Work Experience & Portfolio

Kimberly R. Duckworth

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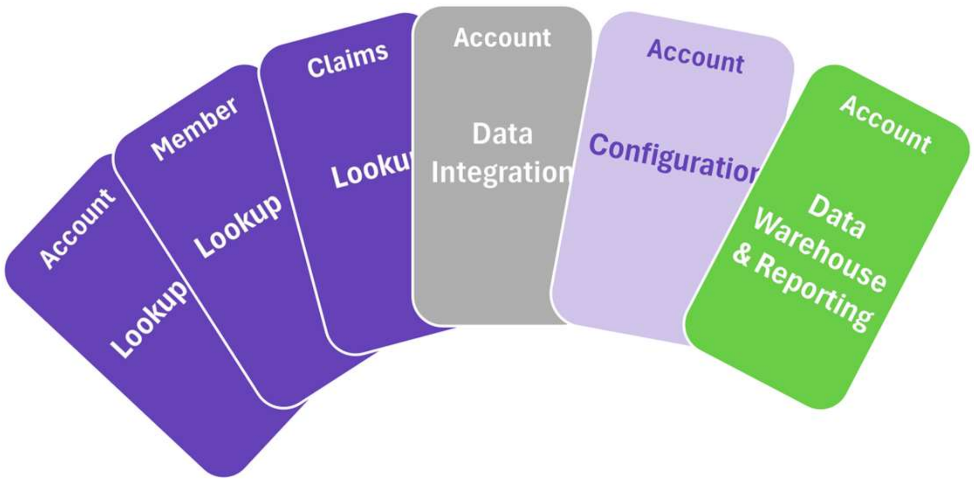


Curriculum Design

A Design to Optimize Communication, Usability & Maintenance

Single-page, combinable topics for just-in-time refreshers or role-specific training

Layered - easy to deepen, lengthen & share learning experiences

Modular - easy to combine to create training that is targeted to a learner's level, project sprint or role

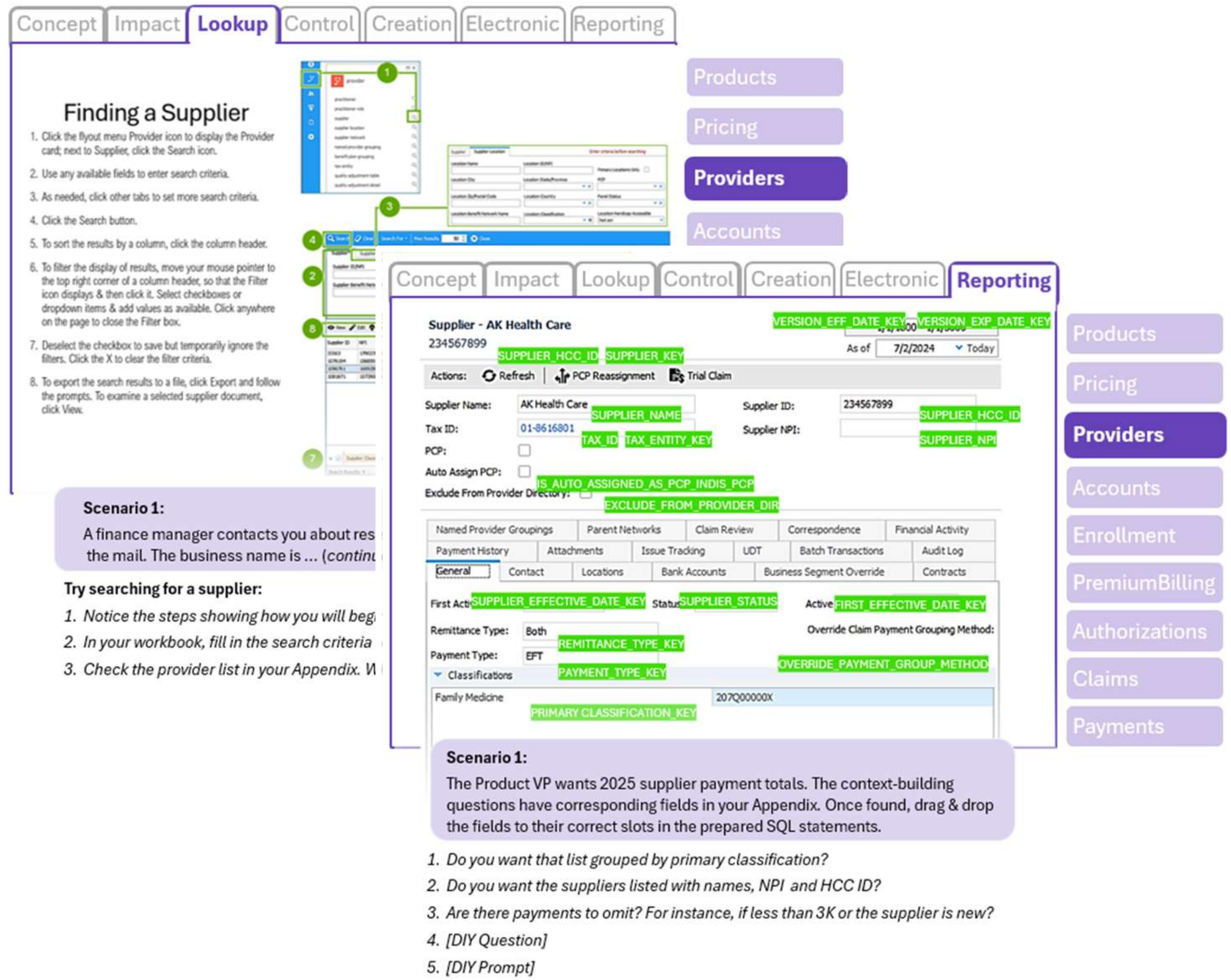
Auditor 1, 2, 3

End-User 1, 2, 3, 5

Business Owner 1, 2, 3, 4

Data Integration 1, 2, 3, 5, 6

Data Analyst 1, 2, 3, 5, 7



Need another curriculum?

Combine courses from this list!

Can't find one for your purpose?

*Let's **create** it!*

HealthRules Payor Course Modules by Category

Getting Started with HealthRules
The HealthRules Business Context 6h
HealthRules Language & Organization of Data 6h
How It Works: Interfaces, Quality Control & Transactions 6h
Claim Transactions & Key HealthRules Concepts 6h

Finding the Information You Need
Member Lookup
Provider Lookup
Finding and Reviewing Claims
Premium Billing Lookup
Claim Finance Lookup
Looking Up Codes
Reading a Benefit Plan
Reading a Supplier Contract
Checking Accumulators
Checking Coverage (Benefit Predictor)
Self-Funded Plan & Payment Lookup
Capitated Plan & Payment Lookup

Day-to-Day Claims Processing
Submitting & Reviewing Claims 12h
Working the Claim Review & Repair Workbasket 12h
Working the Reprocessed Claims Workbasket 6h
Manually Pricing Claims 12h
Adjusting, Voiding & Replacing Claims 6h

Daily Operations (with Workbaskets)
Maintaining & Managing Accounts 12h
Maintaining & Managing Member Enrollment 12h
Maintaining & Managing Providers 12h
Managing, Triggering & Resolving Billing 12h
Utilization Management 12h
Triggering & Resolving Claims Payments 6h
Issues, Service Requests & Customer Service Workbasket 6h
Working Self-Funded Arrangements & Payments 12h
Working Capitated Arrangements & Payments 12h
Adding User Accounts 6h

Setting Up
Account Setup & Validation 6h
Creating & Reviewing Benefit Plans using the Wizard 6h
Member Enrollment Setup & Validations 6h
Utilization Management Setup & Validation 6h
Premium Billing Setup & Validation 6h
Provider Operations Setup & Validation 12h
Claims Processing Setup & Validation 12h
Claims Finance Setup & Validation 6h
Service Category Configuration 6h
User Group & Permissions Set Up 12h

Configuration
Introductory Benefit Plan Configuration 20h
Introductory Supplier Contract Configuration 20h
User Messages, System Messages & Automatic Denials 6h
Labels & Accumulators 12h
Coordination of Benefits Setup 6h
Product Configuration 12h
Benefit Plan Templates, Wraparounds & Riders 20h
Multi-Tier Benefit Plans 12h
Using Value List Components 12h
Using the Out-of-Area Tier 6h
Multi-Product Supplier Contracts 6h
Benefit Network Configuration 6h
Health Care Company Document 12h
Benefit Processing Rules 6h
Pricing Processing Rules 6h
Coordination of Benefits Setup 6h
Custom Validation Policies 12h
User Defined Terms 12h
Configuring & Testing Claim Processing Provisions 12h
Configuring & Testing Claim Finance Provisions 12h
Configuring & Testing Self-Funded Benefit Plans 12h
Configuring & Testing Capitated Contracts 12h
Premium Billing Configuration 20h

Production Support
Transaction Management 12h
Managing Configuration Changes 6h
Provider Data & Claim Matching 12h

Reporting & Analytics
Introduction to HealthRules Data Warehouse 6h
DW for Accounts 12h
DW for Enrollment 12h
DW for Working the Claim Review & Repair Workbasket 12h
DW for Submitting & Reviewing Claims 12h
DW for Providers 12h
DW for Premium Billing 12h
DW for Claims Finance 12h
DW for Customer Service 6h
DW for Transaction Management 12h
Using & Customizing HealthRules Answers 12h
Using & Customizing HealthRules Answers AdHoc 12h

HealthRules Connector (Data Integration)
Introduction to Connector 6h
Connector for Accounts 12h
Connector for Enrollment 12h
Connector for Claims 12h
Connector for Providers 12h
Connector for Premium Billing 12h
Connector for Claims Finance 12h

Custom Consultant **Badge** Program

Level 1

Getting Started with HealthRules
The HealthRules Business Context *S*
HealthRules Language & Organization of Data *S*
How It Works: Interfaces, Quality Control & Transactions *S*

HealthRules Claims Processing
Claim Transactions & Key HealthRules Concepts *S*
Finding & Reviewing Claims *S*
Submitting & Reviewing Claims *M*

