	Proof
HealthTrack supports advancing MITA maturity.	HealthTrack has the ability to seamlessly integrate in real time with other systems, including legacy systems and modern web services.	HealthTrack seamlessly integrates with our Online Enrollment module in Florida and also integrated in real-time with Louisiana's MMIS system, thereby increasing efficiencies and reducing errors resulting from data silos that are not in sync. All web and mobile activities will be integrated with HealthTrack data so that there are no data currency issues.

HealthTrack will offer BMS several benefits over any other system.

"I wanted to take the time to say, because often in the heat of battle it is missed, you have proven to be a very capable, smart, responsive and efficient systems team. It is a pleasure to work with like minded, get it done people such as yourself.

We are closing in on implementing/ transitioning two major, very important projects for the future of the State of Florida and our constituents, which will position the Agency for future flexibility and rapid mobilization for upcoming initiatives. Not to mention that these two projects have occurred inside of one year, this is a feat in itself.

Through strong partnership and flexibility we have advanced the State of Florida Enrollment Broker program in both technology and customer service."

-- Program Administrator

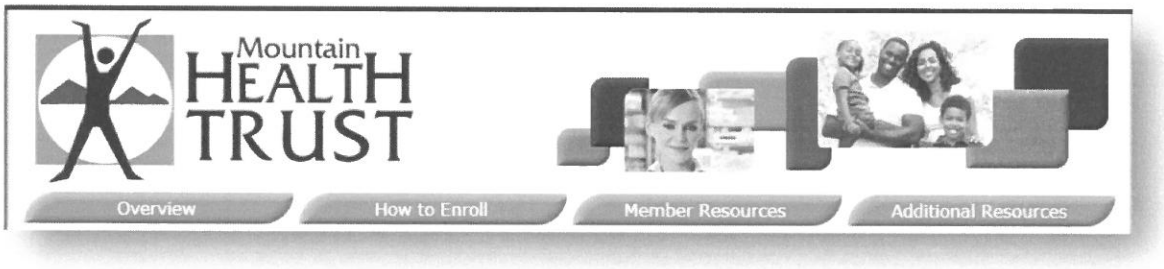
Ongoing Project Enhancements

Throughout the course of our tenure with the MHT Project, we have made numerous enhancements to our systems and processes that are above and beyond our contract requirements. Most notably, in order to provide the best service possible to potential enrollees and enrollees, we voluntary updated the MHT website and include the State's first ever online enrollment module – all at no charge to BMS. The new website is well-designed and easy-to-use (as evidenced below in Exhibit 173) and the new online enrollment module continues to grow in popularity.

DID YOU KNOW?

On a monthly basis, there are nearly 9,000 page views on the MHT website.

Exhibit 173. Enhanced MHT Website



The new MHT website is easy to use and well-trafficked.

We look forward to continuing to provide BMS and the MHT Project with additional system enhancements to further support BMS, provide better service to providers and MCOs, and most importantly, enhance the customer service delivered to potential enrollees and enrollees.

Our Solution Helps Advance West Virginia's MITA Maturity

We would like to close this narrative with a summary of how our solution will assist West Virginia in advancing MITA maturity.

Medicaid Information Technology Architecture (MITA) is both an initiative and a framework developed by CMS, with the goals of promoting improvements in the Medicaid enterprise systems, as well as providing a blueprint of models, guidelines, and principles to be used by States in system redesigns and implementations.

MITA stresses tight integration and collaboration between business and IT in all States, thus it is crucial that we work closely with BMS as we administer and enhance our systems for the MHT Project. We understand that the State must ensure their business goals and objectives are aligned with the MITA goals and objectives, and that all elements of the MITA Framework must be met through the development of strategic and tactical IT goals and objectives.

The MITA Maturity Model[26] contains five levels of increasing sophistication:

- **Level 1**: All technology, policy, statutory enablers exist and are widely used. Agency complies with baseline requirements.
- **Level 2**: All technology, policy, and statutory enablers exist and are widely used. Agency improves important parts of its business.

[26] https://iq.govwin.com/index.cfm?fractal=blogTool.dsp.blog&blogname=PUBLIC&alias=MITA-Maturity-Levels-in-States

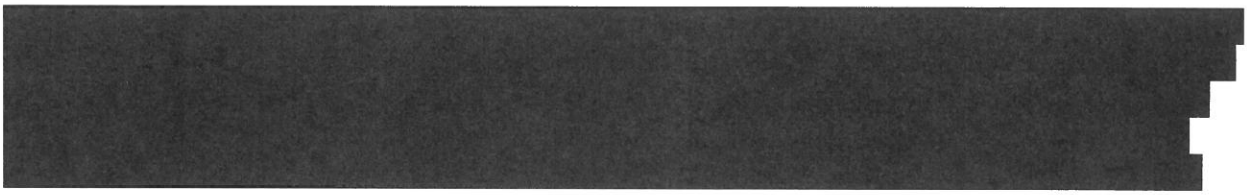
- **Level 3**: Industry standards are widely used. Agency promotes collaboration, data sharing, interoperability, and consolidation of business processes.
- **Levels 4 and 5**: Leverage and reuse of technologies is widely used. Seamless coordination and integration with state and federal exchanges. Data exchange is real-time.

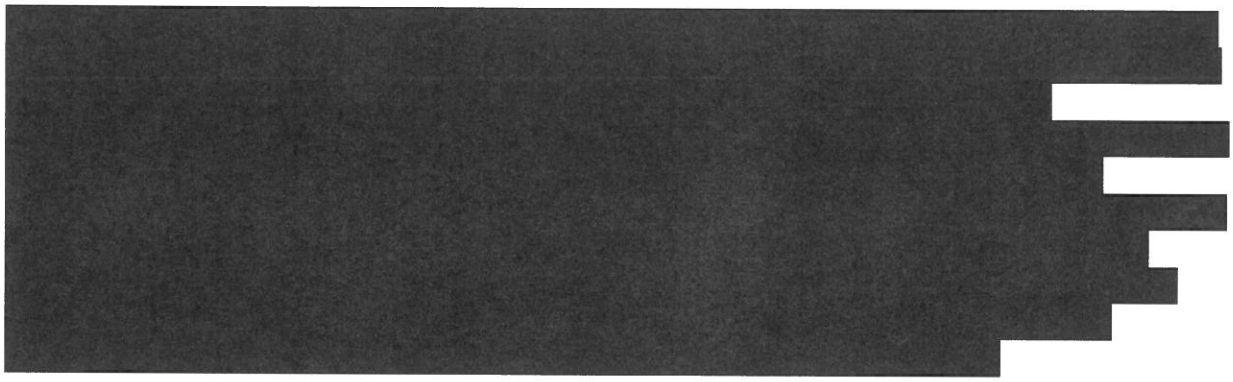
MITA has identified Service-Oriented Architecture (SOA) as the basis of its technical architecture. SOA is an application architecture within which business functions and selected technical functions are performed using documented interfaces. Designed for flexibility and reuse, SOA enables organizations to easily integrate systems, data, applications, and processes through the linking of software services. A software service is a component within SOA that performs a defined function and communicates with other defined services through messaging. A properly executed SOA framework can integrate and leverage many different technologies that communicate with each other.

MITA Goals:

1. Integration and interoperability,
2. Flexibility to rapidly respond to change,
3. Enterprise view to align technology and business needs,
4. Data that supports analysis and decision making,
5. Performance measurement for accountability and planning, and
6. Coordination with partners to improve overall health.

We understand MITA, and in fact we have been aligning ourselves with States and other data exchange partners (e.g., fiscal agents, MCOs, etc.) with whom we interact to increase interoperability and integration between systems for many years. We have designed our systems to be highly-flexible and "loosely-coupled", in that our systems can be integrated with many different State systems without re-engineering all the system components. Our systems have been built following a service-oriented perspective in order to achieve maximum reusability and effectiveness. Services and components interact with each other using programmatic service contracts. For example, our multi-layered software architecture allows us to customize the Data Layer to match different State datasets, without having to reprogram the other layers. Similarly, the business logic is defined within the Business Layer while the user interface (UI) is contained within the Presentation Layer. Our system architecture allows a high degree of flexibility and advancement. As all parties in West Virginia's Medicaid enterprise (including the State, AHS, and other entities) build a library of shared services within the West Virginia SOA framework, we can achieve real-time interoperability across all systems.





Please refer to Exhibit 174 below for examples of Web Services we currently use.

Exhibit 174. Examples of Currently Used Web Services

Project	Description
Ohio Medicaid Hotline	We have recently started integrating with the State's new Web Services as part of the new Ohio Integrated Eligibility Stem developed by Accenture. (We also still maintain integration with the State's legacy MMIS as described earlier.)
CountyCare (Cook County)	We currently have real-time integrations with the claims system operated by Beacon and the prior authorization system operated by Permedion.
Gateway to Better Health (St. Louis)	We currently have real-time integration with our subcontractor, Permedion, to process hundreds of prior authorizations each month.

As evidenced in our technical proposal, we have served the needs and exceeded the expectations of our State customers for the past 30 years. One of our critical success factors is our ability and willingness to understand our customers' needs and implement solutions that exceed those needs and expectations. **We focus on providing working solutions rather than contract negotiations and change orders.** This includes deep collaboration between State and AHS staff to improve program operations and technical processes. For example, at no charge (and without being asked by the State), we recently implemented West Virginia's online enrollment module that is now live and allows people to enroll 24/7 at their convenience.

As BMS looks to modernize West Virginia's Medicaid enterprise systems, we are prepared to assist in any way possible, and in fact we will provide systems and processes that will help the State make immediate improvements to its MITA maturity level. There are many potential benefits of incorporating the MITA framework into West Virginia Medicaid enterprise:

1. Congruence with Federal health vision and standards that are currently optional but will be mandatory in the near future.
2. Enhanced federal match funding for system development and implementation will be based on the state's ability to meet the "Seven Standards and Conditions" established

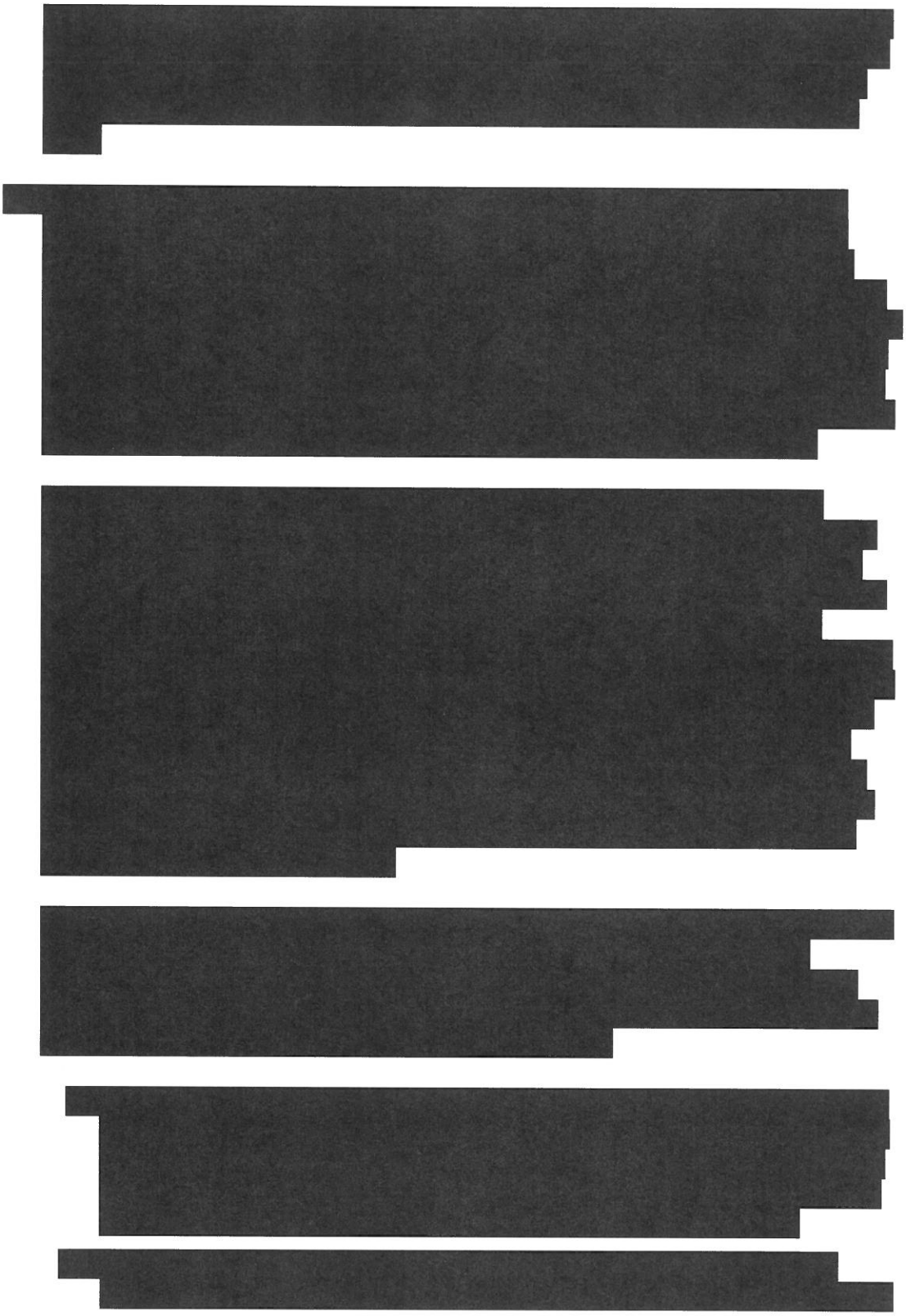
by CMS in 2011. MITA and the overall principle of using flexible, interoperable, and best of breed systems are major parts of this regulation.

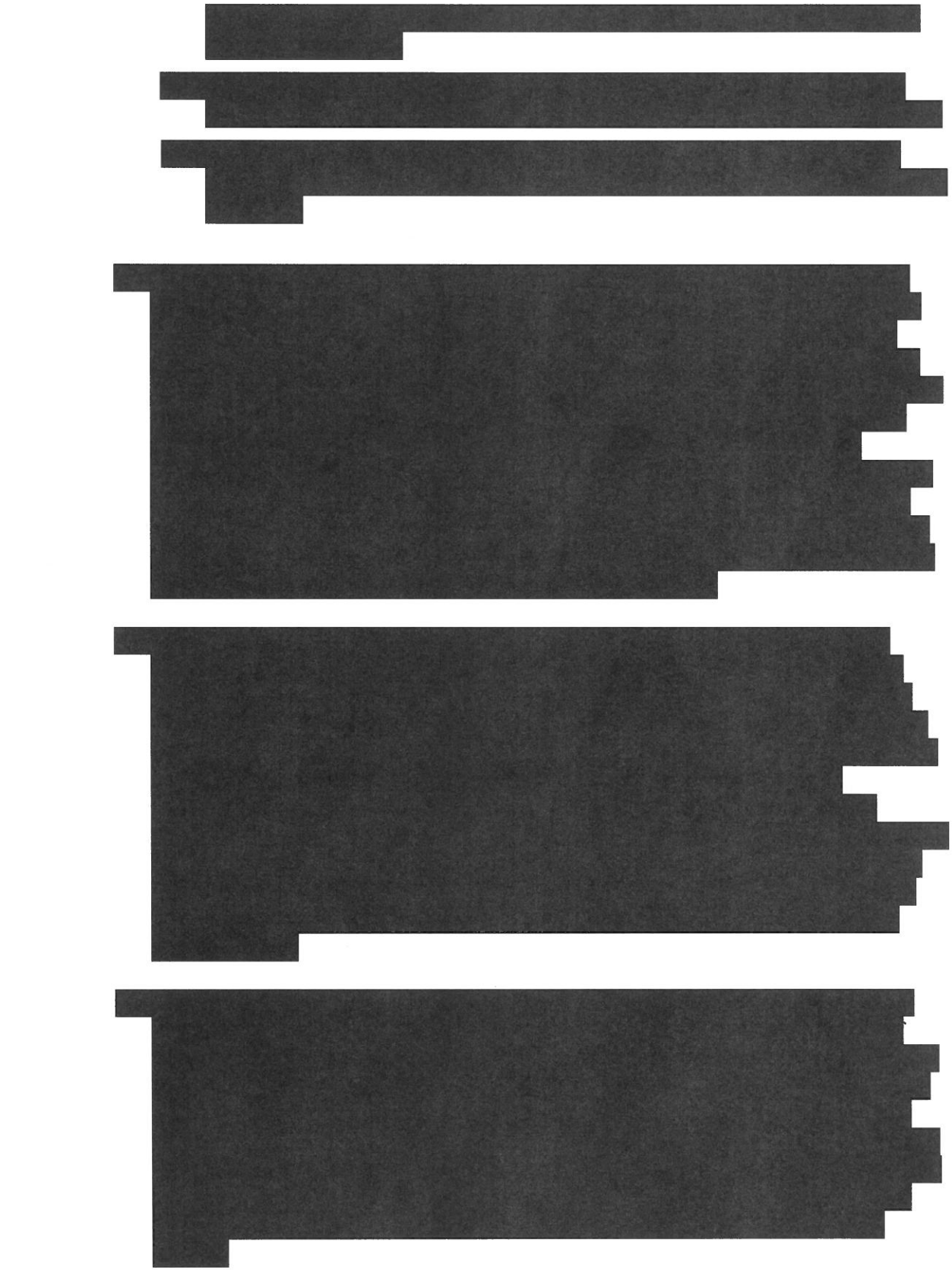
3. Ability to collaborate and exchange parallel technology, data and information with CMS, other state Medicaid programs, and the broader health care marketplace.
4. State of the art design principles based on the "best practice" experiences of Medicaid programs.
5. Systems and information that are more focused on Medicaid consumers and the quality of care they are receiving.
6. Systems that are flexible, adaptable, and can respond rapidly to changes in policies and technology.

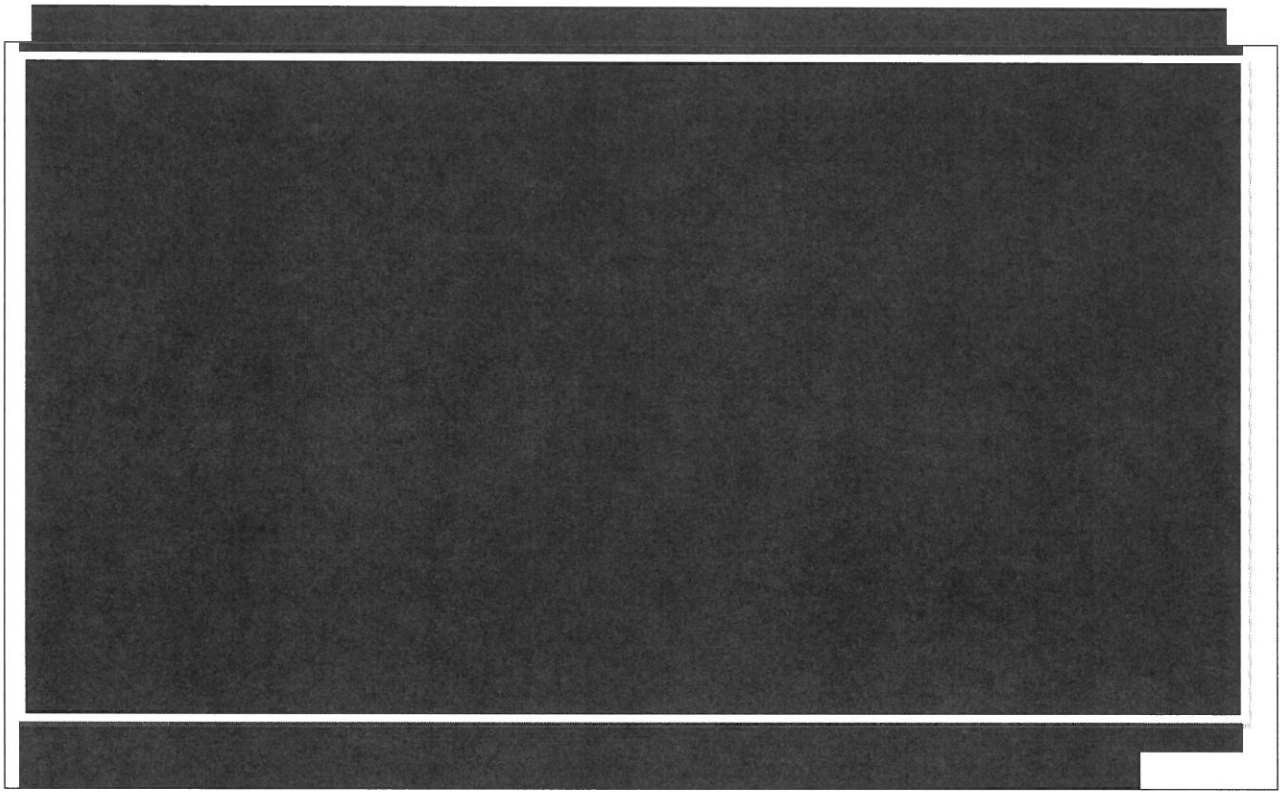
As West Virginia is currently pursuing major improvements to its MMIS system, it is important that all the State's partners are willing and capable to invest in and design next generation systems that help raise the State's MMIS maturity level. As a contractor with a strategically important position that interfaces with many parties, we will continue to work closely with the State and its other business partners to positively impact West Virginia's MITA alignment and maturity level. By implementing systems that allow the MHT Project and the State to have better coordination and collaboration across agencies and vendors, we will help improve cost and effectiveness in West Virginia Medicaid. Our technology allows us to easily exchange data with any number of entities whether in real-time or file exchanges (in EDI or custom file formats), further improving standardization and collaboration. In true partnership with the State in its effort for increased MITA maturity, we are committed to being supportive and innovative in any identified areas where we can provide support, input, skills, and technology.

Our philosophy and track record of staying on the cutting edge of current technologies and innovations, combined with our flexibility in continually meeting the ever-changing demands inherent in the large-scale Medicaid programs we administer (as demonstrated in this proposal), aptly positions AHS as an organization that can facilitate the State's efforts toward achieving increased MITA maturity. We will leverage our business process optimization capabilities and innovative technical solutions to advance the MITA maturity level of the business processes in the West Virginia Medicaid program. After careful review of the RFP, we have identified several key areas where, as the administrator for the MHT Project, we can immediately and positively impact West Virginia' MITA maturity level. Those areas are Member Management, Plan Management (MCOs), and Operations Management. These areas distinctly relate to our relationship as the MHT Project contractors to the key participants in West Virginia Medicaid: the Recipients, the MCOs and their providers, and of course BMS. The details are provided herein.









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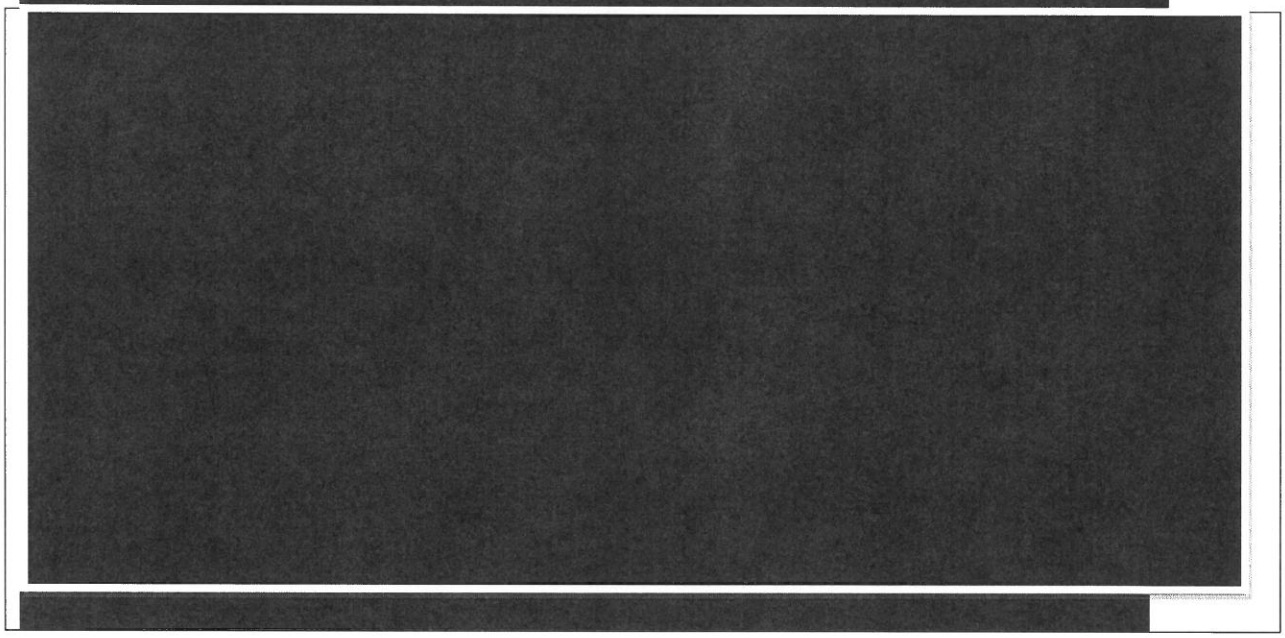

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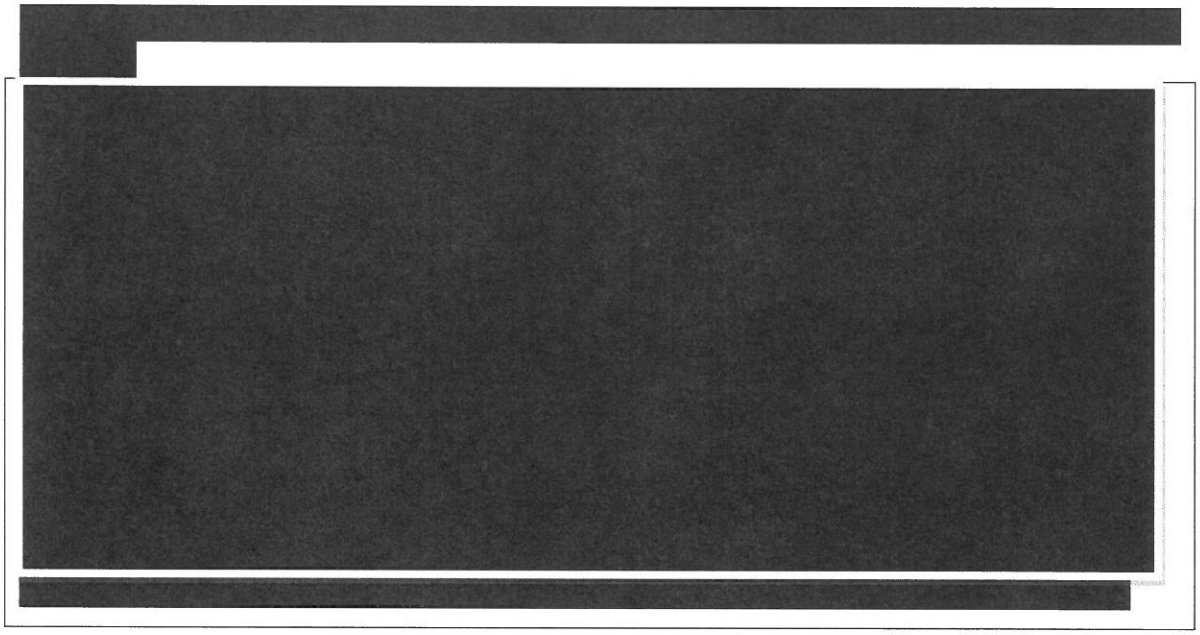


As can be seen from the above, we both understand and are committed to helping BMS maintain its continued movement up the MITA maturity ladder. We have spent a great deal of time and effort in the design of our newest IT applications and systems so they conform to the overall MITA framework and goals, thus providing our state partners assurance that we are part of the solution and not part of the problem. Our reputation for flexibility and going the extra mile will be reflected in our willingness to work with BMS and its business partners to provide both support and solutions that aid in the effort to continually improve West Virginia's MITA maturity.

4.3.6.2 Work with BMS to learn the data entry screens within the MMIS which allows members to be enrolled in a managed care plan or PCP and develop linkage to Recipient Automated Payment and Information Data System (RAPIDS) to facilitate research.

Our approach to using external systems (i.e., MMIS screens or RAPIDS) is based on not only learning the screens, but verifying that staff are using systems optimally on an ongoing basis.

DID YOU KNOW?

As a longstanding contractor to BMS, we already have access to and know all the data entry and research screens.

First, when learning any new system, we take the time for the Project Management and/or IT Team as appropriate to meet with BMS and the Fiscal Agent to learn the screens. As the current MHT Contractor, our project management, IT, and front-line staff are all intimately familiar with each of the data entry screens within MMIS. However, should any new screens be implemented, we will work closely with the State and the Fiscal Agent to learn any new screens.

Second, we develop training materials for staff's use, and naturally provide staff with extensive training on all new screens. In fact, in our current contract, Molina hosted a training and provided training materials to our staff when QNXT was implemented. We then created a truncated version of this manual as a user guide for our staff training. We will continue to participate in ongoing trainings with Molina on the MMIS system.

Last, we monitor staff on an ongoing basis to ensure staff use screens accurately and correctly. As mentioned in Section 4.2.20, we will incorporate ProxyPro into the Project, which will allow us to discretely monitor Benefit Managers' screen proficiency in real-time.

We are confident this approach will be successful throughout the duration of the contract. Most notably, it is the same approach we used in 2007 when Molina became the State's new Fiscal Agent and made significant changes to the State's MMIS. Please note, as described in the previous discussion concerning MITA, while this is the process we currently have in place, we are willing to expand and enhance this process at any time desired by BMS.

As mentioned, we currently understand and are familiar with all the screens needed. We current open the "Member Module" and then use the following screens:

- Summary,
- Eligibility,
- Detail,
- Provider,
- Attributes, and
- Memo Alert.



DID YOU KNOW?

In 2012, when Molina was developing QNXT, our Project Manager was invited to provide input on the enrollment screens, provider search, etc. Molina then incorporated our suggestions to ensure the screens were manageable, user friendly, and displayed the information we needed for look-ups and to process enrollments.

Again, if at any time, additional screens are incorporated or modified, we will ensure we are up-to-date on using them correctly.

4.3.6.3 Work with BMS and the fiscal agent to identify any modifications needed

Suggestions for modifications to any screens will come from our front-line staff who actively use screens each day. Any suggestions for a modification will be forwarded to the Project Manager who will review the recommendation with the staff member, and then provide feedback to BMS. Feedback can

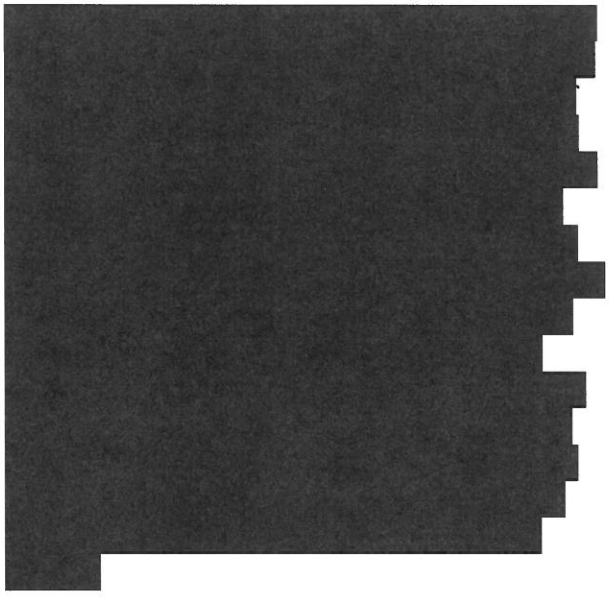
be shared verbally, as part of formal monthly reports, or via email correspondence. In fact, as evidenced in the text box, we have a successful history of collaborating with the Fiscal Agent to identify modifications. We will continue this collaboration in the new contract.

4.3.6.3 Work with BMS in refining the auto assignment algorithm

In our work with West Virginia we have successfully worked with BMS to coordinate the development and implementation of the State's first-ever auto-assignment algorithms in the MHT Project. In addition to our work in West Virginia, most currently, we also perform these activities in Ohio, Florida, and Illinois. Below follows a description of the current MHT auto-assignment process, followed by our ability to support refinements to the auto-assignment algorithm.

Current West Virginia Auto-Assignment Algorithms and Processes

The current auto-assignment algorithm programmed and run by AHS for the MHT Project takes into considerations all the requirements of the RFP. Further, all auto-assignments for the MHT Project are run according to all specified timelines, specifically the last Monday prior to the 10th of the month.



DID YOU KNOW?

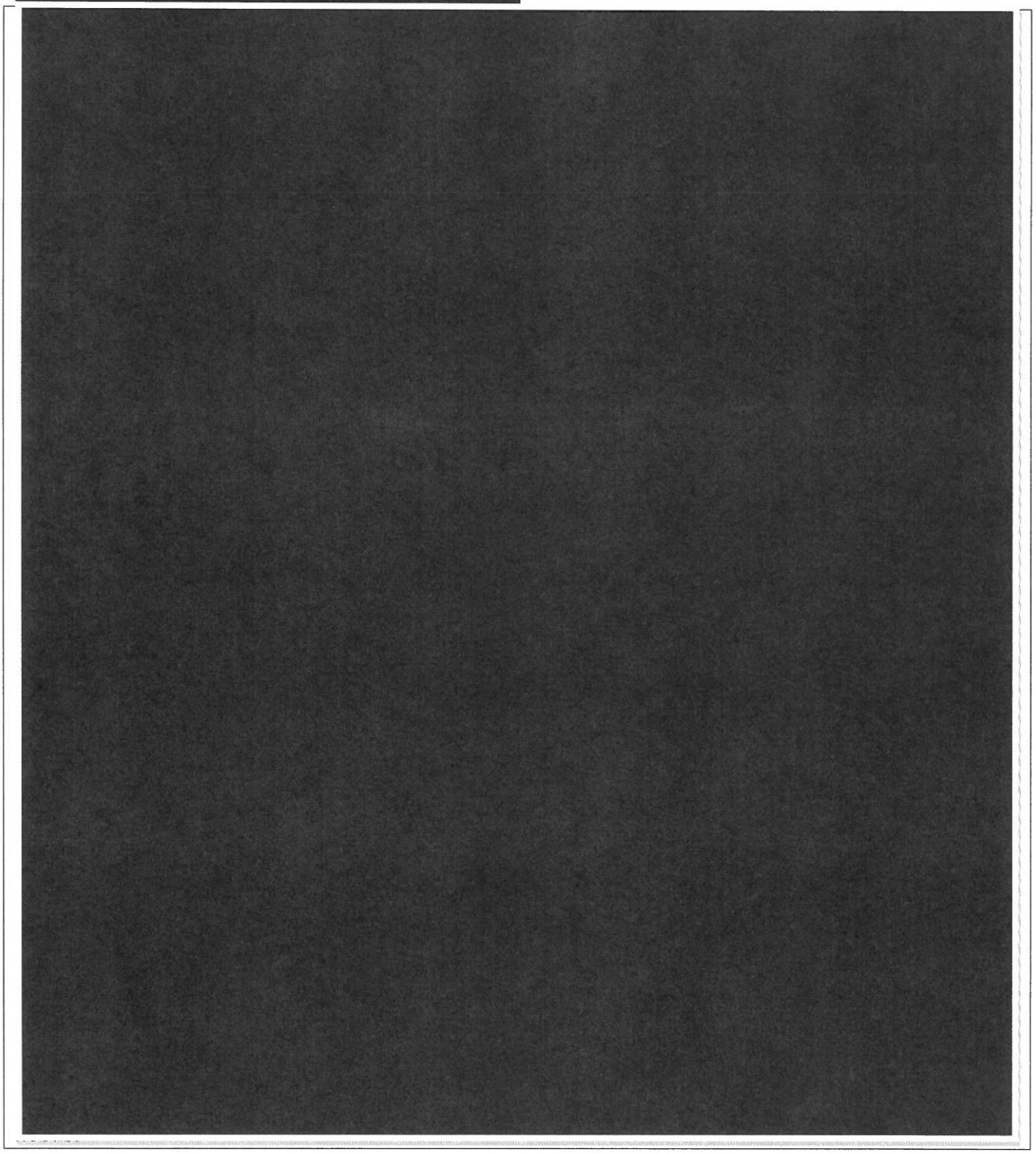
We understand the dynamic nature of Medicaid program administration and ensure our auto-assignment procedures are fully flexible and can easily respond to changing State needs, including not only changes to the populations included or the timing the auto-assignment process is run, but we can also accommodate numerous features in our program that include:

- Paid claims history,
- Previous provider utilization,
- Geographic proximity,
- Enrollment of family members, and
- Specific provider limitations.



Exhibit 178 provides a description of the rules we take into account when conducting auto-assignments.

[redacted]



Ability to Refine Auto-Assignment Algorithm

To highlight our ability to work with the State to accommodate the State's emerging needs, we have repeatedly updated our auto-assignment algorithm to accommodate changes in managed care plan regions. As mentioned, in the past seven years, we have accommodated over 65 changes to managed care plans and regions, all of which required changes to our auto-assignment processing.

We will work closely with BMS in the future contract to assist with any changes to the auto-assignment process resulting from expansions of managed care.

As mentioned, in the new contract, we can accommodate extensive changes to the auto-assignment process if so desired by BMS at any point in the contract, including:

- The timing of the auto-assignment,
- Letters associated with auto-assignment/enrollment reminders,
- Population changes and expansions,
- Factors included in the processing:
    - Paid claims history,
    - Geographic proximity,
    - Previous provider utilization,
    - Assignment of family members, and
    - Specific provider limitations.

Additionally, in the new contract we would like to incorporate several enhancements to our reminder letter, including:

- Printing on black and white with a green accent to match other MHT Project letters and materials,
- Reminding potential enrollees of the ways to enroll (i.e., phone, mail, web – including via Smart Phone),
- Stressing the benefits of selecting an MCO (e.g., the potential enrollee can select the MCO that best meets their needs), and
- Bolding our contact information.

Again, we wish to note that we have extensive experience in developing and maintaining sophisticated auto-assignment algorithms for multiple states, and we have the capability and expertise to modify the algorithm currently used in West Virginia as well as develop new/additional ones to fully meet the needs of BMS as it implements any expansions to

Medicaid managed care. The auto-assignment process is highly configurable, requiring minimal effort to make significant modifications to its rule set. The modular design of the process allows us to add or remove individual components or steps of the logic quickly and easily. **The ability to modify individual portions of the process without affecting other steps grants it a higher degree of reliability and confidence when making changes.**

4.3.6.5 Work with BMS staff in supporting any additional auto-assignment strategies which could include passive enrollment and pay-for-performance (P4P) approaches. BMS reserves the right to modify the methodology for assigning enrollees at any time

We understand the changing enrollment needs of the State, particularly during this dynamic period in Medicaid programming and health care reform. We pledge to work continuously with the State to implement any additional Project strategies, including auto-assignment strategies, throughout the course of the Project. As evidenced below, we have the technical skills, knowledge, programming expertise, and Project and corporate resources to make any needed changes and enhancements to the auto-assignment algorithm at any time. Below follows three specific examples:

1. Potential Support for Auto-Assignment for the SSI Population,
2. Incorporation of P4P Measures, and
3. Potential Passive Enrollment Strategies.

We conclude this section with a description of our work with sophisticated auto-assignment algorithms in other states to provide BMS with confidence in our ability to incorporate any needed changes to the auto-assignment process.

Potential Support for Auto-Assignment for the SSI Population

We currently perform auto-assignments for the SSI population in multiple states, most notably and we understand several critical needs that must be factored into the process, including:

- Continuity of care,
- Development of partnerships,
- Potential to process auto-assignments on a separate timeframe, and
- Ability to accommodate different rules for changing MCOs.

We are aware of the documents prepared by State in preparation for the inclusion of the SSI and SSI-related population as part of the planned expansion schedule. We are prepared to participate in all of the requested activities detailed on the Plan:

- Provide educational presentation to local DHHR offices, and
- Perform site visits to high-volume providers and DHHR offices to educate about program changes.

In addition, we are willing to assume additional responsibilities to alleviate administrative burden on BMS. Such additional responsibilities include but are not limited to:

- Prepare and distribute fact sheet,
- Conduct meetings with key advocacy groups,
- Prepare draft enrollee materials,
- Meet with key provider groups, and
- Host webinars.

DID YOU KNOW?

Our Provider Contact Manager Solution (our blast fax and email system described in Section 4.14) can be of particular support in providing updated information throughout the State on the inclusion of the SSI population.

Naturally as part of our auto-assignment work, if BMS would prefer, we are also able to:

- Draft a potential auto-assignment algorithm and share with the State,
- Program the auto-assignment algorithm,
- Test the auto-assignment algorithm, and
- Conduct the auto-assignment for BMS.

Incorporation of P4P Measures

DID YOU KNOW?

We were responsible for maintaining established ratios of auto-assignments to MCOs serving dual eligibles in our Illinois contract.

We never once had a problem with either the programming or ensuring correct ratios were maintained.

We support BMS' plans to reward MCO's for high performance with financial payments and auto-assignment incentives. As part of this approach, we understand BMS will determine the auto-assignment distribution for each county by: dividing each MCO's score (determined by calculating base points, factoring in any performance decreases, and incorporating any bonus points) by the total number of points received by all MCOs in the county.

We will then monitor the number of auto-assignments made to each plan to ensure the correct ratios are applied and maintained during the minimum of 12 months that the distributions are in effect. When new annual MCO performance is calculated each year, we will update the ratios accordingly.

Potential Passive Enrollment Strategies



Passive enrollment occurs when newly eligible individuals are automatically assigned to an MCO and then provided with the opportunity to select another MCO. BMS has considered incorporating such a strategy for various populations (most recently, this strategy was considered for the Medicaid expansion population).

We are prepared to implement a passive enrollment strategy, and recommend the following proposed functions (please note, all functions incorporated into a passive enrollment strategy would be determined in consultation with BMS. No function would be incorporated without the explicit approval of BMS):

1. **Develop a process to passively enroll eligible individuals into an MCO**: We will develop an assignment algorithm to assign individuals to an MCO. If the population selected for passive enrollment is one where claims data is available, we will incorporate claims data into the algorithm. If claims data is not available for the population selected, we can develop an algorithm that includes a hierarchy that attempts to match individuals based on prior MCO membership and family relationships. We can also incorporate P4P measures into the algorithm.
2. **Develop and produce enrollment materials**: These materials are designed to include a process to notify enrollees of the assignment and may include notification materials (to include information on how the enrollee can change MCOs and the timeframes for doing so), and develop a system for sending initial and follow-up notifications of passive enrollment to enrollees.
3. **Develop systems to allow passively assigned enrollees to select another MCO** (e.g., develop a system that allows enrollees to change MCOs by phone or writing), and provide choice counseling for enrollees wishing to change MCOs.
4. **Update the monitoring process**: We will revise the monitoring strategy to capture relevant measures for the new enrollment process (e.g., number of enrollees who change MCOs, number of enrollees who engage in choice counseling).

There are numerous key features to our approach for passive enrollment, as detailed below in Exhibit 179.

Exhibit 179. Key Features for Passive Enrollment



Our key features for passive enrollment, based on time-tested solutions, ensure a successful implementation and high satisfaction with passive enrollment.

First, if needed, we can support dual systems and approaches to accommodate both the passive enrollment and any operational auto-assignment strategies. We can operate separate strategies based on any parameters set forth by BMS (e.g., various populations, etc.).

Second, we can implement a pre-assignment model to satisfy CMS' requirements for adequate member notification and opportunity for voluntary select. Components of this model may include combinations of mailed and phone outreach to alert members of the enrollment.

Third, we recommend using the current logic incorporated into the West Virginia Project to ensure all members on the case remain together. For example, if a member on the case has already been assigned to an MCO, all other members will be assigned to that MCO, using the P4P ratio as the second step in the algorithm.

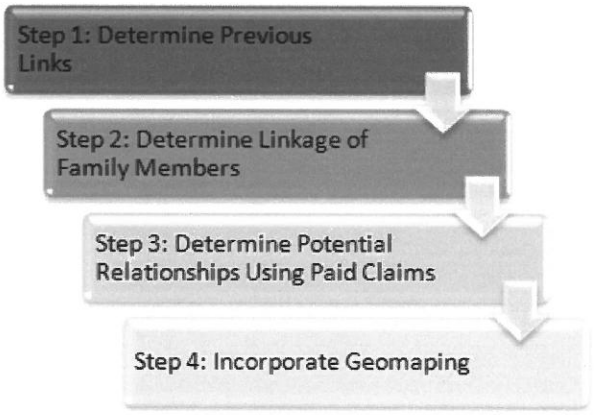
Last, we can implement several strategies to minimize any confusion (e.g., families with members who belong to different population and are enrolled under separate processes). These include:

1. **Staff Education**: We will provide staff with extensive training on the various programs and enrollment processes to ensure they are able to provide pertinent education to potential enrollees/enrollees;
2. **Scripting**: We will develop BMS-approved scripting for staff to follow. This scripting will include critical points on the differences in the educational processes as well as where to seek further assistance; and
3. **Enrollee Education**: We can provide education for enrollees via several routes, including phone, web, and community presentations.

Ability to Respond to Enhanced Auto Assignment Algorithms

As mentioned, we can alter the auto-assignment at any time based on the needs and direction of BMS. To provide the State with confidence in our ability to enhance and modify the auto-assignment process, below follows a brief description of how we have accommodated numerous other factors in our auto-assignment process for one of our other enrollment broker contracts.

Exhibit 180. Steps in the Auto-Assignment Process



We can include sophisticated steps in our Auto-Assignment processing.

Step 1 – Relinks

This linkage is handled on an individual recipient basis. We determine if the enrollee has previously been linked to a participating MCO.

Step 2 – Family Member

We determine if another family member is linked with a participating MCO.

Step 3 – Authorized Claims

We use paid claims to establish a possible PCP-Patient relationship. This step is handled on an individual recipient basis. A paid claim must exist within our system from the PCP for the recipient. Evaluating claims to be used to establish a PCP linkage is handled in a multi-step process.

Procedure codes associated with the claims are compared against a table and preventive office visits are given the highest priority in the selection process. The next series of codes used for the auto-assignment process are the Evaluation and Management (E&M) Codes associated with specific diagnosis codes. Lastly, the appropriate procedure codes or E&M Codes designated as

office visits are reviewed without the associated diagnosis codes in an effort to establish a link. The logic used here is that the recipient did receive services by the provider and has established a relationship in the past.

All claims are reviewed for a recipient prior to creating the auto-assignment. The most recent claim based on the above mentioned hierarchy is used in the process. We use up to three years of claims history from the recipient's eligibility date in this process.

Example of Auto-Assignment Processing

While we have extensive experience with auto-assignment algorithms, our work for the State of Florida is perhaps the best example of both our capabilities and ability to adjust to a wide range of requirements and changes in the development and maintenance of an auto-assignment algorithm. When we first began enrollment broker services for the State of Florida, we were responsible for only five counties involved in a Demonstration Project (Medicaid Reform) that involved up to 11 MCOs. In less than a year we were asked to take over the State's entire managed care program (Medicaid Options). This resulted in an increase to 67 counties divided into 11 specific regions, and 33 participating MCOs. Within these geographic areas, we now had to manage not only the Reform and Medicaid Options Programs, but we also needed to contend with the State's MediPass (PCCM), MediKids and Children's Medical Services Programs as well. Enrollment into one or more of these MCOs within a given region limited where a recipient could be auto-assigned, so we had to program accordingly. In some counties where only one MCO existed along with the MediPass Program, we had to ensure that auto-assignment did **not** occur.

To further complicate matters, some of the MCOs were designated as specialty MCOs where only recipients with specific conditions could be enrolled. Florida also has a unique arrangement with some of the MCOs, where certain MCOs have a sister MCO associated with them. In such cases if a given MCO was at capacity (another ever-changing factor that we include in the auto-assignment algorithm), the algorithm has to be able to identify the sister MCO and assign the enrollee to that MCO.

Our most recent adjustment to the algorithm is called the Recipient County Switcher process. This process applies to recipients who move across counties and requires us to assess over 100 different possibilities along with the other restrictions just described to identify appropriate MCOs with specific providers (specialists) in their networks, within specific counties before an assignment is made.

Step 4 – Geomapping

We use sophisticated geomapping software to match a recipient with a PCP who is the closest distance to the recipient's address. If the recipient does not have a valid address, then geomapping cannot occur.

An additional factor we also consider when so requested is the ratio of total enrollments between the participating MCOs. When this step is required, we monitor the total enrollment for each MCO to ensure once all auto-assignments are active, the correct ratio of enrollments among MCOs is maintained.

4.3.7 Monthly Snapshot of Key Activities

The Vendor should provide BMS with a monthly snapshot of key activities, which includes a comparison of the current month's report with previous periods, as appropriate. The Vendor should also identify trends in enrollment, any issues encountered and recommendations for improvements, policy changes or procedural improvements. Reports should include charts and graphs to illustrate program performance. The Vendor should propose indicators to include in the monthly report; final formal and indicators are subject to BMS approval. A sample report should be provided to BMS that may include some or all of the following elements:

4.3.7.1 Number and type of enrollee mailings related to the MHT program sent by the Vendor;
4.3.7.2 Per outreach effort, the number of enrollees mailed to or contacted through electronic methods along with the reason for the mailing or contact and the date of the mailing or contact;
4.3.7.3 The number of total newborn enrollments;
4.3.7.4 The total number of enrollments per month;
4.3.7.5 The auto-assignment rate per month;
4.3.7.6 The number of defaulted enrollments per month;
4.3.7.7 The number of choice enrollments per month;
4.3.7.8 The number of changes in existing enrollment and reason for change per month;
4.3.7.9 The number and percentage of choice enrollments that are processed accurately within two (2) business days of receipt of completed application;
4.3.7.10 Problems reported by counties or providers and the number and types of questions asked;
4.3.7.11 Number and type of complaints about marketing methods or discrepancies in enrollment materials;
4.3.7.12 Number and type of complaints about the Vendor, including the number of complaints that were resolved, how the complaints were resolved, and the average length of time it took to resolve the complaints;
4.3.7.13 Number of enrollees in the various benefit packages by eligibility groups;
4.3.7.14 Enrollment activities by county, program (i.e., managed care and PAAS), and by MCO, including the number of enrollment forms and enrollment phone calls received per day, and of those, the number processed, the number of contacts made, the number of forms returned and the reason the forms were returned; and
4.3.7.15 Telephone activities, including:
4.3.7.16 Number of days the telephone unit was operations;
4.3.7.17 Number of telephone calls received by all operators and by each operator per day, per week and per month;

4.3.7.18 Total number of telephone calls answered regarding enrollment into the managed care programs by all operators and by each operator per day, per week, and per month;
4.3.7.19 Number of calls abandoned and abandonment rate by all operators and by each operator per day, per week, and per month;
4.3.7.20 Average length of call by all operators and by each operator per day, per week, and per month;
4.3.7.21 Number of calls in the queue at peak times, as determined by the Vendor;
4.3.7.22 Average wait time for calls in queue per operator per day, per week, and per month;
4.3.7.23 Number of calls resulting in information generated to BMS' Third Party Liability (TPL) unit and whether previously unknown resources were referred or if TPL resources were coded on the system that are no longer valid;
4.3.7.24 Active time and inactive time for each operator's line; and
4.3.7.25 Log of requests for presentations for stakeholders, including meeting details and content presented.
The Vendor should respond to BMS requests for additional detail on activities within ten (10) business days.

The purpose of reports is not only to provide the State with daily, weekly, monthly, and quarterly updates on Project activity, but also to provide BMS with:

- The information they need to evaluate the success of West Virginia's Medicaid managed care programs;
- Accurate, reliable information that supports informed decision making with regard to future managed care programs; and
- Accurate information regarding potential enrollee/enrollee experiences with managed care.

In order to meet these goals, the Contractor must:

- Have a clear understanding of BMS' reporting needs;
- Have reporting systems built and customized to BMS' specifications (i.e., not standard systems that are inflexible without the features needed to support West Virginia's programs and future programs);
- Be flexible and responsive in order to supply additional information quickly; and
- Be proactive and able to anticipate future reporting needs, particularly when implementing new programs or expanding the role of the Project.

We have met these objectives for the past 18 years. To meet the goals stated above, we have:

- Built our systems to the specifications of BMS, and built it to be a comprehensive data collection repository and yet still built it to be fully flexible so that additional data elements can be collected and incorporated as needed;
- Revamped our monthly reports to provide information in a more user-friendly format;
- Added new reports to our repertoire at the direction of BMS; and
- Promptly responded to numerous requests for ad hoc reports.

DID YOU KNOW?

We recently elected to enhance our monthly reports submitted to BMS – at no additional charge!

As evidenced through our tenure in West Virginia, we are committed to providing BMS with the information it needs for Project evaluation, policy analysis, and Project planning. Not only did we recently voluntarily upgrade our monthly reports submitted to BMS (at no additional charge to the State), but our current monthly reports provide several features that exceed the requirements of the RFP:

1. **Rolling 12 Month of Data**: Most notably, each month we provide the State with a rolling 12 months of data for all components of the Project (e.g., call center, enrollment, mailings, etc.), which is hyperlinked for easy access.
2. **Written Summary**: Each month we include a written summary of notable accomplishments or changes that took place throughout the months as well as the status of any initiatives. (For example, each month as was appropriate, we provided the State with an update of our work regarding the Pharmacy Expansion or the phase-out of the MHC Program.)
3. **Enrollment Statistics**: Our trended enrollment statistics are broken out by source as well as by MCO.

As described below, for the new contract, we are pleased to offer BMS an enhanced reporting platform.

