

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

B.1 Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

Coventry Health Care, Inc.
6705 Rockledge Dr.
Suite 900
Bethesda, MD 20817
(301) 581-0600

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Corporation

Refer to the enclosed Roster of Directors and Officers

No health professional owns 5% or more financial interest in Coventry Health Care.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Federal Identification Number: 52-2073000
Louisiana Tax Identification Number: 3092798001

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

State of Incorporation: Delaware
State of Commercial Domicile: Maryland

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

None

B.8 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. **Include your organization's parent organization, affiliates, and subsidiaries.**

COVENTRY HEALTH CARE, INC. – Bethesda, MD

Coventry Health Care, Inc. (Coventry) is a diversified national managed health care company based in Bethesda, Maryland. The Company operates health plans, insurance

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

companies, network rental and workers' compensation services companies, serving over 5.1 million members. Coventry operates in three segments: Health Plan and Medical Services, Specialized Managed Care and Workers' Compensation. The Health Plan and Medical Services Division consist of its health plan commercial risk, Medicaid, and Medicare Advantage businesses and products. Coventry Health Care, Inc. has over 13,000 employees and 2010 operating revenue of \$11.6 billion.

Our Organizational Structure

Coventry's organization structure is a balance of decentralized and centralized operations. The decentralized operations focus on local markets and quality initiatives providing autonomy to the local health plan. The individual health plans are separate companies with officers and directors serving each. Each plan has its own corporate headquarters and staff. This structure provides a unique opportunity to understand the health care needs of the local marketplace while instilling a strong, disciplined presence.

The centralized operations are organized around functional areas designed to leverage the collective talents, skills and experiences of Coventry's entire holding company group and take advantage of economies of scale. A number of functional areas support the health plans including, Legal Services, Claims and Customer Service, Benefits Administration, Information Management, Actuarial and Underwriting Services, Corporate Accounting and Financial Reporting, and Billing and Enrollment. These areas report through a central, corporate structure, but are aligned to the individual health plan's needs and objectives.

Refer to the enclosed Coventry Health Care, Inc.'s Organizational Chart (Chart A) that shows its organizational structure.

B.9 Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) if each GSA will differ provide details outlining the differences and how it will differ.

GSAs: A, B, and C

Coventry Health Care of Louisiana's proposed Louisiana Coordinated Care Network Project Team will be led by local leadership. This team is led by J Pegues, Chief Executive Officer of Coventry Health Care of Louisiana, Inc. and is supported by experienced Coventry Medicaid professionals. The team will utilize all personnel necessary to meet all program requirements and deliverables.

Coventry Health Care, Inc. is the parent company and has ultimate responsibility for all Coventry functions and teams connected to the CCN program.

Directors and Officers Roster

<u>Directors</u>		
Name	Address	Telephone Number
Joel Ackerman	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Daniel Newman Mendelson	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Lawrence Nelson Kugelman	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Rodman Wister Moorhead, III	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Elizabeth Edith Tallett	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Allen Floyd Wise	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Timothy Thaddeus Weglicki	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
L. Dale Crandall	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Michael A. Stocker M.D.	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Joseph R. Swedish	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
<u>Officers</u>		
Name	Address	Telephone Number
Allen F. Wise	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
John S. Stelben	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Harvey DeMovick, Jr.	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Shirley R. Smith	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
James E. McGarry	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
John Joseph Ruhlmann	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Thomas C. Zielinski	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Patrisha L. Davis	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Michael D. Bahr	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Randy P. Giles	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Kevin P. Conlin	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Kenneth A. Burdick	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600

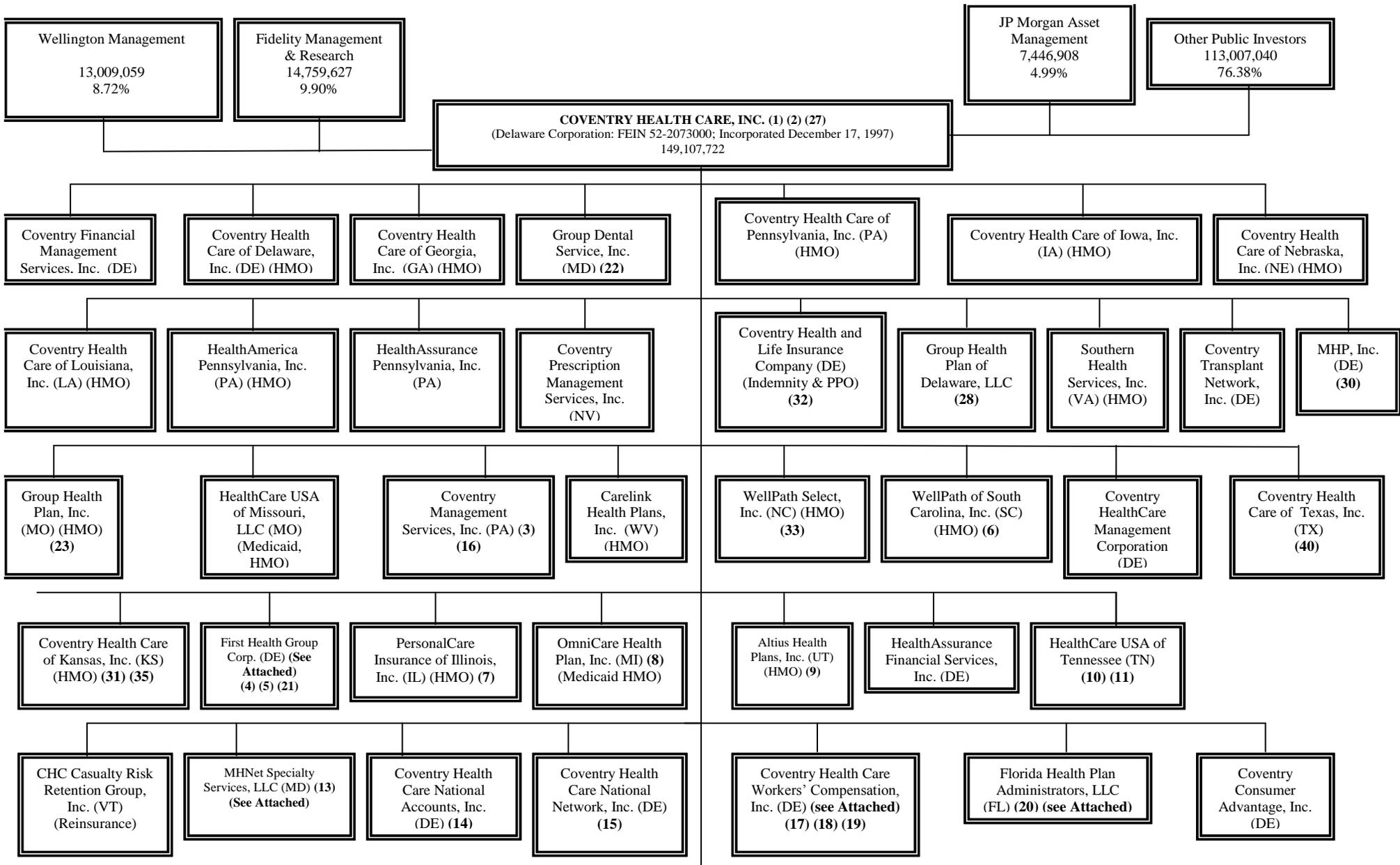
MAJOR SUBCONTRACTOR'S NAME:

COVENTRY HEALTH CARE, INC.

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COVENTRY HEALTH CARE, INC. ORGANIZATIONAL CHART (AS OF MAY 31, 2011)

(CHART A)



(12) (24) (25) (26) (34) (35) (36) (37)(38) (39)

COVENTRY HEALTH CARE, INC. ORGANIZATIONAL CHART (AS OF MAY 31, 2011)

(CHART A)