Level 2

Provider Data Setup & Validation *S*
Account Setup & Validation *S*
Member Enrollment Setup & Validations *S*
Service Category Setup *S*

HealthRules Benefit & Pricing Configuration
Introductory Benefit Plan Configuration *L*
Introductory Supplier Contract Configuration *L*
User Messages, System Messages & Automatic Denials *S*
Labels & Accumulators *M*

Level 3

Premium Billing Setup & Configuration
Managing, Triggering & Resolving Billing *M*
Premium Billing Configuration *M*

Advanced Configuration
Benefit Plan Templates, Wraparounds & Riders *L*
Multi-Tier Benefit Plans *M*
Using Value List Components *M*
Using the Out-of-Area Tier *S*
Multi-Product Supplier Contracts *S*
Benefit Network Configuration *S*
Health Care Company Document *M*
Benefit Processing Rules *S*
Pricing Processing Rules *S*
Coordination of Benefits Setup *S*

Production Support
Managing Configuration Changes *M*

Level 4

Reporting & Analytics
Introduction to HealthRules Data Warehouse *S*
DW Maintaining & Managing Accounts *M*
DW Maintaining & Managing Member Enrollment *M*
DW for Submitting & Reviewing Claims *M*
DW Managing & Maintaining Providers *M*
DW Managing, Triggering & Resolving Premium Billing *M*
DW Managing, Triggering & Resolving Claims Payments *M*
DW for Customer Service *S*
DW for Transaction Management *M*

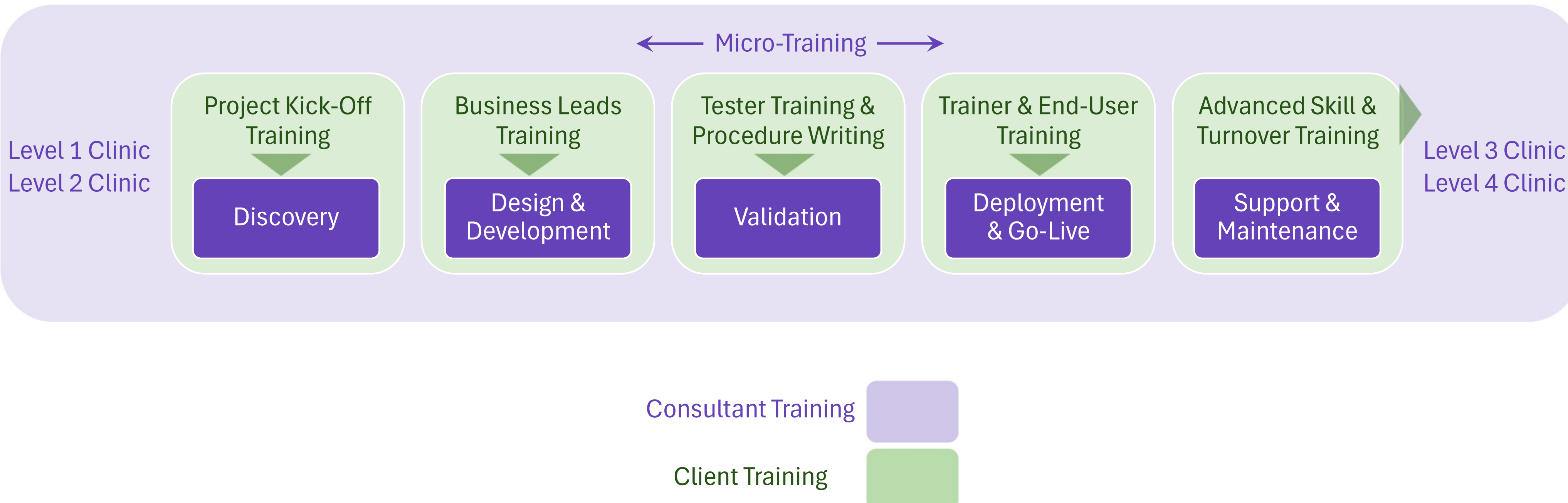
HealthRules Answers
Using & Customizing HealthRules Answers *M*
Using & Customizing HealthRules Answers AdHoc *M*

Each curriculum earns you another level & badge.

For each level, the first certification exam is included.

Annual re-certification is $50 per learner per level

Training in an Implementation Context



Client "Role-Specific" Curriculum

Business Leads

- HealthRules Overview*
- Claim Processing*
- Provider Data & Operations
- Pricing Configuration
- Benefits Configuration
- Account Management
- Benefit Plan Creation
- Member Enrollment
- Premium Billing
- Authorizations
- Claim Finance
- Data Integration
- Data Analytics
- Production Support

Each course fortifies leads to plan for upstream & downstream impact, work allocation, validations & workbasket activity.

End-Users

- HealthRules Overview*
- Provider Call Center
- Member Call Center
- Premium Billing Call Center
- Claim Call Center
- Enrollment Eligibility
- Member Services
- Authorizations
- Billing Adjustments
- Provider Services
- Claim Adjustments
- Claim Review
- Claim Repair

*Each unit has role-specific steps to perform in HealthRules Manager & must be customized to train & implement **desktop procedures**.*

Advanced Skills

- Matching Rules
- Service Categories
- Custom Validations
- Automatic Denials
- Reprocessing Rules
- Health Care Company Rules
- Advanced Benefits or Pricing
- Self-Funded Plans & Finance
- Users, Security, Sensitive Data
- Benefit Predictor Setup
- Multiple Network Tiers
- The Out-of-Area Tier
- Value Lists
- Templates, Riders & Wraps
- Capitated Plans
- User Defined Terms
- PCP Auto-Assignment

** Pre-requisite course*

Consultant "Level-Specific" Curriculum

Level 1 Clinic

- HealthRules Payor Overview
- Architecture
- Business Context
- Data Flow

The below topics include Versioning, Data Warehouse, Data Modeling & Answers:

- Provider Data & Operations
- Account Management
- Premium Billing
- Member Enrollment
- Authorizations
- Claim Processing
- Claim Finance
- Reprocessing Rules

Level 2 Clinic

- Benefits Configuration
- Coordination of Benefits
- User Messages
- Multiple Network Tiers
- The Out-of-Area Tier
- Pricing Configuration
- Capitated Pricing
- User Defined Terms
- Health Care Company Setup
- Matching Rules
- Users, Security, Sensitive Data
- Service Requests
- Code Loading
- Mapping & Conversion

Level 3 Clinic

- Implementation Lead Role
- 5 Client/Peer Reviews
- 1 Senior Review
- 30 Micro-Learnings

Level 4 Clinic

- Implementation Project Lead
- 5 Client/Peer Reviews
- 1 Senior Review
- 30 Micro-Learnings

Micro-Lessons

Reinforcement, Deep Dives, New Material

Custom Validations
Service Categories
Capitation
Value Lists
Benefit Configuration
Pricing Configuration
Data Warehouse

Service Requests
Templates, Riders, Wraps
User Defined Terms
PCP Auto-Assignment
Automatic Denials
Self-Funded Setup
Benefit Predictor Setup

Instructor-Led Training Materials

Lesson 9:

Manually Denying Claims

Introduction

Read the overview statement aloud.

Have participants read aloud the scenarios in the Apply It section to provide context or examples.

Explain that in order to run-through these scenarios, you will need to learn how to complete the tasks on the right.

Have a participant read the tasks aloud.

Ask if there are questions about the focus of this lesson and these tasks.

HealthRules Payor pays or denies c
according to rules in the benefit pl
supplier contract, and health care
company documents. However, cl
may also be denied manually. Clai
may be denied mid-adjudication in
Claim Review and Repair Workbas
thus overriding the system adjudic
entire claim needs to be denied fo
each line needs to be manually de
reason. The denial process include
or user messages for the explanati
different functionality for different

In this lesson, you will:

____ 1. Deny a claim by editing it

____ 2. Deny one of multiple claim

____ 3. Deny a claim in final status

____ 4. Deny a claim or claim line
from the Claim Review and

Lesson 9: Introduction

In this lesson, you will:

- Deny a claim by editing it
- Deny one of multiple claim lines by editing it
- Deny a claim in final status, not open for edit
- Deny a claim or claim line that is mid-adjudication, from the Claim Review and Repair workbasket

Lesson 9:

Manually Denying Claims

Introduction

HealthRules Payor pays or denies claims according to rules in the benefit plan, supplier contract, and health care company documents. However, claims may also be denied manually. Claims may be denied mid-adjudication in the Claim Review and Repair Workbasket, or after finalized, thus overriding the system adjudication. Sometimes the entire claim needs to be denied for a reason. Sometimes each line needs to be manually denied for a different reason. The denial process includes adding related reasons or user messages for the explanation of benefits. There is different functionality for different types of denials.

In this lesson, you will:

____ 1. Deny a claim by editing it

____ 2. Deny one of multiple claim lines by editing it

____ 3. Deny a claim in final status, not open for edit

____ 4. Deny a claim or claim line that is mid-adjudication, from the Claim Review and Repair workbasket

Key Ideas

Explain that the system applies system messages when it finds adjudication information and makes decisions. These are system messages.

When a user makes decisions about adjudication, the user should add (or delete) the relevant user messages. (User messages can be added OR deleted while the claim is open in edit mode.)

User message will need to be configured with an action of Denial in order to manually deny a claim or claim line. Message codes can be associated with an action of denial and a responsibility assignment that overrides the system's default responsibility assignment.

Find examples to share in the UserMessageDomain.

Explain: There are a few ways to deny a claim. Not all users will have priviledges to use all of the ways to deny. These slides discuss the different ways and why you'd use one way over another.

This method is the preferred method because it stages the claim in case it needs to be reprocessed.

If you are denying a claim that awaits manual review or repair in the Claim Review & Repair Workbasket, this is likely the first time the claim is being processed; it is mid-adjudication, and the first version of the claim will be finalized after you complete the denial and resolve the claim to move it out of the workbasket. The reason why a claim is in the workbasket is logged as an exception, on the Exceptions tab of the claim. The reasons remain on the claim so that future reviewers understand the history of the claim.

Remind participants that you can you can toggle among claim versions using the Previous and Next links.