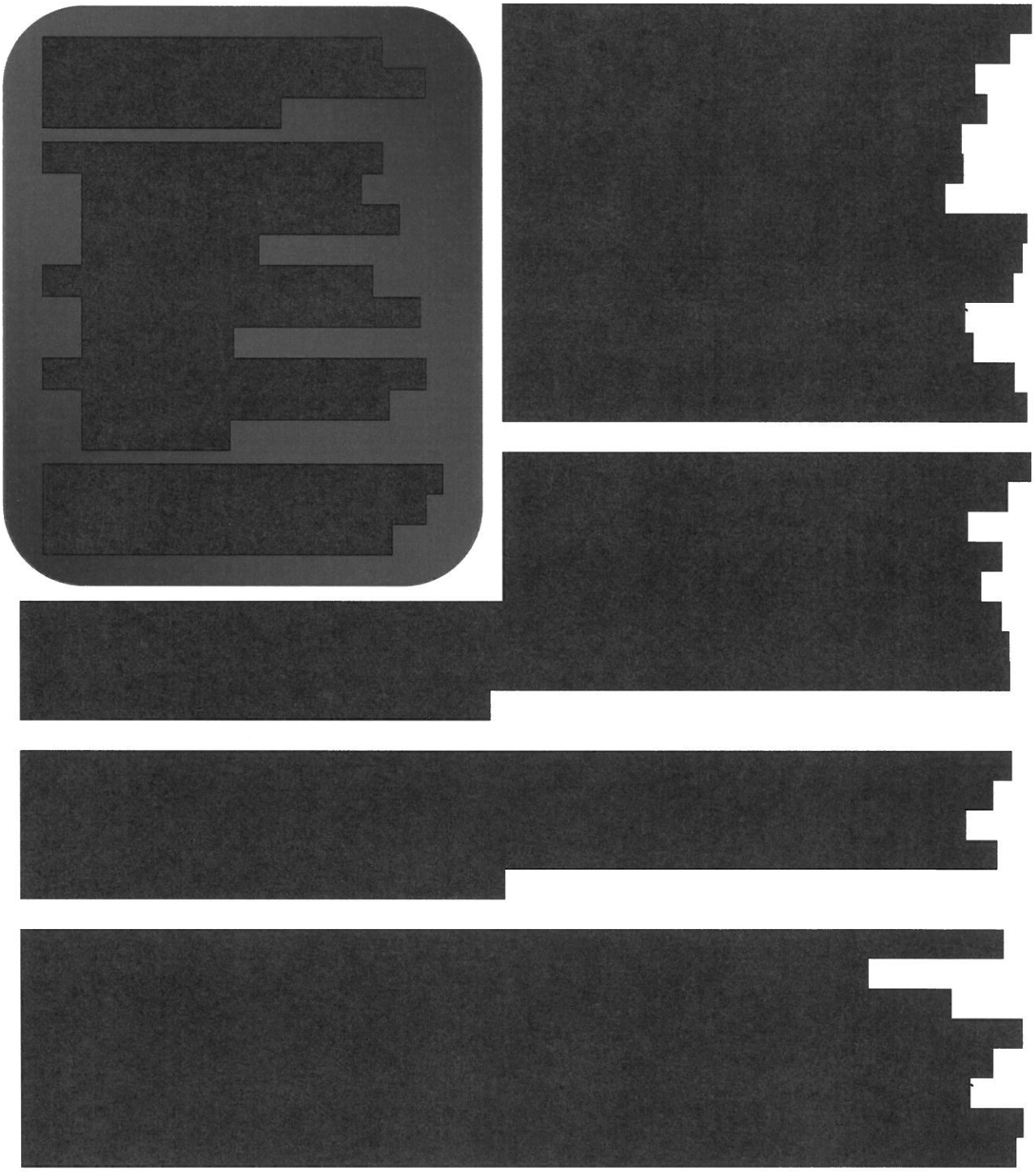
Overall Approach to Generating Reports

We will continue to collaborate with BMS to identify reports needed for the MHT Project. **We are known for our flexibility in report generation and for "going the extra mile" to supply needed data and information to States with minimal turnaround time.** We will bring this same collegial spirit to partnering with BMS for the MHT Project to ensure all reports adhere to state and federal reporting requirements and to the specified schedule.

While the section below details our tools in the reporting process and the exact reports we will generate as the MHT Contractor, the most important tool in our approach to reports is our philosophy of providing critical information to our State partners when they need it. It is this

philosophy that allows us not only to produce quality standardized reports, but also requested ad hoc reports quickly.

Reporting Platform



[redacted]

Delivery of Reports

As mentioned, we are offering BMS a robust reporting package [redacted] Reporting Services isolates report recipients from the complexity of the underlying data sources, while providing personalization and interactivity. Reports can be made available to the State in several ways including:

- Secure online access (on-demand, live data),
- FTP (scheduled), and
- Secure email (scheduled).

In addition to the electronic delivery method of BMS' choosing, should the State desire, we will also produce and submit hard copies of all standardized summary reports.

Report Submission Timeframes

We agree to adhere to all report submission timeframes specified in the RFP and agree to provide reports according to the deadlines specified in Exhibit 181.

Exhibit 181. Reporting Elements for the MHT Project

Report Type	Data Elements	Frequency
Monthly Report	• Number and type of enrollee mailings related to the MHT program sent by the Vendor; • Per outreach effort the number of enrollees mailed to or contacted through electronic methods along with the reason for the mailing or contact and the date of the mailing or contact; • The number of total newborn enrollments; • The total number of enrollments per month; • The auto-assignment rate per month; • The number of defaulted enrollments per month; • The number of choice enrollments per month; • The number of changes in existing enrollment and reason for change per month;	Monthly

Exhibit 181. Reporting Elements for the MHT Project

- The number and percentage of choice enrollments that are processed accurately within two (2) business days of receipt of completed application;
- Problems reported by counties or providers and the number and types of questions asked;
- Number and type of complaints about marketing methods or discrepancies in enrollment materials;
- Number and type of complaints about the Vendor, including the number of complaints that were resolved, how the complaints were resolved, and the average length of time it took to resolve the complaints;
- Number of enrollees in the various benefit packages by eligibility groups;
- Enrollment activities by county, program (i.e., managed care and PAAS), and by MCO, including the number of enrollment forms and enrollment phone calls received per day, and of those, the number processed, the number of contacts made, the number of forms returned and the reason the forms were returned; and
- Telephone activities, including:
  - Number of days the telephone unit was operations;
  - Number of telephone calls received by all operators and by each operator per day, per week and per month;
  - Total number of telephone calls answered regarding enrollment into the managed care programs by all operators and by each operator per day, per week, and per month;
  - Number of calls abandoned and abandonment rate by all operators and by each operator per day, per week, and per month;
  - Average length of call by all operators and by each operator per day, per week, and per month;
  - Number of calls in the queue at peak times, as determined by the Vendor;
  - Average wait time for calls in queue per operator per day, per week, and per month;
  - Number of calls resulting in information generated to

Exhibit 181. Reporting Elements for the MHT Project

	BMS' Third Party Liability (TPL) unit and whether previously unknown resources were referred or if TPL resources were coded on the system that are no longer valid; • Active time and inactive time for each operator's line; and • Log of requests for presentations for stakeholders, including meeting details and content presented.	
As requested	• Additional detail on activities	Within 10 business days
Case-by-Case Basis	• Discrepancies found on the enrollment form (e.g., name spelling, date of birth, number of family members in the home, returned mail, etc.)	Case-by Case Basis
Ad Hoc Report	• As requested	As requested

Please refer to Appendix N for sample reports currently used.

Generation and Provision to BMS of Reports on Request

We understand the evolving needs of a large scale project like the MHT Project in an environment as dynamic as West Virginia Medicaid programming. In all of our projects, we actually expect changes in reporting requirements. **In fact, when we design data collection modules, we anticipate and plan for additional information that customers may need down the road.** Requests for ad hoc reports will be handled by the Project Manager. Not only will BMS, the MCOs, and other business partners need ongoing reports detailing the activities of the Enrollment Broker, but BMS will need to respond to requests from the Legislature as well. Oftentimes these reports need to be produced within extremely tight timeframes. We are experienced with these requests and will work closely with BMS to provide any ad hoc reports as quickly as possible. **Further, it is always our policy to produce any requested report at no additional charge or cost.** When necessary, we will meet directly with BMS to ensure complete understanding about all the requested reports.

We are also sensitive to the often tight timeframes for the development of ad hoc reports and make every effort to meet or exceed these deadlines. From our cutting edge technology and sophisticated processes to ensure data integrity and accurate reconciliation of all systems, to our

quality reporting efforts, we can provide BMS with a comprehensive approach to monitoring, tracking, and reporting of all Enrollment Broker activities.

4.4 Names and Contact Information for Key Staff

The Vendor should provide the names and contact information for key staff assigned to this project, including resumes. Key staff should include the account lead (primary liaison) and direct or indirect reports that manage the functional units. All key staff should demonstrate past experience specifically related to this project. For any key staff not currently employed, the Vendor should submit qualifications, job descriptions and plans for recruiting proposed key staff.

Introduction

With AHS' unique and comprehensive understanding of the contractual and operational requirements of the Project, we have developed a robust staffing plan that will enable us to continue to execute all contract deliverables, exceed all performance metrics, and continue to deliver outstanding services to the potential enrollees, enrollees, providers, agencies, organizations, and other stakeholders we serve.

We Use Multiple Methods to Determine Staffing

We do not rely solely on computerized staffing programs to determine the size of our staff, but also consider operations, workflows, timelines and performance standards for the individual needs of the state as well as our corporate history.

We are offering the State a proven staffing plan, one that has been successfully used to operate the MHT Project for many years. Using this staffing plan, we achieved several important accomplishments of the Project, covering all facets of operations (e.g., phone, field, IT, etc.). While discussed fully in Firm and Staff Qualifications, briefly, a small snapshot of some of these recent highlights are:

- Supported numerous MCO expansions,
- Achieved high satisfaction rates,
- Achieved all service level agreements,
- Implemented several Project enhancements at no cost (e.g., redesigned the MHT and MHC letters and brochure, implemented an online enrollment module, and launched a mobile-friendly version of the MHT website),
- Transferred to the Fiscal Agent's web-based application,
- Provided coordinated support of the State's pharmacy expansion,
- Created draft MCO Comparison Charts for the MHT and WV Health Bridge Plan programs,
- Accommodated the discontinuation of the MCO provider directories in the enrollment packets,

- Outreached to dentists to ensure they were aware of administrative changes for children's dental services, and
- Updated our IT processes to accept new rate codes.

As evidenced, we consider quality staffing a major factor in the success of the contracts we administer. Overall, we give careful consideration to determining the number and type of employees to complete tasks and fulfill contractual obligations. Through thorough data analysis, projections and years of hands-on experience gained while providing all contract services for BMS through the MHT Project, we are confident that our proposed staffing plan is fully responsive to the needs of BMS and the changing MHT Project, and allows us to continue to meet performance standards and provide outstanding services to the State.

Our human resources and program design experience over the past 35 years lends itself to the maintenance of a sound organizational structure for the initiative. We take pride in being able to not only successfully forecast the size of the workforce but also to hire culturally competent and medically sensitive qualified staff with relevant experience in health services administration, community health education, and public health as well as a knowledge of community resources and the range of services needed for low-income individuals and families.

We have not only crafted the staffing plans for the current MHT contract, but also successfully developed the staffing patterns of other similar Medicaid contracts. Currently, we employ approximately 1,000 talented individuals across five states. Our Medicaid contracts range in size from five to over 500 FTEs, demonstrating our ability to implement customized staffing plans in response to individual contract needs. Regardless of the size of the contract, we have successfully projected staffing needs and respond accordingly with highly qualified and trained staff. In addition, we have been able to respond to changes needed to accommodate Project changes in activities and thoughtfully (yet quickly) modify our staffing plan.

In addition to our successful staffing models, we also have a strong history of high retention rates for the MHT Project, which affords BMS several benefits:

1. Our staff have a strong embedded knowledge of Medicaid and BMS programming, allowing them to offer enhanced customer service,
2. Because their understanding is so vast, training on new updates can be rapidly administered, and
3. Our staff can assume additional responsibilities (e.g., respond to dramatic increases in call volume without compromising quality, assume additional outreach efforts, etc.) and projects for BMS without additional resources.

We will continue to bring this expertise and proven approach to our staffing of the MHT Project. Our staff will continue to reflect the demographics of those receiving services as well as be culturally competent and respectful of health-related beliefs, communication styles, cultural values, behaviors and attitudes of the eligible population.

We thoroughly considered Project areas of responsibility, required tasks, pertinent statistics (e.g., eligible population changes, call volumes, talk times, mailing volumes, etc.), and performance standards/service level agreements when developing the statewide MHT Project's staffing plan and organizing its structure. Staff are allocated and arranged into two logical work units including:

- Call Center Unit, and
- Field Unit.

[redacted]

Key management staff will be available to participate in implementation meetings and activities immediately upon BMS' announcement of contract award.

Proposed Key Staff

We propose the following key staff positions and candidates for our administration of the MHT Project:

- Project Manager, Ms. Christy Thomas;
- Field Supervisor, Ms. Debbie Hon; and
- Call Center Supervisor, Ms. Veronica James.

BMS can contract confidently, knowing that we bring an experienced management team to oversee MHT Project operations from Day One and continuing through ongoing operations.

All of our proposed key personnel have practical, relevant West Virginia Medicaid and management experience. Our management team's hands on, West Virginia-specific expertise is unmatched. **Our key management team is a low risk, top performing team that is excited to serve BMS and West Virginia's Medicaid potential enrollees and enrollees.**

An overview of each key position and our proposed candidate's qualifications are highlighted below. Please see Appendix C for each candidate's resume, and Appendix J for job descriptions.

Project Manager

Our Proposed Project Manager, **Ms. Christy Thomas**, is an experienced health care professional with over 20 years' experience specializing in Medicaid operations with proven business and policy development experience. She has a comprehensive knowledge of State and governmental compliance protocol and contract negotiations, as well as a strong reputation as a self-directed professional with excellent problem solving, communication, and business management skills. She has been successful in directing others, developing procedural guidelines and project management operations/workflows in order to improve the quality of services delivered. Her background with West Virginia Medicaid will provide a strong foundation for success as a Project Manager for the MHT Project. With a Bachelor's degree in Organizational Leadership from Mountain State University, she is well prepared to lead the Project in the strategic direction envisioned by the State. Please refer to Appendix C for her resume.

Ms. Christy Thomas can be reached at the contact information below:

Exhibit 183. Contact Information for Christy Thomas

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

As Project Manager, Ms. Thomas will provide leadership in building and maintaining an effective organizational team. She will combine human, financial, and physical resources to successfully implement the MHT Project, the primary goal of which is to maximize the voluntary enrollment of Medicaid consumers into managed care (e.g., MHT or PAAS). She will also be responsible for implementing services to support future managed care enrollment and/or benefit expansion at the State's direction. The Project Manager will establish a close working relationship with DHHR, BMS, and MCO contact persons, and will oversee the community outreach effort. As Project Manager, Ms. Thomas will bear ultimate responsibility for the execution of all MHT Project tasks, and achievement of all Project metrics (e.g., call center abandonment rate, hold time, etc.). This position, based in the Charleston-area Project office, reports directly to AHS' Chief Executive Officer and is dedicated 100% to the Project.

As Project Manager, Ms. Thomas will also play a leading role in the implementation of the new contract. She will work closely with our corporate IT Department to collaborate on the customization and implementation of HealthTrack, will oversee the implementation of Provider Contact Manager, work with BMS on enhancement to the Project website, and will ensure all proposed value-added services are added in accordance with BMS' specifications.

Field Supervisor

Ms. Debbie Hon, our proposed Field Supervisor was introduced in Section 4.1.15. As mentioned, she is an experienced health care management professional with over ten years experience specializing in Medicaid operations. Ms. Hon has an extensive background working with field-based Medicaid Enrollment Broker operations that maximize the outreach and education efforts to consumers, having worked with AHS since 2004. Having demonstrated a strong aptitude for field and consumer relations as an Outreach and

DID YOU KNOW?

Under Ms. Hon's direction, the Field Benefits Managers have achieved several notable accomplishments that have supported BMS in their new initiatives, including but not limited to a few highlights from 2014:

- Outreach to over 500 Medicaid dental providers to ensure they were aware of the administrative changes for children's dental services. Using the list of participating dentists provided by the State, the Field Benefits Managers targeted their site visits to dental providers in their respective territories; tracked and reported any issues and concerns to DHHR; and distributed Scion Dental contact information and the dental information guide on behalf of DHHR;
- Participated in the Scion Dental Workshops and answered questions on Medicaid managed care enrollment and plan options by county; and
- Educated providers, pharmacies, agencies, DHHR offices, consumer groups and advocates about the expansion of The Health Plan (THP) into Lincoln and Putnam counties.

Education Specialist, Ms. Hon was promoted to an Outreach and Education Supervisor in 2013. She has an extensive field-based background to quickly establish and maintain excellent rapport with community resources and ensure partnerships to foster solid relationships with primary stakeholders. She is extensively networked throughout West Virginia and has established numerous strong ties with community agencies (please refer to Section 4.1.15). Her background with Enrollment Brokering, field operations, and Medicaid will provide a strong foundation for success as the Field Supervisor for the MHT Project.

As evidenced in Section 4.1.15, the quality of work performed by the Field Benefits Managers under her direction is a testament to her strength and leadership in this role.

As Field Supervisor, she will continue to supplement the activities of the Project Manager in developing and maintaining an organizational climate that facilitates attainment of the MHT Project's goals and objectives. She provides oversight for staff that are responsible for informing and educating agencies/potential enrollees and enrollees through broad-based promotional and outreach efforts about West Virginia's Medicaid Managed Care Programs, specifically MHT and PAAS and facilitating voluntary enrollment into MHT/PAAS. She is also responsible for working with additional populations (including Medicaid expansion), services for future managed care enrollment, or benefit expansion at the State's direction. She is also responsible for ensuring maximum levels among Medicaid potential enrollees and enrollees of voluntary enrollment in participating MCOs. This traveling position, reports to the Project Manager, and 100% of her time will be devoted to the contract.

Exhibit 184. Contact Information for Debbie Hon

Phone:	(304)345-0436
Cell Phone	(304)-549-9420
Address	405 Capitol Street Suite 406 Charleston, WV 25301
Email:	dhon@automated-health.com or wvregion2@automated-health.com

Call Center Supervisor

Our proposed Call Center Supervisor, Ms. Veronica James, was introduced in Section 4.2.15. Briefly, Ms. James has over 15 years' call center and Medicaid experience, having worked with AHS since 1999. In her current role as a Senior Helpline Information Specialist, she is responsible for assisting the Project Manager with the training and monitoring of the Call Center Unit staff. Ms. James establishes a culture of commitment to exceptional customer service and quality in the training programs she facilitates. As a seasoned member of the leadership team, Ms. James' training, quality oversight, and leadership experience will be leveraged as she continues to provide oversight of the MHT Project's Call Center Unit.

DID YOU KNOW?

Under Ms. James' direction, the Call Center Benefits Managers have achieved several notable accomplishments that have supported BMS in their new initiatives, including but not limited to:

- Providing Medicaid expansion callers with links to helpline resources to assist with co-pay and covering questions;
- Achieving impressive performance statistics for January 2014 (2.45% abandonment rate, average hold time of 10 seconds), despite a 76% increase in call volume over the previous month;
- Assisted callers with their questions regarding the close-out of the MHC program; and
- Met all performance metrics every month for the last several years.

As reflected in the text box as well as described extensively in Section 4.2, Ms. James' oversight of the MHT Call Center has already resulted in impressive performance and continuous attainment of performance metrics, which prepares her well to continue to oversee a unit providing outstanding services to BMS' Medicaid community.

As the Call Center Supervisor, Ms. James will be responsible for monitoring ongoing MHT Call Center activity, mentoring new employees, assisting in the development and facilitation of employee trainings as well as informing and educating potential enrollees and enrollees about MHT and enrolling them into the participating MCO or PAAS PCP of their choice. She will provide answers to enrollment questions for the MHT and PAAS Programs from Medicaid members, providers and the general community, and will provide answers to targeted populations during expansions (e.g., to the Medicaid expansion members or SSI members), as well as for new initiatives implemented into the Project (e.g., enrollment into Health Homes or patient centered medical homes). She will make appropriate referrals for calls received outside the scope of Medicaid managed care, and will log all contacts, enrollments, and plan changes into HealthTrack and the State's MMIS as appropriate. This position, based in the Charleston-area office, reports to the Project Manager and 100% of her time is devoted to the contract.

Exhibit 185. Contact Information for Veronica James

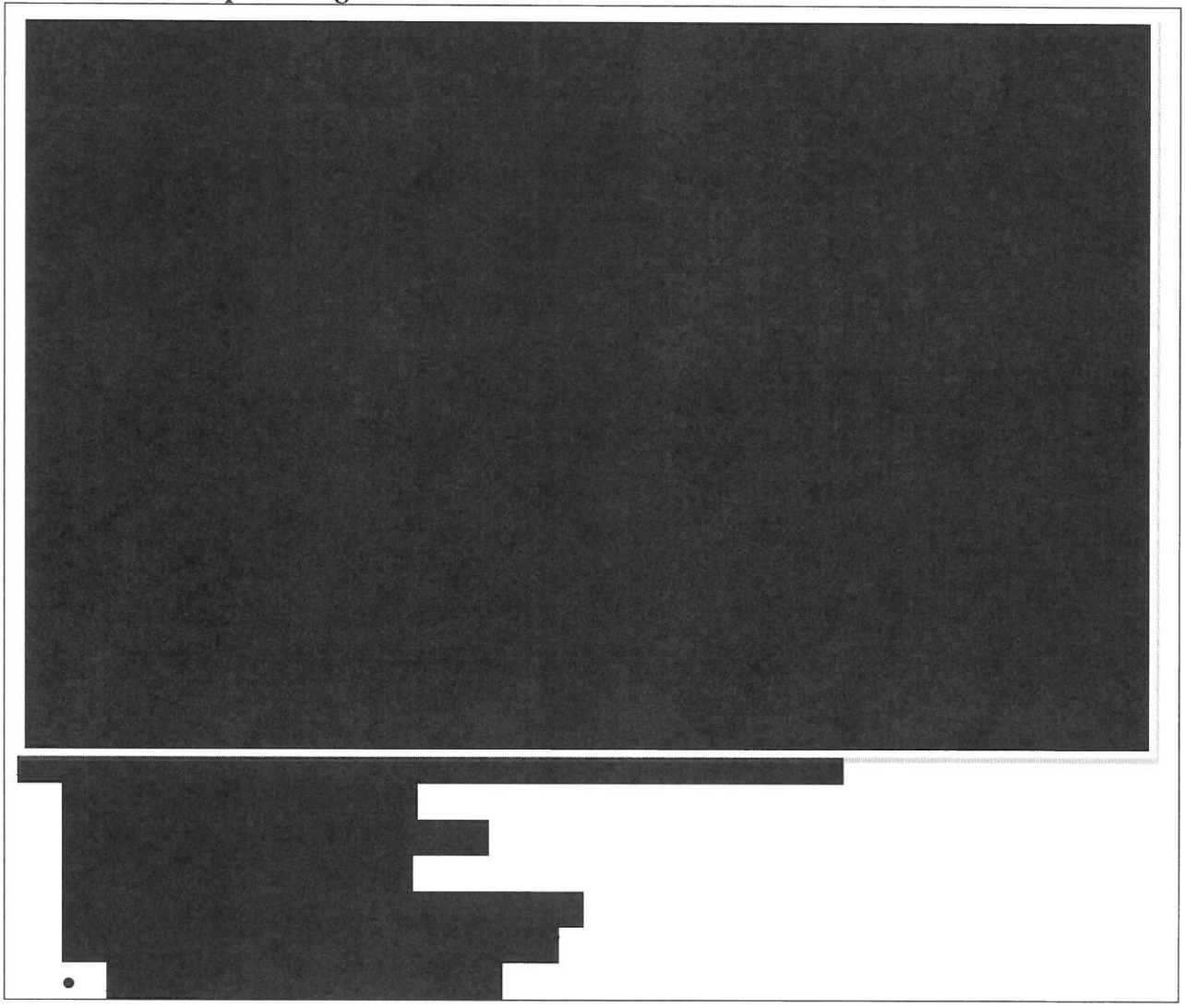
Phone:	(304)345-0436
Cell Phone	Not applicable
Address	405 Capitol Street Suite 406 Charleston, WV 25301
Email:	vjames@automated-health.com

4.4.1 Functional Organizational Chart

The Vendor should provide a functional organizational chart indicating the proposed project structure. The Vendor should indicate on the chart, or separately, the name of each proposed staff member and the percentage of time each proposed staff member will be dedicated to this project, expressed in a full-time equivalent (FTE) percent.

As mentioned, we thoroughly considered Project areas of responsibility, required tasks, pertinent statistics (e.g., eligible population changes, call volumes, talk times, mailing volumes, etc.), and performance standards/service level agreements when developing the statewide MHT Project's staffing plan and organizing its structure. (Please see Exhibit 186. Proposed Project Organization Chart.) All staff depicted on the organizational chart are dedicated 100% to the Project. Additionally, please refer to Exhibit 182 earlier for our staffing plan.

Exhibit 186. Proposed Organizational Chart



4.4.2 Provide Copy of Subcontract Agreement

If the Vendor proposes to subcontract with organizations or individuals, it should provide a copy of the subcontract/agreement and a summary of the subcontractor's size, resources, location and responsibilities under the contract. The primary contractor should assume responsibility for all subcontract work.

We will not engage in any subcontracts for this Project, which will allow us to retain better oversight, and ultimately quality of the Project. In our experience, engaging in multiple subcontractor relationships is problematic, as it is likely that none of the proposed subcontractors/partners have experience operating in the proposed structure.

The benefits of no subcontract arrangements include but are not limited to;

- Reduced exposure to a data breach, as no data will be transferred with external partners (for example, to share mailing files, etc.);
- Reduced costs associated with corporate overhead as less corporate resources are invested into overseeing the performance of subcontractors;
- Reduced risk of missed deadlines as we can more closely control resource allocation; and
- Reduced risk of fragmented services and operational disruptions.

4.5 Propose Solution that May Be Extended

The Vendor should propose a solution that may be extended to other State Agencies, United States Territory or political subdivision upon mutual consent by Vendor and entity.

DID YOU KNOW?

Our nimble corporate culture, including direct access to our Senior Management Team and modular IT systems, allows our approach to be quickly modified to serve other agencies, programs, etc.

Our proposed West Virginia Enrollment Broker operation is based on best practices and practical, affordable solutions that will result in:

- Measured improvements in Project operations,
- Positive potential enrollee/enrollee outcomes, and
- High satisfaction rates with our services.

We have developed our solution based on our understanding of the unique need and characteristics of West Virginia's Medicaid programming, which we then combined with our proven, successful best practices that we have implemented in other Medicaid administrative contracts.

Because of these factors that went into developing our solution, we believe there are countless elements that are incorporated into our solution that can yield positive results to other State Agencies, United States Territory or political subdivision, and we will be happy to work with West Virginia to extend our solution where it may be beneficial.

Attachment B: Mandatory Specification Checklist

List mandatory specifications contained in Section 4, Subsection .5.

Our response to each of the mandatory specifications follows.

5.1 Section 4, Subsection 5.1: Single Lead Point of Contact

The Vendor must agree to, no later than upon award of the Contract, provide a single lead point of contact that will serve as project manager and be immediately available by telephone and email, at a minimum, during business hours of Monday through Friday 8:00 am – 5:00 pm Eastern Standard Time. This person will be responsible for overseeing Vendor performance and act as a liaison between the Vendor, BMS, and the MCOs/PAAS. BMS reserves the right to reject any staff proposed or later assigned to the project and require the successful Vendor to remove them from the project. The Vendor will notify BMS two (2) weeks in advance of replacing any key staff. Any changes or addition in key staff once the contract has begun must be reported to BMS accompanied by resumes.

As evidenced in Section 4.4, we are proposing Ms. Christy Thomas as the Project Manager. Upon contract award, she will be immediately available by phone (via cell phone or at our Charleston office) or via email. Her roles will include overseeing all aspects of our performance under the contract, and serving as a liaison between BMS, the MCOs/PAAS, provider/stakeholder community, and AHS.

We understand and agree that BMS retains the right to reject any staff (e.g., the Project Manager or any other staff assigned to the Project) and request we remove them from the Project. Because of our careful and detailed screening practices, we are confident that all staff will meet the needs of BMS and the Project. However, should for any reason, we be requested to remove a staff member, we will do so promptly.



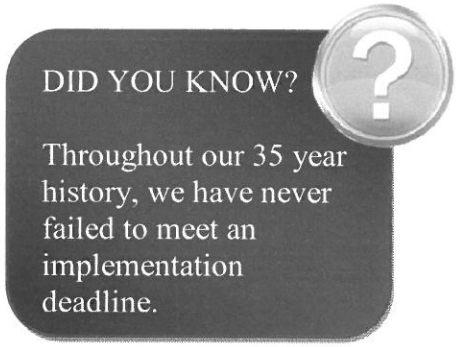
We further agree to provide BMS with a minimum of two weeks' notice before replacing any key staff. Should there be any changes to key staff, we will provide BMS with resumes for proposed replacements.

5.2 Section 4, Subsection 5.2: Draft Implementation Plan

The Vendor must agree to prepare and submit a draft implementation plan as part of its response. The Vendor must further agree to submit any revisions to its implementation plan for review and approval by DHHR/BMS within fifteen (15) calendar days from the date of contract award. In addition, the vendor must agree to complete implementation activities within the timeframe allotted in the implementation plan and no more than (90) calendar days following the award.

Please refer to Appendix L for our draft implementation plan submitted as part of our proposal.

We are pleased to bring to BMS a proven approach to ensuring all implementation milestones are met. As the incumbent, the overwhelming majority of all RFP requirements are currently operating, eliminating all risks associated with failure to meet an implementation deadline. In fact, all critical elements for the MHT Project are currently in operation, and any new elements to be implemented are enhancements to the current operation, the largest, of course, is HealthTrack, our proposed IT solution.



To ensure HealthTrack is ready for Go-Live, our IT Director, Mr. Eng Tan, will oversee the development and installation of HealthTrack. Mr. Tan has extensive experience overseeing the development of several state-of-the-art healthcare administration systems in rapid timeframes. When AHS was awarded the Louisiana CommunityCARE and Florida Enrollment Broker Projects, he was responsible for overseeing the development of two completely separate systems within a three month time period.

Mr. Tan will conduct the majority of his work to oversee the customization of HealthTrack from Pittsburgh; however, he will travel frequently to Charleston to coordinate with BMS, the Fiscal Agent, and other stakeholders as needed, as well as with our Project management and front-line staff. Tasks completed under Mr. Tan's direction include but are not limited to:

- Establishing connectivity and data lines (including determine appropriate secure interfaces, establishing connectivity with the state agency and all associated parties including the Fiscal Agent, testing connectivity, etc.);
- Ensuring appropriate system availability for State staff;
- Customizing HealthTrack (including customizing the enrollment wizard, contact tracking module, performing quality assurance testing, resolving issues identified during quality assurance testing, etc.);
- Ensuring Permissions (including defining roles, associating permissions with roles, linking users to roles, etc.); and
- Reporting (including defining required reports, building reports, coordinating the reporting templates with BMS, performing quality assurance on all reports, etc.).

Mr. Tan will be responsible for:

- Establishing the deadlines and timeframes for each item under his domain that must be completed;
- Determining the order, predecessors, and milestones associated with each task;
- Assigning appropriate resources to each task;

- Monitoring the progress towards the completion of all tasks, including:
  - Identifying potential issues,
  - Troubleshooting problems,
  - Re-allocating resources as needed,
  - Defining priorities for staff completion; and
  - Developing contingency plans for any item in jeopardy of not being completed; and
- Relaying the status of all technical and operational elements to the Project Manager.

5.3 Section 4, Subsection 5.3: No Connections to MCOs

In accordance with 42 CFR §438.810(f) found in Exhibit B, enrollment brokering activities, the Vendor must attest in writing that it has no corporate connections or financial interest in any of West Virginia's MCOs.

We attest that we do not have any corporate connections or financial interest in any of West Virginia's MCOs. We attest that we will continue to maintain this status throughout the duration of our tenure in West Virginia.

5.4 Section 4, Subsection 5.4: Provide Equipment

The vendor must agree to provide telephone, toll free numbers, faxing, paper supplies postage machines, furniture, etc. for its work force. This involves purchasing capital equipment including equipment that will be necessary to carry out the responsibilities of the contract.

As the incumbent contractor, we have already purchased all equipment required for the Project (e.g., telephones, toll-free numbers, fax lines and machines, paper supplies, desks, computers, etc.). We will maintain all equipment in good working order throughout the duration of the Project, and will make needed replacements/repairs when warranted to ensure we continue to have all equipment needed to operate the Project at all times.



5.5 Section 4, Subsection 5.5: Compatible with WVOT

The vendor must agree to provide only hardware, software and communications components which are compatible with the most current West Virginia Office of Technology (WVOT) supported versions of the Microsoft™ Operating System, Microsoft Office™ Suite and Internet Explorer™, and current technologies for data interchange.

In all of our contracts, including for the State of West Virginia, we have routinely complied with all technology requirements. We will continue to ensure all hardware, software and communications components are compatible with the most current West Virginia Office of Technology (WVOT) supported versions of technologies. We will not implement any hardware, software, or telecommunication component that is not compatible with specifications set forth by WVOT.

5.6 Section 4, Subsection 5.6: Outreach Activities

The vendor must agree to continue outreach activities in each county and initiate intensive outreach activities at least forty-five (45) calendar days prior to any change of choice or process in that county..

DID YOU KNOW?

In support of the Pharmacy Expansion, our field staff provided education and support to 648 pharmacy providers, prescribing providers, and DHHR offices within a three month period.

We have a robust approach to outreach, comprised of multiple approaches, consisting of mail, phone, web, and, most notably, extensive field engagement. (Please refer to Section 4.1 for a detailed description of our approach to outreach.)

As described in Section 4.1, we will implement a comprehensive outreach strategy to ensure appropriate outreach and education in all West Virginia counties and will initiative intensive outreach activities at least 45 calendar days prior to any change or process in that county. Such outreach may include but not be limited to:

- Development of member materials,
- Education via webinars,
- Site visits by Benefits Managers,
- Outreach to PCPs,
- Outreach and training to local DHHR offices, and
- Tracking and sharing with BMS any issues and concerns raised by the stakeholder communities.

5.7 Section 4, Subsection 5.7: Enrollment Forms

The vendor must agree to process enrollment forms to effect the member's enrollment or change in enrollment for the following month by the cutoff date, which falls in the third week of the month. MCO/PAAS enrollments are effective from the first day of the month to the last day of the month.

We have always complied with all timelines required for all components of the Project, and will continue to ensure all enrollment forms are processed within the stated timeframes established by BMS. Should these timeframes change at any point during the contract, we will adjust our process to ensure they continue to be met.

5.8 Section 4, Subsection 5.8: Enrollment Materials

The vendor must agree to develop enrollment materials that comply with the requirements of 42 CFR §438.10(e) found in Exhibit B and that are at or below a sixth grade reading level.

We have developed user-friendly, high caliber enrollment materials that comply with all requirements of 42 CFR §438.10(e) and meet the reading level requirements for the Project. We will continue to ensure high-quality enrollment materials that meet the needs of BMS and the potential enrollees/enrollees it serves are available throughout the duration of the Project. Please refer to Section 4.1.3 for our approach to developing high quality materials.

5.9 Section 4, Subsection 5.9: Auto-Assignment Algorithm

The vendor must agree to work with BMS to develop the algorithm that will be used to assign members who do not make a selection to an MCO or PAAS. The algorithm must assign members based on their current PCP affiliation and their geographic access to providers in accordance with relevant Federal regulations. In addition, the Vendor must work with BMS to assure compliance with new and innovative enrollment strategies that may include passive enrollment and auto assignment based on P4P

We currently operate an auto-assignment algorithm in accordance with all BMS specifications, and we have the capacity to implement complex changes to our auto-assignment programming at any time. We pledge to work with BMS throughout the duration of the contract to implement new changes and enrollment strategies that may include passive enrollment and auto-assignment based on P4P. For additional details on our approach to auto-assignments, please refer to Sections 4.3.6.4 and 4.3.6.5.

5.10 Section 4, Subsection 5.10: Agree to Requirements

The vendor must agree to all relevant requirements under 42 CFR 438.100 and 42 CFR 438.10 found in Exhibit B including furnishing the following information to all managed care and PAAS program enrollees:

5.10.1 Notify all enrollees of their disenrollment rights, at a minimum annually;

5.10.2 Notify all enrollees, at the time of enrollment, of the enrollee's rights to change providers or disenrollment for cause;

5.10.3 Notify all enrollees of their right to request and obtain the information listed under 42 CFR §438.10 found in Exhibit B, at least once a year; and

5.10.4 Furnish to each of its enrollees the information specified under 42 CFR §438.10(g) found in Exhibit B within a reasonable time after enrollment.

Per Amendment 1 of the RFP, this requirement has been deleted. However, we have and always will complied with all State and Federal rules and regulations regarding enrollee notice and communication throughout our tenure with each of our enrollment broker contracts, including the MHT Project. We will continue to do so in the new contract.

5.11 Section 4, Subsection 5.11: Free of Conflict of Interest

In accordance with 42 CFR §438.810 found in Exhibit B, the Vendor must affirm that it and its officers, members, employees, and/or subcontractors shall be free from any conflict of interest. Specifically, the Vendor affirms that neither it, nor any employee, subcontractor, or consultant:

5.11.1 Has any direct or indirect interest financial interest in any health care entity or health care provider that furnishes services in West Virginia;

5.11.2 Has been excluded from participation under title XVII or XIX of the Act;

5.11.3 Has been debarred by any Federal agency; or

5.11.4 Has been, or is now subject to, civil penalties under the Act.

The Vendor must covenant that in the performance of the contract, the Vendor shall periodically inquire of its officers, members and employees concerning such interests. Any such interests discovered shall be promptly presented in detail to BMS.

The Vendor must certify that it is independent from any MCO or health care provider that provides coverage in the State of West Virginia.

As an enrollment broker in multiple states including West Virginia, we comply with all requirements of 42 CFR §438.810, and we affirm that all officers, members, and/or subcontractors are free from all relevant forms of conflicts of interest. Specifically, we assert that no owner, officer, or employee of AHS:

- Has any direct or indirect interest, financial interest in any MCO, health care entity or health care provider providing services in West Virginia;
- Has been excluded from participation under title XVII or XIX of the Act;
- Has been debarred by any Federal agency; or
- Has been, or is now subject to, civil penalties under the Act.

We further attest that we will continue to maintain this status throughout the duration of our tenure in West Virginia.

5.12 Section 4, Subsection 5.12: Safeguards

The Vendor must agree to put safeguards in place at least equal to Federal safeguards per Section 1932(d)(3) of the Social Security Act addressing the default enrollment process under the managed care and PAAS programs.

We have always complied with all requirements for safeguards addressing the default enrollment process under the managed care and PAAS programs, and the safeguards we currently have in place meet all requirements (e.g., equal to Federal safeguards per Section 1932(d)(3) of the Social Security Act. We will continue to keep these safeguards in place and will ensure they continue to meet all State and Federal requirements.

5.13 Section 4, Subsection 5.13: Govern Contract by Laws

The Vendor must agree that the contract shall be governed by the laws of the State of West Virginia. The Vendor further agrees to comply with the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), The Age Discrimination Act of 1975, the Rehabilitation Act of 1973, The Americans with Disabilities Act, and all other applicable laws (Federal, State or Local Government) regulations.

We have always and will always continue to administer all of our contracts in accordance with the appropriate laws. For the MHT Project, we will adhere to:

- All laws for the State of West Virginia,
- The Civil Rights Act of 1964,
- The Education Amendments of 1972,
- The Age Discrimination Act of 1975,
- The Rehabilitation Act of 1973,
- The Americans with Disabilities Act, and
- All applicable State, Local, and Federal regulations.

REQUEST FOR PROPOSAL

West Virginia Bureau for Medical Services

RFP # BMS 14028

By signing below, I certify that I have reviewed this Request for Proposal in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that, to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

Automated Health Systems
(Company)

Joseph W. Morton, CEO
(Representative Name, Title)

412-367-3030 ext. 2203; Fax: 412-367-1213
(Contact Phone/Fax Number)

June 18, 2014
(Date)

West Virginia Bureau for Medical Services

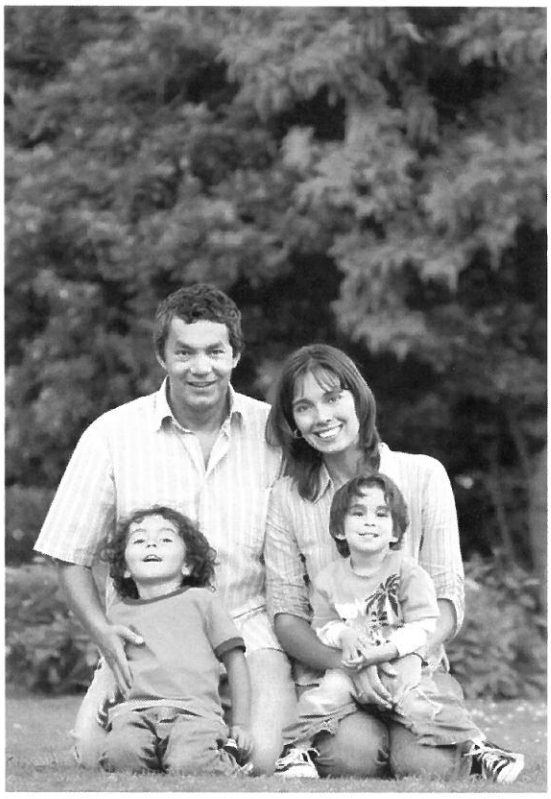
Solicitation # BMS14028
Wednesday, June 18, 2014
1:30pm EST

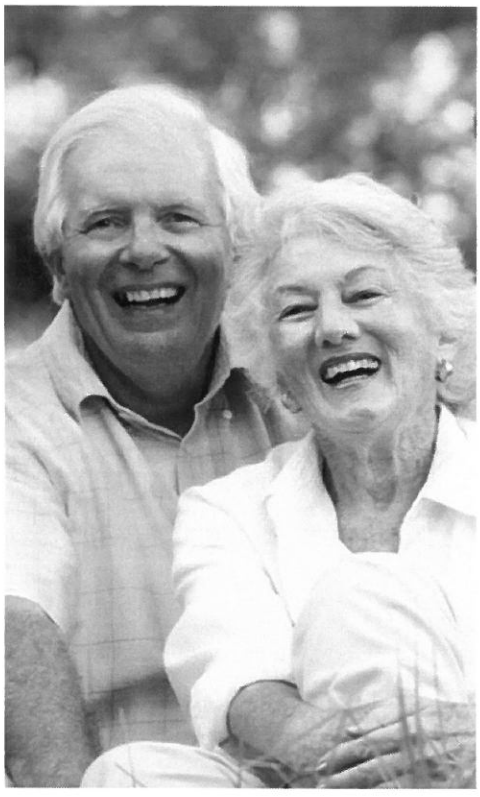
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

APPENDICES - REDACTED

Enrollment Brokerage Services For The Medicaid Managed Care Program







AUTOMATED HEALTH SYSTEMS

9370 McKnight Road - Suite 300 - Pittsburgh, PA 15237

Senior Management Team Resumes

Submitted by:
Automated Health Systems

June 25, 2014

Joseph W. Nocito

Chief Executive Officer

Summary of Qualifications

Mr. Nocito has provided financial guidance to and directed the fiscal affairs of AHS as Chief Financial Officer since 1979. In 1997, Mr. Nocito assumed the operational guidance of AHS as CEO. He is ultimately responsible for negotiating and engaging in all contracts, ensuring that all contracts meet or exceed performance standards and service level agreements, and giving direction and leadership toward the achievement of AHS' mission, goals and objectives. Under his leadership, AHS has been awarded contracts in Florida, Louisiana, Missouri, Ohio, Pennsylvania, New Jersey, Georgia, West Virginia, Wisconsin, New York and Illinois. Upon award of a contract to AHS, he will maintain clear authority over the entire project and its operation.

Professional Experience

Automated Health Systems, Inc. *1979 - Continuing*
Pittsburgh, PA

***Chief Executive Officer** (1997-Present)*

Creates, communicates, and implements AHS' vision, mission and overall direction. Leads the development and implementation of AHS' overall strategy. Fosters innovation and responsiveness while ensuring efficient provision of quality solutions. Leads, guides, and evaluates the work of Senior Corporate Management and Project Management staff. Oversees the complete fiscal and operational management of AHS and its projects. Maintains awareness of both competitive landscape, new business opportunities and industry developments and standards. Negotiates and executes all contracts entered into by AHS. Bears ultimate accountability for AHS' operations company wide.

***Chief Financial Officer, CPA** (1979-1997)*
Provided financial consultation and fiscal reporting. Responsible for overall financial guidance. Reviewed proposals for monetary soundness, developed departmental and corporate budgets, participated in contract negotiations with funding agencies, interfaced with auditing staff, and negotiated with financial institutions for lines of credit and operating capital as needed.

Homewood-Brushton Neighborhood Health Center, Inc. *1975 - 1978*
Pittsburgh, PA

Controller
Provided fiscal management of Health Center employing 130 professional employees rendering a full range of medical and dental services to low income individuals. Supervised an accounting staff of fifteen people responsible for all facets of the accounting process. Interacted with project officers from all segments of Federal, State and local governments. Prepared annual budgets to be

funded by the Department of Health, Education and Welfare. Reported directly to the Executive Director with dual reporting responsibility to the Board of Directors comprised of neighborhood representatives.

Touche Ross & Co. *1970 - 1975*
Pittsburgh, PA

Senior Staff Accountant
Entered the accounting profession as a member of the audit staff of Touche Ross & Co.; passed the CPA exam in May of 1973. Conducted audits of numerous non-profit organizations including Head Start programs, Community Action Pittsburgh, Inc., Homewood-Brushton Neighborhood Health Center, Inc., and the Sisters of Divine Providence. In addition, participated in the audits and financial consultation of various entities, such as La Roche College, Divine Providence Hospital, Nursing Homes and Schools. Also was involved with audits of all phases of business including construction companies, manufacturing concerns and retail operations. Supervised audit of a public offering of a major manufacturing concern.

Education

Robert Morris University
Bachelor of Arts, Degree in Accounting, 1970

Professional Organizations

American Institute of Certified Public Accountants
Pennsylvania Institute of Certified Public Accountants

Board Affiliations

Robert Morris University
Board of Trustees - President of the Board *(2005-present)*

Robert Morris University
Board of Trustees - Vice Chairman of the Board *(1990-2005)*

Honors

Entrepreneur of the Year Award
Massey Center for Business Innovation and Development
at Robert Morris University *(April 28, 2003)*

Heritage Award Recipient
Robert Morris College *(1990)*

Dennis J. Sundo, MS, CPA, CFP

Secretary/Controller

Summary of Qualifications

Mr. Sundo has nearly 30 years of experience in managing day-to-day financial operations for government-funded programs and has demonstrated excellent financial management and accounting skills. With AHS since 1982, he provides all financial management, budgeting, and accounting functions necessary for AHS corporately and across all projects.

Professional Experience

Automated Health Systems, Inc. *1982 - Continuing*
Pittsburgh, PA

Corporate Controller/Secretary
Provides leadership and coordination of AHS' financial planning and budget management functions. Ensures AHS' accounting procedures conform to generally accepted accounting principles. Monitors and analyzes operating results against budgets. Compiles Project costs, compares actual costs to estimates and analyzes variances. Responsible for assuring the smooth fiscal operation of the AHS and its projects. Makes recommendations on future financial plans, creates forecasts, and recommends policies.

Arthur Anderson & Co. *1981 - 1982*
Pittsburgh, PA

Staff Auditor
Participated in financial and operational audits of public and private companies. Performed detailed testing of both the revenue and expense cycle. Tested compliance within internal control structures. Designed and helped implement internal control systems. Prepared financial statements in accordance with GAAP including footnote disclosures. Responsible for review of work of staff members and coordination of all job activities.

Education

Robert Morris University
Master of Science in Taxation, 1988

Duquesne University
Bachelor of Science in Business Administration with an emphasis in Accounting, 1981

Certification

Certified Public Accountant
Certified Financial Planner

Professional Organizations	American Institute of Certified Public Accountants Institute of Certified Financial Planners Pennsylvania Institute of Certified Public Accountants

Kimberly A. Conner, MS, RD

Director of Human Resources, Training and Development

Summary of Qualifications

Ms. Conner was involved in hospital/health care delivery systems for 17 years with overall emphasis in management and staff training before joining AHS in 1994. In addition to currently offering company-wide trainings on health literacy, customer service and confidentiality, she efficaciously handles personnel issues, staffing, recruitment, initial training and ongoing development (particularly in the areas of consumer/employee confidentiality, employee performance evaluations, policy and procedures) and strategic planning. Recently, she has spearheaded a well-received corporate wellness initiative, now offered company-wide.

Professional Experience

Automated Health Systems, Inc. *1994 - Continuing*
Pittsburgh, PA

Director of Human Resources, Training and Development
As a member of the corporate management team, responsible for the administration and implementation of human resources services for a multi-location health management organization (i.e., approximately 1000 employees). Primarily functions as a Corporate Human Resources Administrator, providing support for contracts located in Ohio (Medicaid Managed Care and Medicaid Consumer Hotline), Wisconsin (statewide Medicaid Managed Care), West Virginia (Medicaid Managed Care and Primary Care Case Management), Illinois (Primary Care Case Management and Eligibility/Enrollment), Florida (Medicaid Managed Care), Missouri (Eligibility/Enrollment), and North Dakota (Eligibility and Provider Enrollment). Accumulated over twenty years of broad-based experience in training and development, employee relations, recruitment/employment, standardization of policies, practices and procedures, total quality management (TQM), organizational development and company-wide strategic planning. Also assists in the development, and submission of requests for proposals (RFPs); involved with the support of "start-up" projects, overall project implementation and on-going contract management. Particularly dedicated to the creation of a cohesive work environment built on strong leadership, adaptability, and quality service. Provides training techniques for management and staff to support a positive learning environment for overall organizational growth. Also instituted for over fifteen years, project-specific student internship programs. Continues to promote "prevention" throughout organization through on-going Employee Wellness efforts and the formulation of a company-wide Corporate Health Challenge Program. Recently recognized with an award as one of "Chicago's Healthiest Employers". Reports directly to the CEO of AHS.

Examples of work performed include, but are not limited to:

- Develops and implements a Corporate Human Resources Policy and

Procedures Manual and Employee Handbook for use by management and employees, outlining mutual responsibilities to each other and the corporation;

- Manages the administration of an employee satisfaction survey; evaluates results and implements measures via a formalized strategic planning process that has resulted in ongoing improvements of identified areas;
- Trains managers/supervisors to implement a single performance appraisal process that replaced numerous existing programs and resulted in the alignment of individual departmental goals with the organization's objectives;
- Oversees and monitors the administration of employee professional development programs (i.e., Learning Lab, On-going Educational Series, AHS' Health Promotion/ Wellness Program-Corporate Health Challenge);
- Establishes corporate policies and procedures to comply with employment law and develop employee relations guidelines through effective problem resolution procedures;
- Manages and monitors both human resources staff and project management staff responsible for exempt and non-exempt staff recruitment for a multi-location organization (i.e., contracts held in West Virginia, Wisconsin, Ohio, Illinois, Florida, Missouri, and North Dakota);
- Oversees the administration of policies and procedures regarding employee benefits, compensation and payroll issues;
- Manages the delivery of activities including research, development and implementation of special projects to support management and to accomplish initiatives relative to company- wide strategic goals.

Sewickley Valley Hospital *1982 - 1994*
Sewickley, PA

***Director of Health Promotion** (1987-1994)*
Managed, operated and oversaw preventive health promotion and wellness programs (250 participants at multiple sites). Supervised and coordinated professional, clinical, clerical and volunteer staff (15 full-time employees and 5 volunteers). Expanded the product-line to service local school districts for employee wellness programs. Enhanced continuous education through management training programs such as: How to Supervise Others, Interactive Management, Quality Education System, Behavioral Interviewing Process, Priority Management and Hoshin Planning Techniques. Researched, developed and implemented both employee and community based wellness programs. Overall emphasis was the development, implementation and monitoring of a hospital-wide (1500 employees) injury prevention program (i.e., back injury and other cumulative trauma/repetitive motion injuries). Presented preventive health and wellness seminars and participated in community health fairs/health promotion related events. Also involved in the creation of newsletters, promotional and educational materials; ongoing program development and health promotion implementation. Assisted with "new" employee orientation and

training programs (i.e., provision of management/supervisory skill sets, hospital-wide computer conversion training, quality education/customer relations, team building, wellness education and injury prevention). This position reported to the Staunton Clinic Administrator and VP of Human Resources.

***Health Promotion Specialist** (1982-1987)*
Organized educational programs for businesses, schools, and the community. Developed and implemented community-based health programs. Marketed and promoted programs through the targeted distribution of newsletters, and brochures, and participation in community events (i.e., health fairs and educational speaking engagements). Designed, developed curriculum, and instructed classes for program implementation. This position reported to the Chief of Psychology.

Education

Robert Morris University
Professional Human Resource Management,
Certificate Program Completed, 1995

University of Pittsburgh
Master of Science, School of Education, 1987
Area of Emphasis: Exercise Physiology and Cardiac Rehabilitation

Seton Hill University
Bachelor of Science, Minor: Business Management, 1982

Continuing Education

Seubert-Health Care Reform Seminars- 2012 and 2013
Buchanan Ingersoll, "Important Amendments for the American Disability Act" - 2009
The Human Resources Association of Pittsburgh's Annual Conference - 1999 through 2010
"The Disney Keys to Excellence", Disney Institute – 2005
"The Power of Teams", Dynamic Professionals, Robert Lawson, Ed.D.- 2006
"An Emotionally Intelligent Response to Increased Stress and Anxiety in the Workplace", Pittsburgh Human Resources Association- 2002
The Leadership Challenge: Creating a Successful Organization in the Knowledge Economy - 1999

Professional Organizations

Society of Human Resources Management (SHRM)
American Society for Training and Development (ASTD)
Pittsburgh Human Resources Association (PHRA)
American Dietetic Association (ADA)

Attributes

Registered Dietitian (R.D.) - I.D. Number 632818

Eng Tan, MS

Director of Information Technology

Summary of Qualifications

Mr. Tan has ten years' experience as an IT professional and 10 years' experience working with Medicaid Management Information Systems and various medical, health care, human services, and government computer systems. He has strong hands-on experience in all stages of systems development as both a project manager and programmer including: analysis, design, development, testing, implementation, and maintenance.

Professional Experience

Automated Health Systems, Inc. **2002 - *Continuing***
Pittsburgh, PA

***Director of IT** (2007 - Present)*
Plans, directs, manages and oversees AHS' Corporate IT Department's activities and operations as well as on-site Project IT units. Responsible for all aspects of the IT Department staff performance, project portfolio, procurement, end-user expectations, and overall IT operations in the company. Oversees all IT operations and systems, including software development, technical support, network, servers, back-up systems, security systems, and user help systems.

Manages software development projects through entire lifecycle, ensures proper system design and documentation, performs code reviews, and ensures proper testing and system rollout. Enforces compliance for software licensing, HIPAA, accessibility guidelines and other mandated policies and protocols. Works closely with the Network Administrator and Telecommunications Manager to ensure LAN, WAN and telecommunication components are in optimal working condition to support contractual requirements.

Controls and develops IT budgets to reduce cost and improve efficiency and performs detailed return-on-investment (ROI) analysis. Reports directly to Chief Executive Officer and works closely with internal and external customers as well as vendors.

***Computer Programmer/Analyst** (2002 – 2006)*
Worked as a part of the initial HealthTrack project development team. Developed software for remote access by other AHS offices, taking into account network bandwidth and latency. Consolidated several branch office programs into a single corporate infrastructure. These programs enabled batch file processing instead of manual data entry to state Medicaid Management Information Systems, which resulted in significant process improvements. Performed code reviews, system design and documentation, and participated in all phases of software development lifecycle. Assisted in managing corporate network environment, including Active Directory, Microsoft Exchange 2007, VPN,

firewall, and more. Performed user account management, group policy administration, WSH network scripting..