- (1) Total shares outstanding assumed to be approximately 149,107,722 Common Stock issued and outstanding. Balance held in Treasury: 43,789,704. Unexercised Options outstanding are not included in the calculation of outstanding shares.
- (2) Incorporated in Georgia on January 20, 2005. SouthCare HMO, Inc. merged into its parent Coventry Health Care, Inc. (DE) on December 29, 2006.
- (3) First Health Benefits Administrators Corp. merged into Coventry Management Services, Inc. on November 30, 2005. Effective December 31, 2010 Coventry Product Services, Inc. and Coventry Services, Inc. were merged into Coventry Management Services, Inc.
- (4) Coventry Merger Sub Inc. was incorporated in Delaware on October 12, 2004. On 1/28/05, First Health Group Corp merged into Coventry Merger Sub Inc. and changed its name to First Health Group Corp. See First Health Group Corp Organizational Chart for breakdown of its subsidiaries.
- (5) First Health Insurance Services, Inc. and SouthCare PPO, Inc. merged into First Health Group Corp on 12/31/2007 with First Health Group Corp being the surviving corporation.
- (6) WellPath of South Carolina, Inc. was incorporated in South Carolina on April, 6, 2006.
- (7) PersonalCare Health Management, Inc. merged into its subsidiary PersonalCare Insurance of Illinois, Inc. on September 30, 2006.
- (8) Incorporated in Michigan on April 22, 2004. Effective on October 1, 2004, Coventry Health of Michigan, Inc. changed its name to OmniCare Health Plan, Inc. and operates Medicaid HMO in the State of Michigan.
- (9) Altius Health Administrators Inc. (UT) merged into its parent Altius Health Plans Inc. (UT) on March 31, 2006.
- (10) CHCCares, Inc. was incorporated in Tennessee on March 2, 2006.
- (11) CHCCares, Inc changed name to HealthCare USA on November 17, 2007 with a D/B/A HealthCare USA.
- (12) Provider Synergies, LLC, an Ohio LLC, was acquired on January 1, 2006. On 07/31/2009 Provider Synergies LLC was sold to Magellan Health Services, Inc. Please see Footnote (24) for additional details.
- (13) On February 14, 2008, Coventry Specialty Services, LLC changed its name to MHNet Specialty Services, LLC. Please see MHNet Specialty Services, LLC chart for breakdown of its subsidiaries.
- (14) Coventry Health Care National Accounts, Inc. was incorporated in Delaware on November 16, 2006.
- (15) Coventry Merger Holdings, Inc. was incorporated in Delaware on May 12, 2006 and changed its name to Coventry Health Care National Network, Inc. on 10/27/06.
- (16) Coventry Product Services, Inc. was incorporated in Delaware on January 18, 2007. Effective December 31, 2010 Coventry Product Services, Inc. and Coventry Services, Inc. were merged into Coventry Management Services, Inc.
- (17) Coventry Health Care Workers' Compensation, Inc. was incorporated in Delaware on January 18, 2007. On April 2, 2007 CHC, Inc. Acquire five entities from Concentra: MetraComp, Inc., Medical Examination of NY, P.C., FOCUS Healthcare Management, Inc. (the parent company of FHM Business Corporation of which was also acquired) and First Script Network Services, Inc. See Coventry Health Care Workers Compensation, Inc. Organizational Chart for breakdown of its subsidiaries.
- (18) First Health Priorities Services, Inc., a California corporation, merged into Coventry Health Care Workers Compensation on December 31, 2007.
- (19) FHM merged with and into Coventry Health Care Workers Compensation on August 1, 2008.
- (20) Coventry Health Care, Inc. acquired all membership interests of Florida Health Plan Administrators, LLC on September 10, 2007, which includes its subsidiaries Vista Healthplan, Inc., Vista Healthplan of South Florida, Inc., Vista Insurance Plan, Inc. and Summit Healthplan, Inc. upon receipt of all required regulatory approvals and satisfaction of closing conditions set forth in the Membership Interest Purchase Agreement dated July 6, 2007. (See Florida Health Plan Administrators, LLC Organizational Chart for breakdown of subsidiaries.)
- (21) SouthCare PPO, Inc. merged into First Health Group Corp. on December 31, 2007 with First Health Group Corp being the surviving corporation.

COVENTRY HEALTH CARE, INC. ORGANIZATIONAL CHART (AS OF MAY 31, 2011)

(CHART A)

- (22) Group Dental Services, Inc. was acquired by Coventry Health Care, Inc. on May 14, 2008. See Group Dental Services, Inc. organizational charts for breakdown of subsidiaries.
- (23) Group Health Plan, Inc., through the authority of the sole shareholder, Coventry Health Care, Inc. formulated a subsidiary, Group Health Plan of Delaware, LLC on September 20, 2008. See Group Health Plan, Inc. organizational chart for breakdown of subsidiaries.
- (24) On 07/31/2009 Provider Synergies LLC, and Ohio limited liability company, FHC, Inc. an Ontario Corporation, First Health Services Corporation, a VA corporation, First Health Services of Florida, Inc., a DE corporation, and First Health Services of Montana, Inc., a DE corporation were sold to Magellan Health Services, Inc.
- (25) On 12/14/2009 Coventry PDP Rebate Administrators, LLC was dissolved,
- (26) On 12/14/2009 Coventry Pharmacy Rebate Administrators, LLC was dissolved.
- (27) On December 23, 2009 Coventry Health Care Investment Corporation was merged into Coventry Health Care, Inc.
- (28) On December 28, 2009 Group Health Plan distributed via an extraordinary dividend its interests in Group Health Plan of Delaware, LLC. Group Health Plan of Delaware, LLC is now a wholly owned subsidiary of Coventry Health Care, Inc.
- (29) On February 1, 2010, Coventry Health Care, Inc. acquired Preferred Health Systems, Inc. including 5 subsidiaries: Preferred Health Systems Insurance Company, Preferred Plus of Kansas, Inc., Preferred Health Care, Inc., Kansas Health Plan, Inc. and Preferred Benefits Administrator, Inc., each a Kansas corporation. See Preferred Health Systems, Inc. page for organizational chart of the new subsidiaries.
- (30) On October 1, 2010, Coventry Health Care, Inc. acquired MHP, Inc., a Delaware corporation and 4 subsidiaries: Mercy Health Plans, Mercy Health Plans of Missouri, Inc. ForeSee Health, Inc. and Premier Benefits, Inc. Effective May 1, 2011 Mercy Health Plans merged into Coventry Health and Life Insurance Company. Effective May 1, 2011 Mercy Health Plans of Missouri, Inc. was merged into Group Health Plan, Inc. Effective June 1, 2011 ForeSee Health, Inc. was merged into Group Health Plan, Inc. and effective June 1, 2011 Premier Benefits was merged into Coventry Management Services, Inc.
- (31) On December 31, 2010 Preferred Plus of Kansas, Inc. was merged into Coventry Health Care of Kansas, Inc.
- (32) On December 31, 2010 Preferred Health Systems Insurance Company was merged into Coventry Health and Life Insurance Company.
- (33) On December 31, 2010 WellPath Preferred Services, Inc. was merged into WellPath Select, Inc.
- (34) On April 1, 2011 Preferred Health Systems, Inc. was merged into Coventry Health Care of Kansas, Inc.
- (35) Due to the April 1, 2011 merger of Preferred Health Systems, Inc. into Coventry Health Care of Kansas, Inc., the Company's 3 subsidiaries, Kansas Health Plan, Inc., Preferred Health Care, Inc. and Preferred Benefits Administration, Inc. became wholly owned subsidiaries of Coventry Health Care of Kansas, Inc.
- (36) On May 1, 2011 Mercy Health Plans was merged into Coventry Health and Life Insurance Company.
- (37) On May 1, 2011 Mercy Health Plans of Missouri was merged into Group Health Plan, Inc.
- (38) On June 1, 2011 Foresee Health, Inc. was merged into Group Health Plan, Inc.
- (39) On June 1, 2011 Premier Benefits, Inc. was merged into Coventry Management Services, Inc.
- (40) On June 7, 2011 Coventry Health Care of Texas, Inc. was incorporated in Texas.

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PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

B.1 Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

Coventry Management Services, Inc.
6705 Rockledge Dr.
Suite 900
Bethesda, MD 20817
(301) 581-0600

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Corporation

Refer to the enclosed Roster of Directors and Officers

No health professional owns 5% or more financial interest in Coventry Management Services.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Federal Identification Number: 25-1794529
Louisiana Taxpayer Identification Number: 4977112001

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

State of Incorporation: Pennsylvania
State of Commercial Domicile: Maryland

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

None

B.8 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. **Include your organization's parent organization, affiliates, and subsidiaries.**

COVENTRY HEALTH CARE, INC. – Bethesda, MD
Coventry Health Care, Inc. is a diversified national managed health care company based in Bethesda, Maryland. The Company operates health plans, insurance

PART II: TECHNICAL APPROACH

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Our Organizational Structure

Coventry Management Services, Inc., a Pennsylvania corporation, ("CMS") is wholly owned by Coventry Health Care, Inc. ("Coventry") and part of an affiliated group of companies owned by Coventry (the "Coventry Group"). CMS contracts with affiliated health plans and insurance companies in the Coventry Group to provide administrative services to the affiliated health plans and insurance companies. The services provided by CMS include claims processing and customer service, benefits administration, information management, billing and enrollment and certain pharmacy benefit administration services. This structure allows CMS to provide its affiliates with high quality centralized functions and also benefit from economies of scale by standardizing processes in the most cost efficient manner.

Refer to the enclosed Coventry Health Care, Inc.'s Organizational Chart (Chart A) that highlights Coventry Management Services, Inc.

B.9 Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) if each GSA will differ provide details outlining the differences and how it will differ.

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Coventry Health Care, Inc. is the parent company and has ultimate responsibility for all Coventry functions and teams connected to the CCN program.

MAJOR SUBCONTRACTOR'S NAME:

COVENTRY MANAGEMENT SERVICES, INC.

Directors and Officers Roster

<u>Directors</u>		
Name	Address	Telephone Number
Harvey DeMovick, Jr.	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
<u>Officers</u>		
Name	Address	Telephone Number
Harvey C. DeMovick, Jr	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Shirley R. Smith	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
John Joseph Ruhlmann	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Robert Bennett Fox	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Jonathan D. Weinberg	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600
Melinda Tuozzo	6705 Rockledge, Ste. 900, Bethesda, MD 20817	(301) 581-0600