You can view accumulator thresholds met on the member's Accumulator tab.

How can we compare system and manual denials?

- Based on rules in the benefit plan or supplier contract (an exclusion, exceeded limit, or missing authorization), the system will deny a claim and apply a *system message*
- If the denial is due to a violation of an exclusion or authorization rule in the supplier's contract, the non-covered cost is, by default, assigned to the supplier
- If the denial is due to an exclusion, limit, or authorization rule in the member's benefit plan, the non-covered cost is, by default, assigned to the member
- When a claim is manually denied, the default cost responsibility may change depending on the *user message* chosen to support the manual denial

Lesson 9: Manually Denying Claims

Key Ideas

How can we compare system and manual denials?

- Based on rules in the benefit plan or supplier contract (an exclusion, exceeded limit, or missing authorization), the system will deny a claim and apply a *system message*
- If the denial is due to a violation of an exclusion or authorization rule in the supplier's contract, the non-covered cost is, by default, assigned to the supplier
- If the denial is due to an exclusion, limit, or authorization rule in the member's benefit plan, the non-covered cost is, by default, assigned to the member
- When a claim is manually denied, the default cost responsibility may change depending on the *user message* chosen to support the manual denial

What happens when you use the Deny button, without opening for edit?

- You'll select one denial reason, rather than one for editing and one for denial
- The one denial reason you select is added to the claim header and to each line
- The claim is flagged as "manually priced," preventing future system-reprocessing

When happens when you deny a claim while it is open for edit?

- You may deny the entire claim, or deny only specific lines but allow others
- You may select a different user message to support the denial of each line
- The message you select may override default system responsibility assignment

What if you deny a claim in the Claim Review and Repair Workbasket?

- Likely, the claim is mid-adjudication, being processed for the first time
- The first version finalizes after being resolved and denied from the workbasket
- Exceptions remain on claims resolved in the workbasket as an alert to any who open the claim for edit or review
- If you deny a claim without opening for edit, exceptions remain in RED
- If you deny a claim in "Needs Review" status by opening for edit and then denying, exceptions are automatically approved and turned to GREEN

What other data changes when a claim is manually denied?

- If the claim was previously finalized, it will reprocess, creating a new version
- Accumulator calculations may change
- New financial records will be generated, whether they differ or not from previous ones; and accessed on the claim's Financial History tab

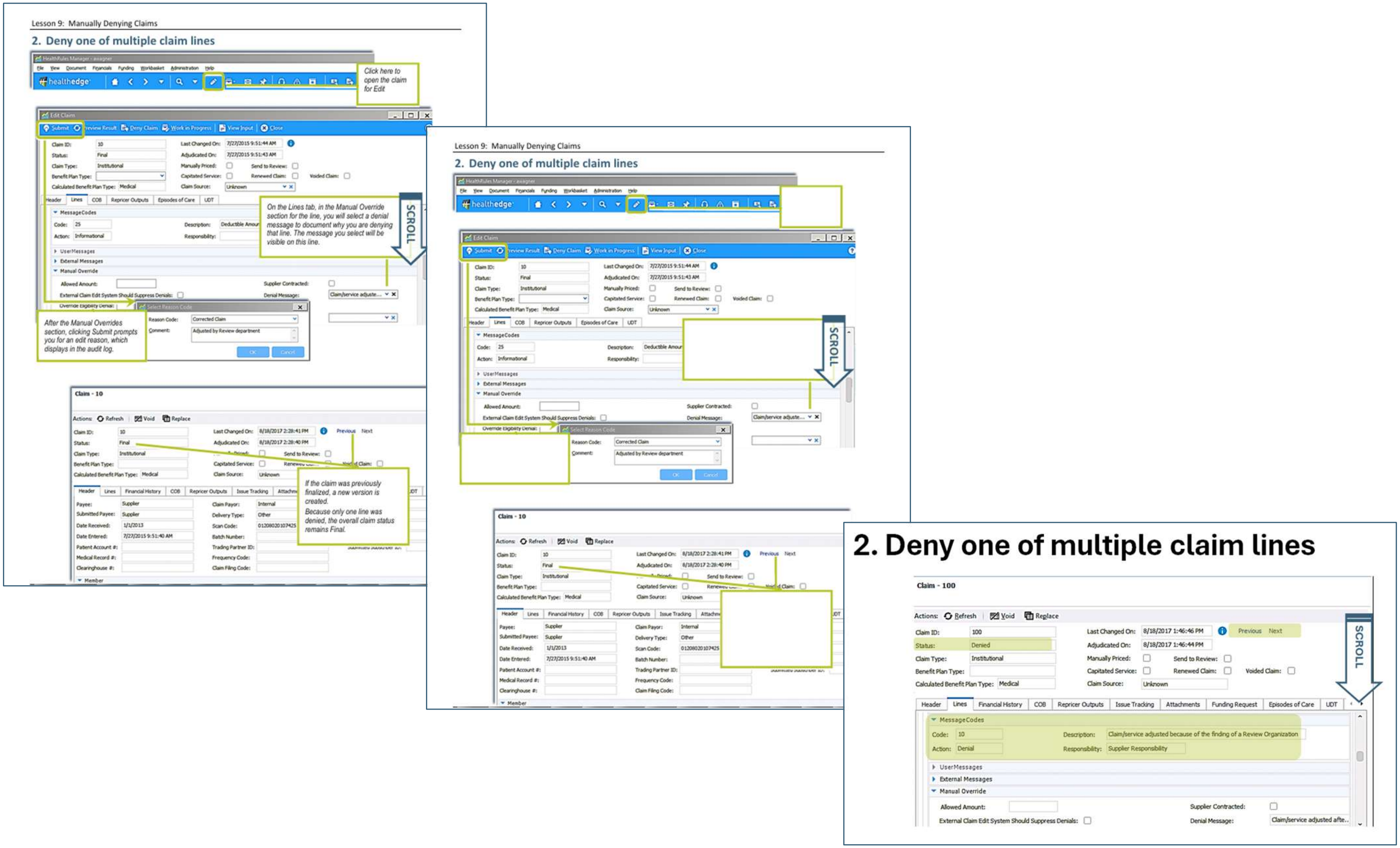
Best Practices

- Add user messages to provide explanation on Explanation of Benefit or Explanation of Payment statements (See Appendix A for denial message codes)
- Include comments to support your action

Key Ideas

How to compare system & manual denials?

- Based on rules in the benefit plan or supplier contract (an exclusion, exceeded limit, or missing authorization), the system will deny a claim and apply a *system message*
- If the denial is due to a violation of an exclusion or authorization rule in the supplier's contract, the non-covered cost is, by default, assigned to the supplier
- If the denial is due to an exclusion, limit, or authorization rule in the member's benefit plan, the non-covered cost is, by default, assigned to the member
- When a claim is manually denied, the default cost responsibility may change depending on the *user message* chosen to support the manual denial



Lesson 9: Manually Denying Claims
2. Deny one of multiple claim lines
Click here to open the claim for Edit
On the Lines tab, in the Manual Override section for the line, you will select a denial message to document why you are denying that line. The message you select will be visible on this line.
SCROLL
After the Manual Overrides section, clicking Submit prompts you for an edit reason, which displays in the audit log.
If the claim was previously finalized, a new version is created.
Because only one line was denied, the overall claim status remains Final.
Lesson 9: Manually Denying Claims
2. Deny one of multiple claim lines
SCROLL
2. Deny one of multiple claim lines
Claim - 100
SCROLL

Lesson 9: Manually Denying Claims

Jumping In

Walk It!

These exercises familiarize with the lesson tasks before applying them in the context of a specific company procedure.

Have participants work in pairs to check and discuss each other's work. Review as a group.

Walk through your Detailed Procedures with your instructor.
Check each task that you cover as you walk through it.

____ 1. Deny a claim by editing it

____ 2. Deny one of multiple claim lines by editing it

____ 3. Deny a claim in final status, not open for edit

____ 4. Deny a claim or claim line that is mid-adjudication, from the Claim Review and Repair workbasket

Ponder It!

These questions encourage participants to think about the generic functionality in the context of their workplace. This should lead them into the Apply It section.

Customize as needed.

A. What are some denial message codes that may be added to a claim when manually denying a claim line?

Add site-specific message codes here.

B. Here, what steps must be taken *prior* to denying a claim line?

Add site-specific steps here.

C. What denial method w

Don't open the claim for edit; sim

D. Let's say an entire mult you proceed?

Don't open the claim for edit; sim

E. What happens to the e workbasket?

Exceptions remain on claims resc review. If you deny a claim with "Needs Review" status by openin turned to GREEN.

F. What claim review reas while open for edit in t

Add site-specific reason code her

Apply It!

These scenarios give the participants the opportunity to witness and practice the lesson content in the context of their work environment. Have the participants practice each one of these scenarios in your HealthRules training environment by first choosing and then implementing the correct denial method and procedure.

Create detailed site-specific scenarios. Participants will use the Detailed Procedure section to complete these scenarios.

A. Claim ID ________ ha trigger indicates a subs member is not current service.

Which Detailed Proced

Deny a claim from the Claim Rev

B. You have determined t for the date of service f

Which Detailed Proced

Deny the claim using open for ed

C. Claim ID ________ ha with all other additiona

Ponder It!

A. What are some denial message codes that may be added to a claim when manually denying a claim line?

B. Here, what steps must be taken prior to denying a claim line?

C. What denial method will select the Manually Priced checkbox?

D. Let's say an entire multi-line claim must be denied for a single reason? How will you proceed?

E. What happens to the exceptions on a claim after it is denied from the workbasket?

F. What claim review reason code should be added to your claim when you deny it while open for edit in the workbasket?

15

Lesson 9: Manually Denying Claims

Jumping In

Walk It!

Walk through your Detailed Procedures with your instructor.
Check each task that you cover as you walk through it.

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Ponder It!

A. What are some denial message codes that may be added to a claim when manually denying a claim line?

B. Here, what steps must be taken *prior* to denying a claim line?

C. What denial method will select the Manually Priced checkbox?

D. Let's say an entire multi-line claim must be denied for a single reason? How will you proceed?

E. What happens to the exceptions on a claim after it is denied from the workbasket?

F. What claim review reason code should be added to your claim when you deny it while open for edit in the workbasket?

Apply It!