US Steel Corporation **2000**
Pittsburgh, PA

Web Application Developer Intern
Designed, developed, maintained, and documented "TechWeb" – an intranet application for paperless inter-departmental requests for new personnel, hardware, software, and other needs. Significantly increased efficiency, accountability, and communication between IT and the end user community. "TechWeb" enabled detailed status tracking and performance reporting, as well as reduced lag time in completing requests. Created a Web-based phone directory for the entire IT department, replacing outdated spreadsheets and office documents. Responsible for all aspects of software development lifecycle, including requirements analysis, system design, development, testing, and implementation. Programming languages and software tools used include ASP, VBScript, JavaScript, SQL, CSS, HTML, and MS Office Suite. Performed hardware and software inventory for the IT department and assisted with various office duties.

Education

Robert Morris University
Master of Science, Information Systems Management, 2006
Graduated with Alpha Iota Mu Honors

Thiel College
Bachelor of Arts, Computer Science, 2002
Graduated Summa Cum Laude

Robert J. Doran, Jr.

Director of Telecommunications

Summary of Qualifications

Mr. Doran has been with AHS since 1986 and has 27 years' experience with health program administration. Specifically, he has over 15 years' experience administering telecommunication systems for call center operations. He is responsible for ensuring the appropriate selection, installment, and functioning of each of our Projects' telecommunications solutions. Also he oversees all telecommunication operations (i.e., transferring phone lines, installing/upgrading hardware and software, testing its functionality, performing on-going maintenance, as well as the ordering and installing of T1 lines and deploying upgrades as needed) and ensures that phone systems meet or exceed project requirements and that new technologies are appropriately deployed.

Professional Experience

Automated Health Systems, Inc. *1986 - Continuing*
Pittsburgh, PA

Director of Telecommunications (1997 – continuing)

Oversees phone operations of all projects in all office locations (i.e., six state projects) and ensures that all phone systems meet or exceed project requirements at all times. Monitors and administers adds, moves, and programming changes to telecommunications systems. Oversees the purchase and installation of telecommunication lines, voice and data, for all projects. Manages the installation of all new office facilities to ensure operations continue on a seamless path. Serves as AHS' primary point of contact for all telecommunication needs. Also is the primary liaison with the key telecommunication vendors including. Designs and implements telecommunication infrastructure in concert with the Director of IT ensuring that the infrastructure will be more than capable of supporting a project's initial needs and expected growth. Serves as the primary telecommunication counterpart for the State and fiscal agent to ensure connectivity to the systems. Plans and executes a solid backup and disaster recovery strategy for the entire organization. Provides complete systems documentation on new and existing systems, using network diagrams, charts, spreadsheets, database programs, and other tools as necessary. Ensures that new and existing systems are in compliance with industry standards and regulations, including HIPAA, and other regulations. Assists with the support of systems operations for all projects. Highlights include:

- Implemented call centers for AHS' CommunityCARE/KIDMED contract in Louisiana and AHS' Medicaid Reform Enrollment Broker contract in Florida. These projects had start dates approximately one month apart; yet, despite these aggressive timelines all facets of these call centers were fully operational on Day One of the projects; and
- Demonstrated the ability to rapidly and significantly increase Call Center capacity due to program expansions. For example, in 10 weeks, upgraded and expanded AHS' Florida Call Center capacity when AHS' role expanded from serving 300,000 eligible Members to 3.3 million eligible Members.

Director of Field Operations (1993–1997)
Provided oversight of the maintenance and expansion of the statewide primary care provider network for the Commonwealth of Pennsylvania's Primary Care Case Management (the Family Care Network) and EPSDT programs. Continuously monitored a statewide provider network, created targeted recruitment plans for areas with low provider participation and developed strategies to increase primary and specialty provider participation.

Provider Representative (1986–1993)
Maintained and expanded within an assigned territory the primary care and specialty provider network for the Commonwealth of Pennsylvania's Family Care Network and EPSDT programs.

Education

Robert Morris College, Pittsburgh, PA
Bachelor of Arts, Business Information Systems, 1986

Continuing Education

AVAYA Basic DEFINITY ECS Administration Training, 2000
AVAYA DEFINITY ECS Call Vectoring Program Training, 2000
International Alliance of AVAYA Users – Pacific Region Conference, October 2001
DEFINITY Audix 4.0 System Administration, November 2001
Call Center Exchange Conference, April 2003
COMDEX – Project Management Workshop, November 2003
ZEACOM SmartConnect Administrator Training, April 2004
AVAYA CM 5.2 Training, June 2010
ZEACOM Administrator Foundation Training, April 2012
AVAYA CM 6.0 Training, May 2012
ZEACOM Desktop Training, June 2012

Computer Skills

Desktop Technologies: Windows 7/Vista/ XP/2003/2000, Microsoft Office Suite 2003-2010, AVAYA CMS R11-R16, Zeacom Administrator – Report Generator – Desktop Application

D & B Report REDACTED

Submitted by:
Automated Health Systems

June 25, 2014

Audited Financial Statements REDACTED

Submitted by:
Automated Health Systems

June 25, 2014

Key Management Team Resumes

Submitted by:
Automated Health Systems

June 25, 2014

Christy D. Thomas

Proposed Project Manager

Summary of Qualifications

Ms. Christy Thomas is an experienced health care professional with over 20 years experience specializing in Medicaid operations with proven business and policy development experience. Ms. Thomas has a comprehensive knowledge of State and Governmental compliance protocols and contract negotiations, as well as a strong reputation as a self-directed professional with excellent problem solving, communication, and business management skills. In her previous positions, Ms. Thomas has been successful in directing others, developing procedural guidelines and project management in order to improve the quality of services delivered. Her background with West Virginia Medicaid will provide a strong foundation for success as a Project Manager for the West Virginia Mountain Health Trust (MHT) Project.

Professional Experience

CNSI **2011 - *Continuing***
Gaithersburg, MD

Operations Manager
Responsible for the Data Service Hub Project, which is associated with the Health Information Exchange as it relates to the Affordable Care Act (ACA). Currently, has responsibility for oversight of the EDI implementation operations. Previously, as the Operations Project Manager, was responsible for providing oversight and management support for the operations implementation project for the State of Louisiana. Also responsible for ensuring the subcontractor on the project was executing and meeting all the requirements stated in the contract.

Accomplishments in this position include:

- Responsible for providing oversight for the Provider Re-Enrollment Project for the State of Louisiana. Supported multiple MMIS proposal submissions for CNSI with emphasis on operations and staffing; and
- Works closely with the subcontractor and client in developing policies and procedures related to the implementation of the project and completed root cause analysis on issues that arose within the project.

Molina Medicaid Solutions **2005-2011**
Charleston, WV

Deputy Account Manager
Responsible for the day-to-day operations, which included the areas of claims, mailroom, provider relations, pharmacy, quality assurance, and other contract-specific functions. Served as the primary point of contact for the Bureau of Medical Services, as well as in the absence of the Executive Account Manager, served as the sole Molina representative in the Medicaid Services Advisory Council. As such, ensured all staff and Project efforts remain focused on achieving all objectives.

Accomplishments in this position include:

- Developed budgets, acted as the internal liaison with each of the MMIS units, facilitated communications in order to prepare operations reports for the mandatory meetings, served as the system representative. Provided leadership and oversight to successfully complete the annual SAS70/SSAE 16 audit for three years with no findings or qualifications;
- Participated in the overall management of a $25 million project, as well as in the leadership and provided directives to over 100 employees on a daily basis;
- Worked to establish annual performance goals with the department managers, so that department goals supported the overall objectives; and
- Facilitated the weekly management review process of key operations to include performance measurements, goal achievement, and initiative progress status reports.

Carelink Health Plans **2001-2005**
Charleston, WV

Senior Provider Relations Representative
Assessed, recruited, and organized vendors for the Medicaid, HMO and PPO provider networks. Served as the primary contact for a number of specific provider groups within the state of West Virginia.

Accomplishments for this position include:

- Negotiated complex contracts with physicians, ancillary, and hospital providers and acted in an advisory capacity to the legal department with regard to the financial and legal impact of provider contracts;
- Managed and provided oversight of the quality of customer service given to the provider practices by resolving problems and advising on new protocols, policies, and procedures;
- Provided oversight for the compliance of the Network Management for the applicable accrediting body (URAC); and
- Contracted with large hospitals and PHOs within West Virginia regarding commercial and Medicaid business, and investigated claims issues for providers.

PrimeONE **1997-2000**
Charleston, WV

Customer Service Supervisor
Responsible for nine direct reports (i.e., Customer Service Representatives, Provider Service Representatives, and Grievance Coordinators). Assisted with the hiring, training and mentoring of all new customer service staff. Developed and implemented the quality and production incentive program for employees. Completed individual monthly quality and production audits on all

representatives. Responsible for the quality and output of the provider and member call centers; specifically, maintained and managed over 60 employer groups as well as a five percent (5%) abandonment rate for a 40-second response time. Further, provided oversight of the appeals processes for providers and members and acted as the liaison for employer groups, enrollees, third party vendors, PEIA, and community resources within the customer service division. Conducted the annual provider workshops. Additionally, provided managerial and administrative support to the Medical Director, Department of Insurance, and medical management. Provided oversight to the claims processing internal audit and was responsible for transitioning customer service and claims to Coventry Health Plans.

Acordia National **1992-1997**
Charleston, WV

Provider Relations Call Center Representative
Responsible for answering, evaluating, and correctly routing incoming provider calls related to the PrimeONE account. Handled calls related to claim status, eligibility, enrollment, prior authorization, and member questions.

Education

Mountain State University, Beckley, WV
Bachelor of Arts, Organizational Leadership, 2013

West Virginia State College, Institute, WV
Associate of Arts, Applied Science, 1994

Computer Skills

Microsoft Office Suite (Word, Excel, Outlook, PowerPoint)

Debbie L. Hon

Proposed Field Supervisor

Summary of Qualifications

Ms. Debbie Hon is an experienced health care management professional with over ten years experience specializing in Medicaid operations. Ms. Hon has an extensive background working with field-based Medicaid Enrollment Broker operations that maximize the outreach and education efforts to consumers. Having demonstrated a strong aptitude for field and consumer relations as an Outreach and Education Specialist, she was promoted to an Outreach and Education Supervisor in 2013. Ms. Hon has an extensive field-based background to quickly establish and maintain excellent rapport with community resources and build solid relationships with primary stakeholders. Her background with Enrollment Brokering, field operations, and Medicaid will provide a strong foundation for success as the Field Supervisor for the West Virginia Mountain Health Trust (MHT) Project.

Professional Experience

Automated Health Systems, Inc. **2004 - *Continuing***
Charleston, WV

Outreach and Education Supervisor (2013-continuing)

Supplements the activities of the Project Manager in developing and maintaining an organizational climate that facilitates attainment of the Project's goals and objectives. Participates in the development and implementation of training that maintains field staff's knowledge of West Virginia Medicaid Programs and enhance their cultural competencies. Develops, coordinates and monitors outreach efforts to increase potential enrollees and enrollees' selection of a best fit MCO. Provides oversight to the Outreach and Education Specialists (4 staff), monitors their interactions for quality and develops corrective actions to ensure the quality of interactions. Accomplishments include:

- Ensuring optimum levels of Medicaid managed care selections through the implementation of field-based activities and broad-based promotional efforts;
- Overseeing the networking and relationship-building of Outreach and Education Specialists to well over 100 community agencies across the State;
- Overseeing ongoing education across the State to providers, agencies, and organizations on ongoing changes to the West Virginia Medicaid program (e.g., the close-out of the MHC program, the Pharmacy Expansion initiative, the MCO carve-in of dental services, etc.);
- Oversaw efforts to outreach to over 500 Medicaid dental providers to ensure they were aware of the administrative changes for children's dental services;
- Reporting monthly outreach and education activity statistics that are in compliance with contract requirements to the Project Manager;
- Working closely with eligibility offices and other relevant agencies' personnel to schedule outreach presentations, "train-the-trainer" presentations and community events; and
- Identifies and recruits relevant health and human service agencies and community groups as resources for outreach and enrollment activities; delivers group presentations (including cultural competency trainings).

Outreach and Education Specialist (2004-2013)
Played an active role in the communities of 11 counties in the Southwest corner of West Virginia in helping them to implement the changes in Medicaid Managed Care. Examples of work performed include, but are not limited to:

- Worked with county DHHR offices to help Medicaid customers through the initial changes from the PAAS program to the Medicaid Managed Care Program;
- Attended Family Resource Network meetings and participated in the planning of community activities and improvement projects;
- Joined Early Childhood teams to work with agencies that have direct contact with the most vulnerable Medicaid populations;
- Joined Literacy and Arthritis coalitions to build networks to help in the distribution of Medicaid enrollment information;
- Worked with the West Virginia Immunization Network to help get more WV children and adolescents immunized and protected against potentially dangerous and very preventable diseases;
- Attended training sessions for Drug and Alcohol Abuse Prevention (PrevNet), Family Centered Practice, Celebrating Connections (education), Making Connections (Direct Action Welfare Group), Mission West Virginia (church), and Mountain State Family Alliance (behavioral health);
- Became a Family Centered Practice Trainer to gain access and build networks with direct service agency workers (mental health, church, DHHR). Family interactions with consumers of all classes, race, and economic backgrounds; and
- Completed two levels of sign language training.

Mattress Warehouse **1998-2004**
Winfield, WV

Logistics Supervisor (2001-2003)
Responsible for routing six delivery trucks that covered Southern West Virginia, parts of Kentucky, Ohio, and Virginia. Transferred merchandise between all stores and warehouses in West Virginia and Kentucky. Worked with team to ensure customer satisfaction and on-time deliveries/set-up.

Sales Associate (1998-2001)
Responsible for providing quality customer service and sales assistance for mattress products. Worked closely with the delivery team and facility trainer to ensure timely follow-up with the customers. Responded to questions and concerns regarding the products.

Pfizer Labs **1991-1998**
Charleston, WV

Sales Consultant (1991-1998)
Responsible for interacting with doctors and pharmacies, in a territory that consisted of ten to twelve counties, to promote cardiovascular, lipid lowering, arthritis, diabetes, antibiotic, and antihistamine products. Volunteered with WV Health Right to help those without insurance coverage in pharmaceutical assistance programs.

Education

University of Vermont, Burlington, VT
Bachelor of Science, Medical Technology, 1991

Continuing Education

WV Rehabilitation Center
Certificate for completion of 2 semesters on sign language (101, 102), 2004

CMR Institute
Certified Medical Representative, 1995

Computer Skills

Microsoft Office Suite (Word, Excel, Outlook, PowerPoint), and Lotus Notes (i.e., Project database)

Community Partnership

CMR Institute Member
Chair of Putnam County Early Childhood Initiative, 2005
Board Member at Large of Joseph's Tree House, 2004
Committee Member of Health & Fitness Wayne
Committee Member of Jobs & Education Wayne
Region 2 Family Centered Practice Trainer
Putnam Wellness
Putnam Young Child Task Force
Board Member Upper Kanawha Valley Starting Points/Parents as Teachers
Board Member Mason & Jackson FRNs – Secretary
Board Member Mingo FRN
Region 2 Our Town Trainer
Region 2 Family Youth Engagement Strategies Trainer
Brain Under Construction Zone Trainer

Veronica A. James

Proposed Call Center Supervisor

Summary of Qualifications

Ms. Veronica James has over 15 years' call center and Medicaid experience, having worked with AHS since 1999. In her current role as a Senior Helpline Information Specialist, Ms. James is responsible for assisting the Project Manager with the training and monitoring of the Helpline Unit staff. Ms. James sets a culture of commitment to exceptional customer service and quality in the training programs she facilitates. As a seasoned member of the leadership team, Ms. James' training, quality oversight, and leadership experience will be leveraged as she provides oversight of the West Virginia Mountain Health Trust (MHT) Project's Call Center Unit.

Professional Experience

Automated Health Systems, Inc. **1999 - *Continuing***
Charleston, WV

Senior Helpline Information Specialist (2005-continuing)

Assists the Project Manager in providing oversight, monitoring, and evaluation of the Helpline Information Specialists (HIS) and the day-to-day operations of the Helpline. Primarily responsible for all aspects of new staff training and orientation. Participates in developing and implementing trainings to increase Project staff's knowledge of Medicaid and related services and to enhance their cultural competency and customer service orientation. Effectively handles enrollees' requests for supervisory assistance. As a working supervisor, performs all Helpline Information Specialist (HIS) duties. Accomplishments include:

- Maintains an abandonment rate for the Call Center significantly under the Project's SLA (the average abandonment rate for 2013 was 3.05%, which is considerably lower than the SLA of 10%);
- Maintains an average hold time for the Call Center of 0:07;
- Ensures the processing of over 10,000 newborn enrollments per year is in accordance with BMS policy;
- Ensures all scripting is up-to-date and makes modifications as needed;
- Serves as a on-going resource for Call Center staff for Project information and assistance;
- Develops and implements training seminars to address HIS proficiencies and skills (i.e., Tone of Voice and Quality Customer Service);
- Ensures emerging issues and feedback is tracked and reported to BMS;
- Provides weekly feedback and guidance to Helpline Information Specialists regarding essential Call Center standards such as accurate data entry, call time, hold time and aftercall time;
- Manages day-to-day Call Center activities (e.g., scheduling and tracking of time off);
- Collects, formats and presents to the Project Manager monthly data regarding Helpline Information Specialists' outcomes;
- Responds to enrollee complaints and escalated issues;
- Fields daily questions regarding program material and company policies and procedures; and
- Troubleshoots technical difficulties within the Helpline and serves as liaison with the Corporate IT Department when necessary.

Helpline Information Specialist (1999-2005)
Responsible for informing and educating eligible consumers in an unbiased manner about the MHT/PAAS Programs and enrolled them into the participating MCO or PCP of their choice. Obtained enrollment/plan change information from potential enrollees/enrollees and entered into the State's MMIS and/or the Project database. Made appropriate referrals for calls received outside the scope of Medicaid managed care. Handled and followed-up with erroneously received mail. Logged and followed up on voicemail messages.

Manpower Temporary Agency **1996-1999**
Charleston, WV

Administrative Assistant
Provided administrative support at Department of Health and Human Resources (DHHR) and was assigned to the Physician Assured Access System (PAAS) Program. Responsible for processing a high volume of insurance claim forms. Served as the primary point of contact to answer the "800" line regarding recipient complaints or requests for information. Provided administrative support to prepare letters and memos to recipients regarding their medical coverage. Performed data entry on recipient's records that changed PAAS medical providers. Maintained an effective filing system to keep track of all correspondence.

Multiple Sclerosis Society **1992-1992**
Charleston, WV

Administrative Support
Provided overall administrative support and assistance to office staff for the day-to-day operations. Assisted with answering a large volume of incoming calls quickly and efficiently. Processed and documented bulk mailings sent from the department to ensure timely delivery. Provided support to management to prepare correspondence and maintained an effective filing system.

Education

Ben Franklin Technical Center, Dunbar, WV
Word/Data Processing Certificate, 1995

Computer Skills

Microsoft Office (Excel, Word, and PowerPoint), Lotus Notes (i.e., Project database), AVAYA, and CMS

Roster of Current Community Involvement

Mountain Health Trust Project

Submitted by Automated Health Systems

Automated Health Systems

Routine Community Outreach

Anti Drug Coalitions
Appalachian Council Head Start Family Services Advisory Committee Meetings
Baby & Me Event
Barbour County Agency Night
Barbour County Community Baby Shower
Barbour County Early Childhood Coalition
Barbour County Health Fair
Barbour County Interagency
Barbour County Kindergarten/ Preschool Registration
Berkeley County Head Start Health Advisory Committee
Berkeley County Health & Human Collaborative
Berkeley County Week of the Young Child
BE WV All Stake Holder & Consumer Assistance Meeting
Boone County FRN
Boone Stop Watch
Boone Tadpole Team
Brooke County FRN
Cabell County FRN
Cabell Partners in Prevention of Child Abuse and Neglect
Cabell Wayne Lincoln Collaborative
Calhoun County FRN
CAMC Teddy Bear Fair
CARES Medical Home Advisory Group
Children's Summit & Collaborative
Drug Effected Children & Infants
Family Central Collaborative (Roane, Jackson, Mason, Putnam, and Kanawha)
Family Leadership First Conference
Family Life Expo
Fayette County FRN
Grant County Energy Express Family Night
Grant County Family Issues Task Force
Grant County Health Fair
Hampshire County Family Resource Council
Hampshire County Partners in Prevention
Hampshire County Title 1 Resource Roundup
Hancock County FRN
Hardy County Community Baby Shower
Hardy County Family Issues Task Force
Jackson County FRN
Kanawha County FRN
Kanawha Literacy Coalition
Lewis County FRN General Membership
Lewis County Salvation Army Angel Tree Distribution
Lincoln County FRN
Logan Boone Mingo Collaborative

Logan County FRN
Logan Diabetes Coalition
Marshall County FRN
Mason County FRN
Mason Fishing Rodeo
Mason Greenbrier Christmas Dream Tree
Mason Health & Wellness
Mason Teen Institute
McDowell County FRN
McDowell Head Start Health Advisory Team
Mineral County FRN General Membership
Mineral County Parenting Fair
Mingo County FRN
Monroe County Baby Shower
Monroe County Christmas Baskets
Monroe County FRN
Morgan County Health Fair
Ohio County FRN
Partners in Prevention of Child Abuse & Neglect
Pendleton County Info Exchange
Pleasants County FRN
Preston County Caring Council
Preston County Community Baby Shower
Preston County Salvation Army Angel Tree Distribution
Putnam County FRN
Putnam Partners in Prevention
Raleigh County FRN
Randolph County Community Baby Shower
Randolph County FRN General Membership
Region 2 Children's Summit
Regional Family Youth Engagement Strategies
Regional Our Town
Regional Service Arrays
Regional Young Child Task Team
Salvation Army Volunteer Bell Ringer in Raleigh County FRN
Service Array Regional
Sharon Dawes Fall Fest
Sharon Dawes Take Your Parent to School Day
Taylor County Community Baby Shower
Taylor County FRN General Membership
Taylor County PATCH (Planned Approach to Community Health) Coalition
Taylor County Preschool Screenings
Thomas Memorial Hospital Kidoodle
TLC at the Monroe Board of Education
Tucker County Early Childhood Festivals
Tucker County Head Start Open House
Unicare Baby Shower
Upper Kanawha Valley Starting Points/ Parents as Teachers

Upshur County FRN General Membership
Upshur County K/Pre-K Registration
Upshur County Pre School Health Fair
Wayne County FRN
Webster County Christmas Store

Community Training/ Workshop Participation

40 Developmental Assets Training
Ages & Stages
Annual Jose Ricard Sports Medicine Conference
Board Training
Brain Under Construction
Bridges Out of Poverty Workshop- Framework for Understanding Poverty
Building Capacity
Celebrating Connections (Early Childhood)
Darkness to Light- Child Sexual Abuse Prevention
Family Leadership Conference
Finding Your Spark
Harrison County Resource Conference- Women's Mental Health & Wellness
Kid Strong/ Immunization Network Conference
Literacy
NCCC Resource Fair & Training- Bullying
Preston County Resource Conference- Ethical Boundary Issues
Riley's Rally/ All 4 One Disabilities and Special Needs
Ruby Payne Training
Share the Vision Prevention Resource Center
SPF SIG (Strategic Prevention Framework State Incentive Grant)
True Colors
West Virginia Immunization Network- Quarterly Training
West Virginia System of Care- Family & Youth Engagement Skills Training
WIN Training
WV Academy of Family Medicine
WV Healthy Start/ HAPI Project Consortium- Our town and the Dynamics of Difference Training
WV System of Care- Family Centered Practice
WV System of Care- Our Town

Sample Scripts

Mountain Health Trust Project

Submitted by Automated Health Systems

Automated Health Systems

Mountain Health Trust Call Center MCO Enrollment Script

Good (Morning, Afternoon or Evening).

Thank you for calling Mountain Health Trust. My name is (your first name only). How may I help you?

Caller may be the potential enrollee or calling on behalf of a potential enrollee in the case.

May I ask your preferred language? _____

If the caller is requesting assistance in another language, secure Language Line Services in the caller's preferred language.

The caller may also be contacting the helpline through the West Virginia Relay Service or TTY. To assist the caller with hearing, speech or vision impairments, follow the procedures described in the Interpretive Services Policy

Before we get started, I will need to confirm some information. Do you have your Medicaid card with you? You will need your Medicaid card along with any of your family member's Medicaid cards who need to enroll.

Before providing any PHI you must confirm at least two of the following:

- ✓ *Medicaid ID #*
- ✓ *Date of Birth*
- ✓ *Last 4 digits of SSN*
- ✓ *Address (address must match the address in Molina)*

If the caller does not have their Medicaid card available, offer to look up the information once they confirm at least 2 out of the 4 confidentiality identifiers listed above.

If the caller is not listed on the case in Molina, verify their information in RAPIDS. If the caller is not listed on the case in RAPIDS either have the caller contact us once he/she is added to the case or, have the potential enrollee available with the caller to give permission over the phone to discuss the case and process the enrollment. Provide the number for the local DHHR office.

What is your Medicaid number? The number that begins with two 00's and is to the left of your name on your state Medicaid card._____

What is your name?_____

What is your address?_____

If the address does not match the address in Molina, refer the caller to the DHHR Change Center to update their information. Emphasize how important it is that the state has their correct address for mailings.

What is your date of birth?_____

What is your telephone number?_____

If the confidentiality guidelines are not met, instruct the caller to call back when he/she has the information. Provide the Helpline number and hours of operation: 1-800-449-8466 from 8:00 am to 8:00 pm Monday – Friday.

If the confidentiality guidelines are met, continue with enrollment assistance.

Confirm the rate code in Molina. If the caller does not have an enrollable MHT rate code, he/she is considered straight Medicaid. Explain to the caller that he/she is not part of Mountain Health Trust and that he/she can use their Medicaid card to access their benefits without enrolling with an MCO. Provide the Molina Call Center phone number for any questions on benefits and covered services.

If the caller has an enrollable rate code, proceed:

Mountain Health Trust offers you a choice of Managed Care Organizations (also called MCO) and a choice of a primary care doctor (your PCP). During our conversation today, I will be referring to the MCO and PCP to process your enrollment.

The MCO you choose will manage your health care and will cover most of the Medicaid services that you might need. Please keep in mind your level of Medicaid benefits will not change from what you currently have.

Explain the Medicaid covered services and freedom of choice for access to family planning services.

I can help you pick an MCO and a PCP today.

For Cabell and Wayne counties potential enrollees can choose from one MCO option and the PAAS Program. Refer to script for enrollment in MCO/PAAS.

List the MCOs that are options in the caller's county of residence.

The MCOs in your county are:_____.

Have you received your enrollment packet of information containing the choices of Managed Care Organizations/PCPs in your area? _____yes _____no

If no, the information contained in the packet should be reviewed with the potential enrollee during your conversation (Enrollment Form, Plan Comparison Chart, MHT Brochure, Plan Brochures).

If yes, proceed . . .

Have you had an opportunity to look at the packet and make a choice?

If no, the information contained in the packet should be reviewed with the potential enrollee during your conversation (Enrollment Form, Plan Comparison Chart, MHT Brochure, Plan Brochures).

If yes, proceed . . .

What MCO did you choose?_____

Do you currently have a family doctor? _____yes _____no

If yes, What is the name of the doctor?_____

Check the online and hard copy provider directories to confirm if the family doctor participates and is part of the MCO network.

If no,

- ✓ *Offer to search the online and hard copy provider directories and provide the names of family doctors in the caller's preferred area;*
- ✓ *Refer them to the mountainhealthtrust.com website if they have internet access or to the m.mountainhealthtrust.com address if they have a mobile device.*
- ✓ *Suggest that the caller talk with family members and/or friends to see who they would recommend as a family doctor.*
- ✓ *Offer to enroll them today if they do not have a doctor and explain that the MCO will pick one for them;*
- ✓ *Explain that they can change their MCO and PCP at anytime.*
- ✓ *Offer to mail hard copy directories for each of the MCOs in their county.*
- ✓ *Remind them that they can also call us back after they have chosen a doctor and to be sure to contact us before the cutoff date (list cutoff date) so the caller is not auto-assigned.*

Before beginning the race, ethnicity and health needs assessment, ask:

May I ask you some further questions? None of the answers will affect your services.

The following two questions on race and ethnicity are optional.

If the potential enrollee does not wish to answer the race and ethnicity questions, skip to the question on health concerns.

What is your race?

____White
____African-American
____Asian
____Other

What is your ethnicity?

____Hispanic
____Non-Hispanic

Do you have any health concerns?_____

If yes, please describe:_____

If the customer has a health concern, enter this information on a Molina Memo/Alert and in HealthTrack for the following conditions:

- ✓ *Tobacco user/smoker*
- ✓ *Pregnancy*
- ✓ *Planned Surgery*
- ✓ *Home care*
- ✓ *Hospice*
- ✓ *Physical Therapy*
- ✓ *Occupational Therapy*
- ✓ *Speech Therapy*
- ✓ *Congestive heart failure*
- ✓ *Heart conditions, such as heart attack, etc.*
- ✓ *Organ transplant list*
- ✓ *Chemotherapy*
- ✓ *Asthma*
- ✓ *Hospitalized 1st day of enrollment*
- ✓ *Specific Health Problem*
- ✓ *Changing doctors would cause harm*
- ✓ *Terminal Illness*
- ✓ *Medicare*

The State of West Virginia offers a smoking cessation program. Is there anyone in your household who would be interested in information regarding this program?

If yes, provide the phone number.

Ask all female callers: Are you pregnant?

If yes, ask for her expected due date and enter this information on a Molina Memo/Alert and in HealthTrack.

If no, proceed . . .

Do you have other family members who receive Medicaid?

If no, skip to the Third Party Liability Section of the interview.

If yes, proceed . . .

What are their Medicaid numbers?_____

What are their names?_____

What are their dates of birth?_____

Who are their doctors?_____

Do they have any health concerns?_____

*If yes, please describe:*_____

If no, proceed . . .

Third Party Liability Section for potential enrollees on the case

Do these persons have any other health insurance?

*If yes, check the Med Resource Code. If the code is a 100, you must complete a **T**hird **P**arty **L**iability Form with the following information:*

What is the name of the health insurance company?_____

What is their phone number? (_____)_____

What is the policy number?_____

What name is the policy under?_____

What is the social security number on that policy?_____

Please refer to the TPL form and complete appropriate sections using the additional questions on the form. Refer the caller to the TPL Unit to report any changes.

If the caller enrolls with an MCO:

You will also be receiving an MCO ID card from them soon. Please remember to take your Medicaid card and the MCO ID card when you go to the doctor.

Please call your MCO if you have any questions concerning your medical coverage.

Also describe some of the Medicaid benefits that are "carved out" or outside the Managed Care Organization and how enrollees can access these services, i.e., Behavioral health, personal care services, etc. Provide referral assistance for other helplines as necessary.

If a choice was made:

Thank you (Ms./Mrs./Mr. Last Name) for calling and choosing an MCO. Now let's recap what we discussed today.

You are now enrolled in *(name of MCO or doctor depending on their options.)* Your begin date is (*current enrollment date.)*

If the potential enrollee is enrolling for the first time with an MCO:

Until your enrollment with (name of MCO) is effective, you can continue to use your Medicaid card as straight Medicaid.

Please remember that you can change your MCO at anytime. If you call within the first two weeks in the month, your new MCO will be effective the first of the following month. You can also change your PCP anytime by contacting your MCO.

Provide phone numbers and contact information for other helplines and resources discussed during the call, e.g., DHHR Change Center, Molina Customer Service, TPL Unit, Local DHHR Office, WV 211 Information and Referral Helpline, etc.

Is there anything else that I can help you with today_____?

If no:

Thank you for taking the time to call us and choose your MCO today.

If a choice was not made:

If you need more information or time to make your decision you can call us back at 1-800-449-8466 Monday through Friday from 8:00 am to 8:00 pm to make a choice. Please remember to call back before (*provide cutoff date)* or you will be automatically assigned to an MCO.

Please remember that you can change your MCO at anytime. If you call within the first two weeks in the month, your new MCO will be effective the first of the following month. You can also change your PCP anytime by contacting your MCO.

Provide phone numbers and contact information for other helplines and resources discussed during the call, e.g., DHHR Change Center, Molina Customer Service, TPL Unit, Local DHHR Office, WV 211 Information and Referral Helpline, etc.

If the caller requested hard copies of the MCO provider directories, please confirm his/her address and that the directories will be mailed to them.

Is there anything else that I can help you with today_____?

If no:

Thank you for your time and we look forward to hearing from you soon with your choice of MCO/PCP.

Mountain Health Trust Call Center MCO PAAS Enrollment Script

Good (Morning, Afternoon or Evening).

Thank you for calling Mountain Health Trust. My name is (your first name only). How may I help you?

Caller may be the potential enrollee or calling on behalf of a potential enrollee in the case.

May I ask your preferred language? _____

If the caller is requesting assistance in another language, secure Language Line Services in the caller's preferred language.

The caller may also be contacting the helpline through the West Virginia Relay Service or TTY. To assist the caller with hearing, speech or vision impairments, follow the procedures described in the Interpretive Services Policy

Before we get started, I will need to confirm some information. Do you have your Medicaid card with you? You will need your Medicaid card along with any of your family member's Medicaid cards who need to enroll.

Before providing any PHI you must confirm at least two of the following:

- ✓ *Medicaid ID #*
- ✓ *Date of Birth*
- ✓ *Last 4 digits of SSN*
- ✓ *Address (address must match the address in Molina)*

If the caller does not have their Medicaid card available, offer to look up the information once they confirm at least 2 out of the 4 confidentiality identifiers listed above.

If the caller is not listed on the case in Molina, verify their information in RAPIDS. If the caller is not listed on the case in RAPIDS either have the caller contact us once he/she is added to the case or, have the potential enrollee available with the caller to give permission over the phone to discuss the case and process the enrollment. Provide the number for the local DHHR office.

What is your Medicaid number? The number that begins with two 00's and is to the left of your name on your state Medicaid card._____

What is your name?_____

What is your address?_____

If the address does not match the address in Molina, refer the caller to the DHHR Change Center to update their information. Emphasize how important it is that the state has their correct address for mailings.

What is your date of birth?_____

What is your telephone number?_____

If the confidentiality guidelines are not met, instruct the caller to call back when he/she has the information. Provide the Helpline number and hours of operation: 1-800-449-8466 from 8:00 am to 8:00 pm Monday – Friday.

If the confidentiality guidelines are met, continue with enrollment assistance.

Confirm the rate code in Molina. If the caller does not have an enrollable MHT rate code, he/she is considered straight Medicaid. Explain to the caller that he/she is not part of Mountain Health Trust and that he/she can use their Medicaid card to access their benefits without enrolling with an MCO. Provide the Molina Call Center phone number for any questions on benefits and covered services.

If the caller has an enrollable rate code and resides in Cabell or Wayne counties, proceed:

In your county (Cabell or Wayne) Mountain Health Trust offers you a choice of enrolling in a Managed Care Organization (also called MCO) and a primary care doctor (your PCP). Or you can choose to enroll in the Physician Assured Access System (PAAS).

If you choose to enroll with the MCO, the plan will manage your health care and cover most of the Medicaid services that you might need. You can access their network of doctors for your health care. You will receive a membership card from the MCO with the name of the PCP.

If you choose to enroll in PAAS, the primary care doctor you pick will be added to your Medicaid card. The PAAS doctor will provide your primary care medical services and give you a referral to go to a specialist.

Explain the Medicaid covered services and freedom of choice for access to family planning services.

You can enroll in the MCO or PAAS today. I can help you enroll by phone.

For all other counties, potential enrollees must choose an MCO. Refer to script for MCO only enrollment.

Explain that only one MCO is an option in the caller's county of residence.

The MCO in your county is CoventryCares.

Explain that the caller can select the PAAS program instead of the MCO.

There is also a network of providers who are PAAS providers in your county.

Have you received your enrollment packet of information containing the choice of the Managed Care Organization and the PAAS Program? _____yes _____no

If no, the information contained in the packet should be reviewed with the potential enrollee during your conversation (MCO/PAAS Enrollment Form, MHT Brochure, Plan Brochure, PAAS Doctor Approval Form and the PAAS Member Rights and Responsibilities).

If yes, proceed . . .

Have you had an opportunity to look at the packet and make a choice?

If no, the information contained in the packet should be reviewed with the potential enrollee during your conversation, (MCO/PAAS Enrollment Form, MHT Brochure, Plan Brochure, PAAS Doctor Approval Form and the Member Rights and Responsibilities).

If yes, proceed . . .

Did you choose the MCO or PAAS?

Do you currently have a family doctor? _____yes _____no

If yes, What is the name of the doctor?_____

Check the online and hard copy MCO provider directory and the PAAS Directory to confirm if the family doctor participates and is part of the MCO or PAAS network.

If no,

- ✓ *Offer to search the online and hard copy provider directories and provide the names of family doctors in the caller's preferred area;*
- ✓ *Refer them to the mountainhealthtrust.com website if they have internet access or to the m.mountainhealthtrust.com address if they have a mobile device.*
- ✓ *Suggest that the caller talk with family members and/or friends to see who they would recommend as a family doctor.*
- ✓ *Offer to enroll them today if they do not have a doctor and explain that the MCO will pick one for them.*

- ✓ *Explain that they can change their MCO and PCP at anytime and they can switch from PAAS to the MCO and from the MCO to PAAS.*
- ✓ *Offer to mail a hard copy directory for the MCO and PAAS providers in their county.*
- ✓ *Remind them that they can also call us back after they have chosen a doctor and to be sure to contact us before the cutoff date (list cutoff date) so the caller is not auto-assigned.*

Before beginning the race, ethnicity and health needs assessment, ask:

May I ask you some further questions? None of the answers will affect your services.

The following two questions on race and ethnicity are optional.

If the potential enrollee does not wish to answer the race and ethnicity questions, skip to the question on health concerns.

What is your race?

____White
____African-American
____Asian
____Other

What is your ethnicity?

____Hispanic
____Non-Hispanic

Do you have any health concerns?_____

If yes, please describe:_____

If the customer has a health concern, enter this information on a Molina Memo/Alert and in HealthTrack for the following conditions:

.

- ✓ *Tobacco user/smoker*
- ✓ *Pregnancy*
- ✓ *Planned Surgery*
- ✓ *Home care*
- ✓ *Hospice*
- ✓ *Physical Therapy*
- ✓ *Occupational Therapy*
- ✓ *Speech Therapy*
- ✓ *Congestive heart failure*
- ✓ *Heart conditions, such as heart attack, etc.*

- ✓ *Organ transplant list*
- ✓ *Chemotherapy*
- ✓ *Asthma*
- ✓ *Hospitalized 1st day of enrollment*
- ✓ *Specific Health Problem*
- ✓ *Changing doctors would cause harm*
- ✓ *Terminal Illness*
- ✓ *Medicare*

The State of West Virginia offers a smoking cessation program. Is there anyone in your household who would be interested in information regarding this program?

If yes, provide the phone number.

Ask all female callers: Are you pregnant?

If yes, ask for her expected due date and enter this information on a Molina Memo/Alert and in HealthTrack.

If no, proceed . . .

Do you have other family members who receive Medicaid?

If no, skip to the Third Party Liability Section of the interview.

If yes, proceed . . .

What are their Medicaid numbers?_____

What are their names?_____

What are their dates of birth?_____

Who are their doctors?_____

Do they have any health concerns?_____

*If yes, please describe:*_____

If no, proceed . . .

Third Party Liability Section for potential enrollees on the case

Do these persons have any other health insurance?

*If yes, check the Med Resource Code. If the code is a 100, you must complete a **T**hird **P**arty **L**iability Form with the following information:*

What is the name of the health insurance company?_____

What is their phone number? (_____)_____

What is the policy number?_____

What name is the policy under?_____

What is the social security number on that policy?_____

Please refer to the TPL form and complete appropriate sections using the additional questions on the form. Refer the caller to the TPL Unit to report any changes.

If the caller enrolls with the MCO:

You will also be receiving an MCO ID card from them soon. Please remember to take your Medicaid card and the MCO ID card when you go to the doctor.

Please call your MCO if you have any questions concerning your medical coverage.

Also describe some of the Medicaid benefits that are "carved out" or outside the Managed Care Organization and how enrollees can access these services, i.e., Behavioral health, personal care services, etc. Provide referral assistance as necessary.

If the caller enrolls in PAAS:

The name of your PCP will appear on your medical card. Please take the medical card with you when you go for medical care.

If a choice was made:

Thank you (Ms./Mrs./Mr. Last Name) for calling and choosing *(MCO or PAAS)*. Now let's recap what we discussed today.

You are now enrolled in *(name of MCO or PAAS doctor.)* Your begin date is (*current enrollment date.)*

If the potential enrollee is enrolling for the first time with an MCO:

Until your enrollment with (name of MCO) is effective, you can continue to use your Medicaid card as straight Medicaid.

Please remember that you can change to the MCO from PAAS or from the MCO to PAAS at anytime. If you call within the first two weeks in the month, your new choice will be effective the first of the following month. If you are enrolled with the MCO, you can also change your PCP anytime by contacting your MCO. You can also change your PAAS provider by contacting the helpline.

Provide phone numbers and contact information for other helplines and resources discussed during the call, e.g., DHHR Change Center, Molina Customer Service, TPL Unit, Local DHHR Office, WV 211 Information and Referral Helpline, etc.

Is there anything else that I can help you with today_____?

If no:

Thank you for taking the time to call us and choose _____ (MCO or PAAS *provider)* today.

If a choice was not made:

If you need more information or time to make your decision you can call us back at 1-800-449-8466 Monday through Friday from 8:00 am to 8:00 pm to make a choice. Please remember to call back before (*provide cutoff date)* or you will be automatically assigned to the MCO.

Please remember that you can change your choice of MCO or PAAS at anytime. If you call within the first two weeks in the month, your new MCO will be effective the first of the following month. You can also change your PCP anytime by contacting your MCO. You can also change your PAAS provider by contacting the helpline.

Provide phone numbers and contact information for other helplines and resources discussed during the call, e.g., DHHR Change Center, Molina Customer Service, TPL Unit, Local DHHR Office, WV 211 Information and Referral Helpline, etc.

If the caller requested hard copies of the MCO and PAAS provider directories, please confirm his/her address and that the directories will be mailed to them.

Is there anything else that I can help you with today_____?

If no:

Thank you for your time and we look forward to hearing from you soon with your choice of MCO or PAAS.

Mountain HEALTH TRUST

ENROLLMENT FORM

If you need help or have any questions, please call 1-800-449-8466.
We're here to help!

1. Please read this form and fill it out.
2. Do not forget to sign the form.
3. Answer the questions on the back of this page.
4. Mail the form in the enclosed postage-paid envelope.

Remember, you can call us at 1-800-449-8466 for help.

Is the following information right? If "No", please correct it.

Name:

Address:

Daytime phone number:

Medicaid ID Number:

Birth date:

Please complete the following information.

Race: White___ African-American ___ Asian ___ Other ___

Ethnicity: Hispanic ___ Non-Hispanic ___

Primary Language Spoken: _____

Please write your choice of provider here: _____

Provider's address and phone number: _____

_____

_____

Is this the provider you are seeing now? ☐ Yes ☐ No

The following is (are) the managed care program choice(s) in your county. Please make an "X" next to your choice.

_____

Your signature on the line above. A parent or guardian must sign for anyone under the age of 18.

Please complete the health risk assessment on the back.

. Do you use smokeless tobacco? No _____ Yes _____

. Do you smoke? No _____ Yes _____

. Are you seeing a doctor for any of the reasons listed below? If you are, please put an "X" next to each one that applies.

_____ Problem pregnancy

_____ Planned surgery in the future

_____ Receiving home care or hospice services

_____ On an organ transplant list

_____ Receiving chemotherapy

_____ Receiving physical/occupational/speech therapy

_____ Heart condition such as congestive heart failure

_____ Lung disorder such as asthma

. Are you pregnant? No _____ Yes _____ Expected Delivery Date: _____

. Do any of these apply to you? If one or more does, please put an "X" next to each one that applies.

_____ Are you in the last three months of your pregnancy?

If you are, who is your OB/GYN? _____

_____ Will you be hospitalized on the first day of enrollment?

_____ Are you currently under treatment for a specific health problem?

_____ Does your doctor think that changing doctors would cause harm?

_____ Do you have a terminal illness?

_____ Are you receiving Medicare?

. Do you have any health insurance other than Medicaid? If you do, please complete the following information.

Name of insurance company: _____

Group Name: _____

Group Number: _____

Policy Number: _____

Name of Insured: _____

Are you enrolled in the Health Insurance Premium Program (HIPP)? (This means that your health insurance premium is being paid by Medicaid.) _____ No _____ Yes

Medical Release Statement: I authorize any health care provider having information related to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me (or my dependent) to give the above information to the managed care program.

_____

Your signature goes here. A parent or guardian must sign for anyone under age 18.

Mountain Health Trust Checklist

This sheet is to help you fill out the paper work for Mountain Health Trust. To enroll by mail, use the list below to make sure your paperwork is complete. Ask yourself each question, and check off each item as it is done.

The set of forms in your packet is to help you pick the doctor and the Managed Care Program that are best for you. You can ask your doctor what MCOs the doctor is in. You can also call us at 1-800-449-8466 if you want help in picking a doctor, have questions or want to enroll over the phone. You can also ask us to mail a printed MCO Provider Directory to you.

You can call Monday-Friday from 8 AM to 8 PM. The call is free. We are happy to help.

You can also visit the **mountainhealthtrust.com** website for more information about Mountain Health Trust and to search for doctors. First click on "How to Enroll" then click "Search for Providers".

Check List for Mountain Health Trust Enrollment	✓ YES
• Did you read the cover letter?	
• Did you or your family pick a primary care doctor?	
• Did you write the doctor's name on the correct line of the enrollment form?	
• Did you mark the Managed Care Program you want to join?	
• Did you answer the questions on the back of the enrollment form?	
• Did you put the form in the postage-paid envelope in the packet?	
• Did you mail the form (or enroll over the phone)?	

Want to talk to us about your choices? Have questions? Need help?
Visit us at www.mountainhealthtrust.com
Call us at 1-800-449-8466 (TTY/TTD 1-800-449-8466). The call is free!
(Monday-Friday from 8 AM to 8 PM)

Welcome to Mountain Health Trust!

Dear Medicaid Member,

Welcome to Mountain Health Trust! We are sending you this packet to let you know that most of your Medicaid services will be provided by the Medicaid managed care organization (MCO) of your choice. This means that most of your health care will be provided by doctors and specialists that are part of the MCO you choose.

Mountain Health Trust members get to make two important decisions about their healthcare. As a member, you get to:

1. Pick a Managed Care Organization (MCO).
2. Pick a primary care provider (PCP).

Your PCP is the family doctor, nurse or other healthcare provider who takes care of you and your family. Please read the information in this packet and pick your MCO and your PCP. It will help you make the best choice for you and your family. The managed care choice(s) in your county can be found at the bottom of the enrollment form.

Because you know your needs best, it is important for you to pick the MCO you want. Mountain Health Trust is here to help you pick the MCO and PCP that meet the needs of you and your family the best. Follow the steps below to enroll. If you do not pick a MCO and PCP within 45 days we will pick one for you.

Thank you!
Mountain Health Trust

3 Easy Steps to Enroll

1. **Pick an MCO:** Review the information included in this package to learn about your MCO choices.
2. **Pick a PCP:** Make sure the PCP is in the MCO you pick. Need help? You can:
   - Call us for help at 1-800-449-8466 (a free call)
   - Ask us to mail a printed MCO provider directory to you.
   - Ask your doctor what MCOs the doctor is in.
   - Search for doctors on the mountainhealthtrust.com website. First click on "How to Enroll" then click "Search for Providers".
3. **Enroll:** Let us know the MCO and PCP you want. It is easy. You can enroll:
   - **BY PHONE:** Call us at 1-800-449-8466.
   - **BY MAIL:** Fill out the forms in this package and mail using the envelope provided.
   - **ONLINE:** www.mountainhealthtrust.com

Want to talk to us about your choices? Have questions? Need help?
Visit us at www.mountainhealthtrust.com
Call us at 1-800-449-8466. The call is free!
(Monday-Friday from 8 AM to 8 PM)

Member Rights

As a member of PAAS, you have the right to:

- Be treated fairly, with dignity and respect.
- Choose your own doctor.
- Change your doctor.
- Access health care services 24 hours a day, seven days a week.
- Participate in your own health care decisions and refuse care.
- Have your doctor explain your treatment, options and any follow-up that is needed.
- Ask questions and have them answered.
- Know that your medical records and any talks with your doctor are private.
- Request and receive a copy of your medical records and request that they be amended or corrected.
- Make a complaint to PAAS or to the Department of Health and Human Resources without fear your services will be affected.
- Have your complaint answered within 30 days.
- Receive spoken or written information that is easily understood and takes into consideration any special need(s).
- Be free from any form of restraint or seclusion.

Member Responsibilities

As a member of PAAS, you have the responsibility to:

- Learn your rights as a member of PAAS.
- Keep your scheduled appointments.
- Cancel all appointments you cannot keep.
- Keep up-to-date on immunizations (shots).
- Tell your doctor about your health needs.
- Treat your doctor with respect.
- Contact your doctor first for care that is not an emergency.
- Get a referral from your doctor before getting care from a specialist.
- Actively participate in your plan of treatment.
- Present your medical card every time you get care.

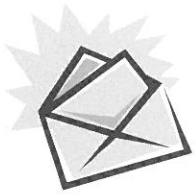
An explanation of your rights and responsibilities is available by calling 1-800-449-8466. Translation, TTY and audio tape services are also available.

WV R&R (11/02)

AUTOMATED HEALTH SYSTEMS

DOCTOR'S APPROVAL FORM

Please look in the Provider Directory for the name of the doctor you want.



If you enroll by mail and the doctor has "*Doctor's Approval Needed" under his or her name:

- Complete the information in the box below.
- Have the doctor sign this form.
- Return the form with your enrollment form in the enclosed postage-paid envelope.
- If you do not return this signed form with your enrollment form, you will be assigned another doctor.

Your Name: _____

Your Medicaid #: _____

Your Phone #: _____

Your Doctor's Name: _____

Your Doctor's Phone #: _____

Signature of Doctor: _____ Date: _____

Doctor's signature indicates acceptance of patient into practice

Or . . .

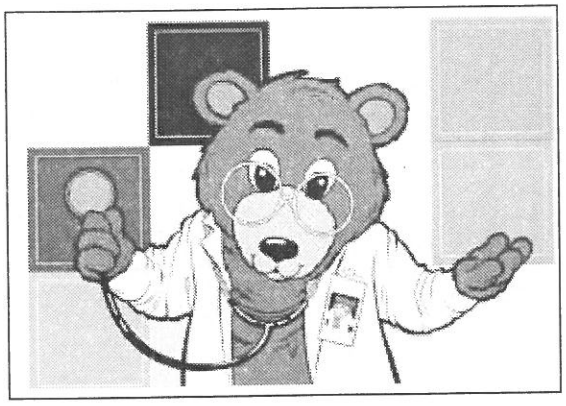


If you enroll by phone (1-800-449-8466) and the doctor has a "*Doctor's Approval Needed" practice:

- Call your doctor's office before calling 1-800-449-8466.
- Receive permission to become a patient of that practice.
- Ask the name of the person at the doctor's office with whom you spoke.
- Give that name to the Enrollment Specialist who takes your enrollment.

Thank you!

CoventryCares Medicaid Difference



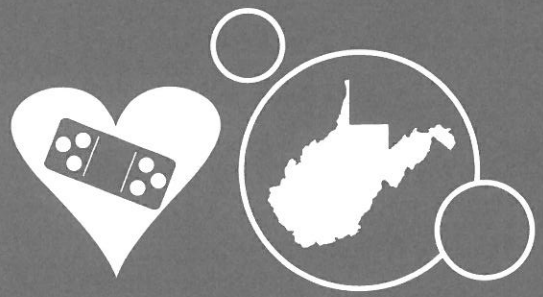
Top 10 Bear Facts

When you pick CoventryCares of West Virginia for your Medicaid plan, you get all the great coverage that you have under WV Medicaid, and much more:

1. Easy access to doctors. No referrals or paperwork needed.
2. Change your doctor at any time during the month.
3. An Outreach Program that works with community groups and local events.
4. A local staff helping school-aged kids form healthy habits.
5. A Pregnancy Program that gives you information while you are pregnant. We even follow up with you after deliver.
6. Toll-free nurse line that is available 24 hours a day, 7 days a week.
7. A large network that has the doctors, dentists, hospitals and pharmacies you know and trust.
8. Disease Management Programs that help members learn ways to improve their health.
9. A Customer Service Department that is open Monday through Friday, 8:30 a.m. to 5:00 p.m. Call 1-888-348-2922.
10. A website just for you. Go to **www.coventrycareswv.com**.

Join CoventryCares of West Virginia Today!

CoventryCares™
of West Virginia
formerly known as Carelink



Mountain Health Trust

Mountain Health Trust is West Virginia's Medicaid managed care program. As a member, you get to:

- Pick a Managed Care Organization (MCO).
- Pick a Primary Care Provider (PCP).

Mountain HEALTH TRUST

www.mountainhealthtrust.com
1-800-449-8466
TTY/TTD 1-800-449-8466



We are here to meet your family's needs.

Mountain Health Trust is the name of West Virginia's Medicaid Managed Care Program.

Mountain HEALTH TRUST

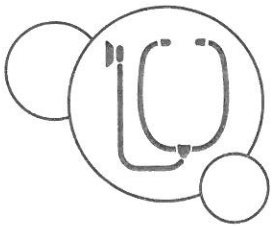
www.mountainhealthtrust.com

What is a Managed Care Organization?

A managed care organization (MCO) is a health care company. It is a group of doctors and hospitals that provide health care services covered by Medicaid. You will need to get health care from the doctors and hospital that are with the MCO you pick.

The MCO can provide almost all of your health care needs. The MCO you choose will ask you to pick a primary care provider (PCP) who will handle most of your medical needs. If you need to see a specialist, your PCP will give you a referral. If you need to go into the hospital, your PCP will arrange that for you.

Mountain Health Trust members may choose the Physicians Assured Access System (PAAS) instead of an MCO in Cabell and Wayne counties. PAAS is also a group of providers who will provide most of your health care needs. You will be asked to choose a PCP. In order to see a specialist you must have a referral.



What is a Primary Care Provider (PCP)?

Your PCP is your family doctor, nurse, or other health care provider at your medical home who takes care of you and your family. Your PCP will work with you to get the health care you need.

3 Easy Steps to Enroll

1. Pick an MCO: The MCOs available to you depend on the county in which you live. The 3 options across the state are: The Health Plan, Coventry Cares of WV and UniCare Health Plan of WV. You can also choose PAAS instead of an MCO in Cabell and Wayne counties. You can view the MCO and PAAS options in your county at www.mountainhealthtrust.com. (Click "How to Enroll". Then click "MCOs in Your County" and select the MCO or PAAS link.)

You may also call us at 1-800-449-8466 (TTY/TTD 1-800-449-8466). An enrollment specialist will explain your choices to you.