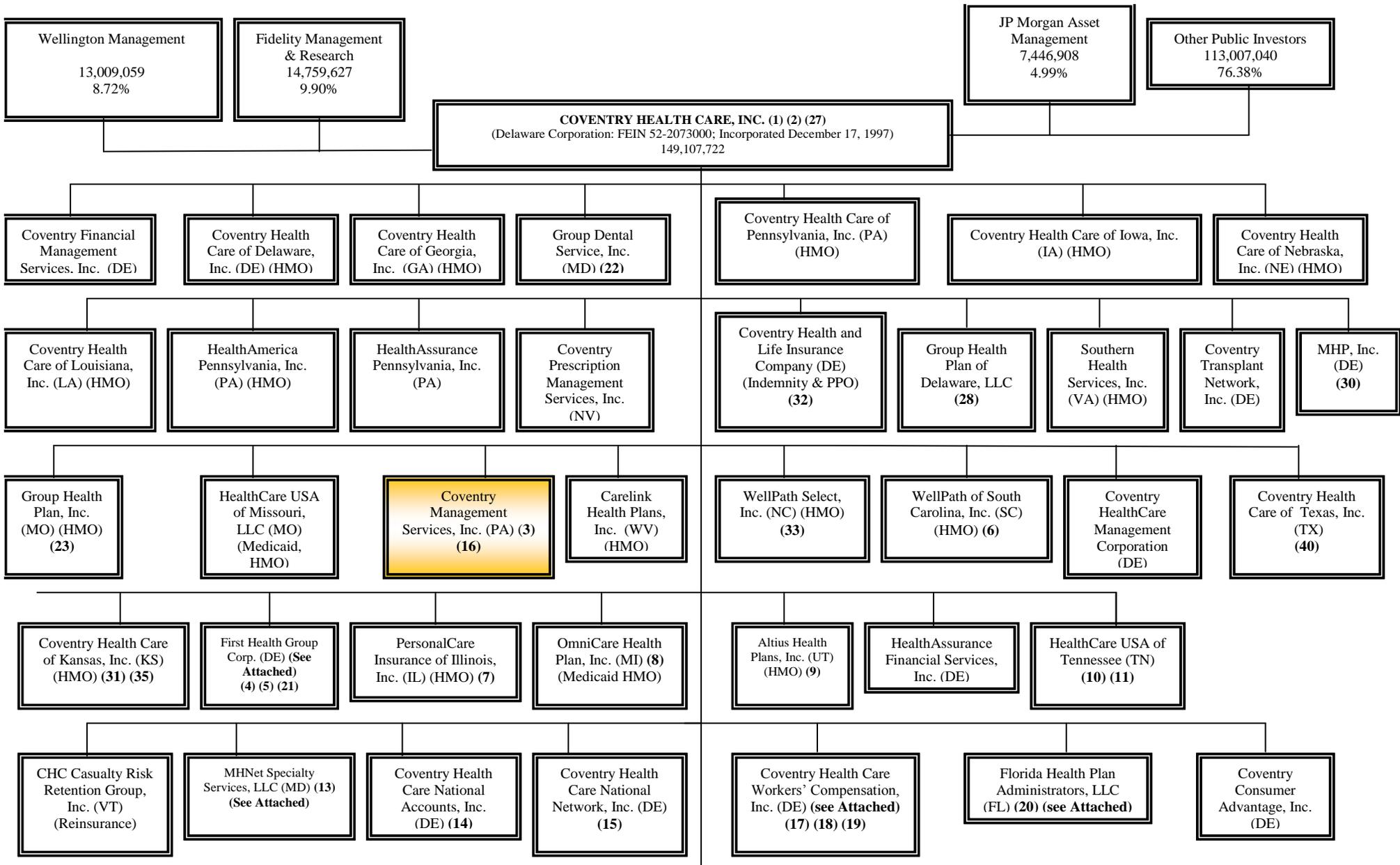
MAJOR SUBCONTRACTOR'S NAME:

COVENTRY MANAGEMENT SERVICES, INC.

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(CHART A)



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PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

B.1 Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

The organization's legal name is Avesis Third Party Administrators, Inc. We do not do business under any other name. The physical address is 3030 North Central Avenue, Suite 300, Phoenix, Arizona 85012 and the mailing address is 10324 South Dolfield Road, Owings Mills, Maryland 21117. The telephone number for the Corporate headquarters is (800) 643-1132. The parent company is Avesis Incorporated.

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Avesis Third Party Administrators, Inc. is an Arizona domestic corporation. The officers and directors are Joel H. Alperstein, President, Treasurer and Director and Michael P. Reamer, Secretary and Director. The mailing address for Mr. Alperstein and Mr. Reamer is 10324 South Dolfield Road, Owings Mills, Maryland 21117 and the phone number is (800) 643-1132, extensions 404 and 304 respectively. The federal tax identification number is 86-0986927. Avesis does not have a Louisiana taxpayer identification number. There is no health professional with an ownership interest in Avesis .

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

Avesis Third Party Administrators, Inc. is domiciled in the state of Arizona. CT Corporation System is our registered agent. Their address is: 5615 Corporate Boulevard, Suite 400B, Baton Rouge, Louisiana 70808.

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

Not applicable

B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. **Include your organization's parent organization, affiliates, and subsidiaries.**

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

There have been no mergers, acquisitions or sales of our organization in the past ten years. There is no change of ownership anticipated during the twelve months following the proposal due date.

B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have **ever** been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. **Include your organization's parent organization, affiliates, and subsidiaries.**

Since 1992, when the current majority ownership/ management of Avesis Incorporated assumed control, none of its affiliates, subsidiaries, employees, agents, independent contractors, or sub contractors have been convicted of, pled guilty to, or pled nolo contendere to any felony and/or any Medicaid or healthcare related offense, or have been debarred or suspended by any federal or state governmental body.

B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. **Include your organization's parent organization, affiliates, and subsidiaries.**

Within the past five years there has been one lawsuit in which the Company has been a party which may be considered to involve the failure to provide timely, adequate or quality health services. The Company was named a co-defendant along with the Georgia Department of Community Health, WellCare of Georgia, Peach State Health Plan, Inc. and Doral Dental Services of Georgia, LLC in a Class Action filing related to the termination of two dental provider groups from the codefendants' Medicaid dental networks on August 22,2007. The suit was dismissed without prejudice on September 28, 2007.

Avesis Third Party Administrators, Inc. was named in the class action suit, Eagle Vision Optometry, Inc. v. Avesis in the Circuit Court of Jefferson County, Alabama during May 2011. Avesis is being represented by Balch & Bingham, LLP in Birmingham, AL. Lead counsel is R. Bruce Barze, Jr. (205-251-8100). Projected damages have not been estimated as of yet as the issue being litigated was worth less than \$16.00 to the lead plaintiff and less than \$9,000 to the entire class.

B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. **Include your organization's parent organization, affiliates, and subsidiaries.**

In the last ten years neither Avesis Third Party Administrators, Inc. nor its parent company, Avesis Incorporated have filed or had filed against it any bankruptcy or insolvency proceeding.

B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.

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

Not applicable

B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

The year ended 2010 audited financial statements for Avesis Incorporated, the parent company of Avesis Third Party Administrators, Inc. along with the signed statement by an authorized representative of the parent organization are attached hereto.

B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.

A roster of key people who will be assigned to perform duties or services under the

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

Contract along with an organization chart has been attached hereto.

If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.

No personnel are current or former Louisiana state employees.

If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.

Not applicable

For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.

Not applicable

B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. **Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable

B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. **Include your organization's parent organization, affiliates, and subsidiaries.**

Avesis' contract with PeachState Health Plan, a Medicaid routine eye care program in Georgia was terminated when PeachState purchased their own eye care company.

Avesis' contract with PeachState Health Plan, a Medicaid dental program in Georgia was terminated within the first twenty days of the tenure of the Plan's fourth CEO in three years.

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

Avesis' contract with Molina Healthcare of Texas, a Medicaid dental program in Texas was not renewed as the parties could not agree on an appropriate Administrative Services Only rate.

B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. **Include your organization's parent organization, affiliates, and subsidiaries.**

The above contracts were not terminated or renewed due to any performance issues or corrective actions taken.

B.19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:

- AM Best Company (financial strengths ratings);
- TheStreet.com, Inc. (safety ratings); and
- Standard & Poor's (long-term insurer financial strength).

Not applicable

B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? **Include your organization's parent organization, affiliates, and subsidiaries.**

Avesis has never been notified by a contracting party that we were in breach of a contract.

B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.

Avesis has never sought accreditation from the NCQA or URAC.

B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. **Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable.

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. **Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable.

B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (**including your organization's parent organization, affiliates, and subsidiaries**) in response to the report.

Avesis has not received any external quality review reports.

B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. **Include your organization's parent organization, affiliates, and subsidiaries.**

Avesis Third Party Administrators, Inc. was charged an administrative penalty by the Connecticut Department of Insurance for its inadvertent failure to disclose an administrative matter in a different state. There have been no letters of deficiency issued or corrective actions requested by any federal or state regulatory entity in the last five (5) years.

B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. **Include your organization's parent company, affiliates and subsidiaries.**

Neither Avesis Third Party Administrators, Inc. nor its parent company, Avesis Incorporated have been the subject of a criminal or civil investigation by a state or federal agency in the past five (5) years.

B.27 Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

- a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:
 - Your/Subcontractor's name;
 - Geographic Service Area(s) for which the reference is being submitted;
 - Reference organization's name; and
 - Reference contact's name, title, telephone number, and email address.
- b. Send the form to each reference contact along with a new, sealable standard #10 envelope;
- c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;
- d. Instruct the reference contact to:
 - Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);
 - Sign and date it;
 - Seal it in the provided envelope;
 - Sign the back of the envelope across the seal; and
 - Return it directly to you.
- e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.

Refer to Attachment B.11(c)_1: Sealed References for Avesis, Inc.

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

Each completed questionnaire should include:

- Proposing Organization/Subcontractor's name;
- GSA (s) for which the reference is being submitted;
- Reference Organization's name;
- Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;
- Date reference form was completed; and
- Responses to numbered items in RFP Attachment # (as applicable).

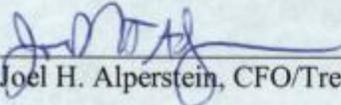
DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.

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June 9, 2011

THE UNDERSIGNED, an authorized representative of **Avesis Incorporated**, the parent company of **Avesis Third Party Administrators, Inc.**, hereby acknowledges that it will unconditionally guarantee performance by Avesis Third Party Administrators, Inc. of each and every obligation, warrant, covenant, term and condition of the Contract.

Dated: June 9, 2011



Joel H. Alperstein, CFO/Treasurer

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AVESIS KEY PERSONNEL

Alan S. Cohn, JD has been President and Chief Executive Officer of Avesis since 1998. Mr. Cohn has been involved in vision, dental, and pharmaceutical companies for over 30 years. Mr. Cohn has been a founder or principal to a variety of companies including: Spectera, formerly United Health Care, a vision, dental and pharmacy benefit management company; Allscripts, Inc., formerly Physician Dispensing Systems, Inc., a pharmaceutical dispensing company; Mail-Rx, a mail-order prescription drug company; National Computer Services, a healthcare software development company; and American Business Information Systems, a direct mail and printing company. Mr. Cohn previously sat on the board of the National Association of Vision Care Plans.