A. Claim ID ________ has been received and is in Needs Review. The trigger indicates a subscription hold. You have determined the member is not current in their premium payments for the date of service.

Which Detailed Procedure instruction will you use?

B. You have determined that a member is not current on their premium payments for the date of service for Claim ID ________.

Which Detailed Procedure instruction will you use?

C. Claim ID ________ has a claim line that needs to be denied for medical records with all other additional lines being allowed at contract rate.

Which Detailed Procedure instruction will you use?

D. Claim ID ________ was processed in error due to a retro-active termination request. Reprocess the claim denying services as member not eligible for date of service.

Which Detailed Procedure instruction will you use?

E. Claim Claim ID ________ was processed in error. Reprocess the claim denying services as member not eligible for date of service.

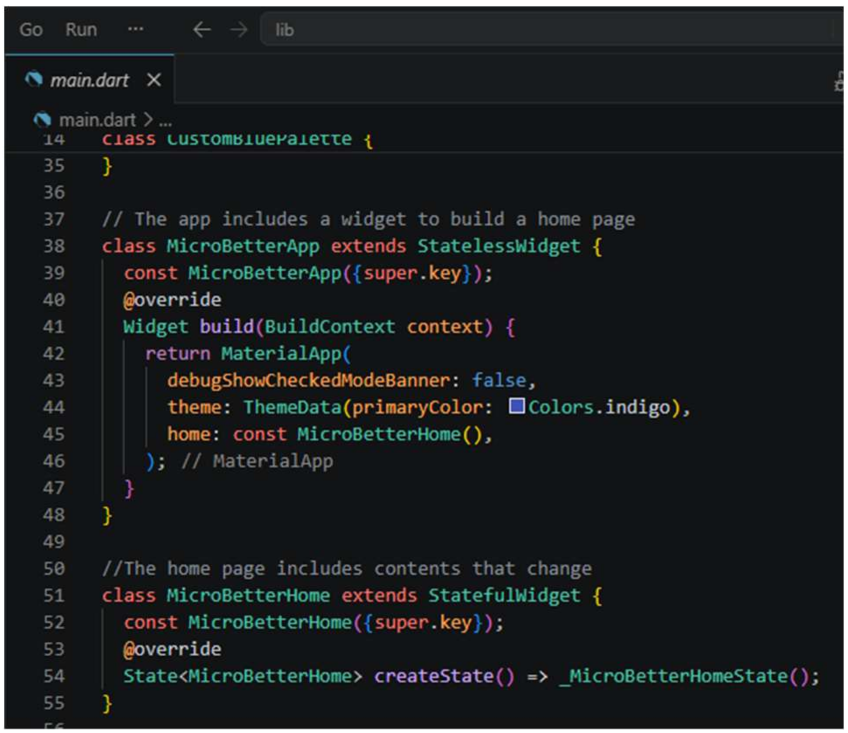
Which Detailed Procedure instruction will you use?

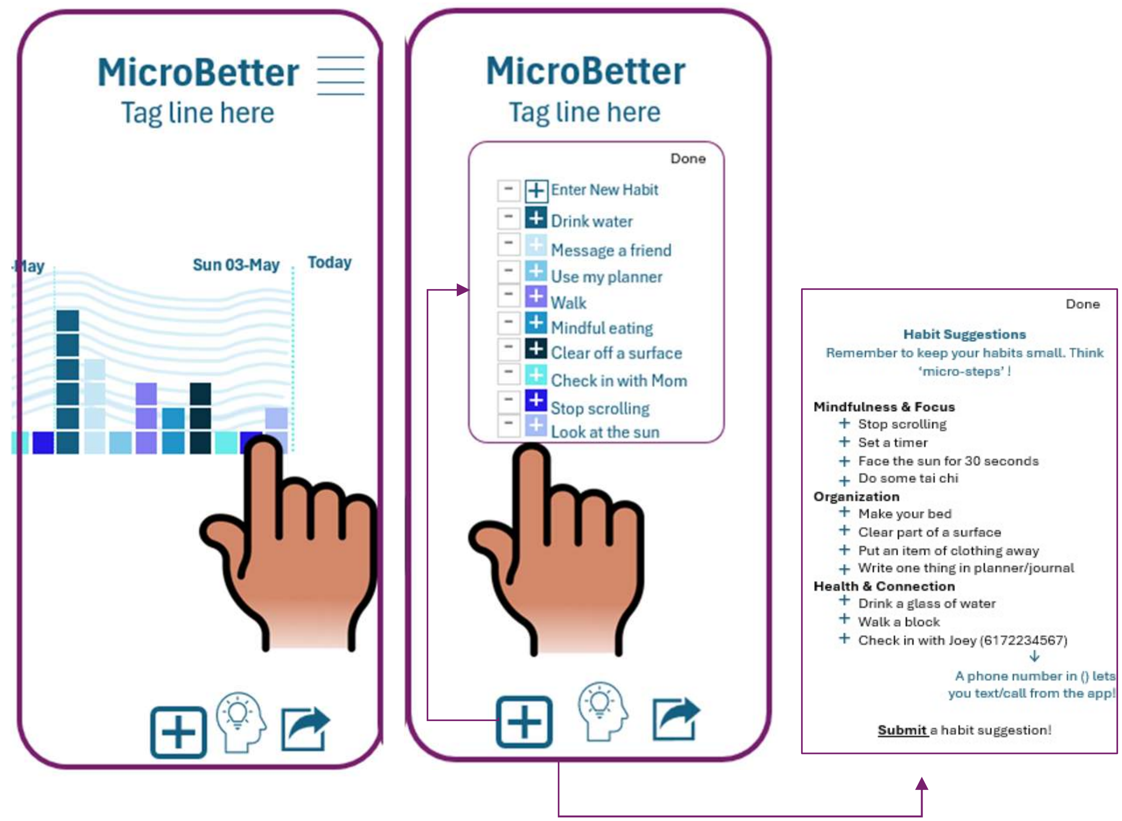
SOPs

Mobile Training & Support

Mobile App

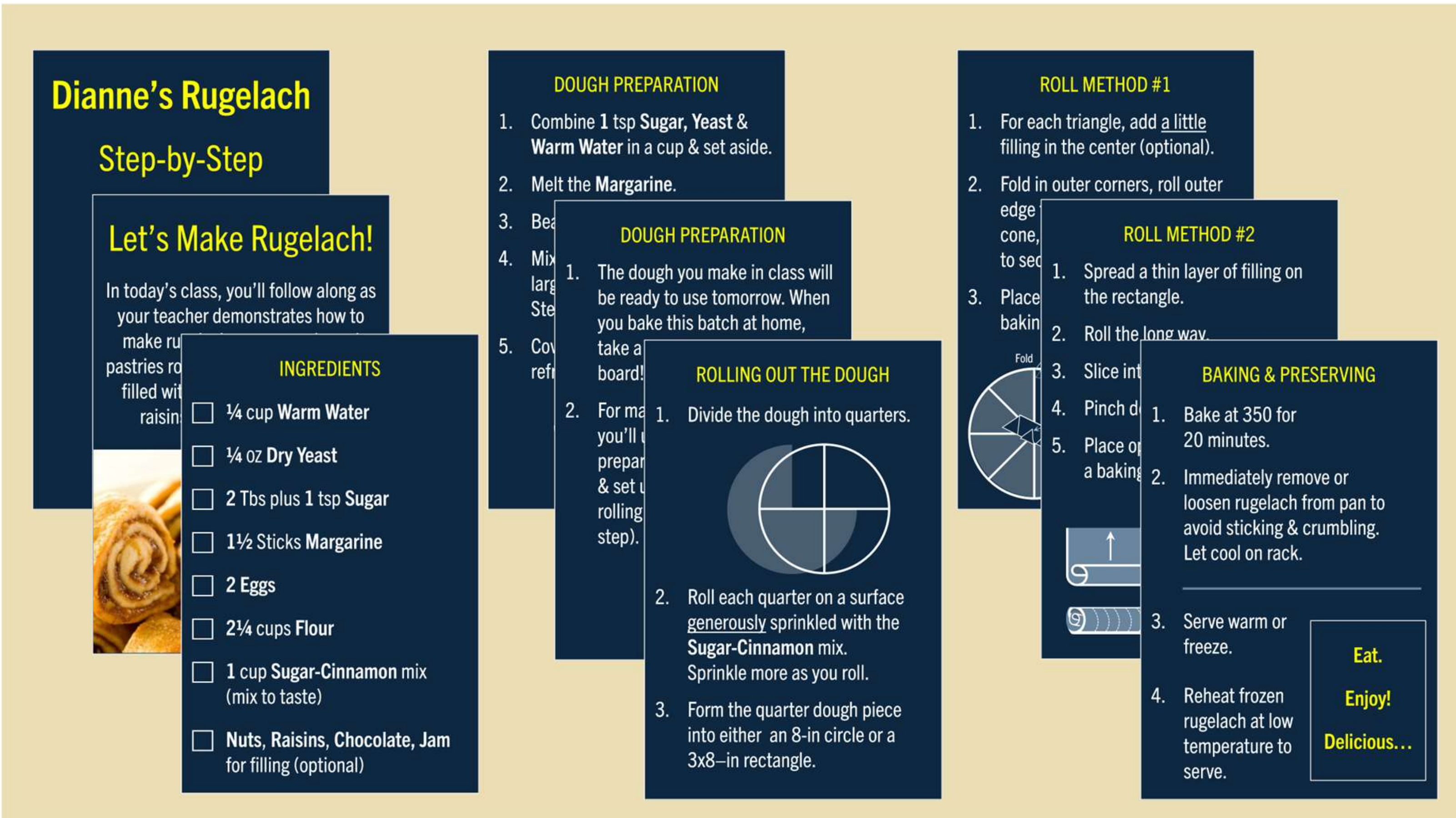
Created as proof-of-concept for how habit development happens by tiny, consistent steps that infiltrate the neural network.