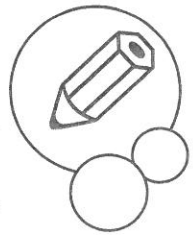
2. Pick a PCP: Think about which PCP is best for you and each of your family members. You do not have to choose the same PCP for all members of your family. You can pick your PCP if you enroll with an MCO or if you enroll with PAAS.

3. Enroll: Let us know the MCO and PCP you want. It is easy. There are three ways to enroll.



How Do I pick a PCP?

- Make sure the PCP is in the MCO you pick or in PAAS.
- Call us for help at 1-800-449-8466.
- Ask your doctor what MCOs he/she is in or if he/she is in PAAS.
- Ask us to mail a printed MCO or PAAS provider directory to you.
- Search for doctors online. Go to www.mountainhealthtrust.com. Click "How to Enroll." Then click "Search for Providers."



What Happens After I Enroll?

If you selected an MCO the name of that MCO will appear on your medical card. Your MCO will send you a membership card. Be sure to take both the medical card and the MCO membership card with you when you go for medical care.

If you have chosen PAAS, the name of your PCP will appear on your medical card. Please take the medical card with you when you go for medical care.

www.mountainhealthtrust.com
1-800-449-8466
TTY/TTD 1-800-449-8466

Mountain HEALTH TRUST

ENROLLMENT FORM

If you need help or have any questions, please call 1-800-449-8466.
We're here to help!

1. Please read this form and fill it out.
2. Do not forget to sign the form.
3. Answer the questions on the back of this page.
4. Mail the form in the enclosed postage-paid envelope.

Remember, you can call us at 1-800-449-8466 for help.

Is the following information right? If "No", please correct it.

Name:

Address:

Daytime phone number:

Medicaid ID Number:

Birth date:

Please complete the following information.

Race: White___ African-American ___ Asian ___ Other ___

Ethnicity: Hispanic ___ Non-Hispanic ___

Primary Language Spoken: _____

Please write your choice of provider here: _____

Provider's address and phone number: _____

_____

_____

Is this the provider you are seeing now? ☐ Yes ☐ No

The following is (are) the managed care program choice(s) in your county. Please make an "X" next to your choice.

_____

Your signature on the line above. A parent or guardian must sign for anyone under the age of 18.

Please complete the health risk assessment on the back.

. Do you use smokeless tobacco? No _____ Yes _____

. Do you smoke? No _____ Yes _____

. Are you seeing a doctor for any of the reasons listed below? If you are, please put an "X" next to each one that applies.

_____ Problem pregnancy

_____ Planned surgery in the future

_____ Receiving home care or hospice services

_____ On an organ transplant list

_____ Receiving chemotherapy

_____ Receiving physical/occupational/speech therapy

_____ Heart condition such as congestive heart failure

_____ Lung disorder such as asthma

. Are you pregnant? No _____ Yes _____ Expected Delivery Date: _____

. Do any of these apply to you? If one or more does, please put an "X" next to each one that applies.

_____ Are you in the last three months of your pregnancy?

If you are, who is your OB/GYN? _____

_____ Will you be hospitalized on the first day of enrollment?

_____ Are you currently under treatment for a specific health problem?

_____ Does your doctor think that changing doctors would cause harm?

_____ Do you have a terminal illness?

_____ Are you receiving Medicare?

. Do you have any health insurance other than Medicaid? If you do, please complete the following information.

Name of insurance company: _____

Group Name: _____

Group Number: _____

Policy Number: _____

Name of Insured: _____

Are you enrolled in the Health Insurance Premium Program (HIPP)? (This means that your health insurance premium is being paid by Medicaid.) _____ No _____ Yes

Medical Release Statement: I authorize any health care provider having information related to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me (or my dependent) to give the above information to the managed care program.

_____

Your signature goes here. A parent or guardian must sign for anyone under age 18.

Mountain Health Trust Checklist

This sheet is to help you fill out the paper work for Mountain Health Trust. To enroll by mail, use the list below to make sure your paperwork is complete. Ask yourself each question, and check off each item as it is done.

The set of forms in your packet is to help you pick the doctor and the Managed Care Program that are best for you. You can ask your doctor what MCOs the doctor is in. You can also call us at 1-800-449-8466 if you want help in picking a doctor, have questions or want to enroll over the phone. You can also ask us to mail a printed MCO Provider Directory to you.

You can call Monday-Friday from 8 AM to 8 PM. The call is free. We are happy to help.

You can also visit the **mountainhealthtrust.com** website for more information about Mountain Health Trust and to search for doctors. First click on "How to Enroll" then click "Search for Providers".

Check List for Mountain Health Trust Enrollment	✓ YES
• Did you read the cover letter?	
• Did you or your family pick a primary care doctor?	
• Did you write the doctor's name on the correct line of the enrollment form?	
• Did you mark the Managed Care Program you want to join?	
• Did you answer the questions on the back of the enrollment form?	
• Did you put the form in the postage-paid envelope in the packet?	
• Did you mail the form (or enroll over the phone)?	

Want to talk to us about your choices? Have questions? Need help?
Visit us at www.mountainhealthtrust.com
Call us at 1-800-449-8466 (TTY/TTD 1-800-449-8466). The call is free!
(Monday-Friday from 8 AM to 8 PM)

Welcome to Mountain Health Trust!

Dear Medicaid Member,

Welcome to Mountain Health Trust! We are sending you this packet to let you know that most of your Medicaid services will be provided by the Medicaid managed care organization (MCO) of your choice. This means that most of your health care will be provided by doctors and specialists that are part of the MCO you choose.

Mountain Health Trust members get to make two important decisions about their healthcare. As a member, you get to:

1. Pick a Managed Care Organization (MCO).
2. Pick a primary care provider (PCP).

Your PCP is the family doctor, nurse or other healthcare provider who takes care of you and your family. Please read the information in this packet and pick your MCO and your PCP. It will help you make the best choice for you and your family. The managed care choice(s) in your county can be found at the bottom of the enrollment form.

Because you know your needs best, it is important for you to pick the MCO you want. Mountain Health Trust is here to help you pick the MCO and PCP that meet the needs of you and your family the best. Follow the steps below to enroll. If you do not pick a MCO and PCP within 45 days we will pick one for you.

Thank you!
Mountain Health Trust

3 Easy Steps to Enroll

1. **Pick an MCO:** Review the information included in this package to learn about your MCO choices.
2. **Pick a PCP:** Make sure the PCP is in the MCO you pick. Need help? You can:
   - Call us for help at 1-800-449-8466 (a free call)
   - Ask us to mail a printed MCO provider directory to you.
   - Ask your doctor what MCOs the doctor is in.
   - Search for doctors on the mountainhealthtrust.com website. First click on "How to Enroll" then click "Search for Providers".
3. **Enroll:** Let us know the MCO and PCP you want. It is easy. You can enroll:
   - **BY PHONE:** Call us at 1-800-449-8466.
   - **BY MAIL:** Fill out the forms in this package and mail using the envelope provided.
   - **ONLINE:** www.mountainhealthtrust.com

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MCO Plan Comparison

Mountain HEALTH TRUST

Standard Services and Benefits			
Services and Benefits*	CoventryCares of West Virginia (formerly known as Carelink)	The Health Plan	UniCare.
	Phone: 1-888-348-2922 TTY 711; TDD 1-800-877-8973 Mon-Fri. 8:30 am-5:00 pm www.coventrycareswv.com	Phone: 1-800-624-6961 TTY: 1-800-622-3925 Mon-Fri. 8:30 am-5:00 pm www.healthplan.org	Phone: 1-800-782-0095 TTY: 1-866-368-1634 Mon-Fri. 8:00 am-6:00 pm www.unicare.com
Inpatient Services	✔	✔	✔
Outpatient Services	✔	✔	✔
Physician/Nurse Practitioner/ Midwife/Rural Health Clinic/ Federally Qualified Health Centers	✔	✔	✔
Home Health Services	✔	✔	✔
Durable Medical Equipment	✔	✔	✔
Family Planning Services and Supplies	✔	✔	✔
Hospice Services	✔	✔	✔
Ambulance	✔	✔	✔
Prescriptions	✔	✔	✔
Tobacco Cessation	✔	✔	✔
Skilled Nursing Care (Up to Age 21)	✔	✔	✔
EPSDT (Up to Age 21)	✔	✔	✔
Vision (Up to Age 21)	✔	✔	✔
Hearing (Up to Age 21)	✔	✔	✔
Dental (Up to Age 21)	✔	✔	✔

*This is not a list of all Medicaid services. Please check the West Virginia Guide to Medicaid for more information on benefits. http://www.dhhr.wv.gov/bms/Documents/YourGuideMedicaid.pdf

Picking your MCO and PCP

There are three MCOs in your county to pick from. Chances are your own PCP may be in one of the MCOs.

- You can ask your PCP which MCOs the PCP is in.
- You can call the Mountain Health Trust Helpline at 1-800-449-8466; TTY/TTD 1- 800-449-8466 (a free call) to ask us.
- You can ask us to mail a hard copy of the MCO Provider Directory to you.
- You can also visit the mountainhealthtrust.com website. First click on "How to Enroll" then click "Provider Search" for the most up to date listing of PCPs.

HEALTH PLAN

St. Clairsville Office
52160 National Road East
St. Clairsville, OH 43950-9365
PH: 1.800.624.6961
Hearing Impaired: 1.800.622.3925
FAX: 740.695.5297
www.healthplan.org

HomeTown Office
100 Lillian Gish Boulevard
P.O. Box 4816
Massillon, OH 44648-4816
PH: 1.877.236.2289
Hearing Impaired: 1.877.236.2291
FAX: 330.837.6869
www.healthplan.org

TO: WV MEDICAID RECIPIENTS
FROM: THE HEALTH PLAN
A HEALTH MAINTENANCE ORGANIZATION (HMO)

About The Health Plan:

The Health Plan is a federally and state qualified Health Maintenance Organization (HMO) based on the "personal doctor" idea. We have about 11,791 doctors, 134 hospitals, and over 354,000 members. The Health Plan is West Virginia's first, and largest, HMO. We've been keeping West Virginians well since 1979. We try to hold down costs and deliver quality healthcare. We currently serve 36 WV Counties with plans to get bigger.

All of our members receive a list of our doctors, hospitals, and other healthcare providers each year. This List has each doctor's name, address, phone number and specialty. It also shows the language he or she speaks. It shows if the practice is closed to new patients. You agree to use our group for your healthcare.

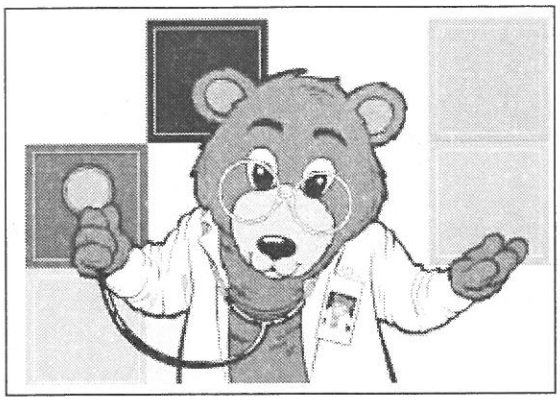
We want you to be able to find out about any medical problems early and get treated. These services are available to you through your own doctor. Your doctor will coordinate your care. You and your doctor decide together about your health. We want our members to have the best possible care. We want you to be healthy. We'll help you get well and stay well.

- Check-ups, shots, mammograms, and other routine services are covered.
- Each family member can choose a different doctor or the whole family can have one doctor.
- If you are sick or hurt away from home, The Health Plan will cover all medically necessary care.
- You don't pay doctor bills. You show your Health Plan ID card and Medicaid card at all office visits. There's very little paperwork.
- The Health Plan is a not-for-profit corporation. We receive a monthly premium for each enrollee from the WV Department of Health and Human Resources. The money goes to providing healthcare, paying the claims, and to a reserve to pay future healthcare costs.

Other benefit highlights:

If you already have a medical condition, you will still be covered. The Health Plan covers routine physicals, shots, and well child exams. We cover prenatal care and mammograms. If you are out of The Health Plan Service Area, you are covered for emergencies. Always call your doctor or The Health Plan for directions on what to do unless it is a true emergency.

CoventryCares Medicaid Difference



Top 10 Bear Facts

When you pick CoventryCares of West Virginia for your Medicaid plan, you get all the great coverage that you have under WV Medicaid, and much more:

1. Easy access to doctors. No referrals or paperwork needed.
2. Change your doctor at any time during the month.
3. An Outreach Program that works with community groups and local events.
4. A local staff helping school-aged kids form healthy habits.
5. A Pregnancy Program that gives you information while you are pregnant. We even follow up with you after deliver.
6. Toll-free nurse line that is available 24 hours a day, 7 days a week.
7. A large network that has the doctors, dentists, hospitals and pharmacies you know and trust.
8. Disease Management Programs that help members learn ways to improve their health.
9. A Customer Service Department that is open Monday through Friday, 8:30 a.m. to 5:00 p.m. Call 1-888-348-2922.
10. A website just for you. Go to **www.coventrycareswv.com**.

Join CoventryCares of West Virginia Today!

COVENTRYCARES™
of West Virginia
formerly known as Carelink

UNICARE HEALTH PLAN OF WEST VIRGINIA, INC.



A PLAN FOR MOMS AND KIDS

Our UniCare plan helps you put your family's health first.

Whether you're about to have your first baby or already have kids, we're here for you. With UniCare Health Plan of West Virginia (UniCare), you get all the usual Medicaid benefits, plus special services that help you take good care of your family.

Here are just some of the great programs we offer to both moms and moms-to-be.

- Maternity management program. If you're having a baby, we can help every step of the way. You get support from a nurse. And you can even earn rewards for getting the care you and your baby need.
- Healthy Mom, Healthy Baby showers across the state. You'll hear from experts and get information on pregnancy and child care. Plus, you'll get gifts and the chance to win prizes like car seats and strollers (provided by participating exhibitors).
- Health fairs in your area. You can talk one-on-one with our outreach specialists at these fairs. They'll answer questions about your plan and the programs we offer.

UNICARE®

ARE YOU A MOM-TO-BE?

This is an exciting time. Taking good care of yourself will help make sure your baby's healthy. Here are some tips:

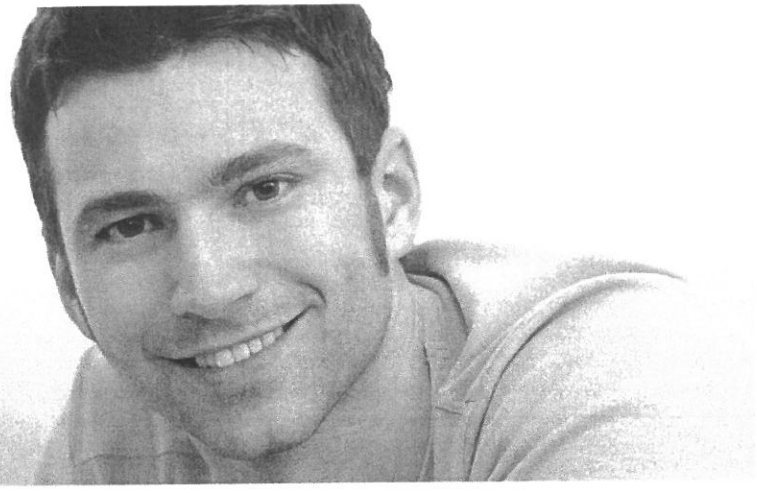
- **Eat healthy**. Talk to your doctor about what foods to eat what to avoid.
- **Don't smoke** and stay away from second-hand smoke
- **Sign up for the Women, Infants and Children** (WIC) program. Just call 1-800-642-8522 and you can get healthy food.
- **Take a birth class** and make a birth plan. Talk to your doctor about doing this.

ARE YOU A NEW MOM?

That's great. We know it's important to you to keep yourself and your baby healthy. Be sure to:

- Set up a visit with your doctor. Do this soon after you have the baby.
- Talk to your doctor if you're feeling down or sad.
- Sign your baby up for Medicaid. Call your eligibility worker at **1-800-449-8466** to do this.

WE HAVE GREAT SERVICES FOR ALL OF OUR MEMBERS.



We care about your health. That's why with UniCare, you get all the benefits Medicaid provides like

- Doctor visits
- Emergency room care
- Dental care for you and your children
- Tests and labs
- And so much more

Plus with UniCare you get:

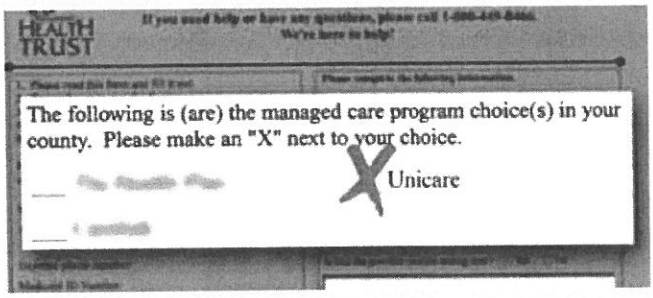
- To choose your primary care provider (PCP).
- A statewide network of doctors and hospitals to choose from.
- A toll-free 24/7 MedCall® nurse line you can call with questions any time.
- Reminders of when to get checkups and shots for your kids.
- Health programs to help with conditions like diabetes and asthma.
- Free Weight Watchers membership to qualifying members.
- Community Resource Coordinators to help you connect to local groups and services that can help with housing, rides to the doctor, social issues, counseling, even money worries.

If you're not sure where to turn, turn to us.

Our plan is to help you get the health care you need. You get one-on-one support with UniCare. Our local outreach staff is friendly and listens to you. They can answer your questions and they respond to phone calls quickly.

READY TO CHOOSE UNICARE?

It's easy to sign up. Just check the UniCare box on the enrollment form that's included in this packet.



Or call the enrollment broker today to sign up: 1-800-449-8466.

If you have questions about UniCare and want to learn more, call 1-888-817-6615. If you have speech or hearing loss, call the TTY line at 1-866-368-1634.

Translation services are available at no cost.

UniCare.com/WVMedicaid

UNICARE®

UniCare Health Plan of West Virginia, Inc. ®UniCare is a registered mark of WellPoint, Inc. ®Weight Watchers is a registered trademark of Weight Watchers International, Inc. and is used under license.

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Mountain Health Trust

Mountain Health Trust is West Virginia's Medicaid managed care program. As a member, you get to:

- Pick a Managed Care Organization (MCO).
- Pick a Primary Care Provider (PCP).

Mountain HEALTH TRUST

www.mountainhealthtrust.com
1-800-449-8466
TTY/TTD 1-800-449-8466



We are here to meet your family's needs.

Mountain Health Trust is the name of West Virginia's Medicaid Managed Care Program.

Mountain HEALTH TRUST

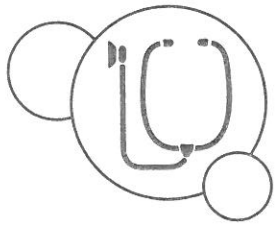
www.mountainhealthtrust.com

What is a Managed Care Organization?

A managed care organization (MCO) is a health care company. It is a group of doctors and hospitals that provide health care services covered by Medicaid. You will need to get health care from the doctors and hospital that are with the MCO you pick.

The MCO can provide almost all of your health care needs. The MCO you choose will ask you to pick a primary care provider (PCP) who will handle most of your medical needs. If you need to see a specialist, your PCP will give you a referral. If you need to go into the hospital, your PCP will arrange that for you.

Mountain Health Trust members may choose the Physicians Assured Access System (PAAS) instead of an MCO in Cabell and Wayne counties. PAAS is also a group of providers who will provide most of your health care needs. You will be asked to choose a PCP. In order to see a specialist you must have a referral.



What is a Primary Care Provider (PCP)?

Your PCP is your family doctor, nurse, or other health care provider at your medical home who takes care of you and your family. Your PCP will work with you to get the health care you need.

3 Easy Steps to Enroll

1. Pick an MCO: The MCOs available to you depend on the county in which you live. The 3 options across the state are: The Health Plan, Coventry Cares of WV and UniCare Health Plan of WV. You can also choose PAAS instead of an MCO in Cabell and Wayne counties. You can view the MCO and PAAS options in your county at www.mountainhealthtrust.com. (Click "How to Enroll". Then click "MCOs in Your County" and select the MCO or PAAS link.)



You may also call us at 1-800-449-8466 (TTY/TTD 1-800-449-8466). An enrollment specialist will explain your choices to you.

2. Pick a PCP: Think about which PCP is best for you and each of your family members. You do not have to choose the same PCP for all members of your family. You can pick your PCP if you enroll with an MCO or if you enroll with PAAS.

3. Enroll: Let us know the MCO and PCP you want. It is easy. There are three ways to enroll.

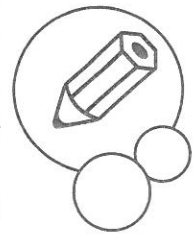
BY PHONE
Call us at 1-800-449-8466 (TTY/TTD 1-800-449-8466).

BY MAIL
Fill out the forms in the enrollment packet and mail using the envelope provided.

ONLINE
www.mountainhealthtrust.com/enroll

How Do I pick a PCP?

- Make sure the PCP is in the MCO you pick or in PAAS.
- Call us for help at 1-800-449-8466.
- Ask your doctor what MCOs he/she is in or if he/she is in PAAS.
- Ask us to mail a printed MCO or PAAS provider directory to you.
- Search for doctors online. Go to www.mountainhealthtrust.com. Click "How to Enroll." Then click "Search for Providers."



What Happens After I Enroll?

If you selected an MCO the name of that MCO will appear on your medical card. Your MCO will send you a membership card. Be sure to take both the medical card and the MCO membership card with you when you go for medical care.

If you have chosen PAAS, the name of your PCP will appear on your medical card. Please take the medical card with you when you go for medical care.

www.mountainhealthtrust.com
1-800-449-8466
TTY/TTD 1-800-449-8466

Mountain HEALTH TRUST

ENROLLMENT FORM

If you need help or have any questions, please call 1-800-449-8466.
We're here to help!

1. Please read this form and fill it out.
2. Do not forget to sign the form.
3. Answer the questions on the back of this page.
4. Mail the form in the enclosed postage-paid envelope.

Remember, you can call us at 1-800-449-8466 for help.

Is the following information right? If "No", please correct it.

Name:

Address:

Daytime phone number:

Medicaid ID Number:

Birth date:

Please complete the following information.

Race: White___ African-American ___ Asian ___ Other ___

Ethnicity: Hispanic ___ Non-Hispanic ___

Primary Language Spoken: _____

Please write your choice of provider here: _____

Provider's address and phone number: _____

_____

_____

Is this the provider you are seeing now? ☐ Yes ☐ No

The following is (are) the managed care program choice(s) in your county. Please make an "X" next to your choice.

_____

Your signature on the line above. A parent or guardian must sign for anyone under the age of 18.

Please complete the health risk assessment on the back.

. Do you use smokeless tobacco? No _____ Yes _____

. Do you smoke? No _____ Yes _____

. Are you seeing a doctor for any of the reasons listed below? If you are, please put an "X" next to each one that applies.

_____ Problem pregnancy

_____ Planned surgery in the future

_____ Receiving home care or hospice services

_____ On an organ transplant list

_____ Receiving chemotherapy

_____ Receiving physical/occupational/speech therapy

_____ Heart condition such as congestive heart failure

_____ Lung disorder such as asthma

. Are you pregnant? No _____ Yes _____ Expected Delivery Date: _____

. Do any of these apply to you? If one or more does, please put an "X" next to each one that applies.

_____ Are you in the last three months of your pregnancy?

If you are, who is your OB/GYN? _____

_____ Will you be hospitalized on the first day of enrollment?

_____ Are you currently under treatment for a specific health problem?

_____ Does your doctor think that changing doctors would cause harm?

_____ Do you have a terminal illness?

_____ Are you receiving Medicare?

. Do you have any health insurance other than Medicaid? If you do, please complete the following information.

Name of insurance company: _____

Group Name: _____

Group Number: _____

Policy Number: _____

Name of Insured: _____

Are you enrolled in the Health Insurance Premium Program (HIPP)? (This means that your health insurance premium is being paid by Medicaid.) _____ No _____ Yes

Medical Release Statement: I authorize any health care provider having information related to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me (or my dependent) to give the above information to the managed care program.

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Your signature goes here. A parent or guardian must sign for anyone under age 18.

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This sheet is to help you fill out the paper work for Mountain Health Trust. To enroll by mail, use the list below to make sure your paperwork is complete. Ask yourself each question, and check off each item as it is done.

The set of forms in your packet is to help you pick the doctor and the Managed Care Program that are best for you. You can ask your doctor what MCOs the doctor is in. You can also call us at 1-800-449-8466 if you want help in picking a doctor, have questions or want to enroll over the phone. You can also ask us to mail a printed MCO Provider Directory to you.

You can call Monday-Friday from 8 AM to 8 PM. The call is free. We are happy to help.

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Check List for Mountain Health Trust Enrollment	✓ YES
• Did you read the cover letter?	
• Did you or your family pick a primary care doctor?	
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• Did you mark the Managed Care Program you want to join?	
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Dear Medicaid Member,

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1. Pick a Managed Care Organization (MCO).
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Your PCP is the family doctor, nurse or other healthcare provider who takes care of you and your family. Please read the information in this packet and pick your MCO and your PCP. It will help you make the best choice for you and your family. The managed care choice(s) in your county can be found at the bottom of the enrollment form.

Because you know your needs best, it is important for you to pick the MCO you want. Mountain Health Trust is here to help you pick the MCO and PCP that meet the needs of you and your family the best. Follow the steps below to enroll. If you do not pick a MCO and PCP within 45 days we will pick one for you.

Thank you!
Mountain Health Trust

3 Easy Steps to Enroll

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MCO Plan Comparison

Mountain HEALTH TRUST

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Inpatient Services	✔	✔
Outpatient Services	✔	✔
Physician/Nurse Practitioner/ Midwife/Rural Health Clinic/ Federally Qualified Health Centers	✔	✔
Home Health Services	✔	✔
Durable Medical Equipment	✔	✔
Family Planning Services and Supplies	✔	✔
Hospice Services	✔	✔
Ambulance	✔	✔
Prescriptions	✔	✔
Tobacco Cessation	✔	✔
Skilled Nursing Care (Up to Age 21)	✔	✔
EPSDT (Up to Age 21)	✔	✔
Vision (Up to Age 21)	✔	✔
Hearing (Up to Age 21)	✔	✔
Dental (Up to Age 21)	✔	✔

*This is not a list of all Medicaid services. Please check the West Virginia Guide to Medicaid for more information on benefits. http://www.dhhr.wv.gov/bms/Documents/YourGuideMedicaid.pdf

Picking your MCO and PCP

There are two MCOs in your county to pick from. Chances are your own PCP may be in one of the MCOs.

- You can ask your PCP which MCOs the PCP is in.
- You can call the Mountain Health Trust Helpline at 1-800-449-8466; TTY/TTD 1- 800-449-8466 (a free call) to ask us.
- You can ask us to mail a hard copy of the MCO Provider Directory to you.
- You can also visit the mountainhealthtrust.com website. First click on "How to Enroll" then click "Provider Search" for the most up to date listing of PCPs.

UNICARE HEALTH PLAN OF WEST VIRGINIA, INC.



A PLAN FOR MOMS AND KIDS

Our UniCare plan helps you put your family's health first.

Whether you're about to have your first baby or already have kids, we're here for you. With UniCare Health Plan of West Virginia (UniCare), you get all the usual Medicaid benefits, plus special services that help you take good care of your family.

Here are just some of the great programs we offer to both moms and moms-to-be.

- Maternity management program. If you're having a baby, we can help every step of the way. You get support from a nurse. And you can even earn rewards for getting the care you and your baby need.
- Healthy Mom, Healthy Baby showers across the state. You'll hear from experts and get information on pregnancy and child care. Plus, you'll get gifts and the chance to win prizes like car seats and strollers (provided by participating exhibitors).
- Health fairs in your area. You can talk one-on-one with our outreach specialists at these fairs. They'll answer questions about your plan and the programs we offer.

UNICARE®

ARE YOU A MOM-TO-BE?

This is an exciting time. Taking good care of yourself will help make sure your baby's healthy. Here are some tips:

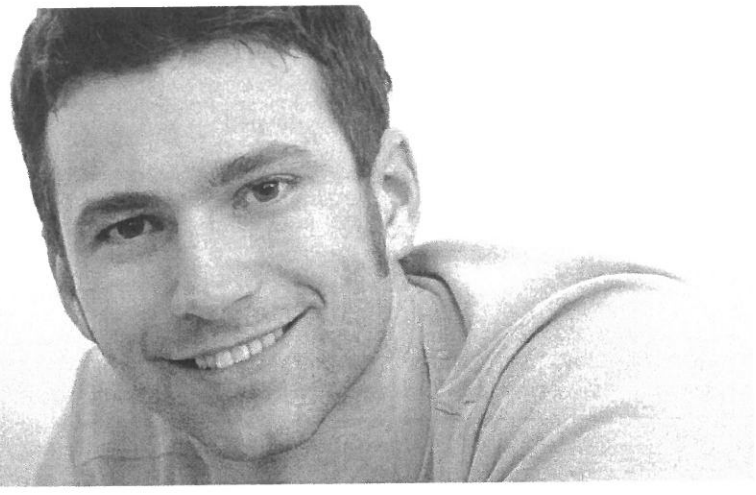
- **Eat healthy**. Talk to your doctor about what foods to eat what to avoid.
- **Don't smoke** and stay away from second-hand smoke
- **Sign up for the Women, Infants and Children** (WIC) program. Just call 1-800-642-8522 and you can get healthy food.
- **Take a birth class** and make a birth plan. Talk to your doctor about doing this.

ARE YOU A NEW MOM?

That's great. We know it's important to you to keep yourself and your baby healthy. Be sure to:

- Set up a visit with your doctor. Do this soon after you have the baby.
- Talk to your doctor if you're feeling down or sad.
- Sign your baby up for Medicaid. Call your eligibility worker at **1-800-449-8466** to do this.

WE HAVE GREAT SERVICES FOR ALL OF OUR MEMBERS.



We care about your health. That's why with UniCare, you get all the benefits Medicaid provides like

- Doctor visits
- Emergency room care
- Dental care for you and your children
- Tests and labs
- And so much more

Plus with UniCare you get:

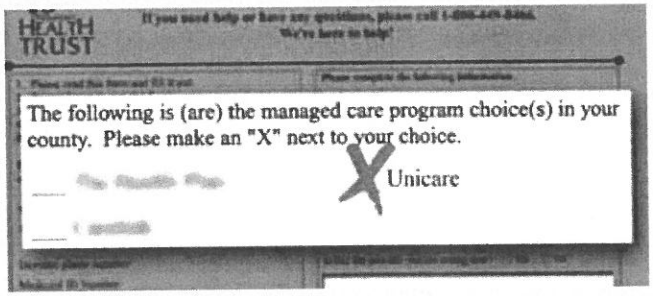
- To choose your primary care provider (PCP).
- A statewide network of doctors and hospitals to choose from.
- A toll-free 24/7 MedCall® nurse line you can call with questions any time.
- Reminders of when to get checkups and shots for your kids.
- Health programs to help with conditions like diabetes and asthma.
- Free Weight Watchers membership to qualifying members.
- Community Resource Coordinators to help you connect to local groups and services that can help with housing, rides to the doctor, social issues, counseling, even money worries.

If you're not sure where to turn, turn to us.

Our plan is to help you get the health care you need. You get one-on-one support with UniCare. Our local outreach staff is friendly and listens to you. They can answer your questions and they respond to phone calls quickly.

READY TO CHOOSE UNICARE?

It's easy to sign up. Just check the UniCare box on the enrollment form that's included in this packet.



Or call the enrollment broker today to sign up: 1-800-449-8466.

If you have questions about UniCare and want to learn more, call 1-888-817-6615. If you have speech or hearing loss, call the TTY line at 1-866-368-1634.

Translation services are available at no cost.

UniCare.com/WVMedicaid

UNICARE®

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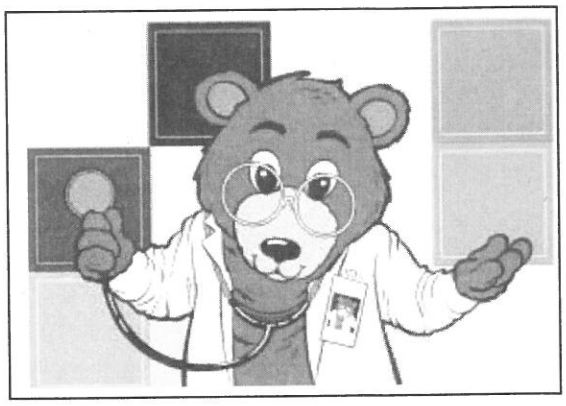
CoventryCares Medicaid Difference



Top 10 Bear Facts

When you pick CoventryCares of West Virginia for your Medicaid plan, you get all the great coverage that you have under WV Medicaid, and much more:

1. Easy access to doctors. No referrals or paperwork needed.
2. Change your doctor at any time during the month.
3. An Outreach Program that works with community groups and local events.
4. A local staff helping school-aged kids form healthy habits.
5. A Pregnancy Program that gives you information while you are pregnant. We even follow up with you after deliver.
6. Toll-free nurse line that is available 24 hours a day, 7 days a week.
7. A large network that has the doctors, dentists, hospitals and pharmacies you know and trust.
8. Disease Management Programs that help members learn ways to improve their health.
9. A Customer Service Department that is open Monday through Friday, 8:30 a.m. to 5:00 p.m. Call 1-888-348-2922.
10. A website just for you. Go to **www.coventrycareswv.com**.

Join CoventryCares of West Virginia Today!

COVENTRYCARES™
of West Virginia
formerly known as Carelink



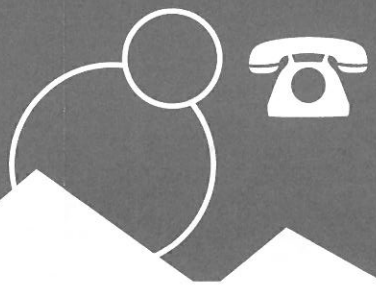
Mountain Health Trust

Mountain Health Trust is West Virginia's Medicaid managed care program. As a member, you get to:

- Pick a Managed Care Organization (MCO).
- Pick a Primary Care Provider (PCP).

Mountain HEALTH TRUST

www.mountainhealthtrust.com
1-800-449-8466
TTY/TTD 1-800-449-8466



We are here to meet your family's needs.

Mountain Health Trust is the name of West Virginia's Medicaid Managed Care Program.

Mountain HEALTH TRUST

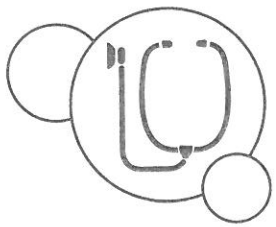
www.mountainhealthtrust.com

What is a Managed Care Organization?

A managed care organization (MCO) is a health care company. It is a group of doctors and hospitals that provide health care services covered by Medicaid. You will need to get health care from the doctors and hospital that are with the MCO you pick.

The MCO can provide almost all of your health care needs. The MCO you choose will ask you to pick a primary care provider (PCP) who will handle most of your medical needs. If you need to see a specialist, your PCP will give you a referral. If you need to go into the hospital, your PCP will arrange that for you.

Mountain Health Trust members may choose the Physicians Assured Access System (PAAS) instead of an MCO in Cabell and Wayne counties. PAAS is also a group of providers who will provide most of your health care needs. You will be asked to choose a PCP. In order to see a specialist you must have a referral.



What is a Primary Care Provider (PCP)?

Your PCP is your family doctor, nurse, or other health care provider at your medical home who takes care of you and your family. Your PCP will work with you to get the health care you need.

3 Easy Steps to Enroll

1. Pick an MCO: The MCOs available to you depend on the county in which you live. The 3 options across the state are: The Health Plan, Coventry Cares of WV and UniCare Health Plan of WV. You can also choose PAAS instead of an MCO in Cabell and Wayne counties. You can view the MCO and PAAS options in your county at www.mountainhealthtrust.com. (Click "How to Enroll". Then click "MCOs in Your County" and select the MCO or PAAS link.)



You may also call us at 1-800-449-8466 (TTY/TTD 1-800-449-8466). An enrollment specialist will explain your choices to you.

2. Pick a PCP: Think about which PCP is best for you and each of your family members. You do not have to choose the same PCP for all members of your family. You can pick your PCP if you enroll with an MCO or if you enroll with PAAS.

3. Enroll: Let us know the MCO and PCP you want. It is easy. There are three ways to enroll.



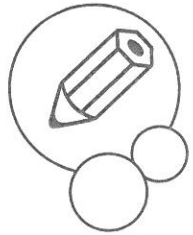
BY PHONE
Call us at 1-800-449-8466 (TTY/TTD 1-800-449-8466).

BY MAIL
Fill out the forms in the enrollment packet and mail using the envelope provided.

ONLINE
www.mountainhealthtrust.com/enroll

How Do I pick a PCP?

- Make sure the PCP is in the MCO you pick or in PAAS.
- Call us for help at 1-800-449-8466.
- Ask your doctor what MCOs he/she is in or if he/she is in PAAS.
- Ask us to mail a printed MCO or PAAS provider directory to you.
- Search for doctors online. Go to www.mountainhealthtrust.com. Click "How to Enroll." Then click "Search for Providers."



What Happens After I Enroll?

If you selected an MCO the name of that MCO will appear on your medical card. Your MCO will send you a membership card. Be sure to take both the medical card and the MCO membership card with you when you go for medical care.

If you have chosen PAAS, the name of your PCP will appear on your medical card. Please take the medical card with you when you go for medical care.

www.mountainhealthtrust.com
1-800-449-8466
TTY/TTD 1-800-449-8466

West Virginia

Enrollee Outreach and Education Plan

Submitted by Automated Health Systems



AUTOMATED HEALTH SYSTEMS

Activity		Description	Goal(s)	Owner	Start Date	Targeted Completion Date	Status
1. Offering Multiple Avenues for Enrollment							
1.1	Telephone Assistance	Statewide toll free helpline 8:00 am to 8:00 pm M-F EST; Access to MHT Call Center staff for counseling, education, and enrollment assistance in the potential enrollee/enrollee's preferred language; Also offer TDD/TTY Service for callers who are deaf or hearing impaired.	Provide potential enrollees/enrollees with culturally sensitive, unbiased, and timely enrollment assistance through the MHT Call Center using DHHR approved Education Guides to encourage a voluntary selection.			Ongoing	
1.2	Mailings	Mountain Health Trus/PAAS Enrollment Packets designed to educate the potential enrollee about the importance of self-selecting an MCO and PCP and how to complete and submit the Enrollment forms offers the potential enrollee the option to contact the Toll Free helpline for voice assistance.	Provide potential enrollees with materials that are easy to understand with detailed instructions on how to voluntarily select their MCO and PCP and complete the hard copy enrollment form and mail it back to our office within the specified timeline for voluntary enrollment.				
1.3	Web based Enrollment	On-line enrollment application available on the Mountain Health Trust Project website with the option for potential enrollees to also contact the toll free MHT Helpline for help enrolling on-line.	Provide potential enrollees with the option to access educational materials on-line and enroll on-line at times when it is most convenient for them.				
1.4	Smart Phone	Mobile-friendly interface that includes enrollment functionality	Offer potential enrollees a convenient alternative to enrolling				

Activity		Description	Goal(s)	Owner	Start Date	Targeted Completion Date	Status
		for Smart Phones	by telephone, mail or on the MHT Project website - leveraging new technology that is user friendly.				
1.5	Face-to-Face Enrollments	Field Benefits Managers provide education and counseling to facilitate enrollment to the potential enrollee in their preferred method and location for receiving personalized assistance; Venues can include at a public event, at a private group session or at a Community Based Organization (CBO).	Provide the potential enrollee, especially those with special needs, with access to face-to-face counseling to overcome barriers for voluntary enrollment. Utilize CBOs as partners to help coordinate individual face-to-face requests from the enrollees they serve and facilitate access to enrollees who are hard-to-reach.				
2. Identifying Enrollees Who Do Not Make a Timely Voluntary Selection							
2.1	Track and Implement Time-sensitive Enrollment Actions	HealthTrack system monitors the 45 day choice period for potential enrollees. Most time sensitive actions occur automatically to remove the chance for error.	Improve the voluntary selection rate to ensure the best MCO and PCP match for the potential enrollee and avoid auto-assignment.				
2.2	Mail Enrollment Packets	Mail MHT and PAAS Enrollment Packets within 2 days of receiving the enrollment file.	Timely mailings will maximize the amount of time the potential enrollee can self-select.				
2.3	Conduct Reminder Calls	Conduct reminder calls to potential enrollees who do not promptly respond to the enrollment mailing within 6 days of mailing.	Prompt potential enrollees to make a voluntary selection within the 45 day timeframe.				

Activity		Description	Goal(s)	Owner	Start Date	Targeted Completion Date	Status
2.4	Utilize CallFire	Utilize an automated call system (CallFire) to expand the frequency and times for phone outreach if no enrollment is received.	Extend our reach to Enrollees at various times during the day and in the evening.				
2.5	Mail Reminder Notices	Reminder notices are mailed on Day 35 if no selection has already been made.	Encourage the potential enrollee to immediately contact our MHT Call Center for assistance, go to the website to enroll, or scan the QR code embedded in the letter to enroll via Smart Phone.				
2.6	Conduct 2nd Reminder Call	Place 2nd reminder call to potential enrollees who have not selected an MCO or PAAS Provider by Day 30-34.	Provide potential enrollees with another opportunity to self-select their MCO and PCP before auto-assignment occurs.				
2.7	Conduct 3rd Reminder Call	Place 3rd reminder call to potential enrollees who have not selected an MCO or PAAS Provider by Day 40-44.	Provide potential enrollees with a final opportunity to self-select their MCO and PCP before auto-assignment occurs.				
3. Setting Individual Targets to Facilitate a High Voluntary Enrollment Rate							
3.1	Create Individual Benefits Manager Targets	Benefits Manager tasks associated with reaching a set number of outbound calls and processing a set number of enrollments each month.	Ensure optimal achievement of the voluntary enrollment rate by setting individual Benefits Manager targets for task completion.				

Activity		Description	Goal(s)	Owner	Start Date	Targeted Completion Date	Status
3.2	Modify Individual Benefits Manager Targets	Benefits Manager tasks adjusted monthly or as needed to reach the voluntary enrollment goals.	Adequately staff the Call Center and establish/modify individual Benefits Manager targets to meet or exceed the monthly voluntary enrollment goals.				
3.3	Monitor Monthly Individual and Project Team Progress	Individual and aggregate Call Center stats assess progress toward achieving the projected monthly voluntary enrollment rate; Benefits Managers access tools in as monitored in HealthTrack through the My Stats feature.	Ensure that the Call Center team is aware of its collective and individual progress towards reaching the monthly voluntary selection goal and provide opportunity to modify/increase our outreach approach to stay on target for achieving the monthly goal.				
3.4	Performance Review	Tool used to evaluate Benefits Manager performance with the attainment of monthly enrollment targets a contributing factor in the Benefits Manager's overall performance rating.	Connect the Benefits Manager with the Project wide voluntary enrollment rate and foster buy-in by integrating the attainment of their individual monthly enrollment targets in their performance review.				
3.5	Access to My Stats for all Project Staff	Provides all members of the Project team (including Benefits Managers and Project management staff) access to the current, aggregate voluntary rate for the Call Center at any time in real time.	Afford all members of the Project Team instant access to the voluntary enrollment rate creating opportunity to forecast, monitor and adjust individual and collective outreach efforts to achieve the monthly voluntary enrollment rate.				

Activity		Description	Goal(s)	Owner	Start Date	Targeted Completion Date	Status
4. Using Empowering Statements							
4.1	Incorporate empowering statements in scripts and all educational material.	Messaging that encourages a potential enrollee to take action and voluntarily select their MCO and PCP: • Incorporate language in scripts and Education Guides • Create materials that use action statements to guide Enrollees through the process	Convince the potential enrollee that selecting a best-fit MCO and PCP is an important health care decision that typically results in healthier, happier Enrollees. Empower the Enrollee to make a voluntary enrollment by providing understandable information, promoting available assistance and enrollment routes, and encouraging the potential enrollee to "Act Now".				
5. Including Specially Trained Staff							
5.1	Allocate and Train Call Center Benefits Managers and Field Benefits Managers	Call Center Benefits Managers and Field Benefits Managers are responsible for assisting potential enrollees and enrollees with Special Needs and require more intensive education and support both in the field and by telephone. • Employ compassionate staff that is sensitive to the unique needs of individuals and groups with Special Needs. • Train staff to ensure that individuals and groups	Ensure that individuals and groups with medical and/or social special needs receive the individualized care and support they need from Enrollment Broker staff to overcome barriers to enrollment enroll in an MCO and select a PCP that best fits their unique needs.				

Activity		Description	Goal(s)	Owner	Start Date	Targeted Completion Date	Status
		receive the most effective means of personal and direct assistance in making informed and unbiased selection.					
6. Conducting Targeted Outreach to Special Needs Groups							
6.1	Work with individuals who self-identify with Special Needs	Special Needs information that is self-reported by the potential enrollee Health Assessment is used to determine the medical/social special need and flag the individual for enhanced support.	Utilize special needs information that is self-reported by the potential enrollee to customize our outreach and education approach to improve their voluntary selection rate.				
6.2	Identify groups of individuals who meet the criteria for Special Needs and agencies who support them	Groups include homeless and homebound individuals, and persons with physical, sensory and/or cognitive disabilities. Special Needs Groups are also supported by specific Agencies, Community Based Organizations (CBOs) and advocacy groups and that can be tapped to promote voluntary enrollment, provide a venue for face to face counseling, help to locate eligible Enrollees, and host presentations.	Provide education and outreach to Special Needs Enrollees/Members in a setting where they are most comfortable and accessible by working with agencies, CBOs and advocacy groups who serve their special social/medical needs.				

	Activity	Description	Goal(s)	Owner	Start Date	Targeted Completion Date	Status
6.3	Target and distribute materials in the appropriate language and format for special needs populations.	Materials are provided to individuals or distributed to groups or agencies that provide support and advocacy for the special needs populations in a format that is literacy and culturally appropriate.	Increase the likelihood that individuals and groups with complex medical and/or social needs will respond to printed and other outreach and education materials within the 45 day window for MCO and PAAS voluntary enrollment.				
7. Promoting Project Messages							
7.1	Community Collaboration	Identify and work with community groups and local and State agencies, including DHHR offices, to facilitate enrollment activities.	Generate interest, strengthen education and outreach efforts and enhance potential enrollee and enrollee awareness of the Mountain Health Trust Program.				
7.2	Train-the Trainer	Conduct Train-the-Trainer sessions with community partners on the various benefits/covered services that most directly impact the group's target population.	Leverage their trusted relationships with the targeted populations to promote voluntary enrollment.				
7.3	Conduct Field Based Education and Outreach	Presentations in group sessions, coordinated counseling sessions, and face- to- face counseling in private group settings, in the home, and/or at community events and venues.	Engage potential enrollees who do not elect to call in venues at a specific time, day and location that is most suitable and supportive of their needs.				

Activity		Description	Goal(s)	Owner	Start Date	Targeted Completion Date	Status
8. Using Consistent Branding							
8.1	Incorporate program logos, taglines and consistent messaging in all printed materials and electronic formats.	Specific logos, taglines and messaging are developed to readily identify the MHT Program. Used in all printed materials and are incorporated in the design of the Project website and other electronic communication, including Smart Phone technology.	Increased recognition of program materials will result in more potential enrollees likely to respond and voluntarily select an MCO and PCP.				
9. Providing Enhanced Reminder Outreach							
9.1	Tiered mail –and phone outreach	Provide repeated attempts through a variety of routes to contact potential enrollees who have not made a voluntary enrollment; continue until 1) the potential enrollee makes a voluntary enrollment, 2) the potential enrollee is auto-assigned, or 3) a Do Not Contact request is made. • Benefits Managers conduct live outreach calls to potential enrollees who have not submitted a voluntary enrollment 6 days after the New Enrollment Packet Mailing. • Call Fire campaigns are scheduled beginning day	Reinforce the importance of voluntary enrolment and provide the potential enrollee with frequent reminders to make a best fit choice.				

Activity		Description	Goal(s)	Owner	Start Date	Targeted Completion Date	Status
		10 through day 44 if no voluntary selection is made. • Reminder letters are sent automatically by HealthTrack 10 days prior to cutoff if no selection is made.					
10. Searching for Good Addresses and Phone Numbers							
10.1	Use NCOA database to correct addresses in HealthTrack	Updates client records in HealthTrack and mailings with the correct address provided by the NCOA service through the US Postal Service prior to sending mailings.	Ensure a higher contact rate with potential enrollees receiving enrollment materials in a timely fashion.				
10.2	Notify the Department of member address changes.	Returned/undelivered mail is opened and processed with the Department notified as to the type of returned mail, efforts made to update the mailing address and the date the material was resent. Corrected addresses provided by NCOA can also be provided to the State and /or Fiscal Agent in any desired format.	Increased accuracy of potential enrollee and enrollee mailing addresses on the daily eligibility file for current and future enrollee mailings.				

Activity		Description	Goal(s)	Owner	Start Date	Targeted Completion Date	Status
11. Using Effective Counseling							
11.1	Train Project Staff	Training modules cover Program- and Position-specific education, Embracing Diversity, Health Literacy and Special Needs Populations, among others.	Heighten awareness and appreciation of how health literacy, cultural diversity, and the varied needs of special populations factor into the enrollment process helps to ensure that MHT and PAAS potential enrollees and enrollees are supported in their decision making and receive unbiased representation of MCOs and enrollment assistance.				
11.2	Use Scripting and Education Guides	Benefits Managers follow scripting and Department approved Education Guides (embedded in HealthTrack) for all enrollment activities. The Education Guides are written at a sixth grade (or lower) reading level.	Ensure that the education and enrollment information provided to potential enrollees and enrollees is accurate and that messages are conveyed in a manner that is understood and acted upon by the recipient.				
11.3	Monitor Calls	Monitor a minimum of four live Benefits Manager calls each month using a Quality Monitoring Tool to document results of their findings.	Ensure MHT Call Center staff is follow scripting, adheres to protocols, deliver accurate information and accurately enters enrollment information and documents call activities.				