Peter D. Liane, OD a nationally recognized management executive with over 18 years of managed vision care experience has been the Chief Optometric Officer of Avesis since 2009. His experience includes plan design, operations, utilization management as well as clinical and regulatory aspects of ophthalmology and optometry. Dr. Liane has held a variety of positions in various organizations including: Chairman of the Board, Florida Board of Optometry; Member, National Board of Examiners in Optometry; Member, American Public Health Association and Member, Florida Public Health Association. Dr. Liane has also served on numerous committees in both the Northeast Florida Optometric Society and the Florida Optometric Association and has served as Chief Executive Officer and Chief Operating Officer of one of the nation's largest vision care companies. Dr. Liane was named the "Optometrist of the Decade" by the Florida Optometric Association in 1997 and continues to practice Optometry on a part time basis.

Paul C. Ajamian, OD, FAAO has been the Chief Eye Care Officer for Avesis since 2006. A practicing optometrist since 1980, Dr. Ajamian is the Center Director for Omni Eye Services of Atlanta and serves as the CE Committee General Chairman for SECO International, LLC. Dr. Ajamian has lectured internationally and has authored numerous publications over the past twenty five years. He is a member of numerous organizations including the Southern Council of Optometrists, Journal Review Committee of the Journal of the American Optometric Association, Georgia Chapter of the American Diabetic Association, and the American Optometric Association where he also served as the Chairman of the AOA task force on Radial Keratotomy. As the Chief Eye Care Officer for Avesis, Dr. Ajamian oversees the Vision Advisory Board, is Co-Chairman of the Credentialing Committee, Chairman of the Peer Review Committee, serves on the Quality Assurance and Utilization Review Committees, annually reviews clinical criteria and protocols as well as the Avesis Policies and Procedures related to the provision of eye care services and the Avesis provider network.

Ahmed Nassar, MD, MS is the Chief Eye Medical Officer for Avesis. An active member in the American Academy of Ophthalmology, American Society of Cataract and Refractive Surgery and American Medical Association, Dr. Nassar has been a practicing ophthalmologist in Georgia since completing his ophthalmology residency in 2004. Dr. Nassar has completed Senior Ophthalmology Externships with honors from Meharry Medical College, Vanderbilt University Medical Center, Bascom Palmer Eye Institute and New York Eye and Ear Infirmary. As the Chief Eye Medical Officer, Dr. Nassar oversees all aspects of the Avesis Eye Medical Programs including quality assurance, utilization review, program-specific policies and chairs the Eye Medical Advisory Board.

Fred L. Sharpe, DDS, JD has been the Chief Dental Officer of Avesis since 2003. As the lead clinician for all Avesis dental programs, Dr. Sharpe is responsible for establishing policy and plan designs for all Avesis dental programs. Additionally, Dr. Sharpe is responsible for the oversight of Avesis' dental quality assurance and utilization management programs. With over 30 years of managed dental care experience, Dr. Sharpe has designed and built dental HMO, PPO and discount programs across the nation. He has spoken nationally on topics of Managed Dental Care, Medicaid and Medicare Dental programs and Dental Professional Liability. In the areas of quality assurance and management, Dr. Sharpe has worked with one of the nation's leading dental CVOs to help gain NCQA accreditation.

Dr. Sharpe works closely with Avesis' dental clients and network providers to insure that our Members receive appropriate and cost-effective dental care services. Dr. Sharpe currently sits on the board of the National Association of Dental Plans.

Joel H. Alperstein, CPA, MBA has been Chief Financial Officer of Avesis since 1999 and Treasurer of the Company since 1997. Mr. Alperstein is also the President of Avesis Third Party Administrators, Inc. From 1997 until 1999 Mr. Alperstein was the Director of Finance for Avesis. Mr. Alperstein is responsible for the oversight of Avesis' accounting, legal, and program integrity departments. Prior to Avesis, Mr. Alperstein spent 6 years in the public accounting and consulting industry working for both regional and "Big 4" firms.

Michael Reamer, MBA has been Chief Marketing Officer of Avesis since 2003. Mr. Reamer has been involved in vision, dental and pharmaceutical companies since 1991. Mr. Reamer joined Avesis in 1993 and has led the organization's sales growth. Prior to Avesis, Mr. Reamer was instrumental in the sales and marketing of Allscripts, Inc., formerly Physician Dispensing Systems, Inc., a pharmaceutical dispensing company; and Mail-Rx, a mail-order prescription drug company.

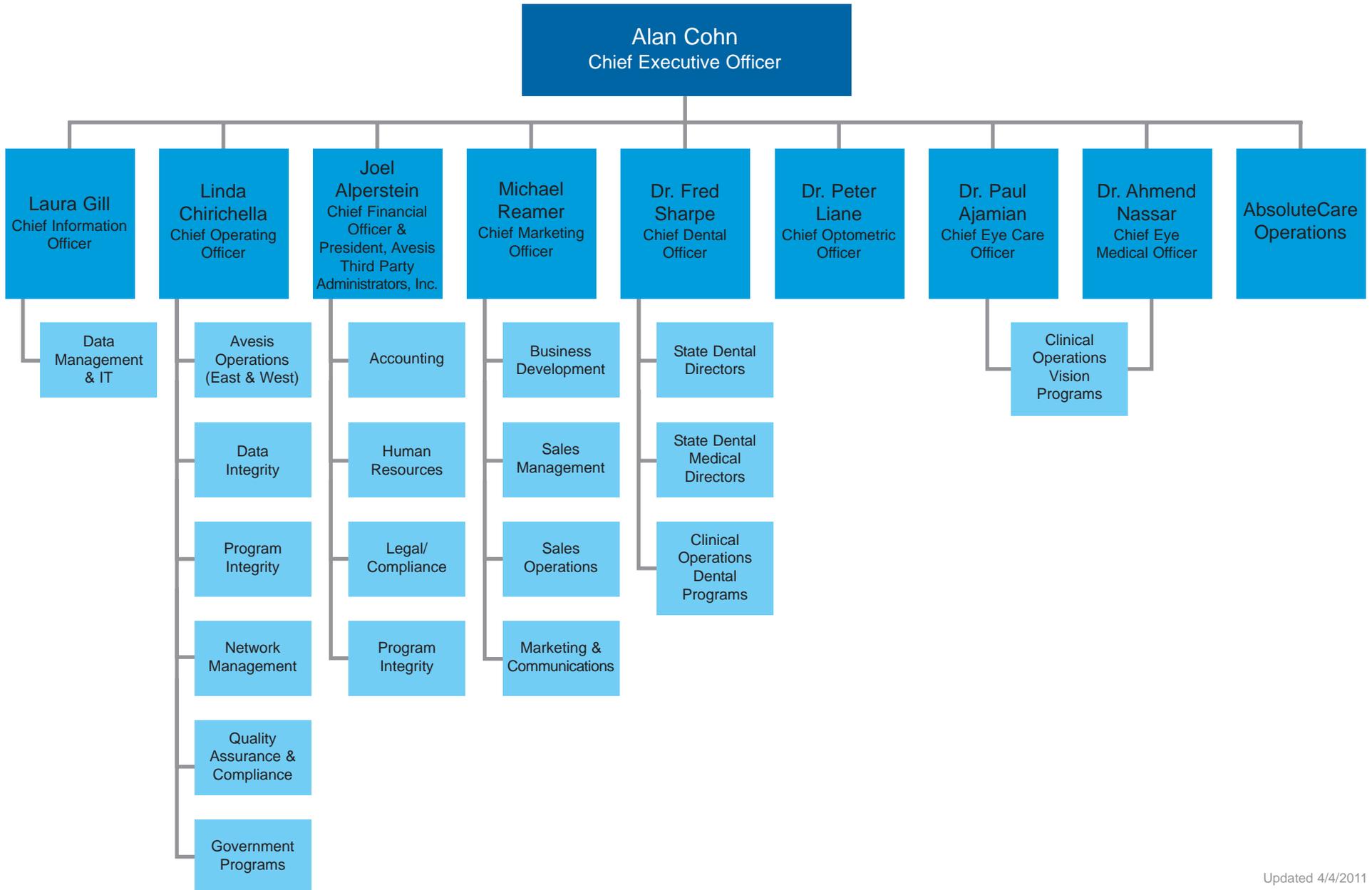
Linda Chirichella has been Chief Operating Officer of Avesis since 2007 after joining the team in 2005. Ms. Chirichella is responsible for the oversight and management of operations for Avesis' managed vision, dental, and hearing programs. Prior to Avesis, Ms. Chirichella spent most of her career in the health care management field working for WellPath Select, Inc, a Coventry Health Care Plan and NYLCare, a New York Life Company as a senior staff member reporting directly to the CEO. Ms. Chirichella was also a member of WellPath's start-up team in 1995 and has extensive experience in customer service, claims, enrollment, billing, and sales account management.

Laura Gill has been Chief Information Officer of Avesis since 2007 after joining the team in 2006. Ms. Gill has over 25 years of experience in both national and international health care. With a focus on operations, operational restructure, technology and infrastructure, Ms. Gill has worked on a diverse group of business development projects. She served as CEO and founder of a national/international consulting firm, as Chief Operating Officer and co-founder of the first live doctors online and e-commerce initiative in the United States, and as Chief Operating Officer and co-founder of the largest Pan-Regional e-health company in Latin America. Ms. Gill has served on many boards including the development of early HIPAA initiatives and Hillary Clinton's health care initiatives. Currently, she serves on the boards of some leading edge technology think tanks.