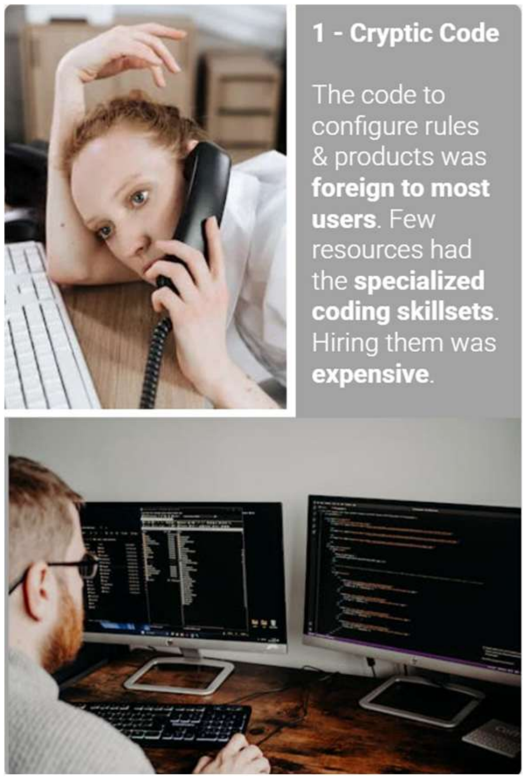




Mobile Training

To see the set, download the TalentCards mobile app on your phone & enter the code: PEXN-AWYK-YJNWE.





Mobile Training for Executives

To see the entire course, download the TalentCards mobile app on your phone & enter the code:

PEXN-AWYK-YJNW

Mobile-Sized Job Aid

* Created for volunteer parent judges of high school Speech & Debate tournaments *

Your Job as a Speech Judge

Run The Round

In www.Tabroom.com, as soon as a ballot arrives:

1. Click the START button, go to the assigned room & take a seat (do not at teachers' desks/podiums)
2. Welcome students as they arrive, confirm they're in the right room & have them jot on the board: Entry #, title & topic (see next step), & if applicable DE or DEWR (Double Entered, Double Entered Will Return)
3. Ask students if their piece could evoke intense emotions due to the subject matter; if so, have them also jot the topic on the board so observers may prepare or leave the room (without penalty)
4. Prepare the room & set the tone to ensure the students have a good experience: silence electronics & have students do the same; as the adult in the room, be mindful of how students may interpret what you do & say; demonstrate respect in every aspect of the word
5. Begin only when all judges arrive & contact the Tab Room if they don't; Semis & Finals need 3 judges, all others vary; do not wait for all students, except in Group
6. At the scheduled start time, call up the 1st student on the ballot; in Extemp & Radio, students wait outside the room & come in only for their turn; If the student up is not present, move to the next one on the ballot
7. Before the performance starts, ask if the student wants time signals ('2 down' for most events; '5 down' in Extemp); set a stopwatch (not a timer) to zero & press Start when they start
8. During the performance, give your full attention, react freely, take notes to use later for scoring & let the student finish their piece, even if over the time limit; all events have a 10-minute limit with a 30-second grace period except, Multiple, Impromptu (6)
9. When the student has finished:
   - Thank them for the delivery
   - Record the total time of the performance; Students who exceed the limit by over 30 seconds may not be ranked 1st
   - Take a moment to finish noting observations; you'll need them later, for scoring
   - Tentatively rank students as they finish; for Place, rank 1 to 6 (1 is best) & for Speaker Points, rank 80 to 100 (most 88-97)
   - Do not give verbal feedback
   - Do not confer with other judges

Repeat steps 7–9 for each student in the ballot order; Submit ranks, times & speaker points within 15 minutes of the round's end; submit comments by end-of-day

Evaluate

To fully & properly evaluate a student's performance, check yourself for any bias or preconceived notions you may have; set aside bias, stereotypes & anything that may unconsciously affect your decisions

Read the criteria on the ballot & use it to evaluate, erring to the benefit of the student

Keep in mind that in each event, students are trying to clear the same bar; observe for things such as:

- *Who communicated their ideas the best using the tools at their disposal?*
- *Did the student do what they set out to do (not what you wish they had done)?*

For guidelines on specific speech events, visit:

MSDLonline.org

Educate

Comments are the most important thing you do; provide a general comment for all students in a round & specific private comments for each

Include at least one positive & one constructive (i.e. praise & a suggestion for improvement)

Give encouragement, suggestions for improvement & explanations to support your decisions, to make sure students won't wonder why they were ranked as they were

Sample Ballot

Children's Literature

Rank: 3 Speaker Points: 88
Title: A Bad Case of Stripes Time: 8:50

Private Comments for Each Speaker:

Good Intro! Nice job talking to us rather than at us.

Slow down. The idea is for kids to enjoy the story

Some voice changes needed. Dad's voice was different, but teachers/doctors/kids sounded similar

Good job with the screams! Funny & exactly what was needed in that moment! :)

Need more eye-contact to draw us into the story

RFD Comments for All:

I really enjoyed this round!

Most of you need to slow down so that we can keep up with what you are saying

Curriculum Management & Course Design

- Master List of training models at various stages of completion, with cost/revenue forecast
- High-level completion plan by quarter
- Course Descriptions
- Storyboard

Discovery Findings & Program Goals

Training Discovery and Goal Document

Table of Contents

About this Document

This document defines the goals, expectations, logistics and requirements for the training program portion of the CoreRules FIDE-SNP & CO D-SNP implementation.

Training Goal

Enable the transition of Neighborhood MA Medicare Medicaid Plan (MMP) to Fully Integrated Dual Eligible Special Needs Plan (FIDE – SNP) (in concert with the State of Rhode Island's Medicaid program for Plan Year 2026) and CO D-SNP by ensuring (1) the impacted team members are proficient in using the relevant CoreRules Payor functionality and (2) the required training modules are able to be sustained and incorporated within the existing training framework.

Design & Development Guidelines

- Design such that materials can be easily leveraged to incorporate into existing training
- Design according to Kirkpatrick Level 1 & Level 2 Training Evaluation
- Preferred format is online self-paced learning and job-aids
- Align language and messaging with OCM communications
- Ensure adoption by fostering engagement, belief and team building while mitigating fear and resistance
- Ensure everyone understands the "why" behind the change
- Follow a structured approach
- Coordinate with cross-functional internal and external training efforts
- Add new terms to a supplemental glossary for Neighborhood L&D to leverage

Training Program Components

Necessary Pieces and How They'll Roll Out

1. The Discovery process exposed a need for three courses (described to follow), each a bundle of independent modules that are leverageable for other training.
2. Each of the three courses shall be instructor-led in a virtual classroom at least once; the individual modules will then be curated and made available via Brainshark.
3. Office hours will be hosted twice per week from mid-October through the end of the year.
4. Downloadable job aids will accompany all new user interface pages and information.
5. The job aids and other screenshots will be leveraged in the event the TEST environment, the planned environment to leverage for training, becomes inaccessible.
6. Teams may have the option of enlisting leads who attend these trainings to then deliver a version of the training to other team members, in lieu of the entire team attending; this option must be approved by Neighborhood's Learning and Development team.

Course 1: New in CoreRules for FIDE-SNP & CO D-SNP

This course introduces Neighborhood's new offerings in the context of the CoreRules product, benefit plan and enrollment structure, then continues along an enrollment lifecycle to view show how the product rules and provisions show up in CoreRules Manager. From government-submitted eligibility data, with examples to illustrate Deeming and Presumptive Eligibility concepts, the tour continues through other lifecycle events; premium billing, claim adjudication, member & provider correspondence data integration, accumulator adjustments and issue classification. Topics are explained using contextual examples and CoreRules Manager navigation.

High-Level Topics:

- High-level context for CoreRules data origin & destination (integrated data, correspondence events & required reports)
- Structure of FIDE-SNP & CO D-SNP offerings: New Products, Benefit Plans, Benefit Networks
- Enrollment model for FIDE-SNP & CO D-SNP, including Account Hierarchies & CAP Codes
- HICN documentation, with explanation of active, presumptive & deeming eligibility
- Plan Provider Directory & Automatic PCP Assignment
- Benefit Predictor Tool
- Claim Adjudication and Line Details for Wrap-Around Plans
- Accumulator Adjustments
- New Dropdowns to Classify Issues

Audience: Intended to unify the Neighborhood community in CoreRules language and references, team members in all functional areas (listed below) will apply the course gains to their respective work: Claim Processing*, Sales & Marketing, Broker Operations, Benefit Implementation & Configuration, Member Enrollment, Member Services**, Provider Services**, Provider Relations, Provider Data Integrity, Provider Contracting, Utilization Management**, Complaints, Grievances & Appeals, Financial Reporting*, Risk Adjustment, Case Management**, Compliance, Reporting, Quality Improvement, Stars, Performance

* Additional role-specific training applies (see courses listed to follow)
** Trainers and leads only; trainers will leverage lessons into team-member training

Course 2: New in CoreRules for FIDE-SNP & CO D-SNP Claim Processing

The course provides introduction and practice for Direct Member Reimbursement claims, new workbasket queues for claim review as well as issues and claim details for wrap-around claims.

High-Level Topics:

- Submitting & reviewing a DMR claim
- Navigating FIDE/CO D-SNP benefit plans or supplier contracts
- Manually adjusting FIDE D-SNP (Wrap Around) claims
- COB pricing allocation in FIDE SPN (Wrap Around) claims
- New workbasket queues for FIDE/CO D-SNP claims
- New classification & routing for DMR, FIDE SNP & CO D-SNP claims issues

Audience: Claim Examiners, Adjusters, Auditors
Prerequisite: New in CoreRules for FIDE-SNP & CO D-SNP

Course 3: New in CoreRules for FIDE-SNP & CO D-SNP Financial Reporting

This course introduces learners to the views, tables & key fields that capture financial information required for both claim payment and premium billing reporting for FIDE-SNP and CO D-SNP plans.