Draft Strategic Outreach Plan

Submitted by:
Automated Health Systems

June 25, 2014

Task		Strategy	Start Date	Status
1.0	**Identify and Collaborate with Partner Agencies**			
1.1	Identify Stakeholders and Partner Agencies	• Deploy a team of seasoned Field Benefits Managers with extensive knowledge and a proven track record of engaging community groups, stakeholders, and partner agencies to maximize outreach and education to promote the MHT Program and support Managed Care initiatives within their designated regions • Create a comprehensive directory of community based organizations (CBOs), advocacy groups, local coalitions, community partnerships, stakeholders and forums to serve as agency partners • Confirm CBO/agency contact information and demographics: o Name of organization o Mission o Service Area o Contact/liaison o Address, phone, fax, email and web address • Outreach to newly identified stakeholders, organizations and other groups serving the MHT target population and expanded populations; • Mail introductory letter to newly identified stakeholders and partner agencies introducing the Field Benefits Manager assigned to the Region • Post the Agency Resource Directory to HealthTrack • Update the Agency Resource Directory with changes as needed • Add new partner agencies to the Agency Resource Directory • Conduct an annual review of all listings in the Agency		

Task		Strategy	Start Date	Status
		Resource Directory		
1.2	Secure Memos of Understanding (MOU)	• Assess level of partnership with agency • Create a MOU with interested agencies/collaboratives demonstrating our partnership: o Establish joint protocol to maximize outreach and education to targeted populations o Submit draft MOU to DHHR for approval o Obtain signatures from both parties on final approved MOU o Index document(s) in HealthTrack o Meet with agency staff to discuss collaboration and protocol o Implement steps to provide education, share information, attend events, and maximize opportunities to promote joint services o Update the MHT Call Center on agency collaboration o Update MOU as warranted		
1.3	Extend Our Outreach to Eligible Enrollees and Special Populations	• Create processes for agencies to connect their constituents for enrollment assistance support through: o the Enrollment Broker Call Center o attendance at health fairs, parenting fairs or other events, o group sessions, and o face-to-face enrollment • Serve as a resource on Medicaid Managed Care and PAAS • Assess whether the partner agencies will allow us to use their site for one-on-one and/or group outreach, education and enrollment meetings with potential enrollees and enrollees		

Task		Strategy	Start Date	Status
		• Serve as ombudsman for enrollees		
1.4	Participate in Joint Trainings/ Informational Sessions	• Share location and date(s) for training/informational sessions • Attend agency sponsored consumer meetings, health fairs, and other venues to extend our reach to potential enrollees and enrollees • Offer to attend the meetings posted on the Consumer Assistance Resources WV Marketplace calendar of events to share MHT information with consumers in the audience who may qualify for Medicaid, collaborating with the IPAs as requested • Complete the West Virginia System of Care Family Centered Practice Training – evidence based training focusing on cultural diversity and sensitivity • Offer to have the Field Benefits Managers who are certified as trainers provide the cultural competency in-service training to interested groups, including DHHR offices (a required training for DHHR staff) • Secure feedback forms from the audience to assess the effectiveness of the training		
1.5	Represent MHT on Boards and Task Force Groups	• Serve as a board member and participate with coalitions, literacy groups, interagency meetings, task force groups, etc. • Establish strong partnerships with the Family Resource Networks		

Task		Strategy	Start Date	Status
		• Participate in general membership meetings • Network with local community groups, educators, and county residents • Assist with planning health-related activities • Attend and participate in Regional Summits		
1.6	Provide Project Low Literacy Materials	• Provide partner agencies with an ample supply of Project materials for display and dissemination to their constituents • Inform partner agencies on how to order MHT materials and their availability in PDF on the MHT website • Determine if the flyers, brochures and other materials are needed in other languages • Ask for agency input on specific pamphlets and other targeted materials for their audience • Utilize agency focus groups to determine if the materials are reaching the intended audience • Submit materials for DHHR approval prior to production • Identify which special populations are served by the agencies and provide targeted flyers/materials based on recommendations from the groups • Encourage partner agencies to promote MHT and provide links to the Project Web site through their consumer newsletters • Identify audience and create DHHR approved MHT articles for inclusion in consumer newsletters		
2.0 Create Deliver Presentations for Targeted Audiences				
2.1	Develop DHHR Approved Training	• Create Power Point presentations and Education Guides on MHT for:		

Task		Strategy	Start Date	Status
	Curriculum	○ Partner agencies ○ Managed Care Organizations ○ DHHR and BMS Staff ○ Molina Health Systems ○ Stakeholders ○ Community Groups and Agency Partners • Include topics on: ○ MHT – MCO and PAAS Enrollment ○ Promoting enrollee choice ○ Enrollee rights and responsibilities ○ Medicaid covered services and benefits ○ Non-MCO covered services ○ MCO options available by county including any change of choice or process ○ Options for enrollment (phone, mail, website, mobile device) ○ Referral resources ○ Expanded populations (when appropriate)		
2.2	Individuals With Special Enrollment Challenges	• Identify: ○ Individuals who are homeless ○ Hard to Reach individuals ○ Individuals unable or unwilling to access information through the local DHHR or community hosted events ○ Language barrier ○ Individuals with other enrollment challenges • Collaborate with agencies who serve the special populations to assess the effectiveness of the MHT enrollment materials • Identify support services they are likely to use		

Task		Strategy	Start Date	Status
		• Utilize feedback from agencies on which counseling strategies and venues will be more effective in reaching their constituents		
2.3	Provide Options for Training Venues	• Promote venue options: o Public Session o DHHR Office o Community meetings o Individual Session o Health Fair		
2.4	Promote Available Training Resources and How to Schedule a Training Session	• Include a reference to available presentations and trainings in communication with agency partners, Community Based Agencies, and other advocacy groups • Offer options for an agency/advocacy group to request a training o Through the Web Portal o By contacting the Call Center o Emailing the request o Notifying the Field Benefits Manager directly		
2.5	Conduct Train the Trainer Sessions	• Prioritize partner agencies • Assess their level of interest in: o Promoting Enrollment Broker services o Providing education on the MHT Program o Assisting enrollees with Web based enrollment as enrollment facilitators • Schedule initial and annual train-the-trainer sessions with interested partner agencies o Who is eligible o Mail, in-person, and web based enrollment options o Enrollment process		

Task		Strategy	Start Date	Status
		○ Other resources • Provide additional training and updates on the MHT program for agency staff as needed • Use fax and email blasts to supplement trainings with CBOs and provide additional notification of program changes • Conduct satisfaction surveys at the conclusion of each session		
3.0 Collaborate with MCOs				
3.1	Identify MCO Liaisons	• Schedule introductory meeting with each MCO ○ Health Plan of the Upper Ohio ○ CoventryCares of West Virginia ○ UniCare • Establish a joint point of contact for the MCOs and AHS staff • Share contact information		
3.2	Establish communication protocol	• Determine frequency of communication/method including in-person meetings, conference call, email, etc. • Participate in joint meetings as directed by DHHR whenever plan options or managed care changes occur • Share calendars for field presentations/events hosted by MCOs/AHS/DHHR • Document and share all meetings/presentations/interactions with the Department • Refer informal enrollee complaints/issues to the MCO		

Task		Strategy	Start Date	Status
		Medicaid Advocate for resolution • Submit monthly MCO Plan Change and Auto-assignment by County reports as directed by DHHR		
3.3	MCO Materials	• Review the Plan Comparison Chart with each MCO to ensure that the benefits and services are accurate and up-to-date • Ensure an adequate inventory of plan specific brochures for inclusion in the enrollment packet • Maintain an adequate inventory of current MCO provider directories for potential enrollees who are requesting a hard copy directory prior to making a choice • Ensure that enrollment packet mailing protocols for each county includes material from all approved MCOs		
3.4	Provide reciprocal training	• Provide reciprocal training on MHT and individual MCO operations and benefits: o Benefits and services offered through each MCO o Role of AHS as Enrollment Broker o Contact and territory information for the Field Benefits Manager o Opportunities to appropriately collaborate on any outreach and educational activities o AHS' role as ombudsman for enrollees		
3.5	Distribute DHHR Approved Materials	• Ensure that AHS has sufficient quantities of the DHHR approved materials supplied by the MCOs • Include approved materials in Enrollment Packets • Distribute pamphlets and Enrollment materials at public		

Task		Strategy	Start Date	Status
		education venues and in-person • Post the approved electronic versions of the materials to the Project website and mobile version • Contact the MCO liaison to re-order pamphlets for inclusion in the Enrollment packets and for distribution in the field as needed		
4.0 Support DHHR and BMS				
4.1	Establish DHHR/BMS Communication Protocol	• Share contact information for AHS key management/ project staff and corporate staff with DHHR/BMS staff assigned to the Enrollment Broker Services Project • Establish protocols for communication including: o Frequency of scheduled implementation and ongoing operational meetings o Meeting agenda, format, and issues log o DHHR preferred method for submitting agenda items, draft materials, work plans, etc. o Format for DHHR approval memos o Names of DHHR staff to be copied on all emails and correspondence • Determine venue for ongoing operational meetings, Task Force Meetings, and other DHHR/BMS events		
4.2	Support DHHR/BMS	• Participate and present MHT and other information as directed by DHHR at the statewide annual provider workshops • Provide training for DHHR/BMS staff on Enrollment Broker Services • At the request of DHHR/BMS, contribute to the content and design of materials as new initiatives are launched		

Task		Strategy	Start Date	Status

		(e.g., Pharmacy Expansion 2013 and Pediatric Dental Services 2014, etc.) including additional populations or services for future managed care enrollment and/or benefits expansion
		• Leverage our field presence:
		  o provide outreach and education to targeted groups including providers, agencies and enrollees and DHHR offices
		  o when new Medicaid managed care initiatives are due to be rolled out
		  o during implementation to ensure that everyone is aware of the change(s)
		• Make available the services of the Project Manager, Field Manager and/or Field Benefits Manager for a provider site visit within one business day upon request for urgent issues
		• Track and report on trends, inquiries, issues received in the field and MHT Call Center from providers, agencies and enrollees for existing programs and new initiatives
		• Present on behalf of DHHR at meetings, conferences and other venues as requested by DHHR, i.e., BCF Supervisors' Conference, etc.
		• Report on any issues, non-approved enrollment activities or materials, or other concerns observed in the field
		• Provide feedback and report on any issues, trends observed or received during field visits with agencies, enrollees, providers, etc		

4.3	Communicate with Local DHHR Offices	• Conduct in person visits at all Local DHHR county offices o Field Benefits Manager establishes contact with the Community Services Managers (CSMs) and		

Task		Strategy	Start Date	Status
		Supervisors at the local DHHR county offices in his/her Region ○ Provides opportunity to communicate (in one location) with workers: ▪ Client Services ▪ Family Support ▪ Social Services • Share contact information and opportunities for training and ongoing support available through the Enrollment Broker • Establish contact and share information with the IPAs stationed at the local DHHR offices • Establish the preferred method for ongoing communication with the local offices, i.e., whether the CMSs/Supervisors prefer an appointment versus a drop in visit, etc. • Provide multiple training options to meet the demands and time constraints at each DHHR county office • Provide Field Benefits Manager phone and email contact information to all DHHR workers		
4.4	Provide Training	• Provide program updates and training through the following opportunities: ○ Routine meetings with CSMs and Supervisors (especially important for areas where CSMs and Supervisors are covering multiple offices) ○ During new worker trainings ○ At monthly meetings or trainings ○ Through email blasts ○ Through webinars upon request by DHHR • Include topics on:		

Task		Strategy	Start Date	Status
		○ MHT – MCO and PAAS Enrollment ○ Promoting enrollee choice ○ Enrollee rights and responsibilities ○ Medicaid covered services and benefits ○ Non-MCO covered services ○ MCO options available by county including any change of choice or process ○ Options for enrollment (phone, mail, website, mobile device) ○ And others as requested • Create tip sheets and other training handouts for DHHR workers • Set up a display table in the county offices during any changes to MHT providing I & R directly to potential enrollees and enrollees • Offer to conduct the West Virginia System of Care Family Centered Practice Trainings (evidence based training focusing on cultural diversity and sensitivity at the local DHHR offices- a required DHHR worker training) • Respond to requests to develop additional MHT Power Points, handouts, and other materials for training		
5.0 Provider Outreach and Education				
5.1	Identify Providers	• Create a Provider Database by county and Region using: ○ Electronic provider files and MCO and PAAS Provider Directories to locate MHT and PAAS PCPs and specialty providers by county and region, including out of state providers in border counties serving our targeted population		

Task		Strategy	Start Date	Status
		○ DHHR provided listing of providers targeted for special outreach initiatives (i.e., dental providers, etc) • Utilize local resources to locate other specialty providers, i.e. behavioral health, substance abuse providers, etc. ○ Information provided at the Regional Summit ○ Shared information from the Service Array Collaboratives ○ DHHR County Offices ○ Family Resource Network Quick Guides ○ Information and Referral Centers ○ Other community agencies and providers • Link the Provider Directory to HealthTrack • Update the Provider Directory with changes as needed		
5.2	Provide Education and Training	• Utilize the provider database to manage and prioritize provider outreach and education ○ Create a site visit rotation to ensure that the MHT and PAAS healthcare providers are visited quarterly ○ Prioritize outreach to high volume providers whenever there are program changes or when directed by DHHR ○ Outreach to specialty providers i.e., pharmacies, behavioral health, etc.) as requested and as time permits during routine county visits ○ Target specialty providers as directed by DHHR • Offer education in a variety of venues ○ Healthcare provider support site visits (drop in or scheduled visits) ○ Annual statewide provider workshops		

Task		Strategy	Start Date	Status
		○ Webinars ○ Fax blast or mailing to communicate program changes ○ One on one at display tables at conferences and events such as: ▪ Office Managers Association of HealthCare Providers Conference ▪ WV Academy of Family Medicine Conference ▪ WV Family Medicine and Sports Medicine Conference ▪ Regional Summits ▪ Family Youth Engagement Skills Trainings ▪ Family Centered Practice Trainings		
5.3	Provider Education Modules	• Provide education (level and scope of training depends on the provider type). Include topics such as: ○ Enrollment Broker roles and responsibilities ○ MHT – MCO and PAAS Enrollment ○ Promoting enrollee choice ○ Enrollee rights and responsibilities ○ Medicaid covered services and benefits ○ Non-MCO covered services ○ MCO options available by county including any change of choice or process ○ Options for enrollment (phone, mail, website, mobile device) ○ Process for referring enrollees who want to change PCP or MCO enrollment to the MHT Call Center		

Task		Strategy	Start Date	Status
		○ MHT Helpline Services ○ Other referral numbers and links to websites for services outside our scope of work (i.e., Molina, Scion, DHHR, MCOs, etc.)		
5.4	Distribute DHHR Approved Materials	• Distribute sample copies of the MHT and PAAS (for Cabell and Wayne County enrollees) Enrollment Packets • Leave a supply of the MHT Brochure and Enrollee Cards for potential enrollees and enrollees to take at the offices • Make available PDF versions of the approved materials on the MountainHealthTrust.com • Distribute other informational tip sheets or guides developed by DHHR and/or the Enrollment Broker		

DRAFT

Letters of Support

Submitted by:
Automated Health Systems

June 25, 2014

Jackson County

Family Resource Network

June 2, 2014

RFP Evaluation Committee
West Virginia Bureau for Medical Services
RFP # BMS 14028

To Whom It May Concern:

The Jackson County Family Resource Network coordinates programs for children and families within Jackson County. Our Mission is:

To serve all the children and families in Jackson County. Through effective communication, the Jackson County FRN will link citizens to needed services, network within the community to involve families, service providers, business and government to educate the community concerning programs available to them.

Automated Health Systems has fit right into this system. As the West Virginia Enrollment Broker for the Medicaid Managed Care Program, they have been very involved within the Jackson County Community and have coordinated their services well within the FRN fold. Their representatives have linked the citizens of the County to those services and networked with the community in a very positive manner.

The Jackson County FRN has just executed a reorganization over the past year and the AHS Outreach Specialist has become engaged with that effort. She not only sat on the reorganization Board but was actively involved with the planning and execution. She regularly attends all sponsored FRN meetings and serves on the FRN Executive Board. The Outreach Specialist has become very involved in all community events and activities. Without that help, the Jackson County FRN would have struggled to gain its effectiveness in the community.

As the Executive Director of the Jackson County FRN, I sincerely hope that we have the opportunity to continuing collaboration with AHS as the Enrollment Broker for the Medicaid Managed Care Program for the State of West Virginia. Their service is vital to Jackson County.

Sincerely,

Greg Fowler
Executive Director, Jackson County FRN, PO Box 641, Ripley, WV 25271

June 2, 2014

RFP Evaluation Committee
West Virginia Bureau for Medical Services
RFP # BMS 14028

To Whom It May Concern:

I am the Director of the Monroe County Early Head Start / Head Start program. We service low income, high risk families and provide services that cover developmental, health, mental health, social services and parent involvement. The families we serve may have children ages birth to four years old. We offer not only center base programs but home base programs as well.

Automated Health Systems (AHS), as the West Virginia Enrollment Broker for the Medicaid Managed Care Program, has supported the mission of our Early Head Start / Head Start program in many ways. A representative has attended our Family Fun Days, Community Baby Showers and our Annual Kiddie Fairs and has shared information about the program to our families. They have gone over and beyond their call of duty to not only provide information, but to truly assist families in the step by step process. A representative is also very involved in our county by attending numerous meetings in order to share their information but to also take information from other programs to families they come in contact with. Such meetings are the Family Resource Network Board meetings and Teaming for Learning with the Community meetings.

I look forward to continuing our collaboration with AHS as the Enrollment Broker for the Medicaid Managed Care Program for the State of West Virginia.

Sincerely,

Jeana Comer Carr

Jeana Comer Carr
Director
Monroe County Early Head Start / Head Start
PO Box 330
Union, WV 24983
(304)772-3284

North Central WV CAA/HS
20 East Main St.
Grafton, WV 26354

Phone: 265-3200
Fax: 265-5037

north central west virginia community action

June 2, 2014

RFP Evaluation Committee
West Virginia Bureau for Medical Services
RFP # BMS 14028

To Whom It May Concern:

North Central West Virginia Community Action Associaltion/Head Start offers early childhood education opportunities and comprehensive services through collaborative partnerships that support children, families, and staff in our communities to meet the challenges of today and the changes of tomorrow. We provide Head Start Preschool services to eighty children in Taylor County; our preschool collaboration with the Taylor County Board of Education services a total of 135-140 children ages 3 or 4 each school year.

Automated Health Systems (AHS), as the West Virginia Enrollment Broker for the Medicaid Managed Care Program, has supported many of the families our organization serves. The AHS Representative has provided education on the Mountain Health Trust Program to the Family Resource Coordinators as they work directly with children and families who may need information on insurance coverage from your organization.

For the past twelve years the Taylor County Collaborative Preschools has conducted a Child Find: Birth-to-Age-Four Screening in the spring. The children are assessed in speech , language, hearing vision, health, nutrition, motor, and concepts. Parents receive information on health care, nutrition, preschool, insurance, community programs for housing, and other family and children's social services in the community. Approximately 140 families attend the two days of screenings each year. The AHS Representative has participated in this community event for the past ten years meeting with numerous parents concerning the Mountain Health Trust Program. The representative is skilled in establishing rapport as she talks with the family and provides information while engaging the children in art or play activities.

Our Head Start is pleased that the services of the AHS Representative have been available and we look forward to continuing the collaboration with AHS as the Enrollment Broker for the Medicaid Managed Care Program for the State of West Virginia.

Sincerely,

Cynthia Steenstra

Cynthia Steenstra
Children's Services Supervisor
NCWVCommunity Action Association/Head Start
Taylor County



Wayne County Family Resource Network, Inc

Date: June 2, 2014

RFP Evaluation Committee
West Virginia Bureau for Medical Services
RFP # BMS 14028

To Whom It May Concern:

Mission Statement: To coordinate and enhance the development and delivery of services for all persons living and/or working in Wayne County. The Wayne FRN provides support and promotes the collaboration of all citizens in Wayne County in order to develop strategies to improve the service delivery system for families. The Wayne Family Resource Network participates in a wide variety of activities aimed at identifying community needs, improving access to services, and mobilizing and evaluating services.

Automated Health Systems (AHS), as the West Virginia Enrollment Broker for the Medicaid Managed Care Program's AHS Outreach and Education Specialist has supported the mission of our organization by

- Providing education on the Mountain Health Trust Program for staff and constituents;
- Engaging in educational programs offered by our organization;
- Attending committee meetings; such as Health and Wellness, Education and etc.
- Participating in community events and activities, including health fairs, monthly Parent Chats, FRN monthly meetings.

The Wayne Family Resource Network looks forward to continuing our collaboration with AHS as the Enrollment Broker for the Medicaid Managed Care Program for the State of West Virginia.

Sincerely yours,
Charity K. Damron

Charity Damron;
Executive Director

PO Box 250
Wayne, WV 25570
Phone :(304)272-6003
Fax: (304) 272-6003
This program is being presented with financial assistance as a grant from the WV Department of Health and Human Resources.

UKVEC

UPPER KANAWHA VALLEY ENTERPRISE COMMUNITY

200 Upper Kanawha Valley Way
Post Office Box 309
Cabin Creek, WV 25035

1-866-27UKVEC
304-595-5991
304 595-5993 Fax
www.ukvec.org

May 29, 2014

RFP Evaluation Committee

West Virginia Bureau for Medical Services
RFP # BMS 14028

To Whom It May Concern:

The Upper Kanawha Valley Starting Points Family Resource Center provides services to families with children from the prenatal stage of life to eighteen years of age through an array of programs with the mission of collaboratively working together with early childhood and family support agencies to meet the unique needs of children and families within our area.

Automated Health Systems (AHS) has supported our work by agreeing to be on the advisory board and making essential decisions about the delivery of our program. More importantly, they have worked with families helping them to understand the choices they have to help them meet their medical needs.

The AHS Outreach and Education Specialist has worked with us to:

- Provide education on the Mountain Health Trust Program for staff and constituents
- Engaged in educational programs offered by our organization
- Attends committee meetings to plan for community activities and events
- Serves as a member of the Starting Points Family Resource Center and Parents as Teachers Advisory Board, Continuous Quality Indicator Team Meetings for our Parents as Teachers (In Home Family Education Program), and is a member of our Partners in Prevention Team
- Provides information to parents, grandparents and caregivers at activities and events such as with our annual Kiddie Health and Information Fall Fest, Baby Safety Showers, Bring a Flower to a Childcare Provider Day, play groups, Circle of Parents Meetings, Bring Your Parent to School Day event and more.
- Shares information regarding funding resources for program sustainability

We value the expertise that the AHS Outreach and Education Specialist has and admire the partnership with Automated Health Systems. We look forward to continuing our collaborative efforts with AHS as the Enrollment Broker for the Medicaid Managed Care Program for the State of West Virginia.

Sincerely,

Diane C. Hughes

Diane Hughes, Director
(304) 993-6919

Family RESOURCE NETWORK

P.O. Box 737
Union, WV 24983

Phone: 304-772-5960
Fax: 304-772-4607
E-mail: monroefrn@frontier.com

Monroe County Coalition for Children & Families, Inc.

May 30, 2014

RFP Evaluation Committee
West Virginia Bureau for Medical Services
FRP # BMS 14028

To Whom It May Concern:

The Monroe Coalition for Children and Families, Inc. was established in 1992 as one of the first five Family Resource Networks in West Virginia. Our mission is to plan, develop, sustain, evaluate, and monitor a comprehensive service system which provides prompt, user-friendly, barrier-free support, prevention and intervention services. Family Resource Networks (FRNs) increase community awareness of local and state issues that affect children and families, support local partnerships to maximize community investments, promote coordination of services, and promote opportunities for families to impact decisions that affect them.

Teresa Long, the AHS Outreach and Education Specialist that has worked extensively with our organization, has been integral in helping us to complete our mission. Some of the specific items Teresa has worked on include:

- Providing education on the Mountain Health Trust Program for staff and constituents;
- Actively engaging in Community Baby Showers and Family Fun Days offered by my organization;
- Attending monthly board meetings; and,
- Participating in the Christmas Giving Program and Kiddie Fair

I look forward to continuing the collaboration with AHS as the Enrollment Broker for the Medicaid Managed Care Program for the State of West Virginia.

Sincerely,

Melissa Hodges

Melissa Hodges
Executive Director

Proud member of the
West Virginia Alliance of Family Resource Networks

Programs of the Monroe County Family Resource Network are supported and presented with financial assistance from the West Virginia Department of Health & Human Resources, Community Connections, United Way of the Greenbrier Valley, Prevent Child Abuse West Virginia, Sister's of St. Joseph Ministry Grants Fund, and individual donations.

Family Resource Network of Mason County

Linking People To Service

May 30, 2014

RFP Evaluation Committee
West Virginia Bureau for Medical Services
RFP # BMS 14028

To Whom It May Concern:

The Mason County Family Resource Network coordinates programs for children and families within Mason County. Our Mission is:

To serve all the children and their families in Mason County. Families are individuals that work together and take the responsibility for and care for one another by protecting, nurturing, supporting and educating. Through effective communication, the Mason County FRN will link citizens to needed services, network with the community to involve families, service providers, business and government.

Automated Health Systems has fit right into this system. As the West Virginia Enrollment Broker for the Medicaid Managed Care Program, they have been very involved within the Mason County Community and have coordinated their services well within the FRN fold. Their representatives have linked the citizens of Mason County to those services and networked with the community in a very positive manner.

The AHS Outreach Specialist has become engaged with educational programs offered by the FRN, they regularly attend all sponsored FRN meetings and serve on the FRN Executive Board. The Outreach Specialist has become very involved in all community events and activities. They help with planning and execution. Without that help, the Mason County FRN would be very deficient in its effectiveness in the community.

As the Executive Director of the Mason County FRN, I sincerely hope that we have the opportunity to continuing collaboration with AHS as the Enrollment Broker for the Medicaid Managed Care Program for the State of West Virginia. Their service is vital to our county.

Sincerely,

Greg Fowler
Executive Director, Mason County FRN

P.O. Box 393 • Point Pleasant, WV 25550 • Phone (304) 593-0072

Family Resource Network
Fayette County, WV
Working together for children and families

nonprofit

Fayette County Family Resource Network
100 Court St / 3rd Floor - PO Box 307
Fayetteville, WV 25840
Office: 304 574 4338 Cell/text: 304 640 0884
Email: fayettefrn@gmail.com
www.fayettefrn.com

June 9, 2014

RFP Evaluation Committee
West Virginia Bureau for Medical Services
RFP # BMS 14028

To Whom It May Concern:

The purpose of the Fayette County Family Resource Network (FRN) is to improve the quality of life through community capacity building; and, to strengthen individuals, families and communities through assessment, education, resource development, interagency coordination, strategic planning, and on-going evaluation.

Automated Health Systems (AHS), as the West Virginia Enrollment Broker for the Medicaid Managed Care Program, has supported the mission of our organization by actively participating in meetings, local fairs and conferences, and interagency coordination.

The AHS Outreach and Education Specialist has worked with our organization to:

- Provide education on the Mountain Health Trust Program for FRN community members;
- Engage in educational programs offered by other FRN organizations;
- Attend community meetings; and,
- Participate in community events and activities, including health fairs, etc.

Also, we have had a very positive relationship with the AHS Outreach and Education Specialist and look forward to continuing our collaboration with AHS as the Enrollment Broker for the Medicaid Managed Care Program for the State of West Virginia.

Sincerely,

Aletha L. Stolar

Aletha L. Stolar
Director

BELINGTON COMMUNITY MEDICAL SERVICES ASSOCIATION, INC.
70 N. Sturmer Street, Belington, West Virginia 26250 (304) 823-2800 FAX: (304) 823-2703

Date: 06/02/2014

RFP Evaluation Committee
West Virginia Bureau for Medical Services
RFP # BMS 14028

To Whom It May Concern:

The Belington Community Medical Services is an FQHC site nestled in a small rural community area and providing services for over forty years to over 6000 active patients. Transportation and work schedules are huge barriers for many of our patients. By providing multiple services such as well and sick visits, Health Checks and Immunizations, DOT, laboratory, behavioral health, diabetic eye exams, women's health, utilizing mobile mammography unit, house calls, and expanded hours for evening and Saturday convenience.

As we all know, patient education and outreach is an important piece to any practice. We have limited staffing and often find it hard to get to events or meetings for updates. Over the past ten years, having Outreach and Education Specialist Marjorie Burdrick, has proven to be most effective to our practice by:

- Offering on-site assistance and providing ongoing education on the Mountain Health Trust Program;
- Explaining program policy changes and program updates regarding Medicaid Managed Care;
- Promoting attendance at provider workshops and webinars;
- Providing links and contact information to additional provider and patient resources;
- Updating staff on MCO plan changes and patient options within their geographic service area;
- Promoting program through community events.

We value the outreach and education these specialists are able to provide. We look forward to working with AHS as the Enrollment Broker for the Medicaid Managed Care Program for the State of West Virginia. This is certainly an opportunity that is a win-win situation for all those involved.

Sincerely,

Debbie Schoonover
COO
Belington Community Medical Services Association, Inc.
70 N Sturmer Street
Belington, WV 26250

Kingwood Family Dental
430 Morgantown St
Kingwood, WV 26537
304-329-3142
304-329-0700

June 2, 2014

Automated Health Systems
Attn: Staci – RFP
405 Capitol St, Suite 406
Charleston, WV 25301

RFP Evaluation Committee
West Virginia Bureau for Medical Services
RFP#BMS 14028

To Whom It May Concern:

We are writing to you concerning Medicaid's Managed Care Program and the Outreach & Education Specialist. The Outreach and Education Specialist in our area is Marjorie Burdick.

Our dental office is located in a rural county where many of our patients are children who are covered by Medicaid. Marjorie visited our office to let us know of the implementation and transition of the West Virginia Children's Medicaid Dental Program from traditional Medicaid billing to Scion. She was very helpful in answering any questions our office had during the initial switch in billing. She is very knowledgeable of the Medicaid Dental Program and is up to date with any changes.

We value the visits from the Outreach and Educator and look forward to working with AHS as the Enrollment Broker for the Medicaid Managed Care Program.

Sincerely,
Christine L Dearth

Christine L. Dearth DDS
Kingwood Family Dental

Regional Family Resource Network

Empowering communities in Boone, Kanawha, and Putnam Counties

May 30, 2014

RFP Evaluation Committee
West Virginia Bureau for Medical Services
RFP # BMS 14028

To Whom It May Concern:

On behalf of the Regional Family Resource Network, which covers Boone, Kanawha, and Putnam Counties, I would like to express support for Automated Health System's renewed contract as West Virginia's enrollment broker for the state's Medicaid program.

The mission of the Regional Family Resource Network is to facilitate a system of prevention, education, and early intervention activities aimed at enabling families, children, and their communities to reach their fullest potential through community-based planning activities. Although the RFRN does not provide direct services, we enable those who do provide direct services to do so more effectively by facilitating assessment, planning, coordination, and information sharing among our collaborative partners.

Automated Health Systems staff persons, Debbie Hon (Outreach and Education Supervisor) along with others, have truly been collaborative partners in the Regional Family Resource Network. They are actively involved in task teams, committees, and coalitions in Boone, Kanawha, and Putnam Counties, contributing their expertise and as well as learning from others ways to reach out to Medicaid customers. They are always available to become involved in outreach events throughout our three counties to help West Virginia Medicaid customers choose their health provider.

I look forward to continued collaboration with Automated Health Systems and hope that their new contract as West Virginia's enrollment broker for Medicaid will be accepted.

Sincerely,

Michele Bowles
Director,
Regional Family Resource Network

1701 Fifth Avenue • STE 18 • Charleston, West Virginia 25387-1900
Phone 304-414-4470 • Fax 304-414-4410 • www.regionalfrn.org

Marshall County Schools
Parent Educator Resource Center
162 Middle Grave Creek Road
Moundsville, WV 26041
304-843-4457

Susie Baker
psbaker@access.k12.wv.us

Cathy Givens
cgivens@access.k12.wv.us

RFP Evaluation Committee
West Virginia Bureau for Medical Services
RFP # BMS 14028

Dear Evaluation Committee:

I am writing to show our support to John Buzzard of Automated Health Systems, Inc. and his company's proposal to continue providing their services to the West Virginia Department of Human Resources. I have been working with the Parent Educator Resource Center for Marshall County Schools in West Virginia for the past 20 years. Our centers mission is: *To empower families and educators through information, support and training in order to make informed choices regarding the children in their care and to network families with community resources and services.* For the past 14 years our center has organized and held a Back to School Fun Fair for our school district. During the Back to School Fund Fair students attend accompanied by parent or guardian and receive a back pack along with variety of school supplies free. The Back to School Fun Fair also provides an opportunity for a free a haircut, screenings for dental, vision and scoliosis along with information from various agencies that serve children and families in our community. Each of the fourteen years, Mr. Buzzard has attended the Back to School Fun Fair providing information about Medicaid Managed Care Program for the State of West Virginia. During the Back to School Fun Fair, Mr. Buzzard has had the opportunity to address families of 800 to 1000 students. Besides this one day event, Mr. Buzzard has always encouraged our center to contact him with any questions we may encounter as our center continues to provide information and support to children and families.

The Parent Educator Resource Center looks forward to our continued partnership with Automated Health System as we both try to enhance the daily lives of children and families not only in Marshall County but the State of West Virginia.

Sincerely,

Susie Baker

Susie Baker,
Parent Educator Resource Center

cc: file

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Taylor County Preschool Collaboration
20 East Main Street
Grafton, West Virginia 26354

May 28, 2014

Marjorie Burdick
Automated Health Systems, Inc.
405 Capitol Street
Charleston, WV 25301

Dear Marjorie,

The Taylor County Collaborative Preschool Core Committee thanks you for your participation in the successful Child -Find, Birth-to-Four Screenings on May 8 & 9, 2014. 134 children and their families participated in the vision, hearing, speech, language, motor, concepts, health, and nutrition screenings. Your services to families and children in our Taylor County Community are appreciated.

Sincerely,

Cynthia Steenstra

Cynthia Steenstra
NCWVCAA/Head Start Children's Services Supervisor

Working together for area families

Brooke Hancock
Family Resource Network

RFP Evaluation Committee
West Virginia Bureau for Medical Sesrvices
RFP # BMS 14028

To Whom It May Concern:

The mission of the Brooke Hancock Family Resource Network is to create a Network of advocates committed to developing grassroots movements to mobilize, engage, and empower the community for positive change.

We have a monthly meeting in which community members and agencies bring information and updates to share. We are grateful that Automated Health Systems is able to regularly attend these meetings. They bring information and materials to share with the group and are always ready and willing to stay to help individuals with specific questions.

We look forward to a growing and continuing relations with AHS as the Enrollment Broker for the Medicaid Managed Care Program for the State of West Virginia.

Sincerely,

Luann M Decker

Luann M. Decker
Executive Director

371 New York Blvd., Weirton, WV 26062-3227 – PHONE: (304) 748-7850 FAX: (304) 224-1267
www.brookehancockfrn.org

Job Descriptions

Submitted by:
Automated Health Systems

June 25, 2014

Job Title: Project Manager
Dept: West Virginia Enrollment Broker Services Project
Reports To: Chief Executive Officer

FLSA Status: Exempt
Supervises: Yes

Approved By:_____

GENERAL FUNCTION:

The Project Manager provides leadership in building and maintaining an effective organizational team, and bears ultimate responsibility for the execution of the Project. This position combines human, financial, and physical resources to successfully operate the Mountain Health Trust (MHT) Project, the primary goal of which is to maximize the voluntary enrollment of Medicaid consumers into managed care (i.e., MHT or the Physician Assured Access System, PAAS). S/he is responsible for overseeing community outreach efforts, and implementing services to support future managed care enrollment and/or benefit expansion at the State's direction. The Project Manager establishes a close relationship with the Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS), and MCO contact persons. This position, based in the Charleston-area Project office, reports to AHS' Chief Executive Officer and is 100% dedicated to the Project.

MAJOR DUTIES AND RESPONSIBILITIES:

- Oversees the Charleston-area office, and in close coordination with other key staff, ensures all Project functions comply with the terms of this contract;
- Establishes policies and procedures for assuring optimal and timely adherence to all MHT Project administrative and reporting requirements;
- Refines and carries out strategic plan for the implementation and execution phases of the Project in conjunction with both DHHR/BMS and AHS Corporate staff;
- Works with AHS corporate staff to sustain a system of accountability and ongoing evaluation, as reflected in internal reporting systems, personnel manuals, and corporate policy;
- Coordinates with AHS corporate financial staff regarding monthly, quarterly and annually forecasted expenditures; responsible for operating the Project within fiscal constraints;
- Coordinates and assists AHS' Director of Human Resources, Training and Development in developing systems for recruiting, staffing (in terms of number, type and location), and optimally training and orienting Project employees to their tasks;
- Supervises and guides all Project training and ensures its relevance to the unique needs of the consumer population; ensures the maintenance and update of the Training Manual;

- Monitors, supervises, and evaluates the work of the Project key staff (i.e., Call Center Supervisor and Field Supervisor); establishes and communicates the Quality Assurance (QA) Plan as the overarching programmatic goal; tracks and reports results;

- Generates monthly, and annual Project written reports of both a qualitative and quantitative nature for internal monitoring and for BMS monitors reports and alerts DHHR/BMS to discrepancies;

- Assists AHS' corporate and Project staff in creating user-friendly, literacy appropriate (i.e., no higher than 6th grade reading level), culturally sensitive, and informative materials in English, Spanish and any other language needed for targeted audiences;

- Maintains and continues an on-going "partnership" with DHHR/BMS; facilitates all DHHR/BMS and Project interface and ensures that DHHR/BMS has ready access to pertinent Project staff, work processes and information; provides oversight for instruction and training of State staff about the Project;

- Dialogues and establishes linkages with relevant stakeholders to provide a broad range of enrollee, community partner and provider input to and support of the Project;

- Anticipates and plans for any future managed care enrollment and benefit expansions as directed by DHHR/BMS; seamlessly integrates any Medicaid managed care policy and program changes to ensure timely rollout;

- Creates and maintains harmonious involvement with the MCOs; monitors and reviews MCO informational materials and keeps the MCOs abreast of Project community promotional activities;

- Offers the expertise and support of the Field Supervisor to the MCOs interested in enhancing their staff's knowledge of MHT/PAAS, the MHT Project and cultural competencies; provides oversight of Project community promotional activities, ensuring necessary coverage;

- Participates with DHHR/BMS in the maintenance of the MCO Task Force and PAAS Advisory Council as broad-based consensus building and problem solving bodies; develops a network of individual and group stakeholders involved in the planning and execution of MHT/PAAS (i.e., Task Force, Advisory Council, MCOs, and other health and human services organizations);

- Serves as chief spokesperson for AHS and represents the MHT Project in major community meetings and promotional activities; attends statewide, regional and national meetings and conferences to disseminate MHT Project information; and

- Assists with assigned projects and performs related duties as required.

"The intent of this job description is to provide a representative summary of the major duties and responsibilities performed by the incumbent of this job. Incumbent may be required to perform job-related tasks other than those specifically presented in this description."

COMMUNICATION WITH OTHERS:

Internal - Regular contact with office staff. Frequent contact with the Call Center Supervisor and Field Supervisor. Maintains regular contact with the corporate office Executive Staff.

External - Maintains regular contact with Department liaison and MCO contact persons.

WORKING CONDITIONS:

Excellent working conditions in an office environment. Occasional travel is required.

SPECIFICATIONS:

Knowledge - Bachelor's degree in Public Health, Education or related field required; Master's Degree preferred. Knowledge of the principles and methods of public program management and health care administration. Requires thorough understanding of Department policies, Medicaid programs, MHT/PAAS and the MHT Project.

Skills/Abilities - Must possess excellent interpersonal communication skills - verbal and written, as well as presentation, cultural competence and interviewing skills. Familiarity with West Virginia Medicaid regulations and trends in Medicaid and health care policy and issues; must be able to assess and evaluate Project components and set policy which will facilitate the attainment of the Project goals and objectives. Must be able to evaluate and monitor Project for compliance with outreach, education, and enrollment objectives, and set policy which facilitates the attainment of Project goals. Must possess a demonstrated awareness of key stakeholders and be able to communicate effectively with them, mobilize and sustain their support of MHT/PAAS and the MHT Project. Must have the ability to work well under pressure with ease and professionalism. Strong organizational and computer skills required.

Experience - Minimum of seven to ten years' management experience, including operational, administrative, and budget management. Minimum of three years' experience with public assistance programs, Medicaid, or the health care industry.

Physical Requirements - Some travel required. Light work - some lifting, bending, reaching, squatting, and kneeling are required occasionally.

"The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions of this job."

Job Title: Field Supervisor
Dept: West Virginia Enrollment Broker Services Project
Reports to: Project Manager

FLSA Status: Exempt
Supervises: Yes

Approved By:_____

GENERAL FUNCTION:

The Field Supervisor supplements the activities of the Project Manager in developing and maintaining an organizational climate that facilitates attainment of the Mountain Health Trust (MHT) Project's goals and objectives. This position provides oversight for staff that are responsible for informing and educating agencies/potential enrollees and enrollees through broad-based promotional and outreach efforts about West Virginia's Medicaid Managed Care Programs, specifically the Mountain Health Trust (MHT) and Physician Assured Access System (PAAS) Programs, and facilitating voluntary enrollment into MHT/PAAS. The Field Supervisor is also responsible for working with additional populations, including Medicaid expansion, and/or services for future managed care enrollment and/or benefit expansion at the State's direction. This position also responsible for ensuring maximum levels among Medicaid potential enrollees and enrollees of voluntary enrollment in participating MCOs or PAAS PCPs. This traveling position, reports to the Project Manager, and is devoted 100% to the contract.

MAJOR DUTIES AND RESPONSIBILITIES:

- Oversees the activities related to the maintenance of a comprehensive initial orientation and on-going training program for the Field Benefits Managers;
- Supervises efforts of the Field Benefits Managers and ensures that all Field Benefits Managers are properly trained and provide accurate and unbiased MHT/PAAS and Enrollment Broker Services information;
- Routinely meets with the Project Manager to discuss Field Benefits Managers' efforts with key groups, agency participation and overall compliance with BMS objectives for MHT/PAAS and the MHT Project;
- Develops and maintains an on-going relationship with the Community Service Managers in the county eligibility offices;
- Monitors field staff to evaluate their activities, assesses their achievements and develops strategies to enhance their performance;
- Reviews all information pertaining to field-related Project activities and generates reports as appropriate; makes recommendations to the Project Manager; assists in implementing appropriate action when indicated to enhance Project objectives; and generates written reports of a qualitative and quantitative nature;

- Identifies and recruits relevant health and human service agencies and community groups as resources for outreach and enrollment activities; delivers group presentations;
- Works with the Field Benefits Managers to ensure Project training for BMS/DHHR personnel, MCOs, and allied agency staff, and provides follow-through as appropriate;
- Provides cultural competency in-service training for interested health and human service providers (including interested MCOs);
- Provides technical support to agencies and groups for the development among their paid or volunteer staff of "change agents" to promote knowledge about MHT/PAAS and the MHT Project, informed decision making concerning healthy behaviors, appropriate use of managed care and other health care services;
- Contributes to the updating of MHT Project materials and manuals in conjunction with the Project Manager, BMS, and the MCOs;
- Ensures that all field staff are informed of changes in policy regarding MHT/PAAS and the MHT Project; and
- Assists with assigned projects and perform related duties as required.

The intent of this job description is to provide a representative summary of the major duties and responsibilities performed by the incumbent of this job. Incumbent may be required to perform job-related tasks other than those specifically presented in this description.

COMMUNICATION WITH OTHERS:

Internal - Daily contact with on-site and field staff. Frequent contact with Project Manager.

External - Contact with MCOs, allied agencies and BMS as necessary.

WORKING CONDITIONS:

Excellent working conditions in an office environment. Extensive travel required.

SPECIFICATIONS:

Knowledge - Bachelor's Degree in related field required. Requires thorough understanding of BMS policies, Medicaid, MHT, and PAAS. A thorough understanding of state and federal guidelines for managed care as well as current health care delivery issues is also required.

Skills/Abilities - Must possess excellent communication skills – verbal and written, as well as presentation and interviewing skills. Familiarity with Medicaid regulations and trends in health care policy, issues, and financing. Must be able to evaluate and monitor Project for compliance with outreach and enrollment objectives. Ability to understand, plan and evaluate Project outreach and enrollment strategies is essential. Must possess a demonstrated awareness of key stakeholders and be able to communicate effectively with them, mobilize and sustain their support of MHT/PAAS and the MHT Project. Must have the ability to work well under pressure and relate well to a broad range of potential enrollees and enrollees. Strong organizational and PC skills (i.e., Microsoft Office) required. Must possess the ability to perform several tasks concurrently with ease and professionalism.

Experience - Minimum of one to two years' supervisory/leadership experience in the public health or social service sector. Experience/education in working with potential enrollees and enrollees, including working with special populations. Background or training in health care related field required.

Physical Requirements - Light work-some lifting, bending, reaching, squatting and kneeling are required occasionally. Occasional lifting of supplies for transport between offices and to/from presentations.

"The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions of this job."

Job Title: Call Center Supervisor
Dept: West Virginia Enrollment Broker Services Project
Reports To: Project Manager

FLSA Status: Exempt
Supervises: Yes

Approved By:_____

GENERAL FUNCTION:

The Call Center Supervisor is responsible for monitoring ongoing Call Center activity, mentoring new employees, assisting in the development and facilitation of employee trainings, and also informing and educating potential enrollees and enrollees about the Mountain Health Trust (MHT) and Physician Assured Access System (PAAS) Programs and enrolling them into the participating MCO or PCP of their choice. The Call Center Supervisor answers enrollment questions for the MHT and PAAS Programs from potential enrollees/enrollees, providers and the general community; makes appropriate referrals for calls received outside the scope of Medicaid managed care; documents all call activities; and obtains enrollment/plan change information from enrollees and enters into the State's MMIS and/or the Project's database (i.e., HealthTrack). This position, based in the Charleston-area office, reports to the Project Manager and 100% of his/her time is devoted to the contract.

MAJOR DUTIES AND RESPONSIBILITIES:

- Assists with the hiring, training and oversight of Call Center Benefit Manager staff who:
    1. Use excellent customer service techniques to provide callers with information pertaining to West Virginia Medicaid,
    2. Assist potential enrollees/enrollees in selecting a "best fit" MCO or PAAS PCP in an efficient, courteous and unbiased manner,
    3. Assist consumers with special communication needs with empathy and compassion,
    4. Promote appropriate utilization of Medicaid services with enthusiasm, and
    5. Have the ability to use multiple computer systems to access and input data, and quickly learn the accurate program information.

- Works closely with the Project Manager to ensure Call Center Benefits Managers receive on-going training; assists the Project Manager in the design and implementation of on-going staff development activities;

- Carries out monitoring, evaluation, and feedback functions; monitors through direct observation and telephone call monitoring and use of ProxyPro to monitor computer use; manages performance of the Call Center Benefits Managers through on-going evaluation and periodic reviews;

- Meets with the Project Manager to discuss Call Center achievements and Call Center Benefits Managers' performance; and evaluates the overall performance of the Call Center;

- Generates written reports of both a qualitative and quantitative nature; and also generates telephone activity reports, provides data analysis, assists with technical reporting and operates the phone system under the direction of the Project Manager;

- Monitors and alters staffing to meet call flow demand;

- Ensures operations equipment and electronic support information is available to the Call Center Benefits Managers at all times;

- Updates State's system and/or Project database with enrollment/change data received from enrollees via daily mail and Call Center; reviews appropriateness of data, outreaching potential enrollees and enrollees when necessary;

- Receives and processes newborn enrollments, researching and referring to appropriate agency newborns not appearing on screens;

- Investigates discrepancies in data; researches and evaluates possible solutions;

- Receives and records all potential enrollee and enrollee complaints;

- Researches enrollments for MCOs and State agencies;

- Alerts management to developing trends noted in interacting with potential enrollees and enrollees;

- Keeps up to date on current issues/changes related to the MHT Project and enrollment issues through research, educational opportunities, training and assisting management as requested;

- Ensures appropriate use of bilingual Call Center Benefits Managers, the Language Line and Telecommunications Text Telephone Typewriter (TTY) and/or West Virginia Telecommunication Relay Service;

- As a working Supervisor, performs all duties of a Call Center Benefits Manager; and

- Assists with assigned projects and performs related duties as required.

"The intent of this job description is to provide a representative summary of the major duties and responsibilities performed by the incumbent of this job. Incumbent may be required to perform job related tasks other than those specifically presented in this description."

COMMUNICATION WITH OTHERS:

Internal – Daily contact with the Call Center Benefits Managers. Frequent contact with the Project Manager.

External – Daily contact with wide range of callers. In the absence of the Project Manager and Field Supervisor, communicates with State, MCOs and providers.

WORKING CONDITIONS:

Excellent working conditions in an office environment.

SPECIFICATIONS:

Knowledge – High School Diploma/GED Certificate required; Associate's Degree in related field preferred. Requires thorough understanding of Department policies, Medicaid programs, MHT, PAAS, and the MHT Project.

Skills/Abilities – Multi-task oriented individual able to assess situations quickly; problem-solver. Strong ability to be self-directed and to motivate, coordinate, and direct on-going team effort. Must acquire sufficient knowledge of Medicaid and other available services for low-income populations to effectively supervise the Call Center. Must possess excellent communication (verbal and written) and organizational skills; experience in data collection and techniques; an ability to work well under pressure and perform several tasks concurrently with ease and professionalism; an ability to evaluate and monitor project staff for compliance with informational, referral and intervention objectives; and an ability to handle sensitive/confidential inquiries from the general public. Must be capable of relating to a broad range of customers and maintain understanding of and sensitivity to special health care issues and requirements. Strong PC skills required.

Experience – Position requires three years' experience in a direct supervisory position with a strong customer service background. Also minimum of two years' experience with health and human services preferred.

Physical Requirements – Light work - some lifting, reaching, squatting, and kneeling is required occasionally.

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Job Title:	**Field Benefits Manager**	**FLSA Status:**	**Exempt**
Dept:	**West Virginia Enrollment Broker Services Project**	**Supervises:**	**No**
Reports To:	**Field Supervisor**	**Approved By:**	_____

GENERAL FUNCTION:

Within an assigned region, the Field Benefits Manager is responsible for informing and educating agencies/potential enrollees and enrollees about West Virginia's Managed Care Medicaid Programs, specifically Mountain Health Trust (MHT) and the Physician Assured Access System (PAAS) programs. She/he is responsible for facilitating voluntary enrollment into MHT/PAAS, educating potential enrollees and enrollees/providers/agencies and introducing other new initiatives at the State's direction, including Medicaid expansion and other managed care program expansions. As such, forges relationships with the traditional and non-traditional agencies throughout the State to promote and extend the MHT Project education and enrollment activities. Conducting outreach and educational presentations in communities is an essential function. Maintains logs of all enrollee interactions in the State's MMIS and/or the Project database (i.e., HealthTrack). This highly mobile traveling position, reports to the Field Supervisor and 100% of his/her time will be devoted to the contract.

MAJOR DUTIES AND RESPONSIBILITIES:

- Paralleling the work of the Call Center Benefits Manager, assists potential enrollee and enrollees in community-based sites (i.e., eligibility offices or other community locations) eligible for participation in MHT/PAAS to promote voluntary enrollment into the MCO or PAAS PCP of their choice, taking into account each individual's health care needs; documents all potential enrollee and enrollee interviews in the Project database (i.e., HealthTrack) and presentation activities; makes appropriate referrals;

- Conducts outreach and education to providers, agencies (including DHHR offices) and potential enrollees/enrollees throughout an assigned region;

- Forms partnerships with community agencies to enhance voluntary enrollment into MHT/PAAS Programs and recruits these agencies as sites and sponsors for group presentations; maintains good relations with partners and seeks opportunities to establish new relationships; represents AHS in the community and identifies areas for potential future involvement;

- Identifies community agencies with a high volume of Medicaid potential enrollees and enrollees, heavy enrollee utilization, home-visiting activities, and/or expertise with enrollees with special needs and networks with these agencies; identifies their willingness to optimize enrollee understanding and use of managed care options;

- Contributes to the development and maintenance of a statewide database with agency/contact network information;

- Receives and refers all complaints from potential enrollees/enrollees to the Project Manager and/or Field Supervisor;

- Maintains high quality consumer service standards (i.e., treats and handles all contacts and interactions with respect and dignity, listens creatively, handles all written and oral information confidentially and effectively manages contacts);

- Attends all scheduled meetings/trainings and statewide annual Provider Workshops; attends and presents at conferences (i.e., setting up and working display tables); keeps up-to-date on current issues/changes related to MHT/PAAS and managed care program expansion;

- Communicates regularly with the Field Supervisor to keep her informed of his/her field activities;

- Meets or exceeds the expected minimum field visit schedule to ensure adequate coverage for all counties within the designated region;

- Remains highly mobile to travel outside of his/her region to provide statewide assistance as needed; and

- Assists with assigned projects and performs related duties as required.

"The intent of this job description is to provide a representative summary of the major duties and responsibilities performed by the incumbent of this job. Incumbent may be required to perform job-related tasks other than those specifically presented in this description."

COMMUNICATION WITH OTHERS:

Internal - Responds daily to communication and relays information needed to the Field Supervisor. If the Field Supervisor is unavailable, either leaves message or confers with Project Manager.

External - Heavy daily contact with providers, agencies and potential enrollees and enrollees. The Field Benefits Manager, in forming partnerships with community agencies, has contact on a regular basis with these agencies in order to schedule educational activities for agency staff and potential enrollees and enrollees regarding MHT/PAAS Programs. Other issues should be directed to management.

WORKING CONDITIONS:

Extensive travel required. This position is responsible for regional coverage and the provision of state-wide assistance as needed.

SPECIFICATIONS:

Knowledge - Bachelor's Degree in health care or related field and/or equivalent experience required. Requires thorough understanding of Department policies, Medicaid and MHT/ PAAS.

Skills/Abilities - Must possess excellent interpersonal communication skills – verbal and written, as well as presentation and interviewing skills. Must have the ability to work well under pressure and relate to a broad range of potential enrollees and enrollees, maintaining cultural sensitivity. Advanced computer skills (i.e., Microsoft Word, Excel, and PowerPoint) required. Must possess the ability to perform several tasks concurrently with ease and professionalism as well as the ability to problem solve, organize, work independently, and manage time.

Experience - Minimum of two years' experience in health or human services with consumer contact and familiarity with computer systems. Experience/education in working with potential enrollees and enrollees, including working with special populations. Background or training in health care related field preferred.

Physical Requirements – Extensive travel; Light work-some lifting, bending, reaching, squatting and kneeling are required occasionally. Occasional lifting of supplies for transport between offices and to/from presentations.

"The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions of this job."

Job Title:	**Call Center Benefits Manager**	**FLSA Status: Non-exempt**
Dept:	**West Virginia Enrollment Broker Services Project**	**Supervises: No**
Reports To:	**Call Center Supervisor**	**Approved By:_____**

GENERAL FUNCTION:

The Call Center Benefits Manager is responsible for answering enrollment questions for the Mountain Health Trust (MHT) and Physician Assured Access Services (PAAS) Programs from potential enrollees/enrollees, providers and the general community. This position informs and educates potential enrollees and enrollees in an impartial manner about MHT/PAAS and enrolling them into the participating MCO or PAAS PCP of their choice. The Call Center Benefits Manager maintains logs of all activities; obtains enrollment/plan change information from enrollees and enters into the State's MMIS and the Project database (i.e., HealthTrack); and makes appropriate referrals for calls received outside the scope of Medicaid managed care. This position, based in the Charleston-area office, reports to the Call Center Supervisor and 100% of his/her time is devoted to the contract.

MAJOR DUTIES AND RESPONSIBILITIES:

- Via the toll-free 1-800-449-8466 line, interviews and outreaches potential enrollees and enrollees eligible for participation in MHT/PAAS to promote voluntary enrollment into the MCO or PAAS PCP of their choice; documents all interactions in the Project's database (i.e., HealthTrack);

- Answers enrollment questions from potential enrollees/enrollees, providers and the general community;

- Performs education, potential enrollee and enrollee choice counseling, and enrollment activities and provides guidance in an impartial manner on how potential enrollees and enrollees may best utilize available services:
  1. Informs potential enrollees and enrollees about the benefits of MHT/PAAS via an unbiased presentation of all enrollee options.
  2. Explains the options available depending on place of residence.
  3. Provides specific information on MCO and PAAS provider networks.
  4. Completes the Health Needs Assessment and assesses any unique healthcare needs to ensure appropriate enrollment.
  5. Determines whether the potential enrollee or enrollee has a current provider/PCP/MCO to maintain existing enrollee/provider relationships.
  6. Processes exemption requests using BMS developed criteria.
  7. Enrolls eligible enrollees into the participating MCO/PAAS PCP of their choice.
  8. Assists enrollees in transferring from one MCO to another, from an MCO to PAAS, from PAAS to an MCO and from one PAAS PCP to another.
  9. Collects TPL information during enrollment, documents information, tracks and reports all forms of TPL to assist State in recovery of primary liability monies.

10. Disenrolls enrollees who are no longer eligible.
11. Refers calls related to EPSDT, family planning services and other non-enrollment issues to the appropriate resource.
12. Documents reasons for changes in MCO and/or PAAS enrollment and including change information in month reports to BMS;

- Triages enrollee calls to the appropriate helplines, (i.e., the MCO Advocate, DHHR offices, etc.), when necessary, to resolve complaints and acts as troubleshooter and enrollee "ombudsman" for enrollees in the program;

- Conducts newborn enrollments for MHT/PAAS; processes newborn enrollments forms, researching and assigning to the appropriate MCO; also, referring to appropriate state agency any newborn forms with eligibility date issues for resolution; coordinates newborn enrollment process between DHHR, AHS and the MCOs;

- Continuously monitors exemption codes and rate code changes to ensure the enrollee is eligible for enrollment;

- Utilizes HealthTrack to document all Call Center activities, including all contacts, inquiries, enrollments, enrollment changes; TPL information, complaints, referrals and other Call Center services;

- Provides navigation support for potential enrollees and enrollees who are using the provider search or online enrollment features on the mountainhealthtrust.com website;

- Accesses MMIS and RAPIDS to determine eligibility for enrollment. Updates MMIS with enrollment/change data received from enrollees via daily mail, Call Center and online; reviews appropriateness of data, outreaching potential enrollees and enrollees when necessary;

- Investigates discrepancies in data; researches and evaluates possible solutions; notifies the Call Center Supervisor on all data discrepancies for tracking and reporting;

- Receives and refers all complaints from potential enrollees and enrollees to the Call Center Supervisor;

- Researches enrollments for MCOs and State agencies;

- Alerts management to developing trends noted in interacting with potential enrollees and enrollees;

- Maintains high quality consumer service standards (i.e., treats and handles all calls and consumer interactions with respect and dignity, listens creatively, handles all information confidentially, and effectively manages callers);

- Participates in all quality assurance activities; attends all scheduled meetings/trainings, prepares assigned presentations and assists in the training of new employees;

- Keeps up-to-date on current issues/changes related to MHT/PAAS, the MHT Project and enrollment issues through research, educational opportunities, and assisting management as requested; and

- Assists with assigned projects and performs related duties as required.

"The intent of this job description is to provide a representative summary of the major duties and responsibilities performed by the incumbent of this job. Incumbent may be required to perform job-related tasks other than those specifically presented in this description."

COMMUNICATION WITH OTHERS:

Internal - Responds daily to communication and relays information needed to the Call Center Supervisor. If the Call Center Supervisor is unavailable, either confers with Field Supervisor or Project Manager.

External - Daily contact with consumers via the Call Center. Frequent contact with community-based agencies.

WORKING CONDITIONS:

Excellent working conditions in an office environment.

SPECIFICATIONS:

Knowledge – High School Diploma/GED Certificate required; Associate's Degree preferred. Requires thorough understanding of Department policies, Medicaid programs, MHT/PAAS and the Enrollment Broker Services Project.