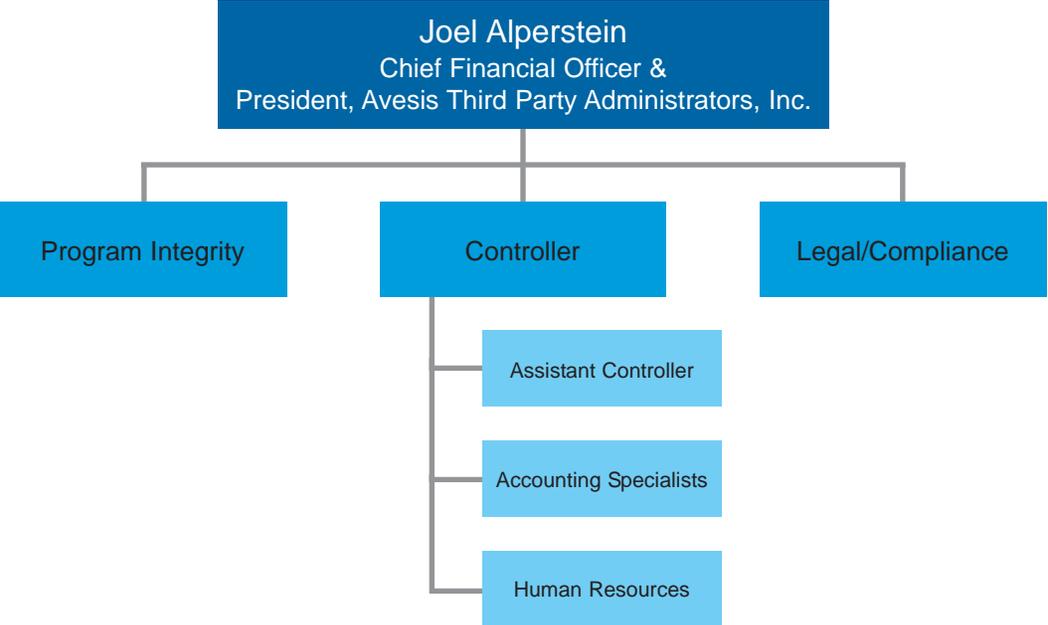
Nichole Mitchell, Director of Government Services, manages Avesis' government partnerships and has been instrumental in creating innovative solutions for provider support and oversight. She has organized most of the protocols for Avesis' government business. Ms. Mitchell joined Avesis' Georgia office in 2005 with a B.S. in Healthcare Management and 16 years of experience in the healthcare industry. This experience included roles in billing management and practice administration both in the primary care and specialty medical fields.

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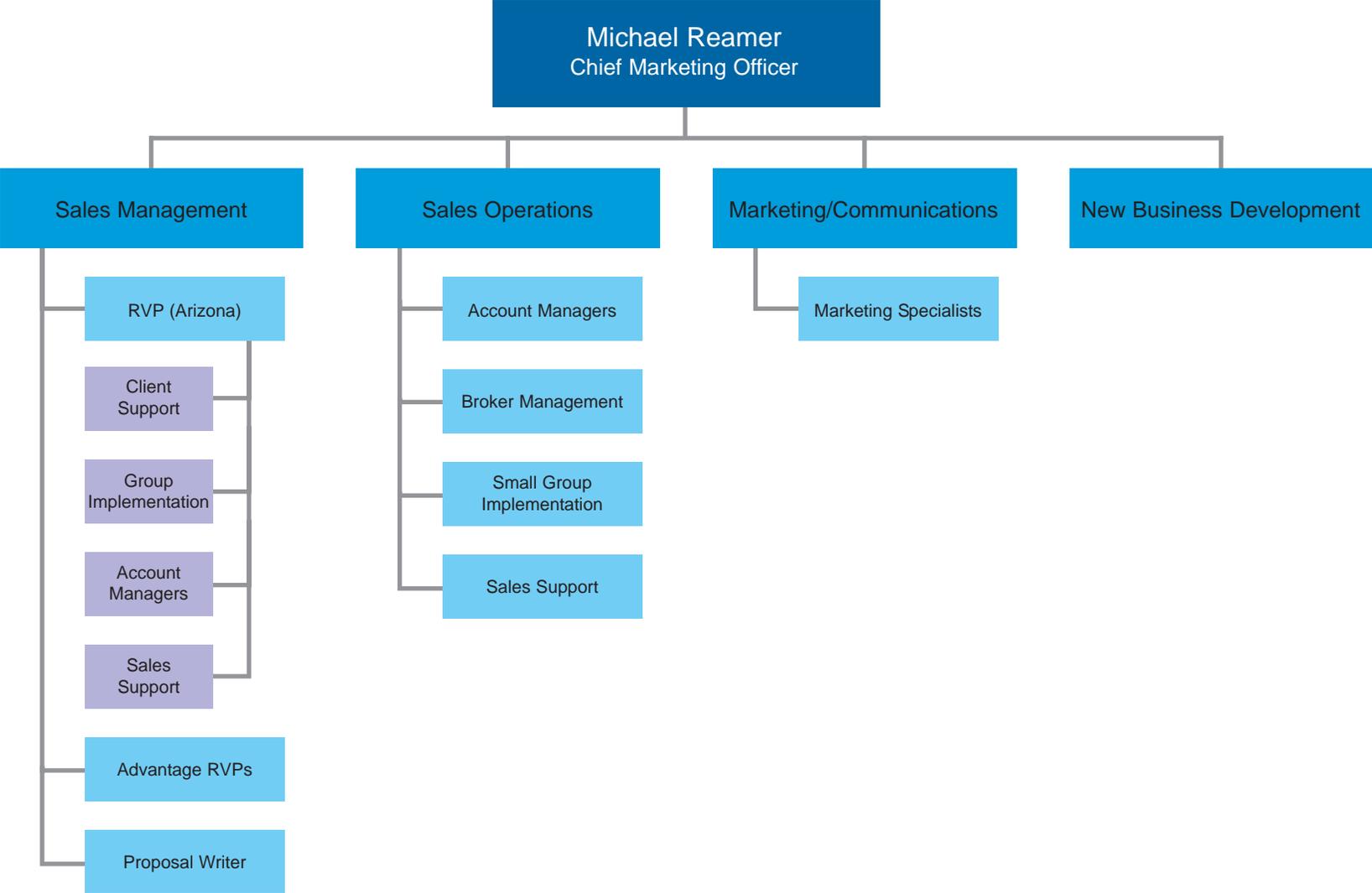
Avesis Incorporated & Subsidiaries