High-Level Topics:

- Premium billing tables, views and fields
- Claim payment tables, views and fields

Audience: Finance Reporting
Prerequisite: New in CoreRules for FIDE-SNP & CO D-SNP

Discovery Activities

The definition of scope, audience and topics for the training program components is the result of extensive discovery activities. Discover included the following actions:

- Gather topic content from HealthEdge documentation
- Determine CoreRules implementation project scope and impact defined in technical and benefit requirement documents
- Conduct interviews with CoreRules users and managers to identify (1) the training requirements that are common to all functional areas as well as (2) the role-specific training requirements
- Find out about adjacent implementation training needs and cross-check this CoreRules training program with those plans and schedules (i.e. Medicare Part C, GuidingCare, MHK)
- Identify & meet SMEs
- Clarify perceived training needs, challenges and assumptions and expectations for measurable and observable outcomes for the training

Out-of-Scope Topics

- How to submit or review CoreRules claims
- Introductory CoreRules navigation
- NEIGHBORHOOD desktop procedures
- Workflows not impacted by the current implementation
- Changes to member, provider, broker portals
- Maintenance of the project's data integration and configuration work *
- CoreRules-agnostic Medicare industry topics
- Finding Medicare pricing
- Researching and/or resolving pricing configuration in Source **
- Accessing reports in Salesforce **
- Team-specific desktop procedures ***

* Training and support for these topics will be handled on-the-job and supported by documentation handed off at the end of the implementation.

** Delivery information for these training topics is unknown.

*** Questions as well as new or amendments to existing desktop procedures will be documented during initial instructor-led trainings.

High Level Project Plan

1. Assess training needs (Aug 1 – 22)
   - Conduct interviews, understand existing content and review documentation
   - Determine high-level topics & learning objectives for impacted roles
   - Decide formats, courses, deliverables for training
   - Confirm environment, role resources and participants
   - Acquire reviews and sign-off's
   - Finalize Training Discovery & Goal Document
2. Design (Aug 25 – Sep 19)
   - Break down learning objectives into enabling objectives & associated content
   - Create design document or storyboards
   - Create diagrams/visuals/assessments
   - Acquire reviews and sign-off's
3. Develop (Sep 22 – Oct 24)
   - Schedule training
   - Run "Under Construction" sessions with sample learners
   - Create learner-facing artifacts
   - Acquire reviews and sign-off's
4. Deliver and Support (Oct 1 – Dec 31)
   - Publish ILT delivery schedule

Training & Enablement Dashboard

Foundations for All

- Reasons for Use (Why)
- System Anatomy (What)
- The New Flow (How)

ENROLL

Mission Page
Roadmap
FAQs
Project Team & Contacts
- New Desktop Procedures

The Data

- Capturing the Data
- Business Processing
- Transforming the Data
- Querying the Data

ENROLL

- Front-End Screenshots
- Data Models

Table Relationship Diagram
The Metadata Tool
SQL Collective

The Tools

- Tableau for Your Role
- Dremio for Your Role
- PowerBI for Your Role
- SQL Developer

ENROLL

Tableau Job Aid
Dremio Job Aid
Power BI Job Aid
Oracle SQL Job Aid
Requesting Access

Micro-Video Library

- Determining ROI
- Determining ROI by Area
- Drilling into ROI
- Finding the Base
- Estimating Total Loss
- Identifying Loss Causes
  - *Watch*
  - *Open Worksheet*
  - *Answers*

Video Worksheet Template
- Sessions with SMEs
  - *Sign Up*
  - *Watch Recording*

Library Owners

Small Business Curriculum Course Syllabi

Small Business Curriculum for Economic Development Center, Lowell, Massachusetts

Course 1: Welcome to the EC coaching program

This course introduces:

- The business phases at a high-level, including their order, inputs, outputs, & high-level tasks
- Business functional areas required to make the business work (the spokes of the wheel), the cog, & the best practices: keep good data, use good systems, have the right space
- Our role as coach in this endeavor (What We Do For You – how we help push your wheel, what coaching looks like, feels like …)

The learner will be able to:

- Name the order, inputs, outputs, & high-level tasks of each business phase
- Name the spokes of the wheel, the cog, & how to keep it greased
- List ways EC coaching helps push the wheel

Course 2: The WHY

This course introduces:

- The importance of defining your Mission
- Values
- Vision
- Impact Statement

The learner will be able to:

- Identify effective mission (and impact) statements from a sample group
- Categorize values, mission, impact, vision
- Explain why these are important

Course 3: Setting Yourself Up for Success

This course gives many examples & explanations of the components of the "grease"

- Systems: Identify appropriate technologies & schedule tasks for each spoke
- Data: Collecting data for each spoke
- Infrastructure/Space: Physically setting up

The learner will be able to:

- Give examples of best practices for systems, for data, for infrastructure
- Give examples of best & worst case scenarios for why these best practices are vital
- Improve a picture of a business set up scene, showing where to implement best practices

Course 4: Essence of Your Business Plan

This course introduces:

- Scope, structure & contents of a business plan
- Choosing a Template

By the end of this course, the learner will be able to:

- List sections to include in a business plan
- Identify best practices for researching, writing, & validating the sections
- List expectations for draft 1 & 2, revisions, etc

Followed by a coaching session to review, analyze, & validate the business plan & assumptions.

Course 5: Essence of a Launch Plan (Critical Path)

This course introduces:

- Critical path planning & backwards launch design
- Operations Launch Project Plan

The learner will be able to:

- List the key elements in a critical path & an operations plan
- Identify the key parts of a project plan that will enable them to hit their launch date
- List expectations for draft 1 & 2, revisions, etc

** Followed by a coaching session to review, analyze, & validate launch plan & assumptions.*

Course 6: Funding

This course introduces:

- Funding types & options
- How to write a comprehensive funding plan

The learner will be able to:

- Choose or be referred to a funder
- Create a funding pitch deck
- Identify key details & gaps of a comprehensive funding plan
- Validate cashflow projections from the business plan against the funding plan
- Troubleshoot & adjust business plan, operations plan, financial plan, & funding plan

Followed by a coaching session to review, analyze, & validate the funding plan & develop a tactical plan.

Course 7: Securing a micro-loan

This course introduces:

- How to fill out the micro-loan application

The learner will be able to:

- Complete the micro-loan application process by application & funding committee referral

High-Level Course Design

Lesson 5	Finding Coverage Terms with the Benefit Predictor Tool
Learning Objective	Describe how to use the Benefit Predictor tool to answer coverage questions
Key Topics	How to launch & interact with Benefit Predictor to determine a member's coverage, thresholds & threshold status for certain claim scenarios
Key Visuals	Screenshot(s) of Benefit Predictor in use, with callouts to describe features, icon & fields
Topic 1	Let's say a member, member representative or provider calls to ask if the member is covered for a service. To answer this question, you will need to know: • What accumulators impact coverage? Which, if any, have been met? • What is the coinsurance and copayment for the service? • Do coverage terms differ if the service is delivered in- versus out-of-network for the service? • Are there specific scenarios in which the service would be excluded altogether? CoreRules offers the Benefit Predictor tool, which you may launch by pressing the button available when viewing a member document. The Benefit Predictor allows you to enter a service code and be presented with provisions from the member's plan -- benefit, limit, deductible, out-of-pocket maximum or authorization -- that matches the code. It also presents the degree of threshold met for any relevant accumulators and the claims that contributed.
Topic 2	The results returned by the Benefit Predictor include any possible matching provisions copied from the benefit plan, including the accumulated threshold for deductibles, limits, out-of-pocket maximums or service authorizations. Notice in the results: • Matching categories of benefits and exclusions display, separated into In- and Out-of-Network sections. • Two blue circle icons indicating a 'match' – a checkmark and an information icon. These can be clicked to display the related benefit plan component. • When benefit results are expanded, you may see a double checkmark indicating accumulators have been met. • For unmet accumulators, notice you also see how much of the threshold is met and how much remains. • Reference text (in quotes), such as Service Category names, allow you to display the content from the reference when double-clicked. Notice in the pane above the results: • A legend to help navigate and interpret the results • An Expand All checkbox to show all the details of the collapsed list of results • Action buttons to adjust screen realestate or use the list outside CoreRules: • Show Search Criteria • Hide Instructions • Export • Copy Results to Clipboard • A page divider bar to drag up or down to adjust real estate
Topic 3	Search options are in the top pane of the Benefit Predictor page. To search the benefit plan, only one search field needs to be populated but you may populate as many as needed to render the results you need. For example: you may add a service code alone or along with a supplier or practitioner. The more fields you populate, the more refined the results. Notes about the Search options: • The member field is already populated. • If a member has had only one benefit plan, the Benefit Plan field will be populated; if a member has switched Benefit Plans or is enrolled in more than one, you'll select from a list to specify the relevant benefit plan to search. • Populating the Service Date field will return only results that were in effect on that date of service. • For some fields, you'll look up a code or document in the system. For others, you'll select from a drop-down. • You may populate multiple fields to narrow results. • Notice the top-most option to select a question. The questions, configured by your configuration team, pre-populate a combination of fields with defined values. You may populate other fields in addition to those populated by the question if you want to narrow the results.
Scenario 1	Use case with finding in- & out-of-network coverage for a given service
Scenario 2	Use case with cost-share thresholds or limits
Scenario 3	Use case with service authorizations & claims
Assessment	Given coverage questions & a labeled Benefit Predictor screenshot, select whether the question may be resolved using Benefit Predictor & if so, the field(s), icon(s) or value(s) to get the answer