Skills/Abilities - Excellent interpersonal communication skills (verbal and written) and a professional phone manner. Demonstrated ability to handle sensitive inquiries from the general public; ability to work well under pressure and relate to a broad range of potential enrollees and enrollees, maintaining cultural sensitivity as well as an understanding of health literacy. Strong organizational and computer skills required.

Experience - Minimum of two years' experience in health or human services with consumer contact and familiarity with computer systems. Experience/education in working with consumers, including working with special needs populations and/or families of special needs children. Background or training in health care related field/managed care industry.

Physical Requirements - Sedentary work – bending, reaching, squatting and kneeling are required occasionally.

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Job Title:	**Administrative Assistant**	**FLSA Status:**	**Non-exempt**
Dept:	**West Virginia Enrollment Broker Services Project**	**Supervises:**	**No**
Reports To:	**Project Manager**	**Approved By:**	_____

GENERAL FUNCTION:

The Administrative Assistant is responsible for assuring the smooth operation of daily office activities. The primary function is to provide administrative, organizational and technical support to the Project management, call center and field staff. S/he assists in the compilation of reports (i.e., tracking the receipt of required data, organizing materials, and final editing and assembling of reports). The Administrative Assistant is also cross-trained to function as a Call Center Benefits Manager during periods of excessive call volume. This position, based in the Charleston-area office, reports to the Project Manager and 100% of his/her time is devoted to the contract.

MAJOR DUTIES AND RESPONSIBILITIES:

- Provides administrative and organizational support to the Project Manager for all contract responsibilities; assists with the compilation of Project reports;
- Maintains confidentiality in the performance of duties, holding in confidence all medical, social, consumer or other company business information; adheres to all corporate policies in terms of attendance, professionalism and appropriate use of company property;
- Purchases and maintains an inventory of all supplies necessary for the operation of the Project;
- Assists the Project Manager with the coordination of recruitment activities according to policies designed for the Project; maintains contact with the Corporate Human Resources Department regarding recruitment activities;
- Transmits all payroll data on a weekly basis; prepares and submits all payroll information including employees' W-4's, I-9's and all relevant information to the Corporate office;
- Assists AHS' Payroll and Benefits Manager to provide new and existing employee benefit information (i.e., health insurance, life insurance, 401(k) plan), ensuring timely responses to benefits questions/concerns;
- Answers and screens non-Call Center telephone calls quickly and efficiently; routes them to the appropriate parties; transfers telephone and facsimile messages accurately and promptly; maintains logs of all activity;
- Serves as liaison between office, field-based staff and Corporate office relaying information and messages;

- Establishes, updates and maintains a current filing system for all Project correspondence;
- Updates computerized tracking system upon completion of follow-up assignments and ensures that follow-through occurs in a timely manner;
- Verifies and mails individual enrollment packets as requested; tracks and reports on returned mail;
- Researches accuracy of potential enrollee and enrollee contact information; provides relevant updates as appropriate;
- Promotes the appropriate utilization of Mountain Health Trust and Provider Assured Access System (PAAS) services; updates tracking system with data on outreach and enrollment activities;
- Assists with employee activities (i.e., Employee Wellness, Corporate Health Challenge Program, Project meetings, etc.);
- As necessary, functions as a Call Center Benefits Manager; and
- Assists with assigned projects and performs related duties as required.

"The intent of this job description is to provide a representative summary of the major duties and responsibilities performed by the incumbent of this job. Incumbent may be required to perform job-related tasks other than those specifically presented in this description."

COMMUNICATION WITH OTHERS:

Internal -Interacts with all management/supervisory staff to ensure protocols are being followed. Establishes a close working relationship with all staff. Has on-going communication with AHS' Corporate Payroll and Benefits Manager and Corporate Human Resources Department.

External - Responsible for maintaining contact with all purchase agents handling office supplies for internal and external staff.

WORKING CONDITIONS:

Excellent working conditions in an office environment.

SPECIFICATIONS:

Knowledge - Associate's Degree or equivalent training/experience required. Health care background preferred.

Skills/Abilities - Must possess excellent interpersonal communication (verbal and written) and organizational skills. Ability to work well under pressure and perform several tasks concurrently with ease and professionalism. Must be capable of relating to a wide range of customers, maintaining cultural sensitivity. Advanced PC skills (i.e., proficiency with Microsoft Word, Excel, and PowerPoint) and the ability to operate basic office machinery (i.e., fax machine, copier, phone system, etc.) required.

Experience - Minimum of two years' administrative experience.

Physical Requirements - Light work – some lifting, reaching, squatting and kneeling are required occasionally.

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Sample Policies and Procedures

Submitted by:
Automated Health Systems

June 25, 2014

Automated Health Systems
West Virginia Enrollment Broker - Mountain Health Trust

Enrollment Changes

Policy: AHS Helpline staff is responsible for assisting members in transferring from one MCO to another, from an MCO to a PCCM provider, and from a PCCM provider to an MCO. Requests for enrollment changes are received from a variety of sources including calls to the Helpline and enrollment forms completed on the Mountain Health Trust website.

Definitions and Acronyms:

AHS:	Automated Health Systems
HMO:	Health Maintenance Organization; term is used interchangeably with MCO
MAID #:	Medicaid ID #
MCO:	Managed Care Organization; term is used interchangeably with HMO
PAAS:	Physician Assured Access System
PCP:	Primary Care Provider
QNXT:	Fiscal Intermediary's MMIS database
Cutoff:	Last date in the month to process enrollments and other changes for an effective date of the first of the following month.

Users:
Project Manager
Outreach and Education Manager
Administrative Assistant
Senior Helpline Specialist
Helpline Specialists

Procedure:

1. Log into QNXT.

2. From the QNXT home page select the Member module.



3. Use the 'Member Search' to locate a member. A search may be conducted based upon partial name, health plan ID, social security number, or date of birth. Once the information is entered in the 'Member Search' field click 'Search'. Click on the name of the member to be enrolled in the search results field. This will bring up the member's case.

4. **Verify all identifying information.** This is very important because of confidentiality guidelines and regulations. Member must provide information; at no point should information be provided for the member to verify.

5. Ask member the name of the MCO/PCP desired.

6. Click on the Provider tab and click the radio button of the current enrollment.

7. Click terminate.

8. Enter the termination date based on the current cutoff. This date will be the last day of the month prior to any new enrollment being effective the first of the following month. Select 'Save'.

    a. If an enrollment form or phone call from member comes in **before cutoff** and the member has already been automatically assigned effective the first of next month delete the automatic assignment span and create a new span showing the 'choice'.
    b. Delete the automatic assignment span even if it is the same as the choice the member has indicated on the form or call.
    c. On the contact sheet, indicate that the 'AD' span was deleted and a 'C' span was entered.

9. Select 'Plan Switch' since member is changing from one MCO to another, then select 'Update'.

10. Select 'Done' and then enter new enrollment by clicking 'Add'.

11. Complete the MCO selection as seen in the 'Initial Enrollment' directions.

Automated Health Systems
West Virginia Enrollment Broker - Mountain Health Trust

Interpretive Services

Policy:
Automated Health Systems will make translation services available for those having hearing, speech or vision impairments. Automated Health Systems will provide an oral explanation of all written materials upon request. Translation services will include utilizing TTY and Relay Services.

Definitions and Acronyms:

AHS:	Automated Health Systems
CSR:	Customer Service Representative
BMS:	Bureau for Medical Services
CA:	TTY Relay Service Communications Assistant
TTY:	Teletypewriter
GA:	Go Ahead
SK:	Stop Keying

TTY Relay Service: Connects TTY users with people who use telephones through a TTY Relay Service Communication Assistant to convert voice- to- text and text- to- voice communication. TTY etiquette was developed using a series of codes to signal go ahead (GA) or stop keying (SK) since communication using TTY or TTY relay service can flow only in one direction.

Users:
Project Manager
Outreach and Education Manager
Administrative Assistant
Senior Helpline Representative
Helpline Representatives

Procedure:
Relay Service/TTY- Traditional Service- Incoming Calls:

1. This service is used to process a MCO enrollment for a consumer who is deaf, deaf-blind, hard-of-hearing or speech-challenged. Relay Service will identify him/herself and explain to you that s/he has (name of person) on the line that needs to enroll with an MCO.

2. Helpline Specialist will speak as though speaking directly to the consumer.

3. The Operator will relay conversation to the consumer. After finished speaking, say "Go Ahead" to let the Relay Operator know you are ready for the TTY user to respond.

4. The CA converts voice to text and text to voice communication. The text is displayed on the consumer's TTY machine.

5. The consumer will then type his/her reply back.

6. The CA will then read the consumer's response to the Helpline Specialist.

7. Complete a Lotus Notes Contact Sheet using the normal procedures except:

    a. Click on the translation prompt. Choose Translation Language.

    b. On the comment line explain the Translation was TTY/Relay.

8. Questions or concerns in performing a TTY MCO Enrollment should be directed to a supervisor or a member of management.

Relay - Outgoing Calls:

1. Call West Virginia Relay Service at 1-800-982-8772. Follow option prompts.

2. Recording will say: "West Virginia Relay. CA #. Area code and number you are calling please."

3. Tell the CA the telephone number you want to call.

4. While call is being relayed, talk as though speaking directly to a person. The CA will relay conversation.

5. When finished speaking, say "Go Ahead" to let the CA know you are ready for the TTY user to respond.

6. To make another relay call when finished, do not hang up. The CA will place your call.

TTY Procedure – Incoming Calls:

1. Call comes in on the 1-800 line and may sound similar to a fax machine or may be "dead space".

2. TTY phone is accessed through Ext 130.

3. Type in greeting. When done type GA (for go-ahead). This alerts the caller that you are ready for their response.)

4. Operator will type response in return with a GA at the end to signal response.

5. Continue in this manner throughout the call. If you need to go to your computer, please let the caller know this through your message.

6. At the completion of the call. Type in SK to signal the end of the call, then hit the shift and TTY on/off button at the same time to disconnect the call.

7. The operator completing the TTY call can log in on that computer using his or her IDs and passwords.

TTY Procedure – Outgoing Calls:

1. Select the dial key at the bottom of the keypad.
2. Make sure to dial 9 for an outside line prior to entering the phone number.
3. Follow the same instructions as above for the remainder of the call.

Vision Impairments:

1. Large type enrollment forms, audiotape enrollment information and/or verbal explanation of written material will be offered by AHS staff to vision impaired customers requesting assistance.

Automated Health Systems
West Virginia Enrollment Broker - Mountain Health Trust

Provider Directory Requests

Background:
Mountain Health Trust (MHT) enrollment packets no longer include the MCO and PAAS provider directories. The MHT welcome letter and MHT brochure refer the member to the MHT website provider search to locate a PCP or to the MHT Helpline to request a mailed copy of the MCO or PAAS provider directories.

Policy:
AHS is responsible for mailing the requested plan directories to the newly eligible members to help the members make an informed MCO and PCP choice. AHS will maintain a sufficient inventory of the up to date provider directories from each of the MCOs (CoventryCares; UniCare; The Health Plan) and the PAAS program for shipment from either the Charleston office or the AHS Pittsburgh mailroom. The provider directories will be mailed within three days of the request

Definitions and Acronyms:

AHS:	Automated Health Systems
MCO:	Managed Care Organization
BMS:	Bureau for Medical Services
MHT:	Mountain Health Trust
PCP:	Primary Care Provider
PAAS:	Physician Assured Access System

Users:
Project Manager
Administrative Assistant
Senior Helpline Specialist
Helpline Specialists

Procedure:

1. If a member contacts the MHT helpline to request a provider directory, the Helpline Specialist will confirm that the member:
    a. is currently eligible for MHT or PAAS;
    b. is not already enrolled with a plan;
    c. resides in a county where the MCO is an option; and/or
    d. resides in a county where PAAS is an option (i.e., Cabell and Wayne).

2. The Helpline Specialist will confirm the mailing address of the member.

3. The Helpline Specialist will send all valid requests to the Administrative Assistant for processing.

4. The Administrative Assistant will add the information to a spreadsheet for tracking.

5. The Administrative Assistant will also include the date of the request and the date the directory (directories) were mailed to the member.

6. The Administrative Assistant will mail the MCO and/or PAAS provider directory (directories) to the member within three days of the request.

7. Helpline staff will document the provider directory requests in Lotus Notes by creating a contact sheet and selecting "Requested Provider Directories" from the drop down box.

8. If a member is already enrolled with a plan but is requesting a change to another plan, AHS will mail the plan directory requested by the member so they can make an informed plan change.

9. If the member is already enrolled with a plan and the member is requesting a provider directory for that plan, Helpline Specialist will redirect the member to their enrolled plan for the provider directory

10. AHS will process all requests for directories made by BMS staff on behalf of a member.

Implementation Plan REDACTED

Submitted by: Automated Health Systems

June 25, 2014

Sample Training Materials

Submitted by Automated Health Systems

June 18, 2014

AUTOMATED HEALTH SYSTEMS

West Virginia Medicaid
An Overview

Automated Health Systems

Outline

- Medicaid Overview
- Medicaid in West Virginia



Understanding Medicaid

What is Medicaid?

"A federally and state-funded program to provide health care to the needy."

- www.thefreedictionary.com

- Began in 1965 by Title XIX of Social Security Act



Understanding Medicaid

How is it funded?

- Medicaid is funded with federal, state, and in some states, county dollars.
- The federal government requires that states provide health insurance for certain populations and provide certain medical services.



Understanding Medicaid

If Medicaid is funded by the State and Federal governments, who does what?

- **States:** Each state administers its own program.
- **Federal Government (The Centers for Medicare and Medicaid Services):** Monitors the program and sets the quality and eligibility standards.





Understanding Medicaid

Who can receive Medicaid services?



Eligibility Group

- Individuals must belong to an eligibility group. Basically, the groups are: Children, Adults with Dependent Children, Pregnant Women, People with disabilities and the elderly.



Lawful

- Must be a US citizen or lawfully admitted immigrant(various requirements and exceptions)



Resource Test

- This test may include things like the value of their bank accounts that can be sold for cash.

Understanding Medicaid

- What services are covered by Medicaid?

Audiology	Hospital services	Eye care	Residential institutional care
Certified Nurse Midwives	Lab and X-ray Services	Prenatal care	Speech and Language therapy
Certified Nurse practitioners	Medicaid equipment	Prescription drugs	Support Coordination
Doctor visits	Mental health clinic services	Physical therapy	Rehabilitation Services
Family planning	Mental health rehabilitation	Podiatry services	Occupational therapy
Medical transportation	Psychiatric hospital care	Hospice Services	

Understanding Medicaid

- What does Medicaid cover for children?

Dental Care	Extended Home Health Services	Eyeglasses	Hearing Aids
Psychological Tests and Therapy	Immunizations	EPSDT	Medical, Dental, Vision and Hearing Screenings
Personal Care Services	Psychiatric Hospital Care	Other Medically Necessary Health Care, Diagnostic Services, and Treatment	

Understanding Medicaid

But, what about Medicare?

- Federal medical care for the elderly and any age disabled.
- Administered by CMS
- Covers Three Main Groups:
  - People age 65 or older with sufficient work credits
  - Disabled adults receiving Social Security benefits for at least 24 months
  - People of any age diagnosed with End-Stage-Renal Disease



Understanding Medicaid

- Medicaid vs. Medicare

	Medicaid	Medicare
Who is eligible?	•Low income children and families, elderly and disabled	•Anyone over age 65 with sufficient work credits •Some disabled groups
Is there a financial means test?	•Yes, for all eligibility groups	•Not for eligibility •Yes, to determine monthly premium amounts
What are the costs?	•No monthly premiums for most programs, although there are exceptions •Minimal co-pays for services	•Possible monthly premiums depending on financial means •Co-pays for services
Who determines coverage?	•Federally mandated basic services, but states can provide additional benefits	•Federally determined
How is it funded?	•Federal, state and in some states county (or parish) dollars	•Federally funded

Understanding Medicaid

Can a person receive Medicaid and Medicare?

- Dual eligibles
- Medicaid pays for services that Medicare does not cover:
  - Prescription drugs (unless Part D)
  - Long-term care
- Medicaid also covers deductibles, coinsurance and premiums.



Understanding Medicaid in West Virginia

- **How does Medicaid "work" in West Virginia?**



Providers: Enroll with Medicaid and must meet national, federal and state licensing and credentialing requirements. In some situations provider may need to enroll with a MCO



Enrollees: Must be eligible for Medicaid, apply and then present their card when receiving services. (Note: Providers can verify eligibility without card)

Understanding Medicaid in West Virginia

How is a person eligible for Medicaid?

- Individuals who receive SSI automatically receive Medicaid coverage.
- Families who receive help from the Temporary Assistance for Needy Families are eligible for Medicaid.

What groups are covered by Medicaid?

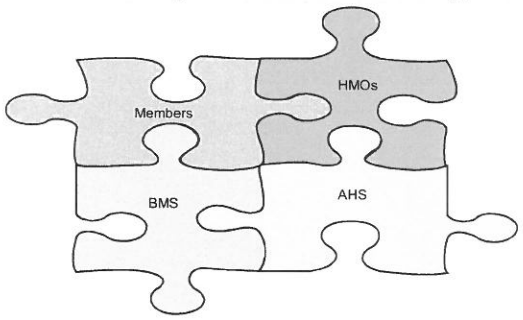
- Children
- Low income parents with dependent children
- Pregnant women
- Individuals over the age of 65
- People with severe disabilities
- Women who need treatment for breast and/or cervical cancer

Understanding Medicaid in West Virginia

How does a person apply for Medicaid?

- At the local office of the WV Department of Health and Human Resources
- Apply online at inROADS – 'Information Network for Resident Online Access and Delivery of Services'.

Understanding Medicaid in West Virginia



Questions



AUTOMATED HEALTH SYSTEMS

Customer Service
An Overview

Automated Health Systems

Courtesy & Cooperation

Tone of Voice → Interaction → Judgment

Incoming Call

- Anyone who calls the 1-800-449-8466 number or front line should receive prompt and courteous attention
- Before placing a consumer on hold, be sure to explain to the person that you are doing so.
- Limit putting a customer on 'mute'
  - Members should never hear "dead air"
- Personalize the Conversation
  - "Yes, Mrs. Smith"
- Answer Promptly
  - Answer on the first ring

Directing Calls

- Your responsibility for screening calls is to decide which you can answer and which ones only the Project Manager, Outreach and Education Manager, or Senior Enrollment Specialist can answer.
- "Warm Transfer"
  - Introduce provide a short summary of the caller's situation to the person to whom you are transferring the call.
- Remember never to underestimate the importance of handling the telephone call properly.
- It is key to the success of our business.

Face-to-Face

- Along with the aforementioned tips, it is also very important to review tips provided within the cultural diversity section of this manual. Body language is an excellent way to attempt to determine if your customer understands the information presented or if they have further questions but have not asked them. Pay close attention to your body language as well. Convey that you respect the customer and that you are there to help him/her. Your facial expression and posture are key here.
- In face-to-face meetings, it is important that we present ourselves as professionals, but that we do not intimidate our customers. We must always dress professionally, but in certain outreach locations, a suit may be intimidating, causing some to be less likely to approach you or ask questions. In these cases, casual/professional dress, such as khaki pants (never jeans or sweat pants) may be appropriate.

AUTOMATED HEALTH SYSTEMS

Quality Customer Service

Automated Health Systems

Quality Service

- Two types of Customer Service
  - ***Quality in fact***: The definition of quality in fact lies solely with how AHS meets our own project goals and specifications.
  - ***Quality in perfection***: This is quality as the customer sees it. AHS achieves quality in perfection when we meet the customer's expectation(s).
- Attention must be given to both ***Quality in fact and Quality in perfection*** for AHS continued successful growth.

Quality Service & YOU

- ***Caller Image:*** The most important aspect of a call is how you greet the caller. Beginning with your greeting, the caller begins to mentally form an image of you and Mountain Health Trust.
- ***Responding to the customer request:*** Your response to questions the caller has must be: *honest, prompt, courteous and reliable.*

Combined Voice

- Your voice projects an image over the telephone from the moment you answer a call. A businesslike voice includes all of the following attributes:
  - Volume
  - Clarity
  - Tone
  - Speed
- The volume, clarity, tone and speed of your combined voice all impact on the caller. This communication promotes a clear and positive image of you and Mountain Health Trust.

Volume & Clarity

- Volume
  - Speak to the person calling as you would speak to someone two or three feet away.
  - Varying the volume of your voice adds interest for the listener and allows you to highlight key points.
- Clarity
  - Clarity comes from the correct pronunciation. Open your mouth wide as you frame your words. Be observant of how you shape and place your tongue to form sounds.

Tone & Speed

- Tone:
  - The tone of your voice conveys a strong message to the caller.
  - Be sincere, empathic and enthusiastic with the caller. Your words combined with your sincere, uplifting voice will be communicated to the caller.
  - Using negative tones of phoniness, pushiness, or boredom conveys a sense of disinterest to the caller.
- Speed
  - This is also an indicator of attitude, according to most listeners. Speaking at a rate of 150-160 words per minute is considered ideal.

Effective Listening Skills

- To communicate, two things *must* happen:
  - ***Active listening***
  - ***Generating Responses***

Active Listening

- Active listening involves three steps
  - **Step 1**: ***Hear*** the words being said. When we hear words we generally make the following assumptions:
    - You assume that what is said is *true*.
    - You try to *imagine* the situation/issue.
    - When you hear the words being said, *listening happens*, and communication has a chance to succeed.
  - **Step 2**: ***Decipher*** what each word means.
  - **Step 3:** You put it all together to *find out* what the whole conversation means and how to respond.

Generating Responses

- When you listen to someone talk, with the first few words you hear, you begin ***generating ideas*** of how you will respond.
- Your responses are based on:
  - Information you already have.
  - Information about the *situation* you and the caller are in, which constitutes much of the context for the statement.
  - Information about what *you* would *say to the caller*.
  - Information about what you would *not say*.
  - Information about the *grammar* of the caller.
- Gathering information *enables* you to generate *accurate* responses to the caller.

- ***Do Not*** say/do the following to a caller:
  - Interrupt
  - Doodle
  - Answer questions with questions
  - Call the person a liar:
    - *"You claim what..."*
    - *"You couldn't have..."*
- When react to *language* with a judgment about the person speaking. We often leap to conclusions like these:
  - "She's only saying that because she didn't take time to read the information from the enrollment packet."
  - "He's only saying this because he insists we can back date the enrollment."

- Additional important effective listening elements in language interactions are:
- The language being used gets *lost* when *you decide* what is important is some aspect of the caller's character, personality or motivation.
  - When this occurs, *all listening stops*. You have rejected the language in advance and concluded, (without effectively listening to the caller), that what the caller is saying is not worth hearing.
  - When this happens, ***communication is doomed***.
- To listen effectively take a break when you are feeling overwhelmed. Admit to yourself that there are *no problem callers*, just callers with problems who are looking to you for information and direction.
- Also, realize that the problem is not about *you*, the problem is the situation.
- Rather than state the caller was *impossible* or *hypercritical*, remember to listen to the callers concerns without trying to define them or take action *before* the caller provides all the information.

- Get in touch with ***their words***.
  - Remember to *build commitment* with the caller using effective listening skills.
  - Breakdown language barriers, by using empathic and positive feedback.
- **KEEP THE COMMUNICATION PROCESS GOING.**

Caller Confrontations

- Tips for handling caller confrontations:
- Remain *polite and calm*.
- Allow the caller to *vent* their feelings.
- Ask the caller to describe the *facts*; this should help you to separate the facts from the emotions.
- Take *notes*, writing down what the key points that will help you understand the caller's situation.
- *Never argue* with a caller; this makes the situation worse.
- *Stay firm*.
- *Empathize* with the caller, offering some soothing remarks. ie: "I am really sorry to hear that..."
- Providing the caller with *options allows them the freedom to choose* how they handle the situation.
- In addition, recommending a *solution* that you can immediately implement or refer the caller to the proper person.

- Always remember *two* things when dealing with angry callers:
- The caller is mad at the situation, *not you.*
- To the caller, *you are Mountain Health Trust.*
- Also, ask yourself, are *you* making your callers angry? Ask yourself four simple questions about your voice pattern on any phone call:
  - Does my voice sound *tired?*
  - Does my voice sound *interrupted?*
  - Is my voice *rough and/or gruff?*
  - Is my voice *timid and shy?*

- When dealing with anger, your physical and emotional body reacts to your *thoughts, feelings and behavior.*
- When a caller is chewing you out, your heartbeat speeds up.
- Ignoring your rapid heart rate, allows your emotions to boil, which increases the speed of your breathing.
- Learn to sense your increasing anger, then breathe slower and use your thoughts to break your anger barrier.
- You may also find it helpful to put some visual cue cards (3x5 index cards) on your desk labeled: *thoughts, feelings and behavior* to remind you to monitor yourself.
- Another technique to calm yourself is simply counting: 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, and 1010 to allow you to regain control of your physical and emotional body.
- Take a moment to reflect on a *peaceful time.* This will break the negative thought process.

- Learning to manage conflict and/or anger involves being aware of how *you* respond to these situations. Positive self-talk gives you the best avenue to break the cycle and positively respond to your callers needs
- Using your proper businesslike voice will always give the caller a positive image of Mountain Health Trust and YOU.



Health Literacy

Automated Health Systems

- Health literacy is the ability to read, understand and effectively use basic medical instructions and information.
- Low health literacy can affect anyone of any age, ethnicity, background, or education level.

- The average American reads at the 8th-9th grade level; however, health information is usually written at a higher reading level.
- Most patients - regardless of their reading or language skills - prefer medical information that is simple and easy to understand.

- Are often less likely to comply with prescribed treatment and self-care regimens.
- Fail to seek preventive care and are at double the risk for hospitalization.

- Remain in the hospital nearly two days longer than adults with higher health literacy.
- Often require additional care that results in annual health care costs that are four times higher than for those with higher literacy skills.

- According to the Institute of Medicine, nearly half of all American adults --90 million people-- have difficulty understanding and using health information.
- Everyone in the United States is susceptible regardless of age, race, education or income.
- Low health literacy costs the health system as much as $58 billion a year.

- Only 50 percent of all patients take medications as directed, leading to compliance issues and possible negative health outcomes.
- Adults with low health literacy average 6 percent more hospital visits - and remain in the hospital nearly two days longer - than adults with higher health literacy.

- Annual health care costs for those with low literacy skills are four times higher than for those with higher literacy skills

Message for AHS Field Staff

- If someone calls the Home Office and the message is for a field staff, simply state that the staff person is not currently in the office.
- If the Outreach and Education Manager (OEM) is in the office, the call should be forwarded to the OEM.
- If the OEM is not in the office, the Administrative Assistant should take a thorough message and forward it to the OEM and appropriate field staff. If the call needs to be returned that day, the call should be forwarded to another member of the management staff for assistance. If the call is enrollment related, the 1-800 unit should handle the call.

West Virginia
Health Benefits Manager
Mountain Health Trust

January 2014

Monthly Status Report

Submitted by Automated Health Systems

February 12, 2014

AUTOMATED HEALTH SYSTEMS

JOSEPH W. NOCITO
CHIEF EXECUTIVE OFFICER

405 CAPITOL STREET, SUITE 406, CHARLESTON, WV 25301 . (304)345-0436 . (304) 345-1581 FAX

February 12, 2014

Brandy Pierce
Director of Managed Care and Procurement Services
Department of Health and Human Resources
350 Capitol Street, Room 251
Charleston, WV 25301

Subject: West Virginia Health Benefits Manager Monthly Status Report – January 2014

Dear Ms. Pierce:

This letter and enclosed documents represent activity performed by Automated Health Systems for January 2014 in support of the West Virginia Health Benefits Manager Project. Please let me know if you have any questions or comments about the information provided in the report. I look forward to hearing from you.

Sincerely,

Janet K. Pritchard

Janet K. Pritchard, MPA, MSW
Interim Project Manager

AUTOMATED HEALTH SYSTEMS

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Section I – Executive Summary

As the Program Administrator for the West Virginia Health Benefits Manager Project, Automated Health Systems (AHS) is pleased to submit the January 2014 Monthly Status Report in accordance with the Project's reporting timeline. The report includes trending data and analyses of Helpline and Field operational activities for the Mountain Health Trust (MHT) Program. In addition, a rolling 12 month data report is included as Appendix A. The Mountain Health Choices (MHC) trending reports are no longer included in the report package due to the conclusion of the program.

Newly Eligible Enrollment Packets

AHS fully transitioned away from inserting the Plan Provider Directories in the Enrollment Packets for newly eligible members in January. The MHT enrollment packets now include the MHT brochure, MCO Plan Comparison Charts, Checklist, Welcome Letter and the plan brochures. All MHT materials outline options for enrollees to search for providers by calling the MHT Helpline or visiting the MHT website. Enrollees in Cabell and Wayne counties have the option of contacting the Helpline or visiting the MHT website to search for PAAS providers.

Mountain Health Trust Website Changes

Effective in January, AHS updated the MHT website to reflect the discontinuance of the MHC program and the changes to the MHT enrollment packet mailing process. Added to the website are links to the revised MHT brochure and the new MCO Plan Comparison Charts. AHS is awaiting receipt of the PAAS provider file to load in the Search For Provider tab. This will assist members in Cabell and Wayne counties with locating a PAAS provider.

Outreach to Dental Providers

By mid-January, AHS received the go-ahead to begin our outreach to dentists to ensure that the dental providers were aware of the administrative changes for children's dental services. Using the list of participating dentists provided by the state, the Outreach and Education Specialists targeted their site visits to dental providers in their respective territories. Staff provided education on how to read the Medical Card; Managed Care enrollment and plan options by county; new billing procedures for children's dental; Medicaid expansion population; and, billing for straight Medicaid, among others. We also distributed the Dental Billing Guide for Medicaid Managed Care Enrollees and provided Scion Dental contact information. AHS tracked and reported any issues and concerns to DHHR and referred questions on credentialing and billing to Scion for immediate follow up. Overall, the feedback from the dental practices has been very positive and they are reporting high satisfaction with the support provided by Scion Dental and they appreciate our on-site visits. 198 dental sites were outreached during the month.

Increased Call Volume and Medicaid Expansion

In January, the MHT Helpline received over 1500 more calls than were reported in December 2013 – a 76% increase. The influx of calls was due in part to adults who received coverage through Medicaid Expansion effective January 1, 2014. Their questions ranged from how to navigate their new health

care, what is covered by Medicaid, and how to find a Medicaid provider. Helpline staff was provided with a list of helpline resources to refer members to, with the majority of the callers referred to Molina for assistance with co-pay and coverage questions.

Increased Enrollments

Also in January, the number of MHT enrollments (i.e., phone, written, on-line, and newborn) increased by over 950 from what was reported in the previous month. AHS is pleased to note that the number of online enrollments continues to trend higher each month – this option offers eligible members the convenience of completing their enrollment at any time during the day or night.

The following sections provide outcomes and trending data for key project management activities during the month of January.

Section II - Call Statistics

The MHT Helpline received 3,505 calls in the month of January, 1519 more calls than were reported for December 2013. Of the calls received, 3,419 were successfully answered. The abandonment rate for the month of January was 2.45% (Figure 2). The average hold time was 0:10 with the average length of call at 3:27 (Figure 3). All call center metrics met or exceeded service level agreements.

Exhibit 1: Call Center Statistics – Jan. 2014	
Calls Received	3,505
Calls Answered	3,419
Abandoned Calls	86
Abandonment Rate	2.45%
Average Length of Call	3:27
Average Enrollee Hold Time	0:10
Busiest Day of the Month	Jan-2

Figure 1: Calls Received vs Calls Answered
February 2013 - January 2014

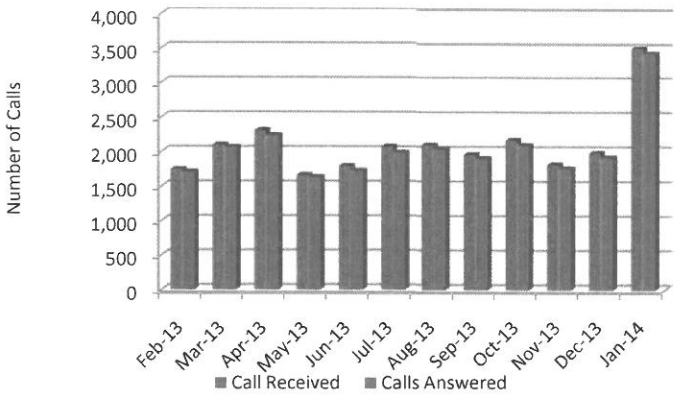


Figure 2: Abandonment Rate
February 2013 - January 2014

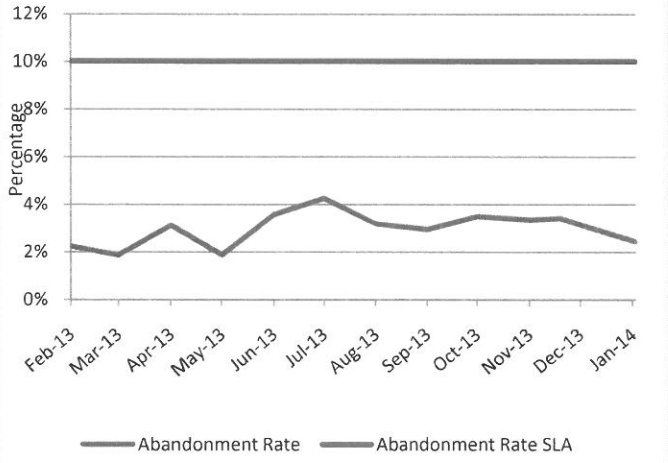
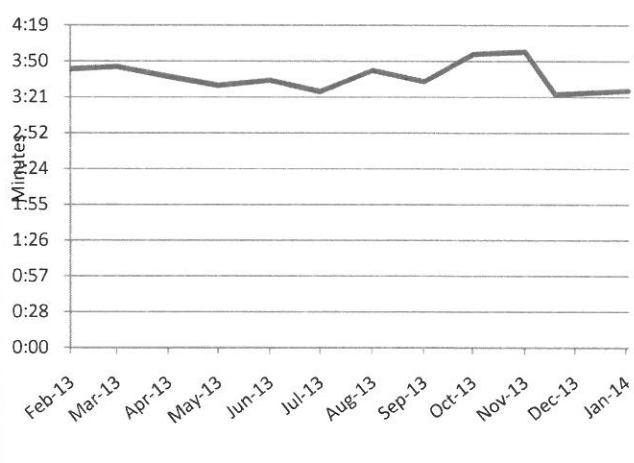


Figure 3: Average Length of Call
February 2013 - January 2014



Call Statistics by Operator

Exhibits 2 and 3 detail the weekly number of calls received, number of calls answered, average length of call, and average queue for each operator. The daily detail for each operator is provided in Appendix A.

Exhibit 2: Daily Call Statistics by Operator – January 2014

	Number of Calls Received							Number of Calls Answered						
Date	Op 4	Op 5	Op 6	Op 7	Op 8	Op 9	Op 10	Op 4	Op 5	Op 6	Op 7	Op 8	Op 9	Op 10
Week 1	103	0	98	121	85	73	21	102	0	95	119	84	73	19
Week 2	188	0	117	168	145	123	20	185	0	114	161	144	120	19
Week 3	307	0	163	229	208	205	48	300	0	162	220	194	192	47
Week 4	132	76	112	37	101	68	17	129	76	111	36	99	68	16
Week 5	82	103	77	99	86	83	10	81	101	77	98	84	83	10
Total	**812**	**179**	**567**	**654**	**625**	**552**	**116**	**797**	**177**	**559**	**634**	**605**	**536**	**111**

Exhibit 3: Daily Call Statistics by Operator – January 2014

	Average Length of Call							Average Queue Time						
Date	Op 4	Op 5	Op 6	Op 7	Op 8	Op 9	Op 10	Op 4	Op 5	Op 6	Op 7	Op 8	Op 9	Op 10
Week 1	2:45	0:00	4:12	2:32	3:00	4:22	2:05	0:11	0:00	0:07	0:08	0:09	0:05	0:05
Week 2	2:37	0:00	4:11	2:53	3:41	3:29	2:47	0:15	0:00	0:11	0:13	0:13	0:03	0:04
Week 3	2:34	0:00	5:02	3:26	4:11	4:51	3:06	0:25	0:00	0:20	0:19	0:24	0:24	0:07
Week 4	2:52	3:33	4:12	3:17	4:15	3:38	2:58	0:21	0:07	0:14	0:05	0:06	0:02	0:06
Week 5	2:35	3:31	4:44	3:09	4:11	3:42	2:10	0:07	0:05	0:08	0:05	0:06	0:02	0:04
Average	**2:40**	**3:32**	**4:28**	**3:03**	**3:51**	**4:00**	**2:37**	**0:16**	**0:06**	**0:12**	**0:10**	**0:12**	**0:07**	**0:05**

*Operator #10 is PT and provides additional coverage for the 4pm -8pm time slot. Operator #5 was on leave for the first three weeks in the month.

Section III - Mountain Health Trust

Enrollments

New enrollments for the month of January 2014 totaled 3,267- 967 more enrollments than were processed in the previous month. Exhibit 4 details enrollment figures by week for each plan and trends enrollments for each plan over the last 12 months. Exhibit 5 displays the rolling 12 month data for enrollments by plan and details the source from which AHS received the enrollment. Of the 1,212 written plan enrollments received this month, 192 were received through the website as online enrollments. Enrollments averaged 2,055 per month over the 12 month rolling period.

Exhibit 4: New Enrollments by Plan – Jan. 2014

	PAAS	HP	CC of WV	UniCare	Total
Week 1	18	108	249	302	677
Week 2	21	153	180	226	580
Week 3	24	161	248	358	791
Week 4	15	254	423	527	1,219
Total	**78**	**676**	**1,100**	**1,413**	**3,267**

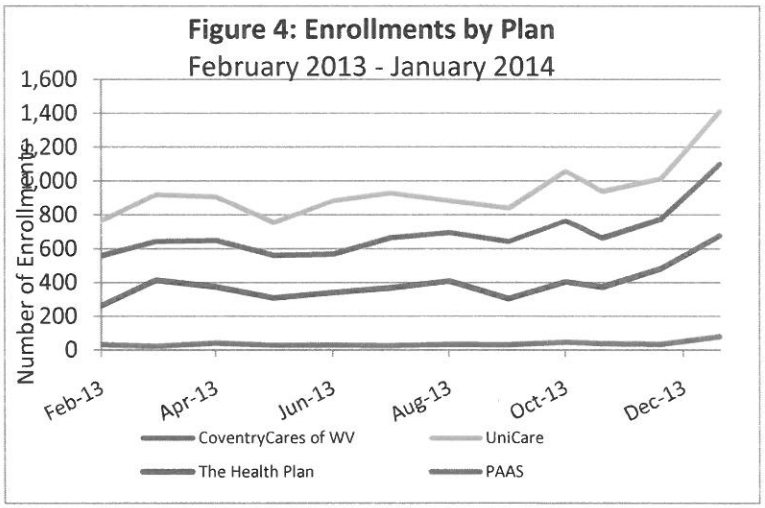


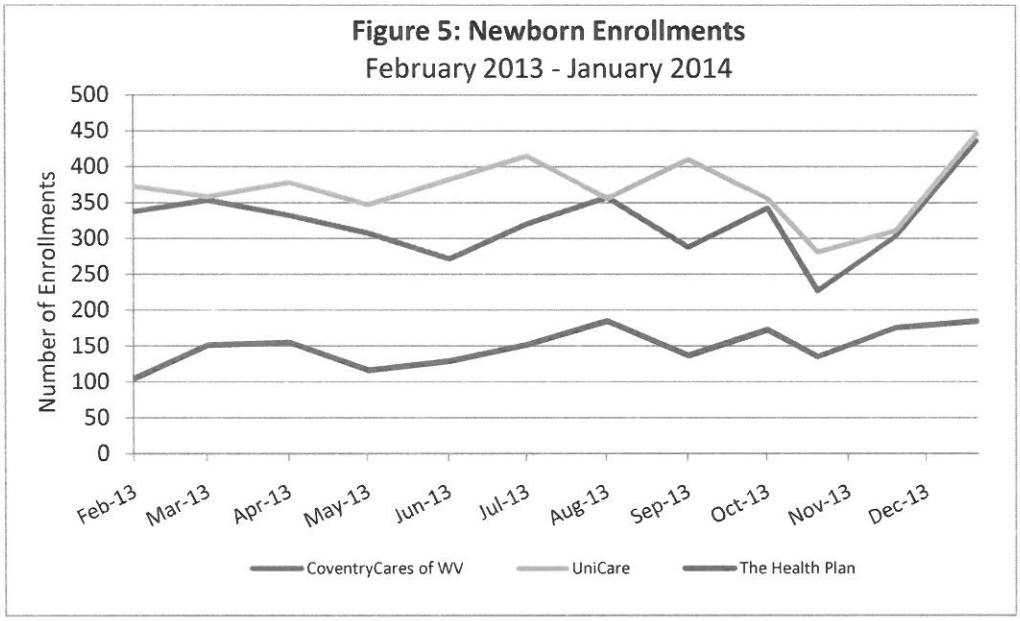
Exhibit 5: Member Enrollment by Plan and Source – January 2014

	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total
Coventry Cares o f WV													
Phone Enrollments	114	156	192	99	142	165	145	184	217	217	267	310	**2,205**
Written Enrollments	106	132	121	152	152	181	191	168	205	218	204	354	**2,184**
Newborn Enrollments	337	353	332	307	271	320	357	288	342	227	303	436	**3,873**
Total Coventry Enrollments	**557**	**641**	**645**	**558**	**565**	**663**	**693**	**640**	**764**	**662**	**774**	**1,100**	**8,262**
The Health Plan													
Phone Enrollments	59	109	90	77	91	88	110	68	106	92	129	160	**1,179**
Written Enrollments	97	151	126	112	119	125	110	98	124	145	175	331	**1,713**
Newborn Enrollments	105	151	155	116	129	152	185	137	173	135	176	185	**1,799**
Total Health Plan Enrollments	**261**	**411**	**371**	**305**	**339**	**365**	**405**	**303**	**403**	**372**	**480**	**676**	**4,691**
Unicare													
Phone Enrollments	164	265	283	189	283	270	270	222	346	322	372	440	**3,426**
Written Enrollments	229	296	244	217	217	242	257	207	357	335	330	527	**3,458**
Newborn Enrollments	372	358	378	347	382	415	356	410	356	281	311	446	**4,412**
Total UniCare Enrollments	**765**	**919**	**905**	**753**	**882**	**927**	**883**	**839**	**1,059**	**938**	**1,013**	**1,413**	**11,296**
PAAS													
Phone Enrollments	17	12	27	14	20	18	18	22	20	18	20	59	**265**
Written Enrollments	13	8	11	12	7	6	13	8	25	18	13	19	**153**
Total PAAS Enrollments	**30**	**20**	**38**	**26**	**27**	**24**	**31**	**30**	**45**	**36**	**33**	**78**	**418**
Total Enrollments	**1,613**	**1,991**	**1,959**	**1,642**	**1,813**	**1,979**	**2,012**	**1,812**	**2,271**	**2,008**	**2,300**	**3,267**	**24,667**

Newborn Enrollments

Exhibit 5 (above) also includes newborn enrollments for each of the last 12 months. Exhibit 6 (below) provides the weekly breakdown of newborn enrollments by plan. In the month of January, 185 newborns were enrolled with The Health Plan, 436 newborns were enrolled with CoventryCares of West Virginia, and 466 newborns were enrolled with UniCare, for a total of 1,067 newborn enrollments, 277 more than the previous month. AHS Helpline staff continues to supplement the MCO newborn form enrollment process using the weekly newborn enrollment file for early identification and enrollment of newborns.

Exhibit 6: Newborn Enrollments – Jan. 2014				
	The Health Plan	**CC of WV**	**UniCare**	**Total**
Week 1	36	127	134	297
Week 2	55	60	65	180
Week 3	34	65	57	156
Week 4	60	184	190	434
Total	**185**	**436**	**446**	**1,067**



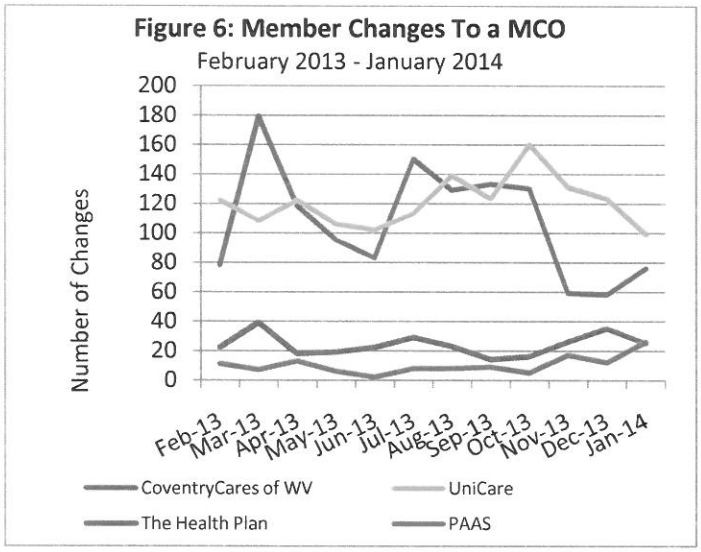
Enrollment Changes

Exhibit 7 shows member enrollment changes for members transferring from one plan to another. Of the MCOs and PAAS, UniCare and PAAS had more members transfer 'to' their plan than transfer 'from' their plan in January.

Figures 6 and 7 show member changes 'to' and 'from' each MCO over the last 12 months.

Exhibit 7: Enrollment Changes – January 2014

	'To' CC of WV	'From' CC of WV	'To' The Health Plan	'From' The Health Plan	'To' UniCare	'From' UniCare	'To' PAAS	'From' PAAS
Week 1	12	27	8	3	18	15	7	0
Week 2	13	21	4	5	13	11	7	0
Week 3	12	13	1	3	12	10	1	0
Week 4	39	58	12	17	56	42	11	1
Total Changes	**76**	**119**	**25**	**28**	**99**	**78**	**26**	**1**



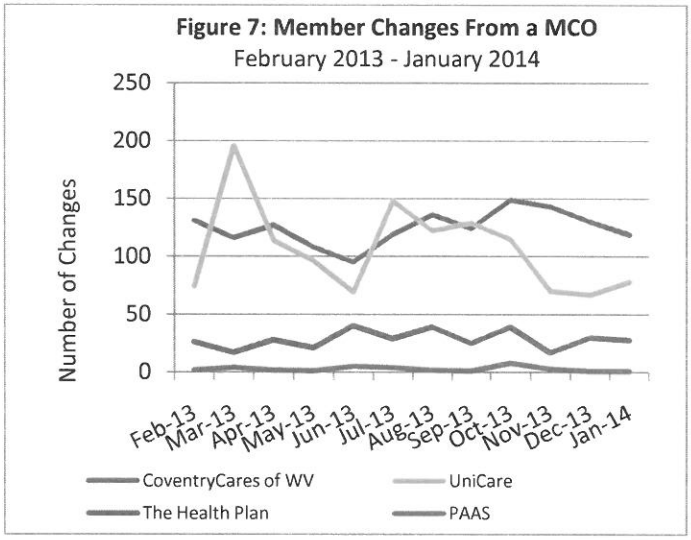


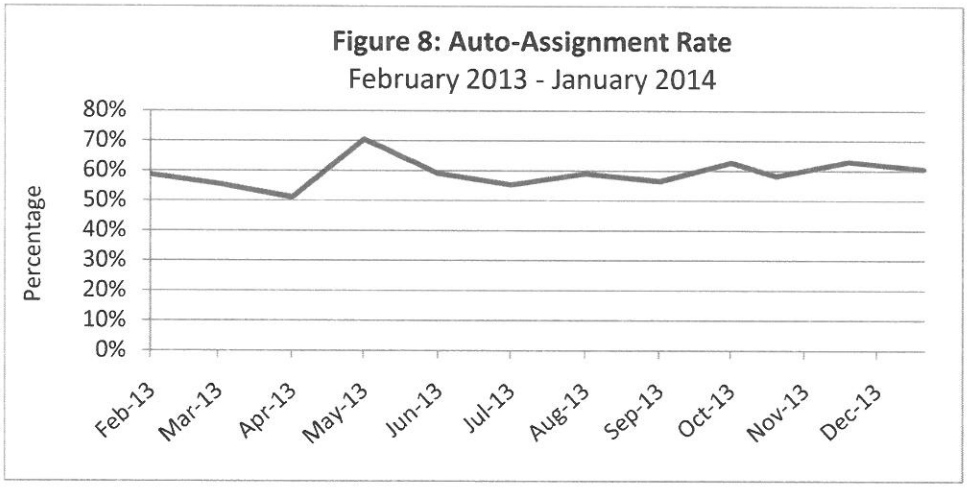
Exhibit 8 displays the most common reasons cited for enrollment changes. Lack of provider participation continues to be the top reason that members switch MCOs.

Exhibit 8: Top Reasons for Enrollment Change from Plan – Jan 2014

	CC of WV	The Health Plan	PAAS	UniCare
Provider Not in Plan	81	8	1	50
Doctor Recommended	11	6	0	3
Auto-Assigned	15	8	0	6
Written Enrollments	8	6	0	8

Auto-Assignment

The auto-assignment rate for the month of January is 60.5%, down slightly from what was reported in December 2013.

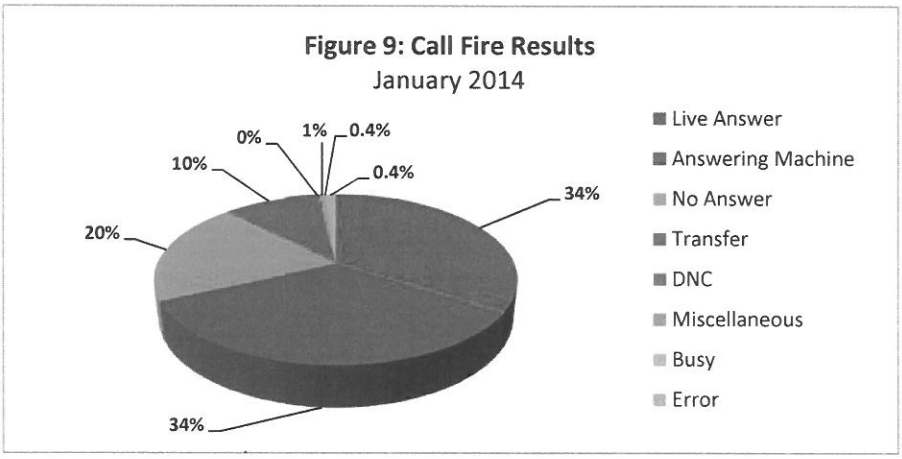


In January, 2,682 members who were scheduled to be auto-assigned effective February 1, 2014 were selected for the Call Fire campaign. As a result, 212 members that were outreached through Call Fire contacted the helpline to choose their MCO prior to auto-assignment.

This table (Exhibit 9) details the results of the campaign by call disposition.

Exhibit 9: Call Fire Results
Auto-Assignment Campaign January 2014

	Live Answer	Answering Machine	No Answer	Transfer	Do Not Call	Misc.	Busy	Error	Total
Total	910	918	525	272	11	15	3	28	**2,682**



Section IV – Mailings

AHS mailed a total of 9,416 pieces of mail for the MHT program in December. Exhibit 10 breaks out the member mailings by type. There were 254 pieces of returned mail. AHS conducted outreach on all returned mail by attempting to obtain a valid address or by contacting the member by phone.

Exhibit 10: Member Mailings – Jan. 2014	
Enrollment Packets	6,373
Reminder Letters	3,043

Enrollment mailings are broken down into phases. The phases are based upon the MCOs that are available within each county. Exhibit 11 details the mailings by phases for MHT through January 2014. The fields for MHC and Caretaker Relative are blank this month due to the end of the MHC program. Exhibit 11 will continue to display the MHC data for the previous months as part of the rolling report.

Exhibit 11: Enrollment Packets Mailed – January 2014													
	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total
Phase 2	235	124	136	233	183	196	268	182	277	208	171	517	2730
Phase 4	1,526	741	1,010	1,275	1,013	1,056	1,419	1,215	1,740	1,138	1,170	3,747	17,050
Phase 8	753	330	497	720	550	541	811	671	962	589	604	2,109	9,137
Phase 10	47	19	26	0	0	0	0	0	0	0	0	0	92
Mountain Health Choices													
Phase 12	107	89	89	112	77	710	121	92	108	117	118	0	1,100
Phase 14	678	475	566	713	584	534	859	708	695	709	808	0	7,329
Phase 18	429	303	338	476	408	351	591	497	489	463	484	0	4,832
Phase 20	24	24	13	0	0	0	0	0	0	0	0	0	61
Caretaker Relative													
Phase 22	50	14	27	30	30	25	48	34	157	44	53	0	512
Phase 24	280	86	191	213	168	178	261	226	1,407	342	436	0	3,788
Phase 28	180	51	114	141	107	118	161	164	850	233	263	0	2,382
Phase 30	8	2	6	0	0	0	0	0	0	0	0	0	16
Total	**4,317**	**2,258**	**3,013**	**3,913**	**3,120**	**3,069**	**4,542**	**3,789**	**6,685**	**3,843**	**4,107**	**6,373**	**49,029**

Section V – Field Activities

Field staff conducted the usual mix of outreach to DHHR, providers, and pharmacies during the month of January with an increased focus on dental providers concerning the changes of children's dental. Dental providers are in the midst of this transition and working to credential and learn the new process for billing children's dental and Scion portal/web access. Outreach to community and medical providers continued to include information about the termination of MHC program. Staff participated in monthly meetings of the Family Resource Network in a number of counties in addition to a variety of committee, task force meetings, and Regional Children's Summits.

Exhibit 12 breaks down outreach by region and selected categories.

Exhibit 12: Combined MHT/MHC/PAAS Field Staff Outreach – January 2014					
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Total**
DHHR	8	3	3	5	**19**
Providers	60	45	65	84	**254**
Potential Consumers	25	10	0	0	**35**
Other Outreach	22	10	17	40	**89**
Presentations	0	0	1	0	**1**
# Attending	0	0	2	0	**2**
Feedback Forms	0	0	10	0	**10**

**Region 2 contacts also include those made by O&E Supervisor.*

Exhibit 13 highlights Mountain Health Trust specific outreach by site type for the month. These numbers may include multiple outreach contacts with a single provider. Numbers increased for dental as outreach was approved mid month. 106 MHC contacts are included in the total.