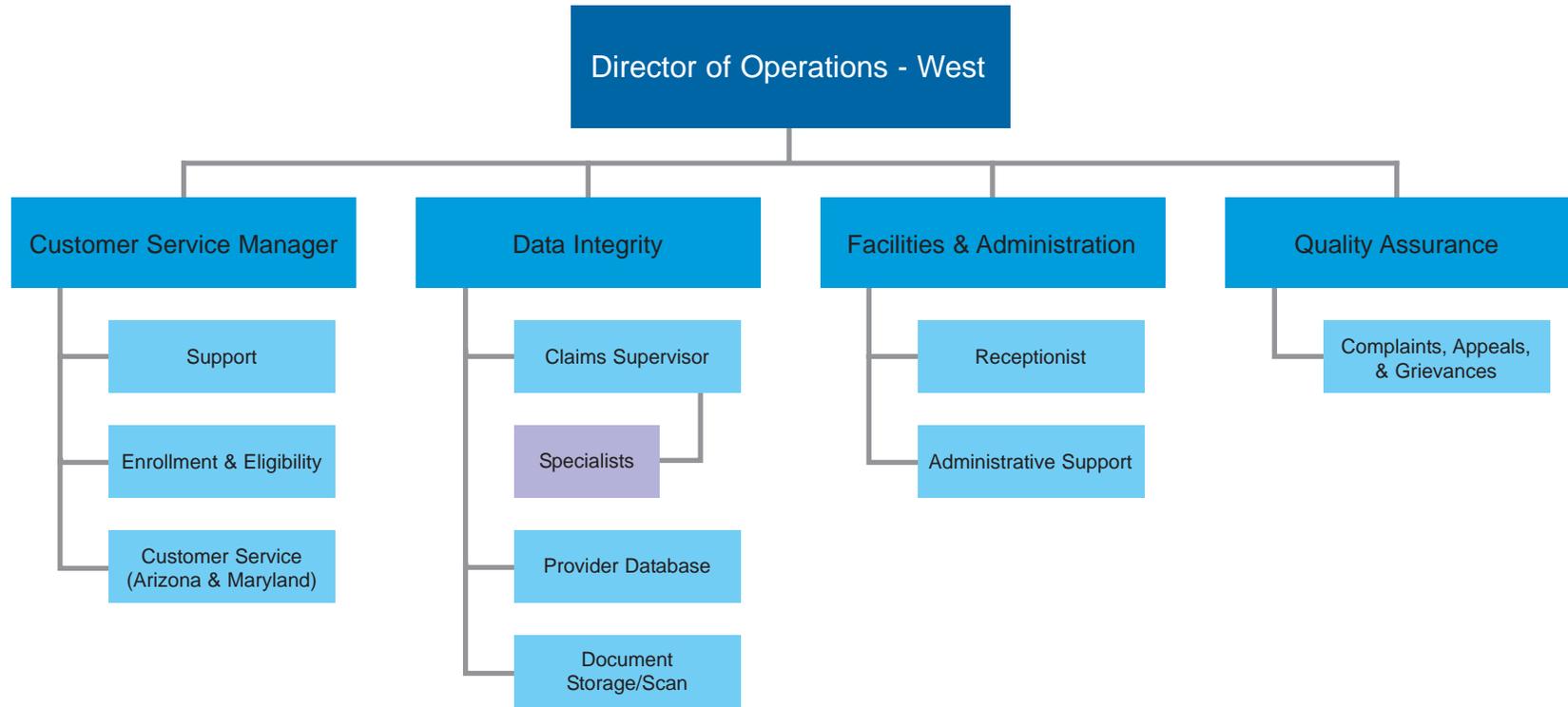
Finance



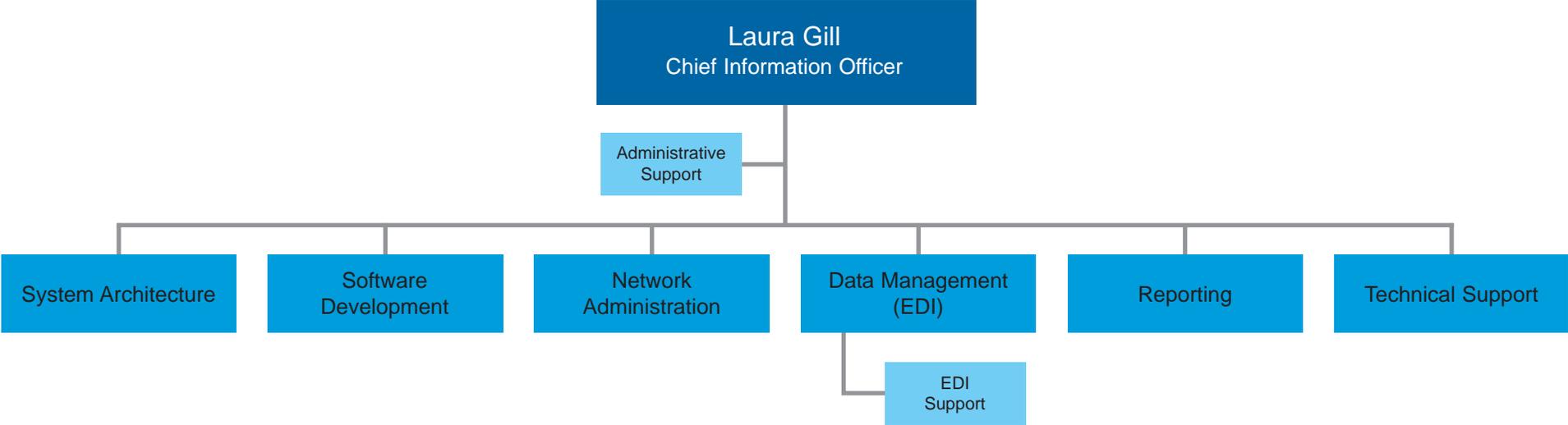
Sales and Marketing



Operations West

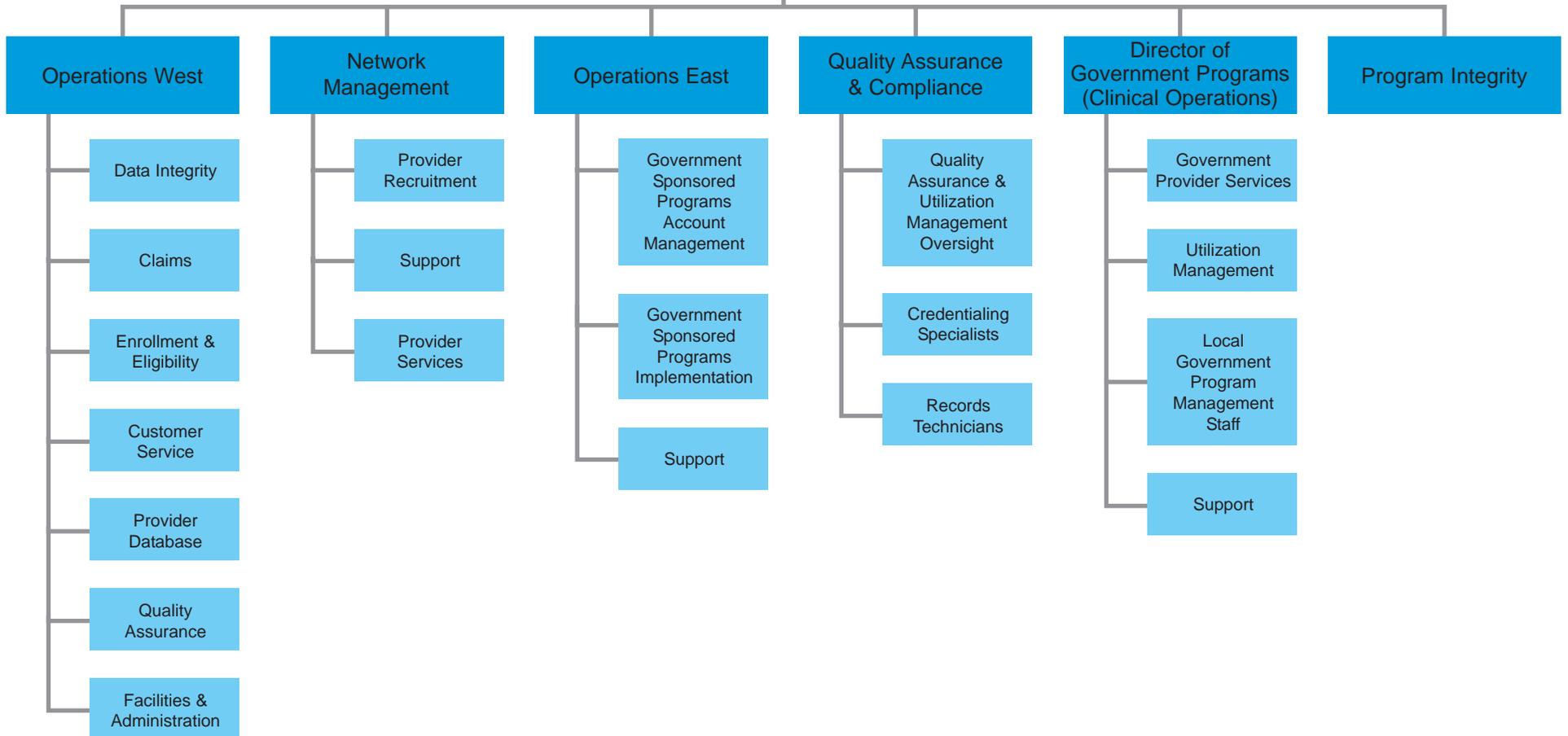


Information Technology



Operations

Linda Chirichella
Chief Operating Officer



Insert Color Slip Sheet

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

B.1 Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

Red-Card Systems, LLC official entity name
RedCard Systems is DBA
7700 Bonhomme Avenue
Suite 200
St. Louis, MO 63105

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest. Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Limited Liability Company

FEIN Number 205388701
RCS does not have a LA taxpayer identification number.

Company Officers: Mailing address for all officers is:
7700 Bonhomme Avenue,
Suite 200, St. Louis, MO 63105

Joe DiMartini – CEO, Managing Partner
Eric Schaefer – President and COO, Managing Partner
Dru Schmitt – CTO, Managing Partner
Rick Jewell – CFO
Dan Battista – EVP

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

Missouri

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

RCS has not been engaged by DHH in the past 24 months.

B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

Date, describe the circumstances of such change and indicate when the change is likely to occur. **Include your organization's parent organization, affiliates, and subsidiaries.**

There have been no mergers, acquisitions or sales of RedCard Systems within the last 10 years.

Parent Company is Red Card Holdings, LLC

Refer to enclosed Organization Chart (CHART A)

B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have **ever** been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. **Include your organization's parent organization, affiliates, and subsidiaries.**

Neither RedCard Systems, its parent, affiliates, subsidiaries or any employee has been convicted, pled guilty or pled nolo contendere to any felony or Medicaid or healthcare related offenses.

B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. **Include your organization's parent organization, affiliates, and subsidiaries.**

There is no pending or recent litigation against RedCard Systems, its parent or any affiliates.

B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. **Include your organization's parent organization, affiliates, and subsidiaries.**

None of RedCard Systems, its parent or any affiliates has filed bankruptcy in the last 10 years.

B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

Report, and the most-recent 10-Q Quarterly report.

NA

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

There have not been any SEC investigations against RedCard Systems, its parent or any of its affiliates in the last 10 years.

B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

RCS is privately held, and does not share its financial statements. Summary financial information can be provided upon request.

Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

RedCard Holdings LLC as 100% owner of RedCard Systems, will unconditionally guarantee the performance of RedCard Systems of each and every obligation, warranty, covenant, term and condition of the Contract.

Refer to enclosed Guarantee Performance Signed Statement

B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.

If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.

For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.

Joe DiMartini

Mr. DiMartini has served as Chief Executive Officer and Co-Founder of RedCard Systems since inception of RedCard Systems in 2006. He also serves as CEO of Columbus Capital Partners (CCP) a business incubation firm located in St. Louis, Missouri. RedCard Systems is one of the current CCP incubated entities.

Prior to his current appointments, Mr. DiMartini served as President of Payer Services at WebMD Business Services, now named EMDEON, from September 2003 - January 2006. From 1998-2003, he served as President and CEO and was a co-founder of Advanced Business Fulfillment (ABF) which was acquired by WebMD in the summer of 2003. Prior to that position, Mr. DiMartini served as EVP and was Co-Founder of Anthony, Allan, and Quinn, a small business incubation company that started and managed 5 successful entities two of which achieved national recognition as #156 and #23 on INC's fastest growing private companies in the USA.

Mr. DiMartini attended the University of Northern Iowa where he studied Accounting and Marketing while playing tennis for UNI Men's Tennis team.

Eric Schaefer

Mr. Schaefer has served as President and Co-Founder of RedCard Systems since inception of RedCard Systems in 2006. He also serves as President of Columbus Capital Partners (CCP) a business incubation firm located in St. Louis, Missouri. RedCard Systems is one of the current CCP incubated entities.

Prior to his current appointments, Mr. Schaefer served as Executive Vice President of Payer Services at WebMD Business Services, now named EMDEON, from September 2003 - January 2006. From 1998-2003, he served as Vice President of Sales and Marketing and was a co-founder of Advanced Business Fulfillment (ABF) which was acquired by WebMD in the summer of 2003. Mr. Schaefer created the alliance structure for ABF's software vendor partnerships and executed marketing alliances with 20+ claim systems vendors. He was also the key player in the sale of the first 50 ABF clients as well as the initial implementation cycles for those clients.