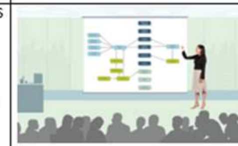
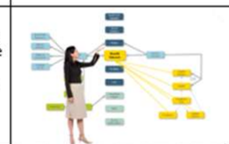
Lesson 6	The Provider Directory and the Provider Finder Tool
Learning Objective	Referring to a screenshot, describe how to use the Provider Finder tool to identify providers for certain member scenarios
Key Topics	How to launch & interact with Provider Finder to determine the ideal providers for a member to see for certain claim scenarios
Key Visuals	Screenshot(s) of Provider Finder in use, with callouts to describe features, icon & fields
Topic 1	**Provider Finder Use Cases** Let's say a member's primary care provider is retiring. Or, let's say the member is looking for a physical therapist to help recover from a leg injury. Using the provider finder, you may select the provider specialty and the tool returns every provider within the appropriate distance and network for you to recommend to the member. The tool uses the Provider Directory, the provider's practice address, age or patient criteria to return the match. The Provider Finder is available when viewing the member document.
Topic 2	**Provider Finder Results** Here is how the results show in the Provider Finder. Notice: a) Multiple providers to choose from b) Gender, languages and distance, *if* relevant search criteria was used c) Association to plan network, if relevant search criteria was used d) For users with permission, a link to create a provider choice selection NOTE: if a practitioner or supplier has opted out of being included in the Provider Directory, evidenced by a selected checkbox on their document header, they will not be included in the search results even if they match the search criteria.
Topic 3	**Provider Finder Search Options** Select the CoreRules provider type to display the relevant Search options: Supplier, Supplier Location or Practitioner If searching for practitioners: • Select the Find PCPs Only checkbox if you are searching only for primary care providers; if selected, you may also select the Accepting New Patients checkbox to narrow results to PCPs taking in new patients • Populate the Specialty field (for practitioners) or the Classification field (for suppliers and supplier locations) to find certain specialists • Select the In Network for Plan checkbox to return only practitioners who are in-network for the member (the default is the Member's active medical plan). • Populate the name fields to check network status or other information for a certain provider • **Populate the Calculate Distance From section to** calculate the distance from the member's residential address, or another address you may enter, to an address in the result set. The system will display the calculated distance next to each result. Click the Clear button to remove the distance calculation values. The following Search criteria are available only for practitioners: • Select a preferred speaking language for the practitioner. Click Add to select multiple languages. • To see locations where a practitioner works, populate one or more **Search by Address** field. Notes: you may add one or more cities or one or more zip codes, but not both cities and zip codes. The default address information is pulled from the member's residential address. • Select from the Gender drop-down to display practitioners of a certain gender: Male, Female, Unknown. • Populate a Supplier or facility name to see only practitioners with a role at a certain location. • Select the Special Needs checkbox for practitioners who specialize in certain conditions, such as 'Visually Impaired' and so on. • Select the EPSDT Certified checkbox to find practitioners who are certified for Medicaid's health services for member's under 21, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. • Populate the Affiliated Hospital field to display only practitioners with roles at a certain facility
Scenario 1	Use case with finding providers with certain specialties
Scenario 2	Use case within a defined distance
Scenario 3	Use case with specific practitioner
Assessment	Given a member medical scenario, select the combination of Provider Finder field(s) & value(s) to use in finding an ideal provider

Draft Storyboard

•

Calculating the Cost Share Storyboard

SCRIPT	VISUAL	NOTES
n/a		Updated the objectives that were used in the mock up
1. Hi, I'm Christine Ling, Vice President for Benefits Administration at our health care company.		
2. In this tutorial we'll focus on the third stage of the adjudication transaction: determining the cost share. As you can see from this diagram, the system has just finished calculating the service cost, by using the allowed amount found either in contract terms or non-participating provider pricing rules.		
3. Just to remind you, in HealthRules, participating[1] and in-network do not necessarily mean the same thing. [2]Participating providers hold a contract, non-participating providers don't.		Reuse images of supplier contract and the non-par stuff. 1. Fade in contract with the label: PARTICIPATING PROVIDER 2. Fade in non-par documents with the label: NON-PARTICIPATING PROVIDER PRICING RULES

4. To determine how the health care company and the member will share the cost, the system performs key steps.		Add an additional step between 3 and 4. This is "Member Responsibility Thresholds are determined." So, the total number of steps will be 10 Have each step fade in sequentially during the narrative.
❶A MATCHING NETOWRK TIER IS IDENTIFIED IN THE BENEFIT PLAN 5. [1]First, the system must determine if that provider is in- or out-of-network for that member's benefit plan.[3]	 b. 	1. Fade in the supplier and supplier contract rectangles with arrows. 2. Fade out the lady 3. Zoom the data model out to full screen
6. So, the system finds the **benefit network**(s)[1] that have been associated to each of the matching provider documents.[2] Let's take a look at an example:		1. Fade in lady 2. Fade in yellow rectangles
7. In this claim, the member's benefit plan uses the Preferred Provider Benefit Network. To continue, click the rectangle containing the benefit network that matches!		Interactivity... the learner needs to click the Preferred Provider Benefit Network rectangle
8. If the plan's network matches the [1]provider's network, the system will use search for matching [2]coverage terms in the corresponding in-network tier		1. Fade in the highlight box/circle and Paula Peters rectangle 2. Fade in the highlight box on the benefit plan

High-level work completion plan by quarter

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	**Topic Area**	**Lead R**	**Courses**	**Modules**	**Cross-Curricu**	**Analysis: Outline, Content, Objectives**				**Design: MVP Content, Flow, Assessments**			**Development: Learner-Facing Artifacts**					**Implement, Evaluate,**	
2						*High-Level O*	*Objective*	*Teach/Feedbc*	*Review and Sig*	*Design Do*	*Teach/Fee*	*Review and Sign-Off*	*LMS Input*	*Lesson Gu*	*Review an*	*End-User*	*Storyboard an*	*Communi*	*Catalogue F*
3																			
4	Data Warehou	David	Update HDW 1000	Fundamentals	Yes	Q1	Q1	Q1	Q1	Q2	Q2	Q2	Q2	Q2	Q2	N/A	2022	Q3	Q3
5			Update HDW 1010	Fundamentals	Yes	Q1	Q1	Q1	Q1	Q2	Q2	Q2	Q2	Q2	Q2	N/A	2022	Q3	Q3
6			Update HDW 2000 Seri	Network Development and Provider Operations DW Modul		Q1	Q2	Q2	Q2	Q3	Q3	Q3	Q3	Q3	Q3	N/A	N/A	Q4	Q4
7				Enrollment and Billing DW Module		Q1	Q2	Q2	Q2	Q3	Q3	Q3	Q3	Q3	Q3	N/A	N/A	Q4	Q4
8				Claims, Medical Management DW Modules		Q1	Q2	Q2	Q2	Q3	Q3	Q3	Q3	Q3	Q3	N/A	N/A	Q4	Q4
9				Claims Finance and Self-Funded DW Modules		Q1	Q3	Q3	Q3	Q4	Q4	Q4	Q4	Q4	Q4	N/A	N/A	Q4	Q4
10				Customer Service DW Module		Q1	Q3	Q3	Q3	Q4	Q4	Q4	Q4	Q4	Q4	N/A	N/A	Q4	Q4
11				Product Development DW Module		Q1	Q3	Q3	Q3	Q4	Q4	Q4	Q4	Q4	Q4	N/A	N/A	Q4	Q4
12				Set Up and Security DW Module		Q1	Q4	Q4	Q4	Q4	2022	2022	2022	2022	2022	N/A	N/A	2022	2022
13																			
14	HRP Connecto	David	Update CNC 1000	Fundamentals	Yes	Q1	Q1	Q1	Q1	Q2	Q2	Q2	Q2	Q2	Q2	N/A	2022	Q3	Q3
15			Update CNC 1050	Fundamentals	Yes	Q1	Q1	Q1	Q1	Q2	Q2	Q2	Q2	Q2	Q2	N/A	2022	Q3	Q3
16			Update CNC 2000 Serie	Network/Provider Operations CNC Modules		Q1	Q2	Q2	Q2	Q2	Q3	Q3	Q3	Q3	Q3	N/A	N/A	Q4	Q4
17				Enrollment and Billing CNC Modules		Q1	Q2	Q2	Q2	Q2	Q3	Q3	Q3	Q3	Q3	N/A	N/A	Q4	Q4
18				Claims, Medical Management CNC Modules		Q1	Q2	Q2	Q2	Q2	Q3	Q3	Q3	Q3	Q3	N/A	N/A	Q4	Q4
19				Claim Finance and Self-Funded CNC Modules		Q1	Q3	Q3	Q3	Q3	Q4	Q4	Q4	Q4	Q4	N/A	N/A	Q4	Q4
20				Customer Service CNC Modules		Q1	Q3	Q3	Q3	Q3	Q4	Q4	Q4	Q4	Q4	N/A	N/A	Q4	Q4
21																			
22	HRP Correspor	David	Create COR 1000	Fundamentals	Yes	Q1	Q2	Q3	Q3	Q4	2022	2022	Q4	Q4	2022	N/A	2022	Q4	Q4
23			Create COR 2000 Serie	Network/Provider Operations		Q1	Q3	Q3	Q3	Q4	2022	2022	Q4	Q4	2022	N/A	N/A	Q4	Q4
24				Enrollment and Billing		Q1	Q3	Q4	Q4	Q4	2022	2022	Q4	Q4	2022	N/A	N/A	Q4	Q4
25				Claims, Medical Management		Q1	Q3	Q4	Q4	Q4	2022	2022	Q4	Q4	2022	N/A	N/A	Q4	Q4
26				Claim Finance and Self-Funded		Q1	Q3	Q4	Q4	Q4	2022	2022	Q4	Q4	2022	N/A	N/A	Q4	Q4
27				Customer Service		Q1	Q3	Q4	Q4	Q4	2022	2022	Q4	Q4	2022	N/A	N/A	Q4	Q4
28																			
29	HRP Conversic	David	Create CNV 1000	Fundamentals	Yes	Q1	Q2	Q3	Q3	Q4	2022	2022	Q4	Q4	2022	N/A	2022	Q4	Q4
30			Create CNV 2000 Serie	Enrollment		Q1	Q3	Q4	Q4	Q4	2022	2022	Q4	Q4	2022	N/A	N/A	Q4	Q4
31				Claims		Q1	Q3	Q4	Q4	Q4	2022	2022	Q4	Q4	2022	N/A	N/A	Q4	Q4
32				Provider Operations		Q1	Q3	Q4	Q4	Q4	2022	2022	Q4	Q4	2022	N/A	N/A	Q4	Q4
33																			
34	Claims Proces	Christi	Expand/Update CLA 1000 Series		Yes	Q1	Q1	Q1	Q1	Q1	Q2	Q2	Q2	Q2	Q2	Q2	Q1, Q2	Q3	Q3
35			Expand/Update CLA 2000 Series			Q1	Q1	Q1	Q1	Q1	Q2	Q2	Q2	Q2	Q2	Q2	N/A	Q3	Q3