Exhibit 13: MHT Field Staff Outreach January 2014	
Behavioral Health	3
Childcare	3
Community Resource Center	19
Dentists	198
DHHR	19
Education	5
Government Agency	24
Medical Provider	56
Other	2
Pharmacy	22
Religion	1
Retail	8
Retail	6
Total	**362**

AUTOMATED HEALTH SYSTEMS

West Virginia
Health Benefits Manager

Mountain Health Trust

January 2014
Appendix A
Rolling 12 Month Data

Submitted by Automated Health Systems

2/14/2014

AUTOMATED HEALTH SYSTEMS

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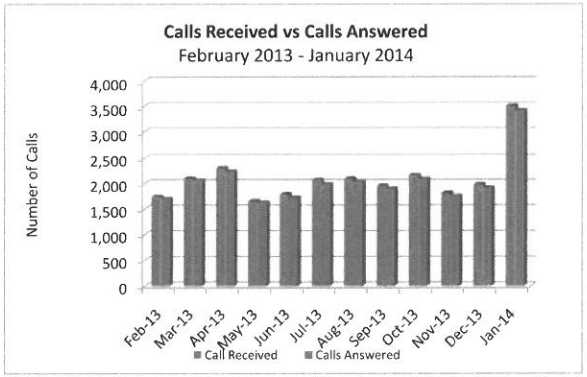
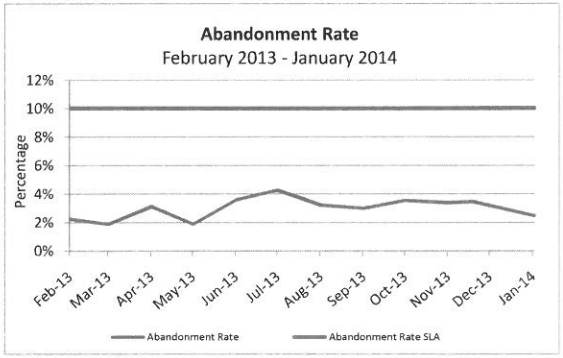
WV Health Benefits Manager
Mountain Health Trust

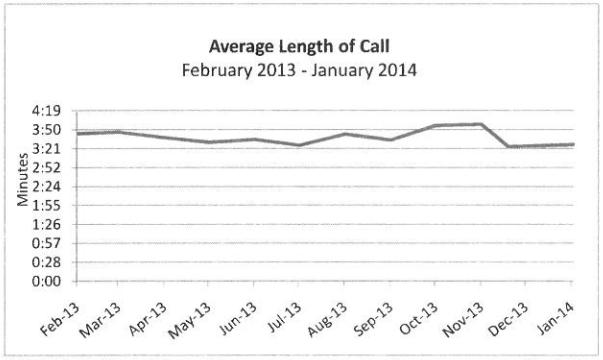
Call Center Statistics
Reporting Period: 1/1/14 - 1/31/14

Report Description: This report identifies call volume and additional key statistics for the Mountain Health Trust Helpline.

	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Average
Call Received	1,745	2,102	2,308	1,661	1,793	2,073	2,100	1,960	2,171	1,819	1,986	3,505	2,102
Calls Answered	1,706	2,063	2,236	1,630	1,726	1,985	2,033	1,902	2,095	1,758	1,918	3,419	2,039
Abandon Calls	39	39	72	31	64	88	67	58	76	61	68	86	62
Abandonment Rate	2.23%	1.86%	3.12%	1.87%	3.57%	4.25%	3.19%	2.96%	3.50%	3.35%	3.42%	2.45%	2.98%
Average Length of Call	3:44	3:46	3:38	3:31	3:35	3:26	3:43	3:34	3:56	3:58	3:24	3:27	3:38
Average Enrollee Hold Time	0:07	0:07	0:07	0:07	0:06	0:06	0:06	0:06	0:07	0:07	0:10	0:10	0:07
Busiest Day of the Month	19-Feb	14-Mar	17-Apr	1-May	12-Jun	15-Jul	14-Aug	11-Sep	17-Oct	12-Nov	17-Dec	2-Jan	-







Run Date: 2/1/2014

Daily Operator Statistics

Reporting Period: 1/1/14 - 1/31/14

Report Description: This report details the number of calls received, number of calls answered, average talk time, and average queue time by operator for each day of the reporting month.

	Number of Calls Received							Number of Calls Answered						
Date	**Op 4**	**Op 5**	**Op 6**	**Op 7**	**Op 8**	**Op 9**	**Op 10**	**Op 4**	**Op 5**	**Op 6**	**Op 7**	**Op 8**	**Op 9**	**Op 10**
1-Jan	**	**	**	**	**	**	**	**	**	**	**	**	**	**
2-Jan	67	0	66	78	53	45	14	66	0	65	77	52	45	14
3-Jan	36	0	32	43	32	28	7	36	0	30	42	32	28	5
Week 1	**103**	**0**	**98**	**121**	**85**	**73**	**21**	**102**	**0**	**95**	**119**	**84**	**73**	**19**
6-Jan	51	0	27	46	41	32	0	51	0	26	44	41	32	0
7-Jan	38	0	27	34	29	28	0	37	0	26	34	28	28	0
8-Jan	34	0	37	28	25	20	6	34	0	37	27	25	18	6
9-Jan	36	0	26	33	25	25	9	35	0	25	31	25	25	8
10-Jan	29	0	0	27	25	18	5	28	0	0	25	25	17	5
Week 2	**188**	**0**	**117**	**168**	**146**	**123**	**20**	**185**	**0**	**114**	**161**	**144**	**120**	**19**
13-Jan	77	0	48	0	71	32	11	75	0	48	0	68	32	11
14-Jan	56	0	30	57	47	40	5	53	0	30	56	43	35	5
15-Jan	62	0	44	55	0	56	13	61	0	43	53	0	55	12
16-Jan	59	0	0	56	43	40	9	58	0	0	54	40	39	9
17-Jan	53	0	41	61	47	37	10	53	0	41	57	43	31	10
Week 3	**307**	**0**	**163**	**229**	**208**	**205**	**48**	**300**	**0**	**162**	**220**	**194**	**192**	**47**
20-Jan	**	**	**	**	**	**	**	**	**	**	**	**	**	**
21-Jan	50	0	39	19	35	25	0	50	0	38	18	34	25	0
22-Jan	37	25	32	0	23	23	5	35	25	32	0	23	23	4
23-Jan	15	21	16	18	17	20	5	15	21	16	18	16	20	5
24-Jan	30	30	25	0	26	0	7	29	30	25	0	26	0	7
Week 4	**132**	**76**	**112**	**37**	**101**	**68**	**17**	**129**	**76**	**111**	**36**	**99**	**68**	**16**
27-Jan	19	19	21	22	25	19	5	19	19	21	22	25	19	5
28-Jan	9	21	15	17	14	18	0	9	19	15	17	14	18	0
29-Jan	15	23	15	18	16	17	5	15	23	15	18	14	17	5
30-Jan	17	15	16	21	18	14	0	16	15	16	20	18	14	0
31-Jan	22	25	10	21	13	15	0	22	25	10	21	13	15	0
Week 5	**82**	**103**	**77**	**99**	**86**	**83**	**10**	**81**	**101**	**77**	**98**	**84**	**83**	**10**
Total	**812**	**179**	**567**	**654**	**625**	**552**	**116**	**797**	**177**	**569**	**634**	**605**	**536**	**111**
	Total Calls Received					**3,505**			**Total Calls Answered**				**3,419**	

	Average Call Time							Average Queue Time						
Date	**Op 4**	**Op 5**	**Op 6**	**Op 7**	**Op 8**	**Op 9**	**Op 10**	**Op 4**	**Op 5**	**Op 6**	**Op 7**	**Op 8**	**Op 9**	**Op 10**
1-Jan	**	**	**	**	**	**	**	**	**	**	**	**	**	**
2-Jan	2:32	0:00	4:12	2:25	2:58	4:36	1:50	0:14	0:00	0:08	0:10	0:07	0:08	0:06
3-Jan	2:58	0:00	4:13	2:40	3:03	4:08	2:20	0:09	0:00	0:07	0:07	0:11	0:03	0:05
Week 1	**2:45**	**0:00**	**4:12**	**2:32**	**3:00**	**4:22**	**2:05**	**0:11**	**0:00**	**0:07**	**0:08**	**0:09**	**0:05**	**0:05**
6-Jan	2:20	0:00	3:38	2:57	3:16	3:25	0:00	0:14	0:00	0:06	0:11	0:14	0:05	0:00
7-Jan	2:36	0:00	4:35	2:59	3:11	2:19	0:00	0:05	0:00	0:06	0:04	0:07	0:02	0:00
8-Jan	3:25	0:00	4:18	3:11	3:52	4:01	5:07	0:23	0:00	0:28	0:31	0:17	0:05	0:04
9-Jan	2:17	0:00	4:16	2:22	3:32	3:12	1:15	0:06	0:00	0:07	0:08	0:07	0:03	0:06
10-Jan	2:29	0:00	0:00	3:00	4:36	4:28	2:00	0:28	0:00	0:00	0:11	0:22	0:02	0:03
Week 2	**2:37**	**0:00**	**4:11**	**2:53**	**3:41**	**3:29**	**2:47**	**0:15**	**0:00**	**0:11**	**0:13**	**0:13**	**0:03**	**0:04**
13-Jan	2:51	0:00	5:25	0:00	3:22	6:19	3:27	0:36	0:00	0:22	0:00	0:52	1:04	0:11
14-Jan	2:47	0:00	5:00	3:17	4:26	4:14	3:00	0:16	0:00	0:10	0:17	0:26	0:16	0:05
15-Jan	2:33	0:00	5:07	3:58	0:00	4:02	3:00	0:35	0:00	0:33	0:20	0:00	0:32	0:10
16-Jan	2:09	0:00	0:00	3:07	4:25	4:08	3:56	0:22	0:00	0:00	0:17	0:09	0:08	0:05
17-Jan	2:30	0:00	4:37	3:22	4:33	5:32	2:10	0:16	0:00	0:18	0:23	0:12	0:04	0:07
Week 3	**2:34**	**0:00**	**5:02**	**3:26**	**4:11**	**4:51**	**3:06**	**0:25**	**0:00**	**0:20**	**0:19**	**0:24**	**0:24**	**0:07**
20-Jan	**	**	**	**	**	**	**	**	**	**	**	**	**	**
21-Jan	2:26	0:00	5:27	4:12	3:15	4:08	0:00	0:47	0:00	0:32	0:06	0:07	0:02	0:00
22-Jan	3:17	0:00	3:25	0:00	4:31	3:47	1:25	0:28	0:12	0:12	0:00	0:05	0:02	0:05
23-Jan	3:00	3:29	3:56	2:23	4:50	3:00	4:00	0:05	0:04	0:07	0:05	0:06	0:02	0:07
24-Jan	2:45	3:37	4:00	0:00	4:25	0:00	3:29	0:07	0:07	0:08	0:00	0:07	0:00	0:07
Week 4	**2:52**	**3:33**	**4:12**	**3:17**	**4:15**	**3:38**	**2:58**	**0:21**	**0:07**	**0:14**	**0:05**	**0:06**	**0:02**	**0:06**
27-Jan	3:19	3:29	4:29	6:13	4:12	3:58	2:00	0:07	0:03	0:08	0:05	0:08	0:02	0:04
28-Jan	2:11	3:03	5:00	2:00	3:36	3:33	0:00	0:13	0:03	0:07	0:05	0:06	0:02	0:00
29-Jan	3:20	3:18	5:13	3:06	3:57	3:18	2:20	0:07	0:05	0:08	0:06	0:06	0:04	0:05
30-Jan	2:00	4:33	4:09	2:10	4:33	2:57	0:00	0:06	0:05	0:07	0:06	0:06	0:02	0:00
31-Jan	2:05	3:12	4:50	2:19	4:38	4:47	0:00	0:06	0:10	0:11	0:06	0:07	0:02	0:00
Week 5	**2:36**	**3:31**	**4:44**	**3:09**	**4:11**	**3:42**	**2:10**	**0:07**	**0:06**	**0:08**	**0:06**	**0:06**	**0:02**	**0:04**
Average	**2:40**	**3:32**	**4:28**	**3:03**	**3:51**	**4:00**	**2:37**	**0:16**	**0:06**	**0:12**	**0:10**	**0:12**	**0:07**	**0:05**
	Average Call Time					**3:27**			**Average Queue Time**				**0:10**	

WV Health Benefits Manager
Mountain Health Trust

AUTOMATED HEALTH SYSTEMS

Monthly Operator Statistics

Reporting Period: 1/1/14 - 1/31/14

Report Description: This report details the average number of calls handled, average call time, and average queue time by operator for each of the past 12 months.

	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Average
Average Calls Answered per Day													
Operator 4	18	18	19	15	13	15	15	16	20	20	24	38	19
Operator 5	17	17	19	18	16	18	17	18	21	26	0	22	17
Operator 6	12	16	14	9	13	13	12	13	15	15	16	29	15
Operator 7	16	18	18	15	17	18	17	19	23	22	24	35	20
Operator 8	15	19	17	11	17	16	14	15	15	17	18	30	17
Operator 9	0	0	0	0	0	0	0	0	0	8	16	27	17
Operator 10	0	0	3	3	4	4	4	4	5	4	4	7	4
Average Call Time													
Operator 4	2:23	2:56	2:55	2:28	2:59	2:38	2:48	2:50	3:08	2:57	2:46	2:40	2:47
Operator 5	3:20	3:20	3:08	3:13	3:47	3:23	3:24	3:07	3:25	2:59	0:00	3:32	3:03
Operator 6	5:32	5:30	5:22	5:38	5:29	5:17	5:42	4:31	5:34	5:04	5:18	4:28	5:17
Operator 7	3:18	3:12	3:23	2:58	2:54	2:55	3:21	0:00	3:30	3:29	3:19	3:03	2:56
Operator 8	4:17	4:09	4:30	4:28	4:06	3:57	4:27	4:18	4:45	5:12	4:36	3:51	4:23
Operator 9	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	5:15	5:05	4:00	4:46
Operator 10	0:00	0:00	2:51	2:37	2:30	2:27	2:32	3:04	3:15	2:50	2:42	2:37	2:44
Average Queue Time													
Operator 4	:07	:07	:09	:07	:06	:05	:07	:07	:08	:08	:09	:16	:08
Operator 5	:04	:04	:05	:05	:05	:05	:05	:04	:05	:05	:00	:06	:04
Operator 6	:09	:08	:07	:07	:07	:06	:06	:06	:08	:08	:23	:12	:09
Operator 7	:05	:06	:05	:04	:04	:04	:05	:05	:07	:08	:11	:10	:06
Operator 8	:08	:09	:08	:07	:06	:07	:08	:07	:07	:10	:12	:12	:08
Operator 9	:00	:00	:00	:00	:00	:00	:00	:00	:00	:03	:11	:07	:07
Operator 10	:00	:00	:03	:05	:04	:04	:05	:06	:05	:05	:07	:05	:04

Run Date: 2/1/2014

WV Health Benefits Manager
Mountain Health Trust

AUTOMATED HEALTH SYSTEMS

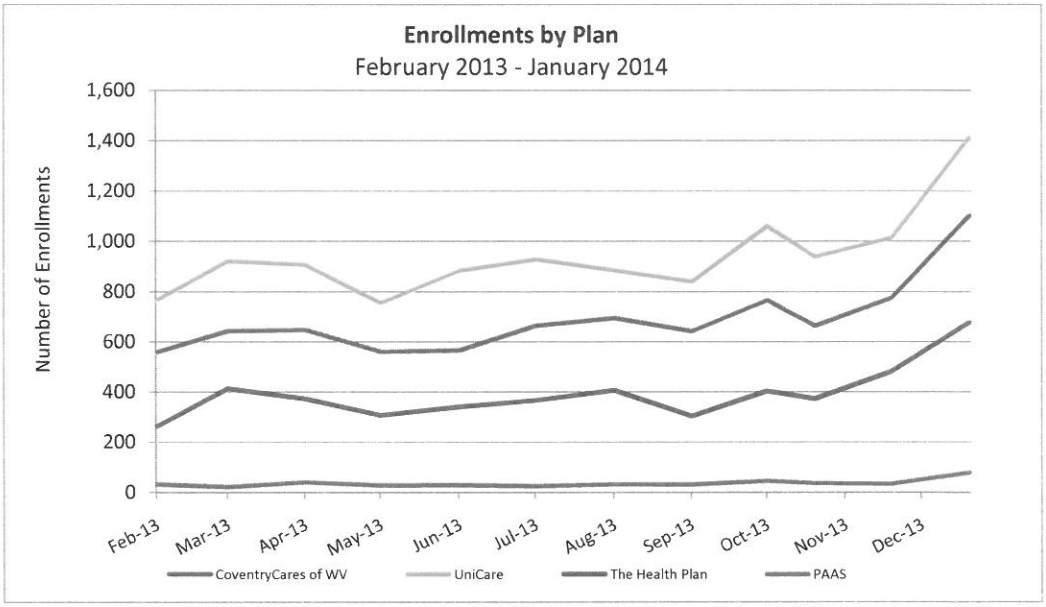
Enrollments By Plan

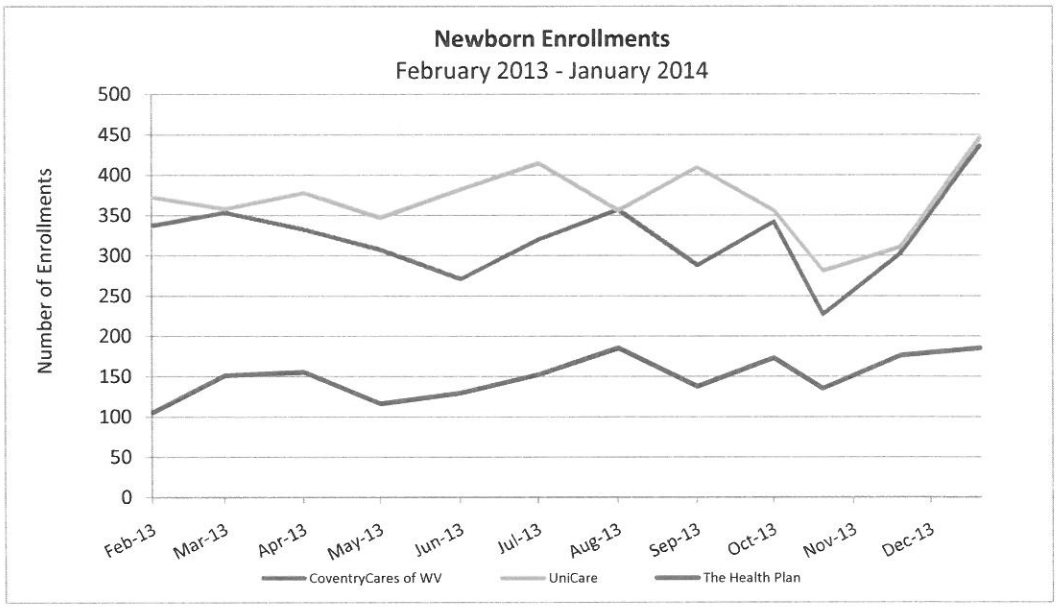
Reporting Period: 1/1/14 - 1/31/14

Report Description: This report identifies the number of enrollments by plan and by type of enrollment.

	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total
CoventryCares of WV Enrollments													
Phone Enrollments	114	156	192	99	142	162	145	184	217	217	267	310	2,205
Written Enrollments	106	132	121	152	152	181	191	168	205	218	204	354	2,184
Newborn Enrollments	337	353	332	307	271	320	357	288	342	227	303	436	3,873
Total Coventry Enrollments	557	641	645	558	565	663	693	640	764	662	774	1,100	8,262
The Health Plan Enrollments													
Phone Enrollments	59	109	90	77	91	88	110	68	106	92	129	160	1,179
Written Enrollments	97	151	126	112	119	125	110	98	124	145	175	331	1,713
Newborn Enrollments	105	151	155	116	129	152	185	137	173	135	176	185	1,799
Total Health Plan Enrollments	261	411	371	305	339	365	405	303	403	372	480	676	4,691
UniCare Enrollments													
Phone Enrollments	164	265	283	189	283	270	270	222	346	322	372	440	3,426
Written Enrollments	229	296	244	217	217	242	257	207	357	335	330	527	3,458
Newborn Enrollments	372	358	378	347	382	415	356	410	356	281	311	446	4,412
UniCare Enrollments	765	919	905	753	882	927	883	839	1,059	938	1,013	1,413	11,296
PAAS Enrollments													
Phone Enrollments	17	12	27	14	20	18	18	22	20	18	20	59	265
Written Enrollments	13	8	11	12	7	6	13	8	25	18	13	19	153
PAAS Enrollments	30	20	38	26	27	24	31	30	45	36	33	78	418
Total Enrollments	**1,613**	**1,991**	**1,959**	**1,642**	**1,813**	**1,979**	**2,012**	**1,812**	**2,271**	**2,008**	**2,300**	**3,267**	**24,667**

Run Date: 2/1/2014


Enrollments by Plan
February 2013 - January 2014
Number of Enrollments
1,600
1,400
1,200
1,000
800
600
400
200
0
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
CoventryCares of WV
UniCare
The Health Plan
PAAS


Newborn Enrollments
February 2013 - January 2014
Number of Enrollments
500
450
400
350
300
250
200
150
100
50
0
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
CoventryCares of WV
UniCare
The Health Plan

WV Health Benefits Manager
Mountain Health Trust

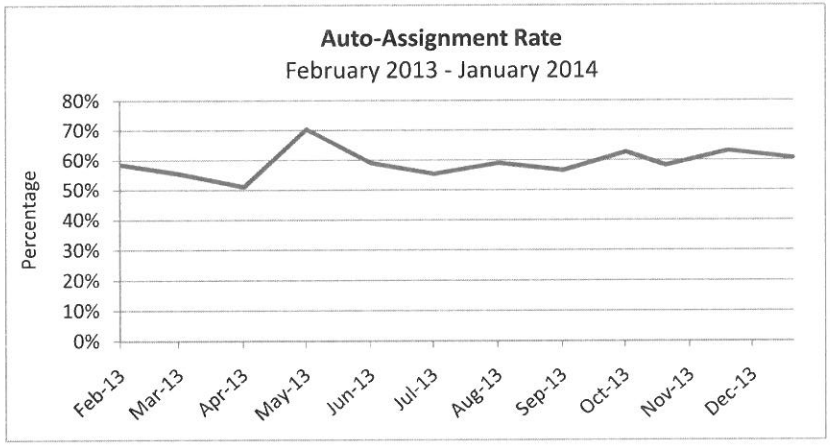
Automated Health Systems

Auto-Assignment

Reporting Period: 1/1/14 - 1/31/14

Report Description: This report identifies the percent of members that were auto-assigned to a MCO. This report also shows the change rate.

	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Average
Members Auto-assigned	2,037	1,636	3,109	2,685	2,250	2,444	2,150	2,329	3,608	2,538	4,454	4,053	2,774
Members Eligible for Auto-assignment	3,486	2,764	5,761	3,727	3,825	4,428	3,656	4,131	5,760	4,369	7,073	6,696	4,640
Auto-Assignment Rate	58.43%	55.40%	50.90%	70.21%	58.82%	55.19%	58.81%	56.38%	62.64%	58.09%	62.97%	60.53%	59%
Change Rate	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	-



Run Date: 2/1/2014

Automated Health Systems

Changes To an MCO
Reporting Period: 1/1/14 - 1/31/14

Report Description: This report identifies the number of members that were assisted in transferring to a MCO, detailed by MCO and reason for transferring.

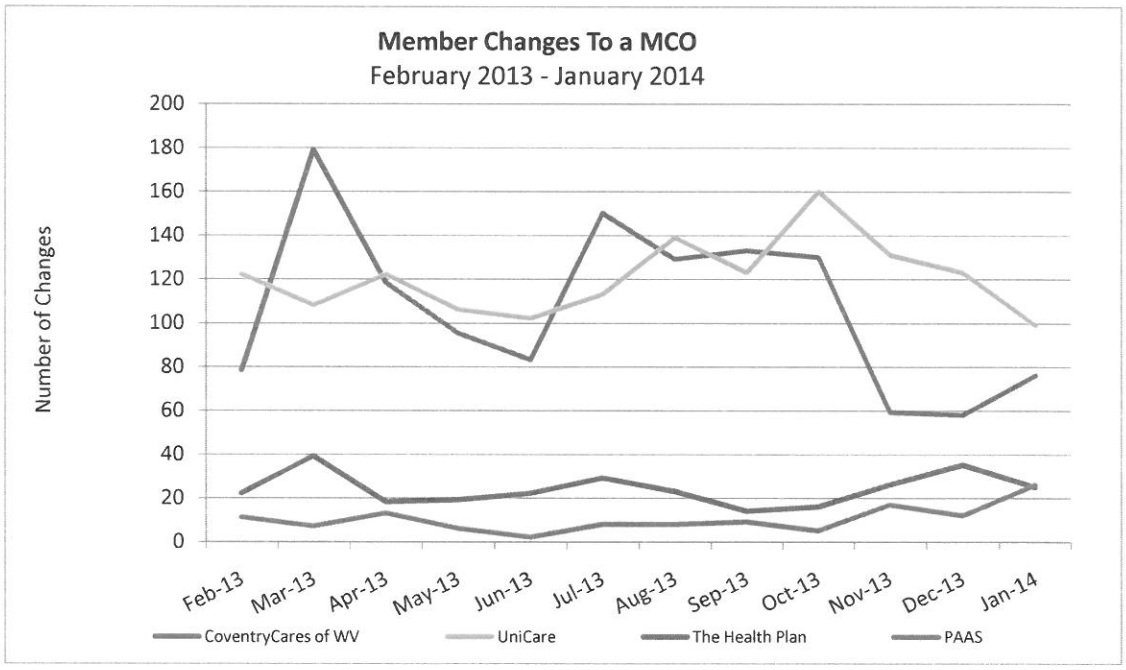
Changes to an MCO	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total
CoventryCares of West Virginia													
Auto-Assigned	2	3	5	3	7	7	7	8	3	5	11	8	69
Provider Not in Plan	42	148	104	78	65	110	90	99	91	41	36	51	955
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	1	0	2	0	0	0	0	1	1	0	4	9
Doctor: Recommended	28	24	7	8	4	22	22	15	17	7	3	3	160
Managed Care County	0	0	0	0	0	0	0	0	0	0	0	0	0
Written Enrollment	3	3	0	2	6	6	5	3	7	4	5	4	48
Other	3	0	2	2	1	5	5	8	11	1	3	6	47
Total Changes To CoventryCares of WV	**78**	**179**	**118**	**95**	**83**	**150**	**129**	**133**	**130**	**59**	**58**	**76**	**1,288**
The Health Plan													
Auto-Assigned	2	0	2	0	0	2	2	1	0	3	6	3	21
Provider Not in Plan	10	28	13	8	19	17	16	6	11	15	16	15	174
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Doctor: Recommended	7	9	0	5	1	4	0	1	1	4	0	1	33
Managed Care County	0	0	0	0	0	0	0	0	0	0	0	0	0
Written Enrollment	3	1	2	6	2	3	5	5	4	2	8	5	46
Other	0	1	1	0	0	3	0	1	0	2	5	1	14
Total Changes To The Health Plan	**22**	**39**	**18**	**19**	**22**	**29**	**23**	**14**	**16**	**26**	**35**	**25**	**288**
UniCare													
Auto-Assigned	10	6	4	7	18	16	10	8	11	18	22	14	144
Provider Not in Plan	82	81	101	85	73	65	101	104	120	92	80	54	1,038
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	0	0	3	0	0	0	1	3	0	0	0	7
Doctor: Recommended	26	18	4	4	3	25	12	6	18	18	14	14	162
Managed Care County	0	0	0	0	0	0	0	0	0	0	0	0	0
Written Enrollment	3	1	11	4	7	6	12	0	3	3	2	13	65
Other	1	2	2	3	1	1	4	4	5	0	5	4	32
Total Changes To Unicare	**122**	**108**	**122**	**106**	**102**	**113**	**139**	**123**	**160**	**131**	**123**	**99**	**1,448**
PAAS													
Auto-Assigned	0	0	4	2	0	0	1	1	2	1	0	4	15
Provider Not in Plan	9	4	9	4	2	5	6	5	3	12	10	20	89
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Doctor: Recommended	0	2	0	0	0	3	0	3	0	1	2	2	13
Managed Care County	0	1	0	0	0	0	0	0	0	0	0	0	1
Written Enrollment	2	0	0	0	0	0	1	0	0	0	0	0	3
Other	0	0	0	0	0	0	0	0	0	3	0	0	3
Total Changes To PAAS	**11**	**7**	**13**	**6**	**2**	**8**	**8**	**9**	**5**	**17**	**12**	**26**	**124**

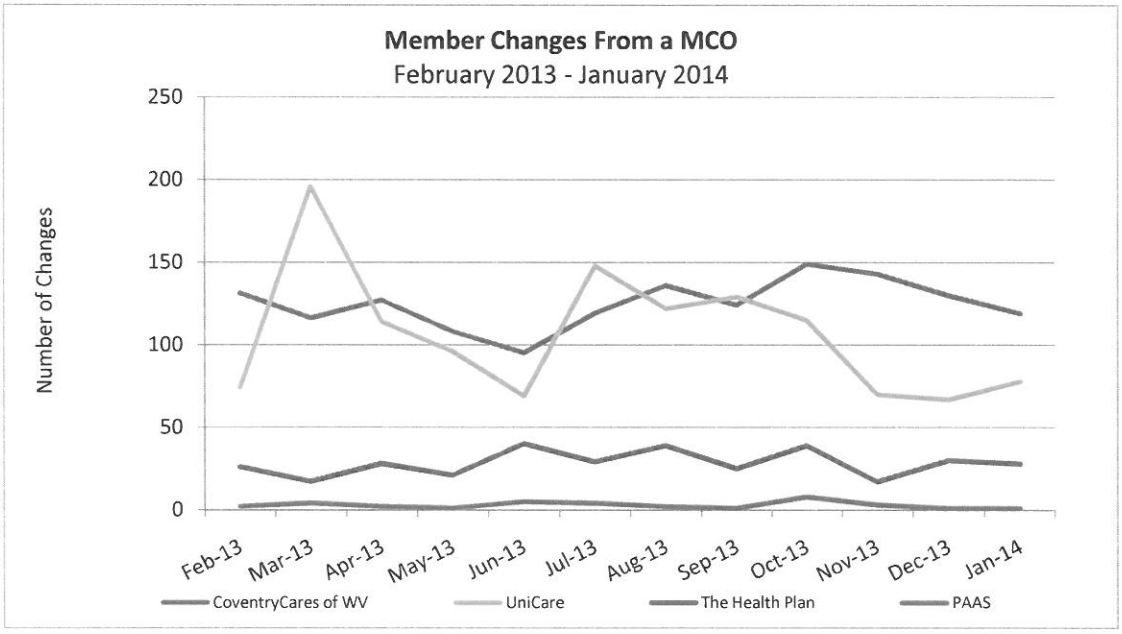
Automated Health Systems

Changes From an MCO
Reporting Period: 1/1/14 - 1/31/14

Report Description: This report identifies the number of members that were assisted in transferring from a MCO, detailed by MCO and reason for transferring.

Changes from an MCO	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total
CoventryCares of West Virginia													
Auto-Assigned	9	4	9	7	10	9	10	6	9	18	17	15	123
Provider Not in Plan	87	87	104	86	77	72	102	103	113	101	90	81	1,103
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	0	0	3	0	0	0	1	3	0	0	0	7
Doctor: Recommended	29	21	4	4	1	31	8	9	17	19	15	11	169
Managed Care County	0	0	0	0	0	0	0	0	0	0	0	0	0
Written Enrollment	6	2	9	6	6	6	14	1	2	3	5	8	68
Other	0	2	1	2	1	1	2	4	5	2	3	4	27
Total Changes from CoventryCares of WV	**131**	**116**	**127**	**108**	**95**	**119**	**136**	**124**	**149**	**143**	**130**	**119**	**1,497**
The Health Plan													
Auto-Assigned	3	2	0	3	10	12	4	6	4	1	12	8	65
Provider Not in Plan	16	14	21	14	22	13	21	17	25	14	9	8	194
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	0	0	1	0	0	0	0	0	0	0	0	1
Doctor: Recommended	5	0	0	0	4	0	8	0	2	0	2	6	27
Managed Care County	0	0	0	0	0	0	0	0	0	0	0	0	0
Written Enrollment	1	1	4	1	4	4	2	1	6	2	2	6	34
Other	1	0	3	2	0	0	4	1	2	0	5	0	18
Total Changes from The Health Plan	**26**	**17**	**28**	**21**	**40**	**29**	**39**	**25**	**39**	**17**	**30**	**28**	**339**
UniCare													
Auto-Assigned	2	3	6	2	5	4	6	6	3	8	10	6	61
Provider Not in Plan	38	156	100	75	56	108	88	93	86	44	42	50	936
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	1	0	1	0	0	0	0	1	1	0	4	8
Doctor: Recommended	27	32	7	12	3	23	18	16	11	11	2	3	165
Managed Care County	0	1	0	0	0	0	0	0	0	0	0	0	1
Written Enrollment	4	2	0	5	5	5	7	6	6	4	8	8	60
Other	3	1	1	1	0	8	3	8	8	2	5	7	47
Total Changes from UniCare	**74**	**196**	**114**	**96**	**69**	**148**	**122**	**129**	**115**	**70**	**67**	**78**	**1,278**
PAAS													
Auto-Assigned	0	0	0	0	0	0	0	0	0	0	0	0	0
Provider Not in Plan	2	4	2	0	4	4	2	1	1	1	1	1	23
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Doctor: Recommended	0	0	0	1	0	0	0	0	6	0	0	0	7
Managed Care County	0	0	0	0	0	0	0	0	0	0	0	0	0
Written Enrollment	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	1	0	0	0	1	2	0	0	4
Total Changes from PAAS	**2**	**4**	**2**	**1**	**5**	**4**	**2**	**1**	**8**	**3**	**1**	**1**	**34**


Member Changes To a MCO
February 2013 - January 2014
Number of Changes
200
180
160
140
120
100
80
60
40
20
0
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
CoventryCares of WV
UniCare
The Health Plan
PAAS


Member Changes From a MCO
February 2013 - January 2014
Number of Changes
250
200
150
100
50
0
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
CoventryCares of WV
UniCare
The Health Plan
PAAS

WV Health Benefits Manager
Mountain Health Trust

AUTOMATED HEALTH SYSTEMS

Health Risk Assessment

Reporting Period: 1/1/14 - 1/31/14

Report Description: This report identifies the number of members who self identified as having one of the conditions listed below.

	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total
Asthma	40	65	55	56	64	88	69	64	90	94	95	120	900
Diabetes	10	10	8	12	16	15	13	16	23	11	35	12	181
Heart Condition	20	30	20	20	22	17	17	20	29	40	34	34	303
Newborn	812	867	870	770	788	897	900	837	873	649	787	1,066	10,116
Smoker	124	143	126	107	127	112	140	150	178	327	361	348	2,243
Planned Surgery	13	12	12	9	15	12	14	4	19	16	15	14	155
Pregnancy	194	229	210	194	221	259	222	168	206	131	154	352	2,540
Smokeless Tobacco	11	13	7	11	7	7	9	8	5	33	37	41	189
Other	73	105	86	80	88	109	99	78	121	134	163	232	1,368
Total	**1,297**	**1,474**	**1,394**	**1,259**	**1,348**	**1,516**	**1,483**	**1,345**	**1,544**	**1,435**	**1,681**	**2,219**	**17,995**

Run Date: 2/1/2014

WV Health Benefits Manager
Mountain Health Trust

Automated Health Systems

Referrals

Reporting Period: 1/1/14 - 1/31/14

Report Description: This report identifies agencies that members were referred to by AHS.

	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total
BMS	2	7	4	4	4	3	5	6	5	5	3	7	55
Change Center	28	45	47	38	37	44	56	49	60	43	27	51	525
Client Services	21	12	14	17	15	26	9	26	21	9	9	56	235
DHHR	27	33	41	24	35	31	35	45	40	17	21	25	374
MCO	91	83	212	107	110	117	129	129	80	116	64	85	1,323
Medicaid Advocate	5	5	14	5	9	5	9	5	5	13	13	7	95
Molina	37	40	76	65	54	75	78	67	78	39	33	176	818
Other Agency	19	15	25	22	14	16	28	25	17	18	11	39	249
PAAS	1	1	0	0	1	1	0	0	0	0	0	0	4
Physician/Pharmacist	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**231**	**241**	**433**	**282**	**279**	**318**	**349**	**352**	**306**	**260**	**181**	**446**	**3,678**
Third Party Liability (TPL)													
TPLs Received	26	54	33	34	36	38	40	19	22	30	27	105	**464**

Run Date: 2/1/2014

WV Health Benefits Manager
Mountain Health Trust

AUTOMATED HEALTH SYSTEMS

Field Activities

Reporting Period: 1/1/14 - 1/31/14

Report Description: This report identifies the number and type of field visits conducted during the reporting month.

	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total
Medicaid Redesign													
Booth/Display	1	6	25	9	5	5	9	4	9	3	0	0	76
Conference	0	1	0	2	2	0	0	0	1	0	0	0	6
Drop-in	320	379	274	283	186	252	209	213	264	98	202	299	2,979
Follow-up	14	9	24	5	5	3	8	10	4	26	30	23	161
Inquiry	5	6	7	4	2	4	10	5	16	3	5	26	93
Issue	5	3	9	9	5	5	3	6	14	3	4	9	75
Meeting	21	20	16	28	12	18	25	22	24	10	3	14	213
Presentation	1	1	3	2	2	6	2	1	4	0	1	1	24
Referral	0	0	0	0	0	0	0	0	9	13	2	0	24
Scheduled Appointment	0	1	0	0	0	0	0	0	0	0	3	6	10
Mountain Health Trust													
Booth/Display	1	6	25	9	5	5	9	4	10	4	2	0	80
Conference	0	1	0	2	2	0	0	1	1	2	0	0	9
Drop-in	324	455	294	319	258	260	246	227	312	179	226	97	3,197
Follow-up	16	9	33	6	5	3	8	13	14	35	31	2	175
Inquiry	18	7	9	7	5	5	10	5	16	5	5	0	92
Issues	5	3	9	9	10	5	3	6	21	11	4	0	86
Meeting	21	20	16	28	12	18	25	22	26	20	3	7	218
Presentation	1	1	3	2	2	6	2	1	5	6	1	1	31
Referral	0	0	1	0	0	0	0	1	16	26	2	0	46
Scheduled Appointment	0	1	0	0	0	0	0	0	0	3	4	2	10

Run Date: 2/1/2014

WV Health Benefits Manager
Mountain Health Trust

AUTOMATED HEALTH SYSTEMS

Mailings

Reporting Period: 1/1/14 - 1/31/14

Report Description: This report identifies the number of enrollment packets that were sent to members in each of the last 12 reporting months.

	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total
Phase 2	235	124	136	233	183	196	268	182	277	208	171	517	2,730
Phase 4	1,526	741	1,010	1,275	1,013	1,056	1,419	1,215	1,740	1,138	1,170	3,747	17,050
Phase 8	753	330	497	720	550	541	811	671	962	589	604	2,109	9,137
Phase 10	47	19	26	0	0	0	0	0	0	0	0	0	92
Phase 12	107	89	89	112	77	70	121	92	108	117	118	0	1,100
Phase 14	678	475	566	713	584	534	859	708	695	709	808	0	7,329
Phase 18	429	303	338	476	408	351	594	497	489	463	484	0	4,832
Phase 20	24	24	13	0	0	0	0	0	0	0	0	0	61
Phase 22	50	14	27	30	30	25	48	34	157	44	53	0	512
Phase 24	280	86	191	213	168	178	261	226	1,407	342	436	0	3,788
Phase 28	180	51	114	141	107	118	161	164	850	233	263	0	2,382
Phase 30	8	2	6	0	0	0	0	0	0	0	0	0	16
Total	**4,317**	**2,258**	**3,013**	**3,913**	**3,120**	**3,069**	**4,542**	**3,789**	**6,685**	**3,843**	**4,107**	**6,373**	**49,029**

Run Date: 2/1/2014

WV Health Benefits Manager
Mountain Health Trust

Automated Health Systems

Returned Mail

Reporting Period: 1/1/14 - 1/31/14

Report Description: This report identifies the number of pieces of returned mail and the reason why the mail was returned.

	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total
Mountain Health Trust													
Attempted: Not Known	14	23	30	32	29	29	25	32	40	18	51	29	352
Box Closed	0	0	0	0	0	0	0	0	0	0	0	0	0
Insufficient Address	9	9	5	1	6	21	12	12	18	8	17	8	126
Moved/Left No Address	0	0	2	3	3	1	7	10	0	3	1	10	40
No Mail Receptacle	3	3	6	5	1	0	2	8	6	3	14	3	54
No Such Number/Address	13	12	14	12	16	14	15	15	22	10	27	14	184
Not Deliverable as Addressed	1	0	0	7	0	0	5	0	0	0	0	0	13
Other	0	0	0	2	0	0	1	0	0	0	0	0	3
Refused	2	5	4	2	4	3	3	4	5	4	2	3	41
Return to Sender	37	44	40	44	47	71	64	68	83	50	130	95	773
Unable to Forward	22	31	23	26	25	35	43	50	46	31	56	54	442
Unclaimed	7	21	5	17	33	28	25	25	19	26	33	27	266
Vacant	3	2	0	2	4	3	9	1	7	2	5	11	49
Total	**111**	**150**	**129**	**153**	**168**	**205**	**211**	**225**	**246**	**155**	**336**	**254**	**2,343**
Mountain Health Choices													
Attempted: Not Known	11	25	24	24	7	13	13	7	23	6	2	0	155
Box Closed	0	0	0	0	0	0	0	0	0	0	0	0	0
Insufficient Address	9	17	7	3	0	10	8	9	7	3	0	0	73
Moved/Left No Address	4	0	2	2	0	1	1	11	0	3	0	0	24
No Mail Receptacle	6	2	6	3	2	0	2	4	2	2	0	0	29
No Such Number/Address	13	11	8	7	1	4	17	6	16	6	0	0	89
Not Deliverable as Addressed	15	26	21	16	6	16	5	1	5	0	1	0	112
Other	0	0	1	0	0	2	0	0	0	0	0	0	3
Refused	3	2	4	1	0	3	0	2	3	0	0	0	18
Return to Sender	17	21	17	22	4	30	25	19	30	26	0	0	211
Unable to Forward	14	23	16	17	8	10	25	19	18	14	0	0	164
Unclaimed	3	8	1	3	3	9	11	13	11	18	1	0	81
Vacant	3	4	2	3	3	2	5	2	0	0	0	0	24
Total	**98**	**139**	**109**	**101**	**34**	**100**	**112**	**93**	**115**	**78**	**4**	**0**	**983**

Run Date: 2/1/2014

West Virginia
Health Benefits Manager
Mountain Health Trust

February 2014

Monthly Status Report

Submitted by Automated Health Systems

March 13, 2014

AUTOMATED HEALTH SYSTEMS

JOSEPH W. NOCITO
CHIEF EXECUTIVE OFFICER

405 CAPITOL STREET, SUITE 406, CHARLESTON, WV 25301 • (304)345-0436 • (304) 345-1581 FAX

March 13, 2014

Brandy Pierce
Director of Managed Care and Procurement Services
Department of Health and Human Resources
350 Capitol Street, Room 251
Charleston, WV 25301

Subject: West Virginia Health Benefits Manager Monthly Status Report – February 2014

Dear Ms. Pierce:

This letter and enclosed documents represent activity performed by Automated Health Systems for February 2014 in support of the West Virginia Health Benefits Manager Project. Please let me know if you have any questions or comments about the information provided in the report. I look forward to hearing from you.

Sincerely,

Janet K. Pritchard

Janet K. Pritchard, MPA, MSW
Interim Project Manager

AUTOMATED HEALTH SYSTEMS

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Section I – Executive Summary

As the Program Administrator for the West Virginia Health Benefits Manager Project, Automated Health Systems (AHS) is pleased to submit the February 2014 Monthly Status Report in accordance with the Project's reporting timeline. The report includes trending data and analyses of Helpline and Field operational activities for the Mountain Health Trust (MHT) Program. In addition, a rolling 12 month data report is included as Appendix A.

Outreach to Dental Providers

The Outreach and Education Specialists continued their site visits to dental providers in their respective territories. Staff provided education on how to read the Medical Card; Managed Care enrollment and plan options by county; new billing procedures for children's dental; Medicaid expansion population; and, billing for straight Medicaid, among others. We also distributed the Dental Billing Guide for Medicaid Managed Care Enrollees and provided Scion Dental contact information. The dental offices are reporting high satisfaction with the support provided by Scion Dental and they also appreciate our on-site visits. 203 dental sites were outreached during the month.

MCO Expansion

Early in February, AHS was notified that The Health Plan (THP) would be expanding into two additional counties (i.e., Lincoln and Putman) with choice effective April 1, 2014 and auto-assignment May 1, 2014. To support the expansion, AHS mailed the notification letter to members who reside in the affected counties; updated the Mountain Health Trust website; reconfigured the mailing phases for the counties to include the THP brochure in the newly eligible enrollment packets; updated helpline and field staff on the effective dates for choice and auto-assignment; and, educated providers, pharmacies, agencies, DHHR offices, consumer groups and advocates about the MCO expansion.

Newborn Enrollments

During the month, the Contract Monitor requested that AHS implement a new process for managing the newborn enrollment forms due to date of birth eligibility issues. Going forward, AHS will enter the enrollment for the available eligibility date then scan and send to the Contract Monitor via secure email all of the newborn forms with birth date eligibility issues so that the state can correct the information. AHS will continue to recheck the scanned forms and attach the backdated eligibility as the eligibility issue is resolved.

MHT Enrollment Process Tip Sheet

At the request of the Contract Monitor, AHS created a draft MHT DHHR Tip sheet that describes the MHT enrollment process and effective dates for newly enrolled Medicaid members, MHT members who lose and regain Medicaid eligibility, and MHT members who want to change their MCO. The tip sheet includes effective date scenarios to help the DHHR workers understand the instances when an enrollment is effective based on the monthly cut-off dates. AHS is awaiting feedback on the content and design of the form. Once approved, the Outreach & Education Specialists will distribute the tip sheet during their routine DHHR office visits and they will also use it as a training tool.

The following sections provide outcomes and trending data for key project management activities during the month of February.

Section II - Call Statistics

The MHT Helpline received 2,520 calls in the month of February, 985 fewer calls than were reported for January 2014. Of the calls received, 2,443 were successfully answered. The abandonment rate for the month of February was 3.06% (Figure 2). The average hold time was 0:07 with the average length of call at 4:09 (Figure 3). All call center metrics met or exceeded service level agreements.

Exhibit 1: Call Center Statistics – Feb. 2014	
Calls Received	2,520
Calls Answered	2,443
Abandoned Calls	77
Abandonment Rate	3.06%
Average Length of Call	4:09
Average Enrollee Hold Time	0:07
Busiest Day of the Month	Feb-14

Figure 1: Calls Received vs Calls Answered
March 2013 - February 2014

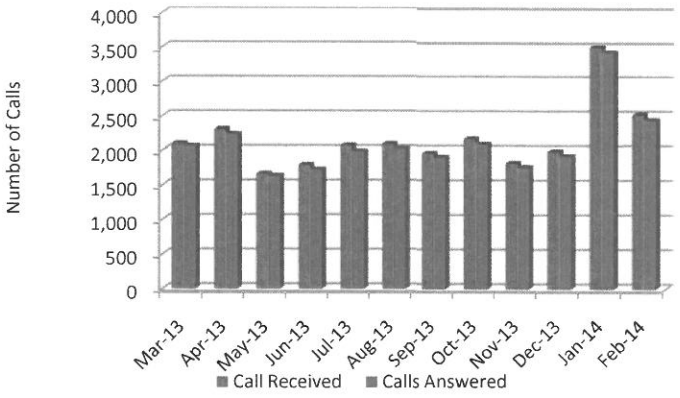


Figure 2: Abandonment Rate
March 2013 - February 2014

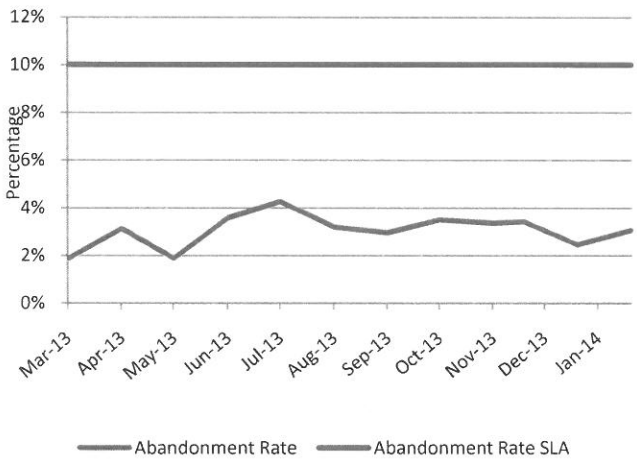
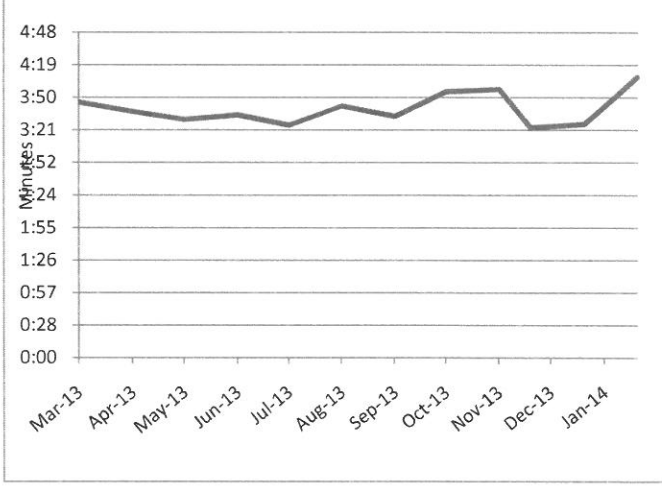


Figure 3: Average Length of Call
March 2013 - February 2014



Call Statistics by Operator

Exhibits 2 and 3 detail the weekly number of calls received, number of calls answered, average length of call, and average queue for each operator. The daily detail for each operator is provided in Appendix A.

Exhibit 2: Daily Call Statistics by Operator – February 2014

	Number of Calls Received							Number of Calls Answered						
Date	Op 4	Op 5	Op 6	Op 7	Op 8	Op 9	Op 10	Op 4	Op 5	Op 6	Op 7	Op 8	Op 9	Op 10
Week 1	112	132	117	46	97	56	0	112	130	115	45	94	55	0
Week 2	184	155	160	136	150	108	0	174	153	151	128	143	102	0
Week 3	112	112	100	0	94	39	0	111	109	93	0	91	38	0
Week 4	143	142	133	0	148	44	0	142	140	130	0	143	44	0
Week 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**551**	**541**	**510**	**182**	**489**	**247**	**0**	**539**	**532**	**489**	**173**	**471**	**239**	**0**

Exhibit 3: Daily Call Statistics by Operator – February 2014

	Average Length of Call							Average Queue Time						
Date	Op 4	Op 5	Op 6	Op 7	Op 8	Op 9	Op 10	Op 4	Op 5	Op 6	Op 7	Op 8	Op 9	Op 10
Week 1	2:51	3:16	5:20	2:35	4:24	7:18	0	0:06	0:06	0:13	0:05	0:10	0:03	0
Week 2	2:47	3:01	5:20	3:40	4:12	6:06	0	0:06	0:09	0:06	0:07	0:08	0:04	0
Week 3	2:44	4:21	5:22	0:00	3:57	5:27	0	0:07	0:04	0:11	0:00	0:05	0:02	0
Week 4	2:20	3:44	5:01	0:00	4:22	5:20	0	0:10	0:09	0:12	0:00	0:16	0:04	0
Week 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Average	**2:40**	**3:36**	**5:16**	**3:08**	**4:14**	**6:03**	**0**	**0:07**	**0:07**	**0:10**	**0:06**	**0:10**	**0:03**	**0**

*Operator #10 is Part Time and provides additional coverage for the 4pm -8pm time slot. This position was vacant for the month of February.

Section III - Mountain Health Trust

Enrollments

New enrollments for the month of February 2014 totaled 2,860- 407 fewer enrollments than were processed in the previous month. Exhibit 4 details enrollment figures by week for each plan and trends enrollments for each plan over the last 12 months. Exhibit 5 displays the rolling 12 month data for enrollments by plan and details the source from which AHS received the enrollment. Of the 1,220 written plan enrollments received this month, 137 were received through the website as online enrollments. Enrollments averaged 2,159 per month over the 12 month rolling period.