Eric attended The University of Northern Iowa where he obtained degrees in finance and international business and has studied finance at the graduate level at Drake University and St. Louis University.

Dru Schmitt

Mr. Schmitt has served as Chief Technology Officer and Co-Founder of RedCard Systems since inception of RedCard Systems in 2006. He also serves as CTO of Columbus Capital Partners (CCP) a business incubation firm located in St. Louis,

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

Missouri. RedCard Systems is one of the current CCP incubated entities.

Prior to his current appointments, Mr. Schmitt served as CIO/CTO of Payer Services at WebMD Business Services, now named EMDEON, from September 2003-September 2005. From 1998-2003, he served as CIO and CTO and was a co-founder of Advanced Business Fulfillment (ABF) which was acquired by WebMD in the summer of 2003. Prior to that position, Mr. Schmitt served as Secretary and was Co-Founder of Anthony, Allan, and Quinn, a small business incubation company that started and managed 5 successful entities two of which achieved national recognition as #156 and #23 on INC's fastest growing private companies in the USA.

Mr. Schmitt attended the University of Northern Iowa where he obtained his degree in Information Technology.

Daniel Battista

Mr. Battista joined RedCard Systems in March 2009. He is a technology executive with more than 25 years of experience, specializing in start-up operations.

Prior to joining Red Card System, Mr. Battista was Senior Vice President of Product Development at XM Satellite Radio, where he was the executive in charge of engineering and manufacturing for all XM branded consumer electronics receivers through the company's formative years. From 1995 to 2001, Mr. Battista resided in Shanghai, China, where he established an Electrical Engineering design center for General Motors.

Mr. Battista attended the Massachusetts Institute of Technology and the University of Southern California where he obtained Engineering degrees.

Ron Fredrickson, Senior Project Manager. 15 years experience in print management and 5 years healthcare specific. Led all large Medicare/Medicaid implementations for RedCard

Christy Jones, Director of Client Services and Technical Support. 15 years experience in print management, document design and 6 years in healthcare specific applications. Leads technical support for client using the DOCS system, and coordinates with larger RCS clients who have CMS business.

Eric Schaefer, President and COO. 15 Years experience in healthcare processing and technology development. Executive Sponsor. Led previous engagement at prior firm managing the State of LA group benefits print/mail program.

B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. **Include your organization's parent organization, affiliates, and subsidiaries.**

All of contracts are as Business Associates of Medicare/Medicaid FI's are listed below.

- *Coventry*
- *Aultcare*
- *HealthNow (PCIP)*

RedCard's 10 Largest Non Medicaid/Medicare customers after Coventry (largest customer) are:

- *Meritain (Aetna) - ID Cards and Enrollment, 400,000 members, Commercial*
- *Trustmark/Coresource – ID Cards and Enrollment, 200,000 members, Commercial*
- *HealthSmart - ID Cards and Enrollment, 200,000 members, Commercial/PPO*
- *RMSCO – ID Cards and Enrollment, 100,000 members, Commercial*
- *Gilsbar - ID Cards and Enrollment, 100,000 members, Commercial*
- *Aultcare – ID Cards and Enrollment, 100,000 members, Commercial/PPO*
- *Primary Physician Care - ID Cards and Enrollment, 100,000 members, Commercial/PPO*
- *Delta Health Systems - ID Cards and Enrollment, 100,000 members, Commercial*
- *Allied Benefit Systems - ID Cards and Enrollment, 75,000 members, Commercial*
- *Benefit Administrative Systems - ID Cards and Enrollment, 50,000 members, Commercial*

B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. **Include your organization's parent organization, affiliates, and subsidiaries.**

RedCard Systems, its parent, affiliates or subsidiaries has not had any contract terminated or not renewed in the last 5 years.

B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. **Include your organization's parent organization, affiliates, and subsidiaries.**

NA

B.19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:

- AM Best Company (financial strengths ratings);

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

- TheStreet.com, Inc. (safety ratings); and
- Standard & Poor's (long-term insurer financial strength).

NA

B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? **Include your organization's parent organization, affiliates, and subsidiaries.**

NA

B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.

RedCard Systems is not currently seeking application to either of these entities although we do have some minor interaction with the NCQA on their technical initiatives.

B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. **Include your organization's parent organization, affiliates, and subsidiaries.**

NA

B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. **Include your organization's parent organization, affiliates, and subsidiaries.**

NA

B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (**including your organization's parent organization, affiliates, and subsidiaries**) in response to the report.

NA

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. **Include your organization's parent organization, affiliates, and subsidiaries.**

RedCard Systems, its parent, affiliates or subsidiaries has not had any regulatory action against it in the last 5 years.

B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. **Include your organization's parent company, affiliates and subsidiaries.**

To our knowledge, RedCard Systems, its parent, affiliates or subsidiaries is not currently the subject of a criminal or civil investigation by a state or federal agency for any reasons.

B.27 Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

- a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:
 - Your/Subcontractor's name;
 - Geographic Service Area(s) for which the reference is being submitted;
 - Reference organization's name; and
 - Reference contact's name, title, telephone number, and email address.
- b. Send the form to each reference contact along with a new, sealable standard #10 envelope;
- c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;
- d. Instruct the reference contact to:
 - Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);
 - Sign and date it;
 - Seal it in the provided envelope;

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

- Sign the back of the envelope across the seal; and
 - Return it directly to you.
- e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.

Refer to Attachment B.11(d)_1: for our three Sealed References

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

Each completed questionnaire should include:

- Proposing Organization/Subcontractor's name;
- GSA (s) for which the reference is being submitted;
- Reference Organization's name;
- Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;
- Date reference form was completed; and
- Responses to numbered items in RFP Attachment # (as applicable).

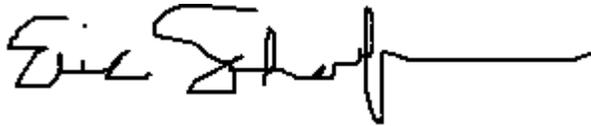
DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.

Guarantee Performance Signed Statement

B.7

Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

RedCard Holdings LLC as 100% owner of RedCard Systems, will unconditionally guarantee the performance of RedCard Systems of each and every obligation, warranty, covenant, term and condition of the Contract.



Print Name: Eric Schaefer

Date: 6/7/11

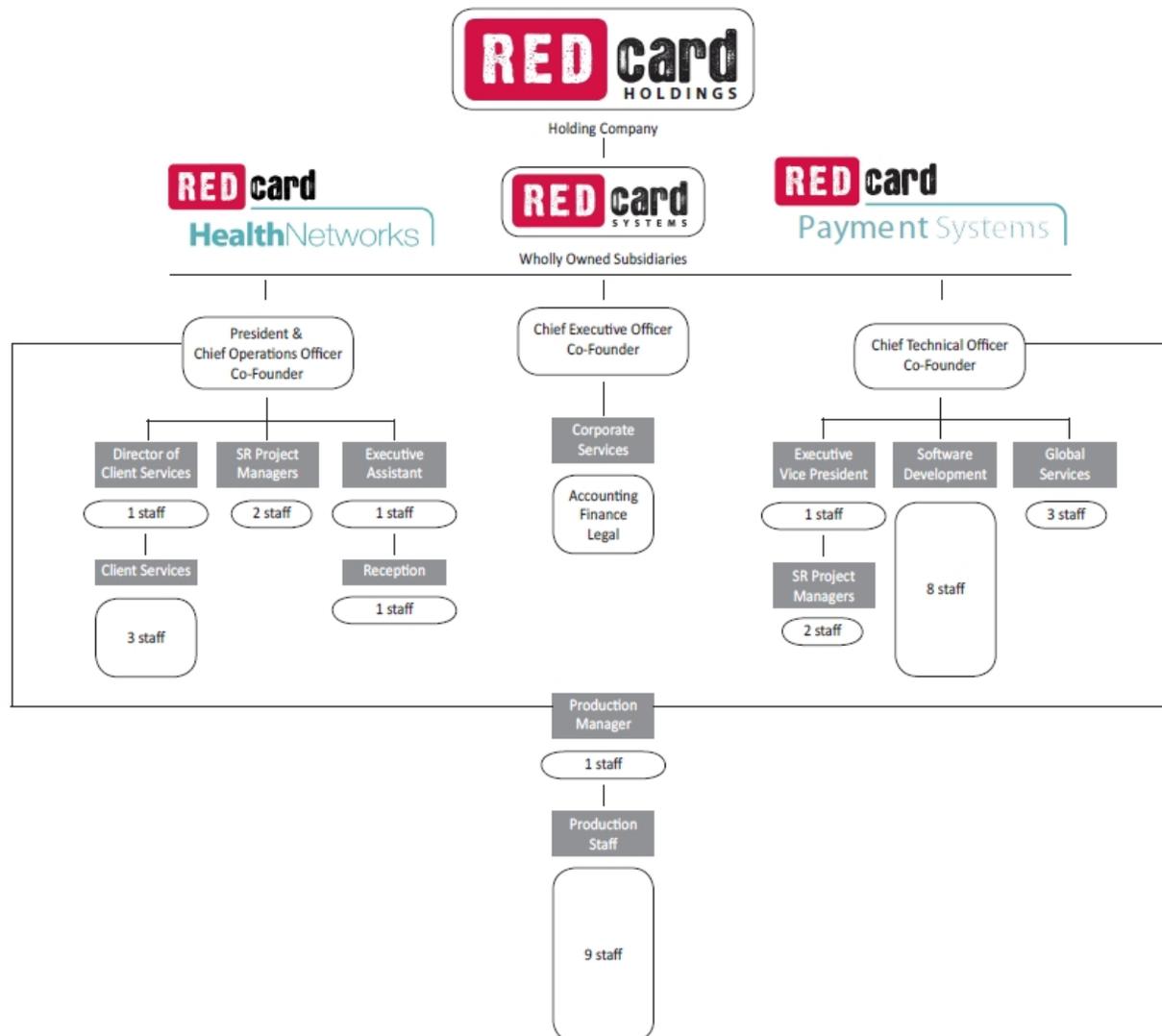
Authorized Representative

RedCard Holdings, LLC

MAJOR SUBCONTRACTOR'S NAME:

REDCARD SYSTEMS

Organizational Chart (CHART A)



MAJOR SUBCONTRACTOR'S NAME:

REDCARD SYSTEMS

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Insert Color Slip Sheet

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

B.1 Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

*McKesson Health Solutions (McKesson)
355 Interlocken Parkway
Broomfield, CO 80021
303-466-9500*

McKesson Health Solutions has offices in Malvern, PA, Newton, MA, and Broomfield, CO.