Curriculum Inventory, Planning & Forecasting Worksheet

	A	B	C	D	F	G	H	I	J	K	L	M	N	P	Q	R
1	Category	Functional Area	Course	Lessons	Status	Months	Resources	Internal Learners/Year	Paying Learners/Year	Hours	Cost to HealthEdge	Annual Revenue	Payback Period	Value-Add Score	Four-Year Revenue	Minus Expense
11	Analytics	HealthRules Payor Data Warehouse	106	HealthRules Payor Data Warehouse for Business Analysts	ILT	4	1	100	100	3	40000	24000	16000	3	96000	56000
21	Analytics	HealthRules Answers	154	HealthRules Answers Fundamentals	ILT	1.5	1	100	60	1	15000	4800	10200	3	19200	4200
22	Analytics	HealthRules Payor Data Warehouse	155	Data Warehouse Queries for HealthRules Payor	ILT	2	1	100	100	3	20000	24000	-4000	3	96000	76000
24	Analytics	HealthRules Payor Data Warehouse	158	Data Warehouse Fundamentals	ILT	2	1	100	100	1	20000	8000	12000	3	32000	12000
36	HealthRules Payor	Global Operations	124	Configuring the HCC	M	2	2	100	125	6	40000	60000	-20000	5	240000	200000
37	HealthRules Payor	Product Configuration	103B	HealthRules Language Workshop	ILT	2	1	100	60	2	20000	9600	10400	4	38400	18400
40	HealthRules Payor	Support	20	What You Need for Implementation	Backlog	2	1	100	0	2	20000	0	20000	5	0	-20000
57	HealthRules Payor	Support	20	Licenses for other software and when to load	Backlog	1	1	100	0	1	10000	0	10000	5	0	-10000
58	HealthRules Payor	Support	30	Resources, planning, needs for upgrades to HealthRules Payor	Backlog	1	1	100	0	1	10000	0	10000	5	0	-10000
59	HealthRules Payor	Support	20	Required environments and usage	Backlog	1	1	100	0	1	10000	0	10000	5	0	-10000
83	HealthRules Payor	Claims Processing	114	Verifying Accumulators	SP	1	1	150	150	1	10000	12000	-2000	5	48000	38000
84	HealthRules Payor	Claims Processing	114	Researching Financial History of the Claim	SP	1	1	150	150	1	10000	12000	-2000	5	48000	38000
85	HealthRules Payor	Claims Processing	114	Editing Claim Input Information	SP	1	1	150	150	1	10000	12000	-2000	5	48000	38000
86	HealthRules Payor	Claims Processing	114	Adjusting Claim Financial Results	SP	1	1	150	150	1	10000	12000	-2000	5	48000	38000
87	HealthRules Payor	Claims Processing	114	Approving Automatically Reprocessed Claims	SP	1	1	150	150	1	10000	12000	-2000	5	48000	38000
88	HealthRules Payor	Claims Processing	114	Claims Processing Review and Repair	SP	1	1	150	150	1	10000	12000	-2000	5	48000	38000
89	HealthRules Payor	Claims Processing	114	Managing Batches	SP	1	1	150	150	1	10000	12000	-2000	5	48000	38000
113	HealthRules Payor	Network Configuration	177	Configuring Capitation Pricing	Dev	3	1	35	60	4	30000	19200	10800	5	76800	46800
127	HealthRules Payor	Conversion	102	Overview of Conversion	Backlog	2	1	150	60	1	20000	4800	15200	5	19200	-800
128	HealthRules Payor	Conversion	102	Loading codes	Backlog	1	1	150	60	1	10000	4800	5200	5	19200	9200
129	HealthRules Payor	Conversion	102	Planning for Mapping (Practice and Scenarios)	Backlog	1	1	150	60	1	10000	4800	5200	5	19200	9200
130	HealthRules Payor	Conversion	102	Conversion Inventory	Backlog	1	1	150	60	1	10000	4800	5200	5	19200	9200
131	HealthRules Payor	Conversion	102	Conversion Tool	Backlog	1	1	150	60	1	10000	4800	5200	5	19200	9200
132	HealthRules Payor	Conversion	102	Preparing Files for Conversion	Backlog	1	1	150	60	1	10000	4800	5200	5	19200	9200
133	HealthRules Payor	Conversion	102	Troubleshooting Conversion	Backlog	1	1	150	60	1	10000	4800	5200	5	19200	9200
134	HealthRules Payor	Conversion	102	Loading Fee Tables	Backlog	1	1	150	60	1	10000	4800	5200	5	19200	9200
135	[illegible]	Integration	129	The Role of HealthRules Connector	[illegible]	1	1	150	50	1	[illegible]	[illegible]	6000	[illegible]	[illegible]	[illegible]

Master List of Training Modules | Delight Your Customer | Sheet3 | Sheet1

➊ Get Ready

A. Be ready:
   1. Have equipment set up
   2. Have metronome ready
   3. Close other programs
   4. Check posture

B. Review lesson agenda

➋ Warm Up

Repeat prior exercises:

A.

B.

C.

Help Your Teacher Warm Up

A.

B.

C.

➌ Demonstrate Homework

A. Play homework for instructor

B. Refine:
   1. Ask: What is one thing I can improve?
   2. Teacher models *correct and incorrect*
   3. You model *correct and incorrect*

C. Repeat B two more times.

➍ Move On

A. Introduce new topic

B. Build understanding:
   1. Why is this important
   2. How does it sound when right?
   3. How does it sound when not right?

C. Practice
   1. Help Your Teacher Practice
   2. Swap Roles

➎ Assign New Homework

A. Write down the assignment

B. Play the assignment

C. Discuss and circle the new topic areas on the assignment

➏ Practice After Class

Practice 30 min Wed, Fri, Sun

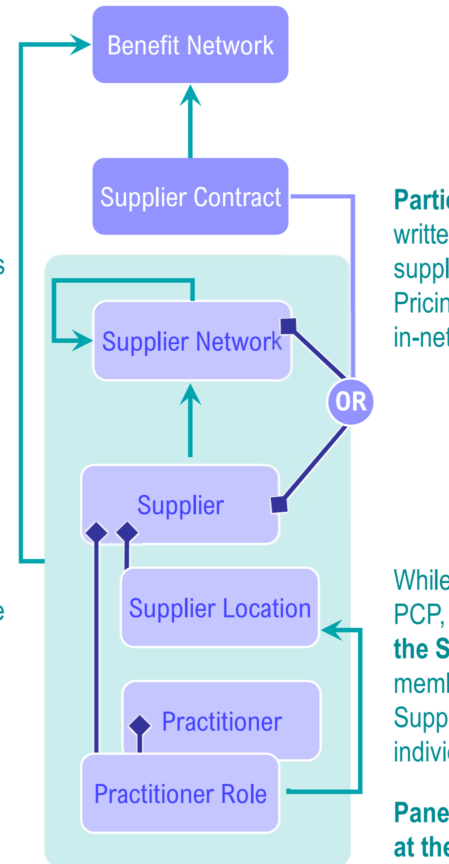
- Do previous homework twice
- Do new homework rest of time
- Be ready for next class ➋ and ➌

HealthRules “Providers”

In HealthRules Payor, no entity is termed “provider.” Strong distinction is made among the various types of provider entities, which include:

- **Supplier Network**: clinics, hospitals, labs, and other businesses united by a common agreement (outside of HealthRules Payor) or united under the management / leadership of a business organization; for example: Texas State Medical System, Mayo Health Network
- **Supplier**: a business or sole proprietorship that bills the insurance company in exchange for equipment or services received by members; for example, a lab, a pharmacy, a hospital, a clinic, a durable medical equipment vendor *(AKA vendor, corporation)*
- **Supplier Location**: an office location, division, or branch of a supplier business; for example, a suburban pediatric clinic’s city office, a city hospital’s suburban outpatient facility, a women’s health provider’s radiology facility *(AKA office location)*
- **Practitioner**: a person who oversees, recommends or delivers care; for example: a doctor, a therapist, a chiropractor, a lab physician’s assistant *(AKA provider)*
- **Practitioner Role**: a practitioner’s role or job at a particular supplier business or business location; for example, Dr. Jones working at McDoogle Hospital on Monday & Wednesday evenings, Drl Jones working at Jones Family Medical Clinic Tuesday through Friday. *(AKA practitioner mapping)*

In-Network: Any provider entity is in-network by association to a plan Benefit Network. At Gold Coast Health Plan, the **Supplier has the in-network association**, but practitioner roles are also associated to benefit networks so they display as par or non-par in downstream applications**.**



Participating: Pricing terms are written into contracts owned by suppliers or supplier networks. Pricing can be specific to product or in-network claims.

When adding a Supplier Location, the Supplier must exist first.

When adding a Practitioner Role, the Practitioner, Supplier, and Supplier Location must exist first.

While any provider entity may be a PCP, at Gold Coast Health Plan, **the Supplier Locations are PCPs**; members choose or are assigned a Supplier Location rather than an individual doctor as their PCP.

Panels and member limits are set at the Supplier Location, not at the Practitioner or Role levels.

Optional Relationship (0,*)
May be associated to zero or many (*)

Required Relationship (1,1)
Must belong to one and only one

Finding a Supplier Location

1. Click the flyout menu Provider icon to display the Provider card; next to Supplier Location, click the Search icon.
2. Use any available fields to enter search criteria.
3. As needed, click other tabs to set more search criteria.
4. Click the Search button.
5. Search results display here.
6. To sort the results by a column, click the column header.
7. To filter results, point the mouse at the column header top right corner & click the Filter icon that displays. Select checkboxes or dropdown items & add values as available.
8. Notice your filter criteria displays at the bottom of the window, along with the number of matching search results. Deselect the checkbox to save but ignore the filters. Click the X to clear filter criteria.
9. To export the search results to a file, click Export and follow the prompts. To examine a selected supplier document, click View.