Exhibit 4: New Enrollments by Plan – Feb. 2014

	PAAS	HP	CC of WV	UniCare	Total
Week 1	11	125	253	315	704
Week 2	19	241	273	439	972
Week 3	4	171	207	250	632
Week 4	2	105	159	286	552
Total	**36**	**642**	**892**	**1,290**	**2,860**

Figure 4: Enrollments by Plan
March 2013 - February 2014

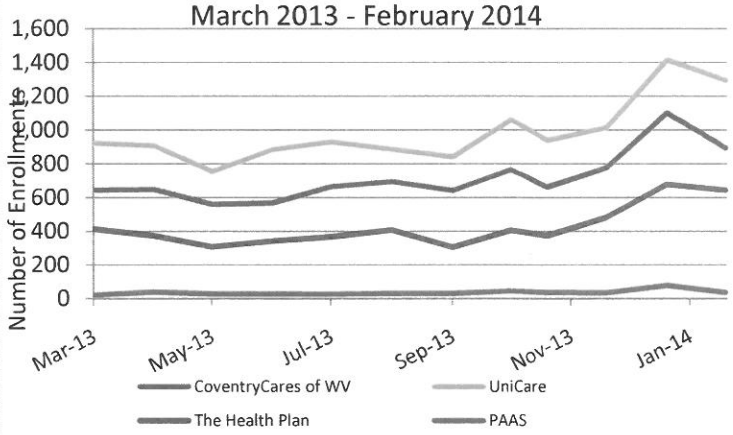


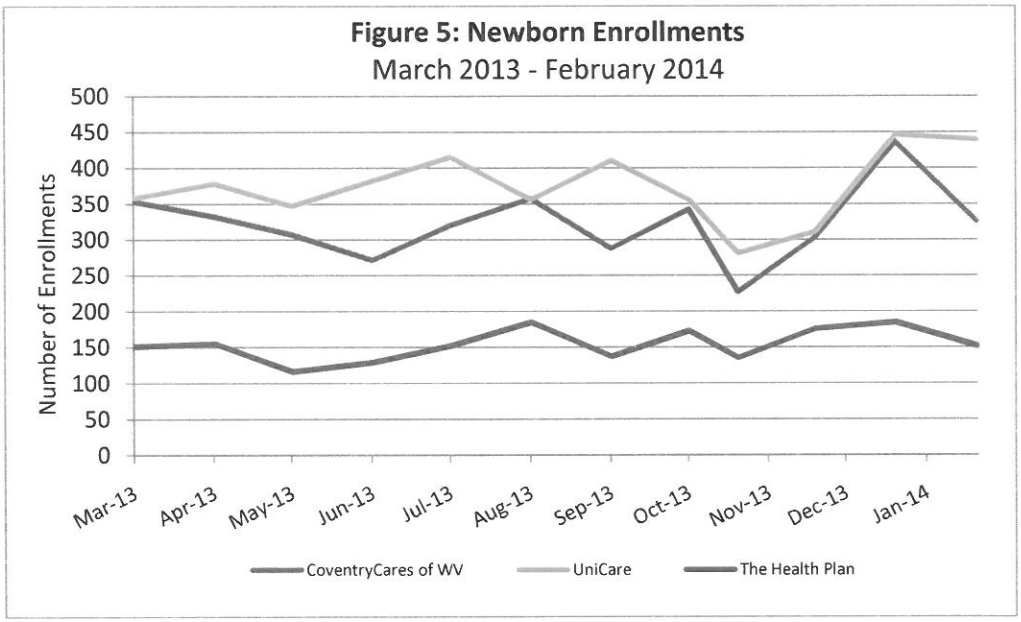
Exhibit 5: Member Enrollment by Plan and Source – February 2014

	Mar-13	Apr- 13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total
Coventry Cares o f WV													
Phone Enrollments	156	192	99	142	165	145	184	217	217	267	310	229	**2,320**
Written Enrollments	132	121	152	152	181	191	168	205	218	204	354	337	**2,415**
Newborn Enrollments	353	332	307	271	320	357	288	342	227	303	436	326	**3,862**
Total Coventry Enrollments	**641**	**645**	**558**	**565**	**663**	**693**	**640**	**764**	**662**	**774**	**1,100**	**892**	**8,597**
The Health Plan													
Phone Enrollments	109	90	77	91	88	110	68	106	92	129	160	163	**1,283**
Written Enrollments	151	126	112	119	125	110	98	124	145	175	331	327	**1,943**
Newborn Enrollments	151	155	116	129	152	185	137	173	135	176	185	152	**1,846**
Total Health Plan Enrollments	**411**	**371**	**305**	**339**	**365**	**405**	**303**	**403**	**372**	**480**	**676**	**642**	**5,072**
Unicare													
Phone Enrollments	265	283	189	283	270	270	222	346	322	372	440	305	**3,567**
Written Enrollments	296	244	217	217	242	257	207	357	335	330	527	546	**3,775**
Newborn Enrollments	358	378	347	382	415	356	410	356	281	311	446	439	**4,479**
Total UniCare Enrollments	**919**	**905**	**753**	**882**	**927**	**883**	**839**	**1,059**	**938**	**1,013**	**1,413**	**1,290**	**11,821**
PAAS													
Phone Enrollments	12	27	14	20	18	18	22	20	18	20	59	26	**274**
Written Enrollments	8	11	12	7	6	13	8	25	18	13	19	10	**150**
Total PAAS Enrollments	**20**	**38**	**26**	**27**	**24**	**31**	**30**	**45**	**36**	**33**	**78**	**36**	**424**
Total Enrollments	**1,991**	**1,959**	**1,642**	**1,813**	**1,979**	**2,012**	**1,812**	**2,271**	**2,008**	**2,300**	**3,267**	**2,860**	**25,914**

Newborn Enrollments

Exhibit 5 (above) also includes newborn enrollments for each of the last 12 months. Exhibit 6 (below) provides the weekly breakdown of newborn enrollments by plan. In the month of February, 152 newborns were enrolled with The Health Plan, 326 newborns were enrolled with CoventryCares of West Virginia, and 439 newborns were enrolled with UniCare, for a total of 917 newborn enrollments. AHS' Helpline staff continues to supplement the MCO newborn form enrollment process using the weekly newborn enrollment file for early identification and enrollment of newborns.

Exhibit 6: Newborn Enrollments – Feb. 2014				
	The Health Plan	**CC of WV**	**UniCare**	**Total**
Week 1	36	100	108	244
Week 2	45	52	109	206
Week 3	43	94	80	217
Week 4	28	80	142	250
Total	**152**	**326**	**439**	**917**



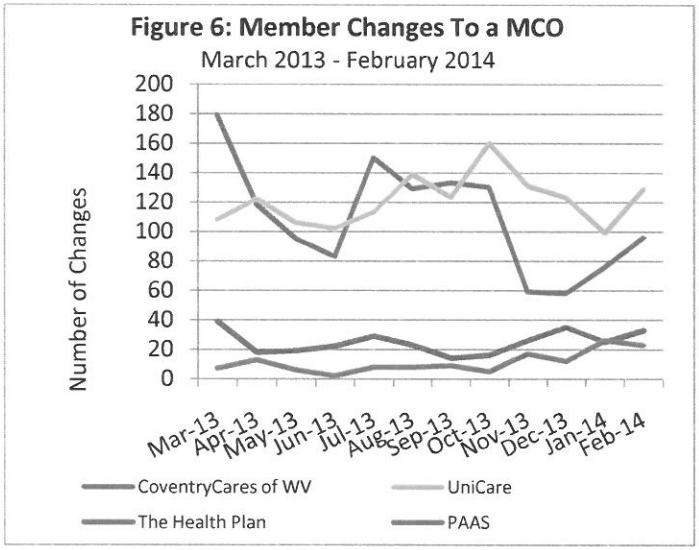
Enrollment Changes

Exhibit 7 shows member enrollment changes for members transferring from one plan to another. Of the MCOs and PAAS, only CoventryCares had more members transfer "from" their plan than "to" their plan in February.

Figures 6 and 7 show member changes 'to' and 'from' each MCO over the last 12 months.

Exhibit 7: Enrollment Changes – February 2014

	'To' CC of WV	'From' CC of WV	'To' The Health Plan	'From' The Health Plan	'To' UniCare	'From' UniCare	'To' PAAS	'From' PAAS
Week 1	26	38	15	13	31	23	4	2
Week 2	15	18	4	4	18	13	1	3
Week 3	23	36	6	5	29	23	6	0
Week 4	32	59	8	10	51	34	12	0
Total Changes	**96**	**151**	**33**	**32**	**129**	**93**	**23**	**5**



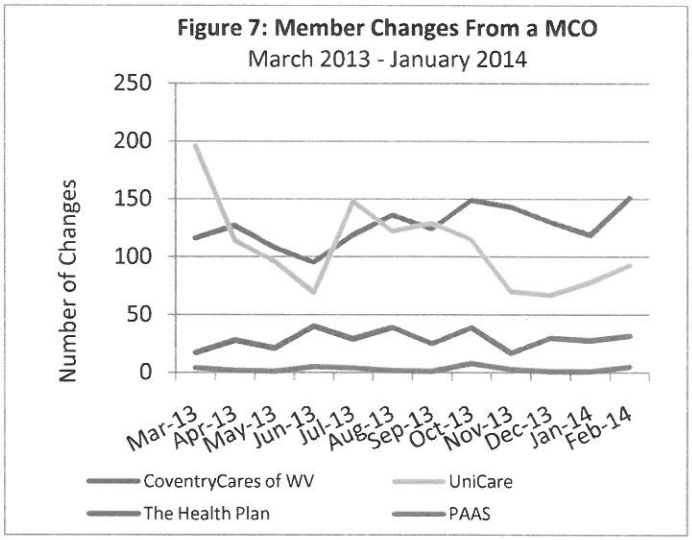


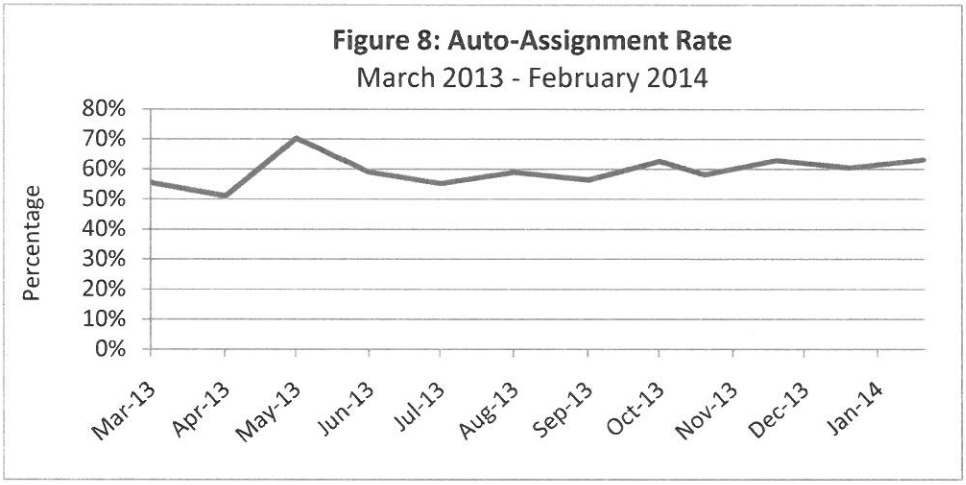
Exhibit 8 displays the most common reasons cited for enrollment changes. Lack of provider participation continues to be the top reason that members switch MCOs.

Exhibit 8: Top Reasons for Enrollment Change from Plan – Feb 2014

	CC of WV	The Health Plan	PAAS	UniCare
Provider Not in Plan	116	18	5	50
Doctor Recommended	9	1	0	3
Auto-Assigned	17	9	0	21
Written Enrollments	7	4	0	12

Auto-Assignment

The auto-assignment rate for the month of February is 63% - up slightly from what was reported in January 2014.

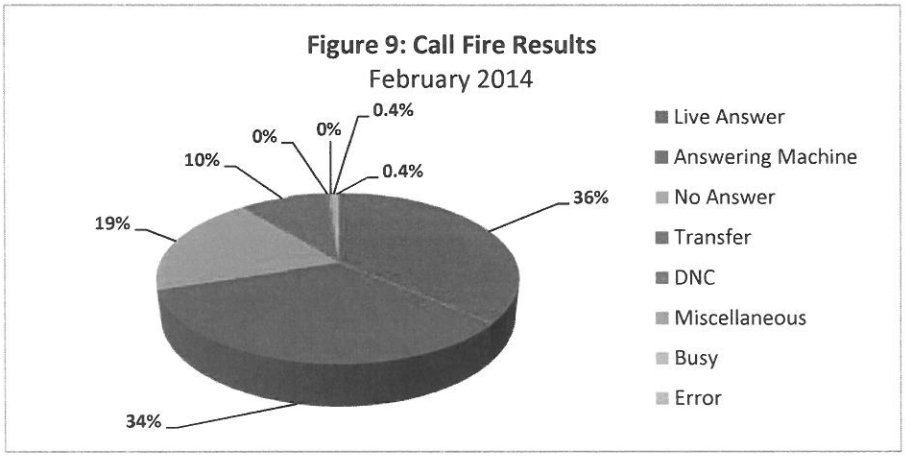


In February, 1,942 members who were scheduled to be auto-assigned effective March 1, 2014 were selected for the Call Fire campaign. As a result, 157 members that were outreached through Call Fire contacted the helpline to choose their MCO prior to auto-assignment.

This table (Exhibit 9) details the results of the campaign by call disposition.

Exhibit 9: Call Fire Results
Auto-Assignment Campaign February 2014

	Live Answer	Answering Machine	No Answer	Transfer	Do Not Call	Misc.	Busy	Error	Total
Total	706	654	373	183	7	7	4	8	**1,942**



Section IV – Mailings

AHS mailed a total of 11,239 pieces of mail for the MHT program in February. Exhibit 10 breaks out the member mailings by type. There were 263 pieces of returned mail. AHS conducted outreach on all returned mail by attempting to obtain a valid address or by contacting the member by phone.

Exhibit 10: Member Mailings – Feb. 2014	
Enrollment Packets	5,001
Reminder Letters	6,238

Enrollment mailings are broken down into phases. The phases are based upon the MCOs that are available within each county. Exhibit 12 details the mailings by phases for MHT through February 2014. The fields for MHC and Caretaker Relative are blank for January - February 2014 due to the end of the MHC program effective January 1, 2014. Exhibit 11 will continue to display the MHC data for the previous months as part of the rolling report.

Exhibit 11: Enrollment Packets Mailed – February 2014													
	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total
Phase 2	124	136	233	183	196	268	182	277	208	171	517	412	2,907
Phase 4	741	1,010	1,275	1,013	1,056	1,419	1,215	1,740	1,138	1,170	3,747	3,102	18,626
Phase 8	330	497	720	550	541	811	671	962	589	604	2,109	1,487	9,871
Phase 10	19	26	0	0	0	0	0	0	0	0	0	0	45
Mountain Health Choices													
Phase 12	89	89	112	77	710	121	92	108	117	118	0	0	993
Phase 14	475	566	713	584	534	859	708	695	709	808	0	0	6,651
Phase 18	303	338	476	408	351	591	497	489	463	484	0	0	4,403
Phase 20	24	13	0	0	0	0	0	0	0	0	0	0	37
Caretaker Relative													
Phase 22	14	27	30	30	25	48	34	157	44	53	0	0	462
Phase 24	86	191	213	168	178	261	226	1407	342	436	0	0	3,508
Phase 28	51	114	141	107	118	161	164	850	233	263	0	0	2,202
Phase 30	2	6	0	0	0	0	0	0	0	0	0	0	8
Total	**2,258**	**3,013**	**3,913**	**3,120**	**3,069**	**4,542**	**3,789**	**6,685**	**3,843**	**4,107**	**6,373**	**5,001**	**49,713**

Section V – Field Activities

Field staff conducted the usual mix of outreach to DHHR, providers, and pharmacies during the month of February. Field staff participated in monthly meetings of the Family Resource Network in a number of counties in addition to a variety of committee and task force meetings. This also included a booth at Celebrating Connections which brings together early childhood and daycare providers in addition to educators. The focus continues to be on dental providers with children's dental move to Scion Dental. Dental providers have been happy to receive the Dental Billing Guide. Field staff will attend upcoming Scion provider workshops in March in Charleston and Morgantown. Outreach in Putnam and Lincoln Counties is underway with the addition of The Health Plan to county options.

Exhibit 12 breaks down outreach by region and selected categories.

Exhibit 12: Combined MHT/MHC/PAAS Field Staff Outreach – February 2014					
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Total**
DHHR	6	7	3	7	**23**
Providers	9	6	4	0	**14**
Dental	53	32	59	47	**191**
Potential Consumers	0	20	40	0	**60**
Other Outreach	4	12	23	35	**74**
Presentations	0	0	0	1	**1**
# Attending	0	0	0	4	**4**
Feedback Forms	0	0	11	18	**29**

Exhibit 13 highlights Mountain Health Trust specific outreach by site type for the month. These numbers may include multiple outreach contacts with a single provider. Nine MHC contacts are included in the total.

Exhibit 13: MHT Field Staff Outreach February 2014	
Basic Needs	2
Childcare	1
Community Resource Center	18
Dentists	203
DHHR	23
Education	3
Government Agency	23
Medical Provider	19
Other	12
Pharmacy	10
Religion	1
Retail	5
Total	**320**

AUTOMATED HEALTH SYSTEMS

West Virginia
Health Benefits Manager

Mountain Health Trust

February 2014
Appendix A
Rolling 12 Month Data

Submitted by Automated Health Systems

3/13/2014

AUTOMATED HEALTH SYSTEMS

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Mountain Health Trust
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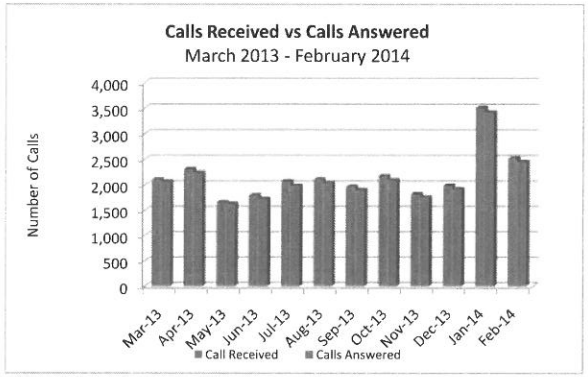
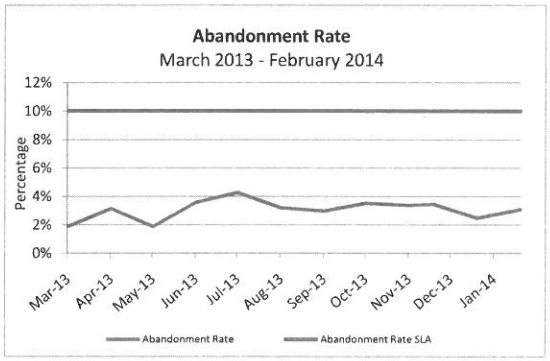
WV Health Benefits Manager
Mountain Health Trust

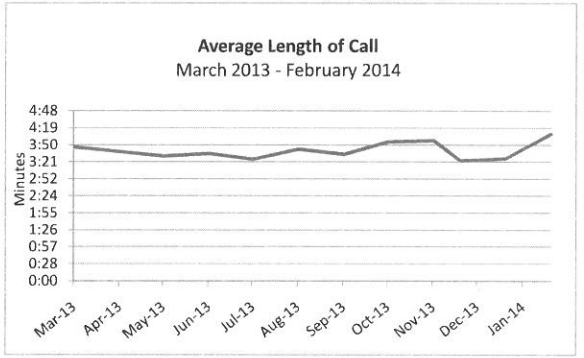
Call Center Statistics
Reporting Period: 2/1/14 - 2/28/14

Report Description: This report identifies call volume and additional key statistics for the Mountain Health Trust Helpline.

	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Average
Call Received	2,102	2,308	1,661	1,793	2,073	2,100	1,960	2,171	1,819	1,986	3,505	2,520	2,167
Calls Answered	2,063	2,236	1,630	1,726	1,985	2,033	1,902	2,095	1,758	1,918	3,419	2,443	2,101
Abandon Calls	39	72	31	64	88	67	58	76	61	68	86	77	66
Abandonment Rate	1.86%	3.12%	1.87%	3.57%	4.25%	3.19%	2.96%	3.50%	3.35%	3.42%	2.45%	3.06%	3.05%
Average Length of Call	3:46	3:38	3:31	3:35	3:26	3:43	3:34	3:56	3:58	3:24	3:27	4:09	3:40
Average Enrollee Hold Time	0:07	0:07	0:07	0:06	0:06	0:06	0:06	0:07	0:07	0:10	0:10	0:07	0:07
Busiest Day of the Month	14-Mar	17-Apr	1-May	12-Jun	15-Jul	14-Aug	11-Sep	17-Oct	12-Nov	17-Dec	2-Jan	14-Feb	-







Run Date: 3/1/2014

Daily Operator Statistics

Reporting Period: 2/1/14 - 2/28/14

Report Description: This report details the number of calls received, number of calls answered, average talk time, and average queue time by operator for each day of the reporting month.

	Number of Calls Received						Number of Calls Answered					
Date	Op 4	Op 5	Op 6	Op 7	Op 8	Op 9	Op 4	Op 5	Op 6	Op 7	Op 8	Op 9
3-Feb	24	42	32	0	23	15	24	41	31	0	23	14
4-Feb	21	22	19	23	20	14	21	22	19	23	20	14
5-Feb	17	18	29	0	16	18	17	18	29	0	15	18
6-Feb	28	30	22	0	22	0	28	29	22	0	21	0
7-Feb	22	20	15	23	16	9	22	20	14	22	15	9
Week 1	**112**	**132**	**117**	**46**	**97**	**56**	**112**	**130**	**115**	**45**	**94**	**55**
10-Feb	46	0	27	42	31	25	45	0	26	39	30	24
11-Feb	34	44	39	36	45	26	31	43	38	36	44	24
12-Feb	36	37	30	33	32	22	35	36	26	32	31	22
13-Feb	23	30	25	0	0	0	22	30	25	0	0	0
14-Feb	45	44	39	25	42	35	41	44	36	21	38	32
Week 2	**184**	**155**	**160**	**136**	**150**	**108**	**174**	**153**	**151**	**128**	**143**	**102**
17-Feb	**	**	**	**	**	**	**	**	**	**	**	**
18-Feb	50	52	42	0	41	0	50	50	40	0	40	0
19-Feb	19	23	19	0	17	16	19	23	18	0	15	15
20-Feb	30	18	24	0	17	14	29	18	22	0	17	14
21-Feb	13	19	15	0	19	9	13	18	13	0	19	9
Week 3	**112**	**112**	**100**	**0**	**94**	**39**	**111**	**109**	**93**	**0**	**91**	**38**
24-Feb	21	30	27	0	21	19	21	30	26	0	20	19
25-Feb	21	33	26	0	26	20	21	32	25	0	25	20
26-Feb	37	34	19	0	29	5	37	34	18	0	29	5
27-Feb	35	13	33	0	35	0	34	13	33	0	33	0
28-Feb	29	32	28	0	37	0	29	31	28	0	36	0
Week 4	**143**	**142**	**133**	**0**	**148**	**44**	**142**	**140**	**130**	**0**	**143**	**44**
Total	**551**	**541**	**510**	**182**	**489**	**247**	**539**	**532**	**489**	**173**	**471**	**239**
	Total Calls Received					**2,520**		**Total Calls Answered**				**2,443**

	Average Call Time						Average Queue Time					
Date	Op 4	Op 5	Op 6	Op 7	Op 8	Op 9	Op 4	Op 5	Op 6	Op 7	Op 8	Op 9
3-Feb	2:17	3:16	5:54	0:00	4:13	9:00	0:08	0:11	0:28	0:00	0:12	0:04
4-Feb	2:43	3:27	4:35	2:48	4:35	8:19	0:06	0:03	0:06	0:05	0:08	0:04
5-Feb	3:16	3:17	4:52	0:00	5:07	3:34	0:06	0:05	0:17	0:00	0:05	0:08
6-Feb	3:26	3:33	5:14	0:00	2:38	0:00	0:06	0:05	0:08	0:00	0:22	0:00
7-Feb	2:36	2:50	6:07	2:23	5:27	8:22	0:06	0:06	0:07	0:06	0:07	0:02
Week 1	**2:51**	**3:16**	**5:20**	**2:35**	**4:24**	**7:18**	**0:06**	**0:06**	**0:13**	**0:05**	**0:10**	**0:03**
10-Feb	2:02	0:00	6:09	3:37	3:53	6:15	0:07	0:00	0:06	0:07	0:06	0:04
11-Feb	3:20	3:26	5:11	4:18	4:00	8:11	0:09	0:08	0:05	0:07	0:10	0:02
12-Feb	2:54	3:00	5:23	4:18	4:20	4:09	0:05	0:11	0:06	0:06	0:06	0:09
13-Feb	2:14	2:03	4:48	0:00	0:00	0:00	0:05	0:14	0:12	0:00	0:00	0:00
14-Feb	3:25	3:36	5:12	2:29	4:35	5:50	0:06	0:06	0:05	0:10	0:11	0:05
Week 2	**2:47**	**3:01**	**5:20**	**3:40**	**4:12**	**6:06**	**0:06**	**0:09**	**0:06**	**0:07**	**0:08**	**0:04**
17-Feb	**	**	**	**	**	**	**	**	**	**	**	**
18-Feb	2:50	3:08	4:33	0:00	3:30	0:00	0:10	0:06	0:24	0:00	0:19	0:00
19-Feb	2:16	5:27	5:34	0:00	4:20	4:27	0:05	0:04	0:07	0:00	0:06	0:02
20-Feb	2:12	4:17	4:36	0:00	4:34	6:21	0:09	0:04	0:07	0:00	0:08	0:02
21-Feb	3:38	4:34	6:46	0:00	3:26	5:33	0:05	0:04	0:07	0:00	0:06	0:03
Week 3	**2:44**	**4:21**	**5:22**	**0:00**	**3:57**	**5:27**	**0:07**	**0:04**	**0:11**	**0:00**	**0:05**	**0:02**
24-Feb	2:00	5:29	3:46	0:00	4:05	5:11	0:06	0:05	0:06	0:00	0:07	0:02
25-Feb	2:33	2:59	4:24	0:00	4:56	4:10	0:08	0:06	0:06	0:00	0:12	0:08
26-Feb	2:35	3:14	6:17	0:00	4:30	6:40	0:17	0:26	0:12	0:00	0:08	0:03
27-Feb	2:08	3:38	6:13	0:00	4:30	0:00	0:15	0:05	0:30	0:00	0:32	0:00
28-Feb	2:26	3:24	4:29	0:00	3:53	0:00	0:06	0:04	0:06	0:00	0:24	0:00
Week 4	**2:20**	**3:44**	**5:01**	**0:00**	**4:22**	**5:20**	**0:10**	**0:09**	**0:12**	**0:00**	**0:16**	**0:04**
Average	**2:40**	**3:36**	**5:16**	**3:08**	**4:14**	**6:03**	**0:07**	**0:07**	**0:10**	**0:06**	**0:10**	**0:03**
	Average Call Time					**4:09**		**Average Queue Time**				**0:07**

WV Health Benefits Manager
Mountain Health Trust

AUTOMATED HEALTH SYSTEMS

Monthly Operator Statistics

Reporting Period: 2/1/14 - 2/28/14

Report Description: This report details the average number of calls handled, average call time, and average queue time by operator for each of the past 12 months.

	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Average
Average Calls Answered per Day													
Operator 4	18	19	15	13	15	15	16	20	20	24	38	28	20
Operator 5	17	19	18	16	18	17	18	21	26	0	22	30	19
Operator 6	16	14	9	13	13	12	13	15	15	16	29	26	16
Operator 7	18	18	15	17	18	17	19	23	22	24	35	29	21
Operator 8	19	17	11	17	16	14	15	15	17	18	30	26	18
Operator 9	0	0	0	0	0	0	0	0	8	16	27	17	17
Operator 10	0	3	3	4	4	4	4	5	4	4	7	0	4
Average Call Time													
Operator 4	2:56	2:55	2:28	2:59	2:38	2:48	2:50	3:08	2:57	2:46	2:40	2:40	2:48
Operator 5	3:20	3:08	3:13	3:47	3:23	3:24	3:07	3:25	2:59	0:00	3:32	3:36	3:04
Operator 6	5:30	5:22	5:38	5:29	5:17	5:42	4:31	5:34	5:04	5:18	4:28	5:16	5:15
Operator 7	3:12	3:23	2:58	2:54	2:55	3:21	0:00	3:30	3:29	3:19	3:03	3:08	2:56
Operator 8	4:09	4:30	4:28	4:06	3:57	4:27	4:18	4:45	5:12	4:36	3:51	4:14	4:22
Operator 9	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	5:15	5:05	4:00	6:03	5:05
Operator 10	0:00	2:51	2:37	2:30	2:27	2:32	3:04	3:15	2:50	2:42	2:37	0:00	2:29
Average Queue Time													
Operator 4	:07	:09	:07	:06	:05	:07	:07	:08	:08	:09	:16	:07	:08
Operator 5	:04	:05	:05	:05	:05	:05	:04	:05	:05	:00	:06	:07	:05
Operator 6	:08	:07	:07	:07	:06	:06	:06	:08	:08	:23	:12	:10	:09
Operator 7	:06	:05	:04	:04	:04	:05	:05	:07	:08	:11	:10	:06	:06
Operator 8	:09	:08	:07	:06	:07	:08	:07	:07	:10	:12	:12	:10	:09
Operator 9	:00	:00	:00	:00	:00	:00	:00	:00	:03	:11	:07	:03	:06
Operator 10	:00	:03	:05	:04	:04	:05	:06	:05	:05	:07	:05	:00	:04

Run Date: 3/1/2014

WV Health Benefits Manager
Mountain Health Trust

AUTOMATED HEALTH SYSTEMS

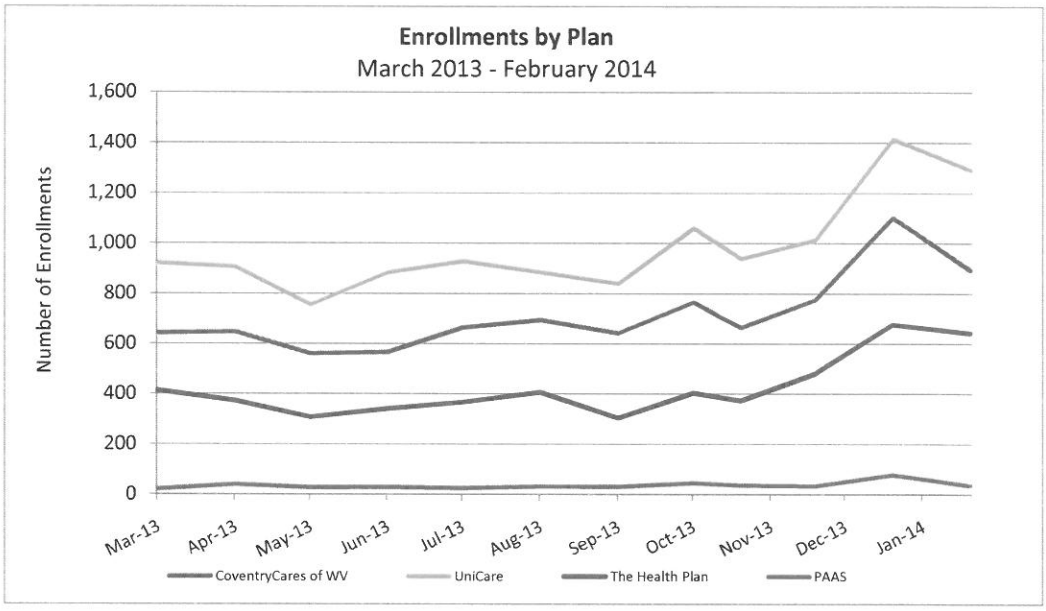
Enrollments By Plan

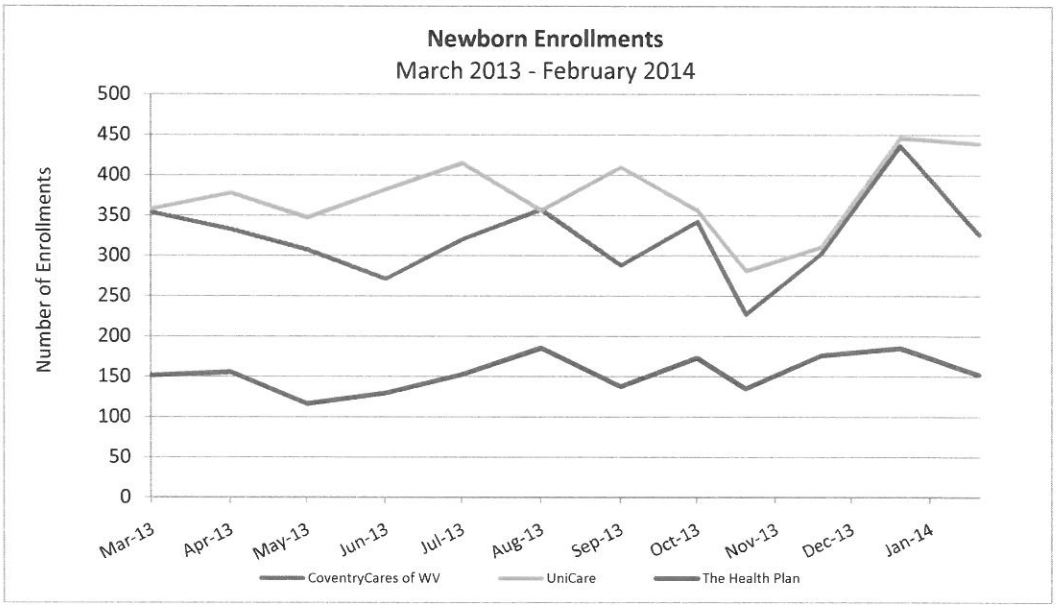
Reporting Period: 2/1/14 - 2/28/14

Report Description: This report identifies the number of enrollments by plan and by type of enrollment.

	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total
CoventryCares of WV Enrollments													
Phone Enrollments	156	192	99	142	162	145	184	217	217	267	310	229	2,320
Written Enrollments	132	121	152	152	181	191	168	205	218	204	354	337	2,415
Newborn Enrollments	353	332	307	271	320	357	288	342	227	303	436	326	3,862
Total Coventry Enrollments	641	645	558	565	663	693	640	764	662	774	1,100	892	8,597
The Health Plan Enrollments													
Phone Enrollments	109	90	77	91	88	110	68	106	92	129	160	163	1,283
Written Enrollments	151	126	112	119	125	110	98	124	145	175	331	327	1,943
Newborn Enrollments	151	155	116	129	152	185	137	173	135	176	185	152	1,846
Total Health Plan Enrollments	411	371	305	339	365	405	303	403	372	480	676	642	5,072
UniCare Enrollments													
Phone Enrollments	265	283	189	283	270	270	222	346	322	372	440	305	3,567
Written Enrollments	296	244	217	217	242	257	207	357	335	330	527	546	3,775
Newborn Enrollments	358	378	347	382	415	356	410	356	281	311	446	439	4,479
UniCare Enrollments	919	905	753	882	927	883	839	1,059	938	1,013	1,413	1,290	11,821
PAAS Enrollments													
Phone Enrollments	12	27	14	20	18	18	22	20	18	20	59	26	274
Written Enrollments	8	11	12	7	6	13	8	25	18	13	19	10	150
PAAS Enrollments	20	38	26	27	24	31	30	45	36	33	78	36	424
Total Enrollments	**1,991**	**1,959**	**1,642**	**1,813**	**1,979**	**2,012**	**1,812**	**2,271**	**2,008**	**2,300**	**3,267**	**2,860**	**25,914**

Run Date: 3/1/2014


Enrollments by Plan
March 2013 - February 2014
Number of Enrollments
1,600
1,400
1,200
1,000
800
600
400
200
0
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
CoventryCares of WV
UniCare
The Health Plan
PAAS


Newborn Enrollments
March 2013 - February 2014
Number of Enrollments
500
450
400
350
300
250
200
150
100
50
0
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
CoventryCares of WV
UniCare
The Health Plan

WV Health Benefits Manager
Mountain Health Trust

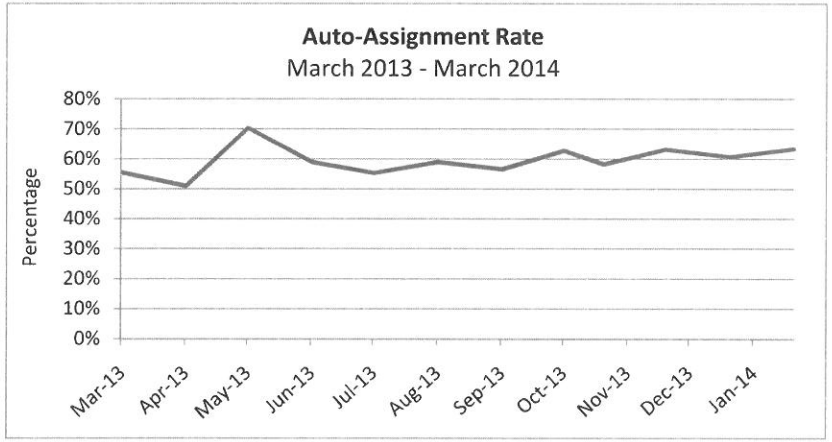
Automated Health Systems

Auto-Assignment

Reporting Period: 2/1/14 - 2/28/14

Report Description: This report identifies the percent of members that were auto-assigned to a MCO. This report also shows the change rate.

	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Average
Members Auto-assigned	1,636	3,109	2,685	2,250	2,444	2,150	2,329	3,608	2,538	4,454	4,053	4,182	2,953
Members Eligible for Auto-assignment	2,764	5,761	3,727	3,825	4,428	3,656	4,131	5,760	4,369	7,073	6,696	6,618	4,901
Auto-Assignment Rate	55.40%	50.90%	70.21%	58.82%	55.19%	58.81%	56.38%	62.64%	58.09%	62.97%	60.53%	63.19%	59%
Change Rate	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	-



Run Date: 3/1/2014

Automated Health Systems

Changes To an MCO

Reporting Period: 2/1/14 - 2/28/14

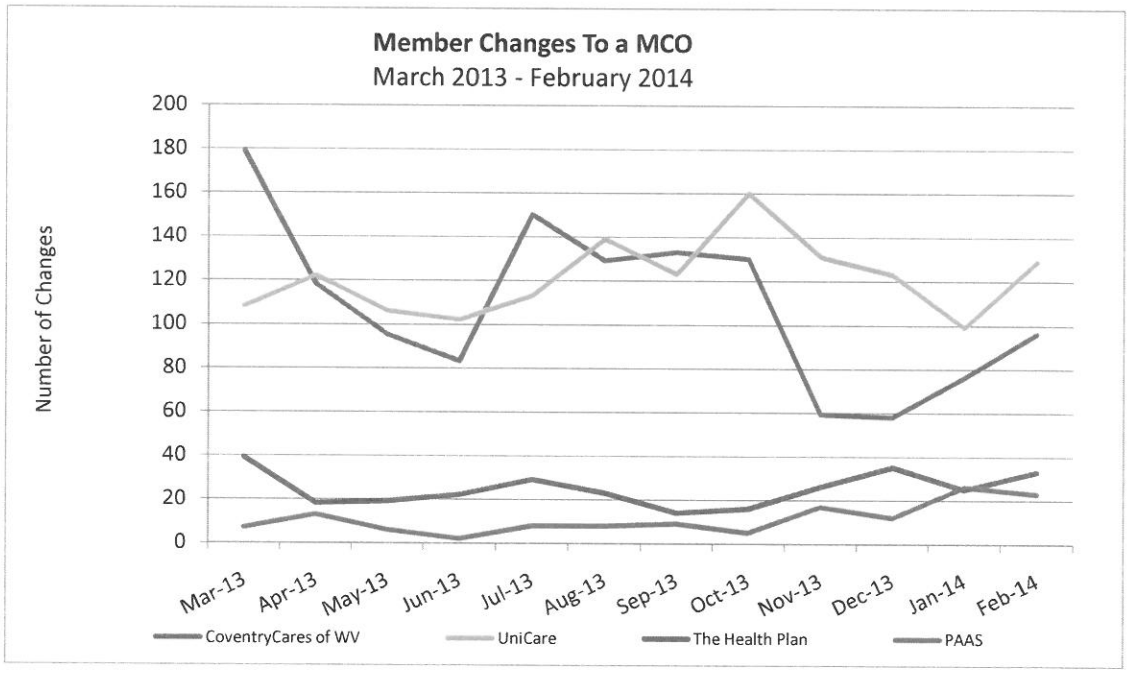
Report Description: This report identifies the number of members that were assisted in transferring to a MCO, detailed by MCO and reason for transferring.

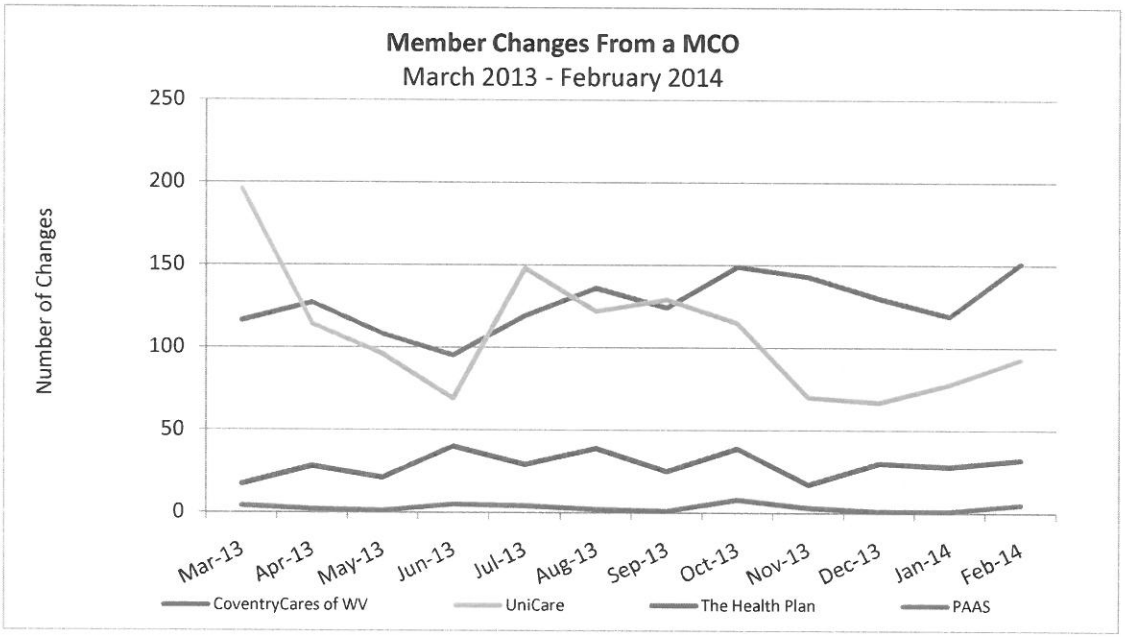
Changes to an MCO	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total
CoventryCares of West Virginia													
Auto-Assigned	3	5	3	7	7	7	8	3	5	11	8	19	86
Provider Not in Plan	148	104	78	65	110	90	99	91	41	36	51	57	970
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	1	0	2	0	0	0	0	1	1	0	4	2	11
Doctor: Recommended	24	7	8	4	22	22	15	17	7	3	3	2	134
Managed Care County	0	0	0	0	0	0	0	0	0	0	0	0	0
Written Enrollment	3	0	2	6	6	5	3	7	4	5	4	11	56
Other	0	2	2	1	5	5	8	11	1	3	6	5	49
Total Changes To CoventryCares of WV	**179**	**118**	**95**	**83**	**150**	**129**	**133**	**130**	**59**	**58**	**76**	**96**	**1,306**
The Health Plan													
Auto-Assigned	0	2	0	0	2	2	1	0	3	6	3	11	30
Provider Not in Plan	28	13	8	19	17	16	6	11	15	16	15	14	178
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Doctor: Recommended	9	0	5	1	4	0	1	1	4	0	1	2	28
Managed Care County	0	0	0	0	0	0	0	0	0	0	0	0	0
Written Enrollment	1	2	6	2	3	5	5	4	2	8	5	6	49
Other	1	1	0	0	3	0	1	0	2	5	1	0	14
Total Changes To The Health Plan	**39**	**18**	**19**	**22**	**29**	**23**	**14**	**16**	**26**	**35**	**25**	**33**	**299**
UniCare													
Auto-Assigned	6	4	7	18	16	10	8	11	18	22	14	17	151
Provider Not in Plan	81	101	85	73	65	101	104	120	92	80	54	96	1,052
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	0	3	0	0	0	1	3	0	0	0	2	9
Doctor: Recommended	18	4	4	3	25	12	6	18	18	14	14	8	144
Managed Care County	0	0	0	0	0	0	0	0	0	0	0	0	0
Written Enrollment	1	11	4	7	6	12	0	3	3	2	13	6	68
Other	2	2	3	1	1	4	4	5	0	5	4	0	31
Total Changes To Unicare	**108**	**122**	**106**	**102**	**113**	**139**	**123**	**160**	**131**	**123**	**99**	**129**	**1,455**
PAAS													
Auto-Assigned	0	4	2	0	0	1	1	2	1	0	4	0	15
Provider Not in Plan	4	9	4	2	5	6	5	3	12	10	20	22	102
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Doctor: Recommended	2	0	0	0	3	0	3	0	1	2	2	1	14
Managed Care County	1	0	0	0	0	0	0	0	0	0	0	0	1
Written Enrollment	0	0	0	0	0	1	0	0	0	0	0	0	1
Other	0	0	0	0	0	0	0	0	3	0	0	0	3
Total Changes To PAAS	**7**	**13**	**6**	**2**	**8**	**8**	**9**	**5**	**17**	**12**	**26**	**23**	**136**

Changes From an MCO
Reporting Period: 2/1/14 - 2/28/14

Report Description: This report identifies the number of members that were assisted in transferring from a MCO, detailed by MCO and reason for transferring.

Changes from an MCO	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total
CoventryCares of West Virginia													
Auto-Assigned	4	9	7	10	9	10	6	9	18	17	15	17	131
Provider Not in Plan	87	104	86	77	72	102	103	113	101	90	81	116	1,132
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	0	3	0	0	0	1	3	0	0	0	2	9
Doctor: Recommended	21	4	4	1	31	8	9	17	19	15	11	9	149
Managed Care County	0	0	0	0	0	0	0	0	0	0	0	0	0
Written Enrollment	2	9	6	6	6	14	1	2	3	5	8	7	69
Other	2	1	2	1	1	2	4	5	2	3	4	0	27
Total Changes from CoventryCares of WV	**116**	**127**	**108**	**95**	**119**	**136**	**124**	**149**	**143**	**130**	**119**	**151**	**1,517**
The Health Plan													
Auto-Assigned	2	0	3	10	12	4	6	4	1	12	8	9	71
Provider Not in Plan	14	21	14	22	13	21	17	25	14	9	8	18	196
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	0	1	0	0	0	0	0	0	0	0	0	1
Doctor: Recommended	0	0	0	4	0	8	0	2	0	2	6	1	23
Managed Care County	0	0	0	0	0	0	0	0	0	0	0	0	0
Written Enrollment	1	4	1	4	4	2	1	6	2	2	6	4	37
Other	0	3	2	0	0	4	1	2	0	5	0	0	17
Total Changes from The Health Plan	**17**	**28**	**21**	**40**	**29**	**39**	**25**	**39**	**17**	**30**	**28**	**32**	**345**
UniCare													
Auto-Assigned	3	6	2	5	4	6	6	3	8	10	6	21	80
Provider Not in Plan	156	100	75	56	108	88	93	86	44	42	50	50	948
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	1	0	1	0	0	0	0	1	1	0	4	2	10
Doctor: Recommended	32	7	12	3	23	18	16	11	11	2	3	3	141
Managed Care County	1	0	0	0	0	0	0	0	0	0	0	0	1
Written Enrollment	2	0	5	5	5	7	6	6	4	8	8	12	68
Other	1	1	1	0	8	3	8	8	2	5	7	5	49
Total Changes from UniCare	**196**	**114**	**96**	**69**	**148**	**122**	**129**	**115**	**70**	**67**	**78**	**93**	**1,297**
PAAS													
Auto-Assigned	0	0	0	0	0	0	0	0	0	0	0	0	0
Provider Not in Plan	4	2	0	4	4	2	1	1	1	1	1	5	26
Doctor: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
MCO: Not Satisfied	0	0	0	0	0	0	0	0	0	0	0	0	0
Doctor: Recommended	0	0	1	0	0	0	0	6	0	0	0	0	7
Managed Care County	0	0	0	0	0	0	0	0	0	0	0	0	0
Written Enrollment	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	1	0	0	0	1	2	0	0	0	4
Total Changes from PAAS	**4**	**2**	**1**	**5**	**4**	**2**	**1**	**8**	**3**	**1**	**1**	**5**	**37**


Member Changes To a MCO
March 2013 - February 2014
Number of Changes
200
180
160
140
120
100
80
60
40
20
0
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
CoventryCares of WV
UniCare
The Health Plan
PAAS


Member Changes From a MCO
March 2013 - February 2014
Number of Changes
250
200
150
100
50
0
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
CoventryCares of WV
UniCare
The Health Plan
PAAS

WV Health Benefits Manager
Mountain Health Trust

AUTOMATED HEALTH SYSTEMS

Health Risk Assessment

Reporting Period: 2/1/14 - 2/28/14

Report Description: This report identifies the number of members who self identified as having one of the conditions listed below.

	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total
Asthma	65	55	56	64	88	69	64	90	94	95	120	132	992
Diabetes	10	8	12	16	15	13	16	23	11	35	12	15	186
Heart Condition	30	20	20	22	17	17	20	29	40	34	34	36	319
Newborn	867	870	770	788	897	900	837	873	649	787	1,066	916	10,220
Smoker	143	126	107	127	112	140	150	178	327	361	348	315	2,434
Planned Surgery	12	12	9	15	12	14	4	19	16	15	14	16	158
Pregnancy	229	210	194	221	259	222	168	206	131	154	352	162	2,508
Smokeless Tobacco	13	7	11	7	7	9	8	5	33	37	41	29	207
Other	105	86	80	88	109	99	78	121	134	163	232	222	1,517
Total	**1,474**	**1,394**	**1,259**	**1,348**	**1,516**	**1,483**	**1,345**	**1,544**	**1,435**	**1,681**	**2,219**	**1,843**	**18,541**

Run Date: 3/1/2014

WV Health Benefits Manager
Mountain Health Trust

Automated Health Systems

Referrals

Reporting Period: 2/1/14 - 2/28/14

Report Description: This report identifies agencies that members were referred to by AHS.

	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total
BMS	7	4	4	4	3	5	6	5	5	3	7	9	62
Change Center	45	47	38	37	44	56	49	60	43	27	51	53	550
Client Services	12	14	17	15	26	9	26	21	9	9	56	36	250
DHHR	33	41	24	35	31	35	45	40	17	21	25	29	376
MCO	83	212	107	110	117	129	129	80	116	64	85	93	1,325
Medicaid Advocate	5	14	5	9	5	9	5	5	13	13	7	10	100
Molina	40	76	65	54	75	78	67	78	39	33	176	135	916
Other Agency	15	25	22	14	16	28	25	17	18	11	39	29	259
PAAS	1	0	0	1	1	0	0	0	0	0	0	0	3
Physician/Pharmacist	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**241**	**433**	**282**	**279**	**318**	**349**	**352**	**306**	**260**	**181**	**446**	**394**	**3,841**
Third Party Liability (TPL)													
TPLs Received	54	33	34	36	38	40	19	22	30	27	105	71	**509**

Run Date: 3/1/2014

WV Health Benefits Manager
Mountain Health Trust

AUTOMATED HEALTH SYSTEMS

Field Activities

Reporting Period: 2/1/14 - 2/28/14

Report Description: This report identifies the number and type of field visits conducted during the reporting month.

	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total
Medicaid Redesign													
Booth/Display	6	25	9	5	5	9	4	9	3	0	0	0	75
Conference	1	0	2	2	0	0	0	1	0	0	0	0	6
Drop-in	379	274	283	186	252	209	213	264	98	202	299	7	2,666
Follow-up	9	24	5	5	3	8	10	4	26	30	23	1	148
Inquiry	6	7	4	2	4	10	5	16	3	5	26	0	88
Issue	3	9	9	5	5	3	6	14	3	4	9	0	70
Meeting	20	16	28	12	18	25	22	24	10	3	14	1	193
Presentation	1	3	2	2	6	2	1	4	0	1	1	0	23
Referral	0	0	0	0	0	0	0	9	13	2	0	0	24
Scheduled Appointment	1	0	0	0	0	0	0	0	0	3	6	0	10
Mountain Health Trust													
Booth/Display	6	25	9	5	5	9	4	10	4	2	0	1	80
Conference	1	0	2	2	0	0	1	1	2	0	0	3	12
Drop-in	455	294	319	258	260	246	227	312	179	226	97	249	3,122
Follow-up	9	33	6	5	3	8	13	14	35	31	2	21	180
Inquiry	7	9	7	5	5	10	5	16	5	5	0	29	103
Issues	3	9	9	10	5	3	6	21	11	4	0	18	99
Meeting	20	16	28	12	18	25	22	26	20	3	7	15	212
Presentation	1	3	2	2	6	2	1	5	6	1	1	1	31
Referral	0	1	0	0	0	0	1	16	26	2	0	0	46
Scheduled Appointment	1	0	0	0	0	0	0	0	3	4	2	6	16

Run Date: 3/1/2014

WV Health Benefits Manager
Mountain Health Trust

Automated Health Systems

Mailings

Reporting Period: 2/1/14 - 2/28/14

Report Description: This report identifies the number of enrollment packets that were sent to members in each of the last 12 reporting months.

	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total
Phase 2	124	136	233	183	196	268	182	277	208	171	517	412	2,907
Phase 4	741	1,010	1,275	1,013	1,056	1,419	1,215	1,740	1,138	1,170	3,747	3,102	18,626
Phase 8	330	497	720	550	541	811	671	962	589	604	2,109	1,487	9,871
Phase 10	19	26	0	0	0	0	0	0	0	0	0	0	45
Phase 12	89	89	112	77	70	121	92	108	117	118	0	0	993
Phase 14	475	566	713	584	534	859	708	695	709	808	0	0	6,651
Phase 18	303	338	476	408	351	594	497	489	463	484	0	0	4,403
Phase 20	24	13	0	0	0	0	0	0	0	0	0	0	37
Phase 22	14	27	30	30	25	48	34	157	44	53	0	0	462
Phase 24	86	191	213	168	178	261	226	1,407	342	436	0	0	3,508
Phase 28	51	114	141	107	118	161	164	850	233	263	0	0	2,202
Phase 30	2	6	0	0	0	0	0	0	0	0	0	0	8
Total	**2,258**	**3,013**	**3,913**	**3,120**	**3,069**	**4,542**	**3,789**	**6,685**	**3,843**	**4,107**	**6,373**	**5,001**	**49,713**

Run Date: 3/1/2014

WV Health Benefits Manager
Mountain Health Trust

AUTOMATED HEALTH SYSTEMS

Returned Mail

Reporting Period: 2/1/14 - 2/28/14

Report Description: This report identifies the number of pieces of returned mail and the reason why the mail was returned.

	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total
Mountain Health Trust													
Attempted: Not Known	23	30	32	29	29	25	32	40	18	51	29	30	368
Box Closed	0	0	0	0	0	0	0	0	0	0	0	0	0
Insufficient Address	9	5	1	6	21	12	12	18	8	17	8	3	120
Moved/Left No Address	0	2	3	3	1	7	10	0	3	1	10	2	42
No Mail Receptacle	3	6	5	1	0	2	8	6	3	14	3	7	58
No Such Number/Address	12	14	12	16	14	15	15	22	10	27	14	16	187
Not Deliverable as Addressed	0	0	7	0	0	5	0	0	0	0	0	0	12
Other	0	0	2	0	0	1	0	0	0	0	0	0	3
Refused	5	4	2	4	3	3	4	5	4	2	3	1	40
Return to Sender	44	40	44	47	71	64	68	83	50	130	95	139	875
Unable to Forward	31	23	26	25	35	43	50	46	31	56	54	48	468
Unclaimed	21	5	17	33	28	25	25	19	26	33	27	14	273
Vacant	2	0	2	4	3	9	1	7	2	5	11	3	49
Total	**150**	**129**	**153**	**168**	**205**	**211**	**225**	**246**	**155**	**336**	**254**	**263**	**2,495**
Mountain Health Choices													
Attempted: Not Known	25	24	24	7	13	13	7	23	6	2	0	0	144
Box Closed	0	0	0	0	0	0	0	0	0	0	0	0	0
Insufficient Address	17	7	3	0	10	8	9	7	3	0	0	0	64
Moved/Left No Address	0	2	2	0	1	1	11	0	3	0	0	0	20
No Mail Receptacle	2	6	3	2	0	2	4	2	2	0	0	0	23
No Such Number/Address	11	8	7	1	4	17	6	16	6	0	0	0	76
Not Deliverable as Addressed	26	21	16	6	16	5	1	5	0	1	0	0	97
Other	0	1	0	0	2	0	0	0	0	0	0	0	3
Refused	2	4	1	0	3	0	2	3	0	0	0	0	15
Return to Sender	21	17	22	4	30	25	19	30	26	0	0	0	194
Unable to Forward	23	16	17	8	10	25	19	18	14	0	0	0	150
Unclaimed	8	1	3	3	9	11	13	11	18	1	0	0	78
Vacant	4	2	3	3	2	5	2	0	0	0	0	0	21
Total	**139**	**109**	**101**	**34**	**100**	**112**	**93**	**115**	**78**	**4**	**0**	**0**	**885**

Run Date: 3/1/2014