MHS Care Management is a subsidiary of McKesson Corporation. McKesson Corporation is headquartered at One Post Street, San Francisco, CA 94104 and is a public corporation traded as MCK on the New York Stock Exchange. Incorporated in the state of Delaware, McKesson Corporation's IRS Employer Identification Number is: 94-3207296.

Refer to Attachment B.11 (e)_1 for a listing of McKesson Corporation Officers.

McKesson is currently providing Nurse Advice Line services for the State Of Louisiana through a sub-contracted relationship with Automated Health Systems under contract number: 689685.

B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. **Include your organization's parent organization, affiliates, and subsidiaries.**

McKesson Health Solutions LLC (McKesson Health Solutions) was involved with the

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

following mergers, acquisitions, and sales within the last ten years:

(a) in approximately 2002, a divestiture of Amisys;

(b) in approximately 2005, an acquisition of Intelliclaim;

(c) on July 1, 2010. a divestiture involving McKesson Asia-Pacific Party Limited, which was a direct wholly-owned subsidiary of McKesson Corporation, but rolled into McKesson Health Solutions from a financial reporting perspective.

To the best of McKesson Health Solutions' knowledge no change in ownership is anticipated during the twelve months following the Proposal Due Date.

McKesson Health Solutions is part of the McKesson Corporation, a fortune 15 company. See Form 10K/Q of McKesson Corporation for information about its business, legal proceedings, stock holder matters, financial statements, corporate governance and other similar items related to McKesson Corporation and its subsidiaries.

See Form 10K/Q of McKesson Corporation, which can be found in Attachment B.11 (e)_2: or at the following link:

<http://sec.gov/Archives/edgar/data/927653/000095012311045634/0000950123-11-045634-index.htm>

B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have **ever** been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. **Include your organization's parent organization, affiliates, and subsidiaries.**

McKesson Health Solutions provides its response to this question with respect to its Care Management division only.

To the best of McKesson Health Solutions' knowledge ,within the last 3 years, no employees of McKesson Health Solutions have been convicted of, pled guilty to, or pled nolo contendere to a felony and/or a Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body. McKesson Health Solutions has procedures in place to review and monitor whether any of its employees, agents, independent contractors, or subcontractors providing services under its nurse advice line contracts are convicted of, plead guilty to, or plead nolo contendere to any felony and/or any Medicaid or health care related offense or are debarred or suspended by any federal or state governmental body.

McKesson Health Solutions is part of the McKesson Corporation, a fortune 15 company. See Form 10K/Q of McKesson Corporation for information about its business, legal proceedings, stock holder matters, financial statements, corporate governance and other similar items related to McKesson Corporation and its

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

subsidiaries.

See Form 10K/Q of McKesson Corporation, which can be found in Attachment B.11 (e)_2: or at the following link:

<http://sec.gov/Archives/edgar/data/927653/000095012311045634/0000950123-11-045634-index.htm>

B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. **Include your organization's parent organization, affiliates, and subsidiaries.**

McKesson Health Solutions provides its response to this question with respect to its Care Management division only. In addition, McKesson Health Solutions' response does not include any employment, bankruptcy and other matters not directly related to the provision of its Care Management Services.

To the best of McKesson Health Solutions' knowledge, there are no pending or recent (within the past 5 years) litigation against McKesson Health Solutions.

McKesson Health Solutions is part of the McKesson Corporation, a fortune 15 company. See Form 10K/Q of McKesson Corporation for information about its business, legal proceedings, stock holder matters, financial statements, corporate governance and other similar items related to McKesson Corporation and its subsidiaries.

See Form 10K/Q of McKesson Corporation, which can be found in Attachment B.11 (e)_2: or at the following link:

<http://sec.gov/Archives/edgar/data/927653/000095012311045634/0000950123-11-045634-index.htm>

B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. **Include your organization's parent organization, affiliates, and subsidiaries.**

McKesson Health Solutions provides its response to this question with respect to its Care Management division only.

To the best of McKesson Health Solutions' knowledge, there are no pending or recent (within the past 5 years) bankruptcy or insolvency proceedings filed by or against it,

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors against McKesson Health Solutions.

McKesson Health Solutions is part of the McKesson Corporation, a fortune 15 company. See Form 10K/Q of McKesson Corporation for information about its business, legal proceedings, stock holder matters, financial statements, corporate governance and other similar items related to McKesson Corporation and its subsidiaries.

See Form 10K/Q of McKesson Corporation, which can be found in Attachment B.11 (e)_2: or at the following link:

<http://sec.gov/Archives/edgar/data/927653/000095012311045634/0000950123-11-045634-index.htm>

B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.

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

See Form 10K/Q of McKesson Corporation, which can be found in Attachment B.11 (e)_2: or at the following link:

<http://sec.gov/Archives/edgar/data/927653/000095012311045634/0000950123-11-045634-index.htm>

McKesson Health Solutions has not provided a response with respect to Paragraph 2 of B.6-please see McKesson Corporations' 10K/Q.

B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

See Form 10K/Q of McKesson Corporation, which can be found in Attachment B.11 (e)_2: or at the following link:

<http://sec.gov/Archives/edgar/data/927653/000095012311045634/0000950123-11-045634-index.htm>

McKesson Health Solutions maintains adequate insurance for its business and will provide documentation as requested by the State to verify its financial capabilities. A corporate guarantee is not necessary for the proposed work under this RFP.

B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.

If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.

If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.

For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.

Refer to Attachment B.11 (e)_3: for resumes of key personnel, job descriptions and a organizational chart.

Ms. Mary Jo Marx will be the Account Manager and Ms. Coriann Batz will be the Client Service Manager to the Contract.

B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. **Include your organization's parent organization, affiliates, and subsidiaries.**

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

Refer to Attachment B.11 (e)_4 for list of Managed Care/ Non-Managed Care Contracts.

B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. **Include your organization's parent organization, affiliates, and subsidiaries.**

McKesson Health Solutions provides its response to this question with respect to its Care Management division only. McKesson has not had any contracts terminated or not renewed in the past 5 years.

McKesson Health Solutions is part of the McKesson Corporation, a fortune 15 company. See Form 10K/Q of McKesson Corporation for information about its business, legal proceedings, stock holder matters, financial statements, corporate governance and other similar items related to McKesson Corporation and its subsidiaries.

See Form 10K/Q of McKesson Corporation, which can be found in Attachment B.11 (e)_2: or at the following link:

<http://sec.gov/Archives/edgar/data/927653/000095012311045634/0000950123-11-045634-index.htm>

B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. **Include your organization's parent organization, affiliates, and subsidiaries.**

McKesson Health Solutions provides its response to this question with respect to its Care Management division only. McKesson has not had any contracts terminated or not renewed in the past 5 years

McKesson Health Solutions is part of the McKesson Corporation, a fortune 15 company. See Form 10K/Q of McKesson Corporation for information about its business, legal proceedings, stock holder matters, financial statements, corporate governance and other similar items related to McKesson Corporation and its subsidiaries.

See Form 10K/Q of McKesson Corporation, which can be found in Attachment B.11 (e)_2: or at the following link:

<http://sec.gov/Archives/edgar/data/927653/000095012311045634/0000950123-11-045634-index.htm>

B.19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:

- AM Best Company (financial strengths ratings);
- TheStreet.com, Inc. (safety ratings); and

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

- Standard & Poor's (long-term insurer financial strength).

Non Applicable

B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? **Include your organization's parent organization, affiliates, and subsidiaries.**

McKesson Health Solutions provides its response to this question with respect to its Care Management division only.

To the best of McKesson Health Solutions' knowledge, it has not been in receipt of any notices of contract breach within the past 5 years.

McKesson Health Solutions is part of the McKesson Corporation, a fortune 15 company. See Form 10K/Q of McKesson Corporation for information about its business, legal proceedings, stock holder matters, financial statements, corporate governance and other similar items related to McKesson Corporation and its subsidiaries.

See Form 10K/Q of McKesson Corporation, which can be found in Attachment B.11 (e)_2: or at the following link:

<http://sec.gov/Archives/edgar/data/927653/000095012311045634/0000950123-11-045634-index.htm>

B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.

URAC: *McKesson is accredited under the Health Call Center Standards, version 4.1. The URAC accreditation process demonstrates a commitment to quality and a commitment to quality services and serves as a framework to improve business processes through benchmarking organizations against nationally recognized standards. McKesson's URAC accreditation expires September 1, 2012 and McKesson plans on renewing our accreditation once it expires.*

NCQA: *McKesson holds National Committee for Quality Assurance Full Accreditation for Health Information Product (HIP) #4/Health Information Line. McKesson also holds National Committee for Quality Assurance Full Accreditation for Patient and Practitioner Oriented Disease Management for Asthma, Cardiovascular Disease, CHF, COPD and Diabetes. McKesson's NCQA Disease Management accreditation expires on*

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

October 31, 2011 and McKesson plans on renewing our accreditation once it expires.

B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. **Include your organization's parent organization, affiliates, and subsidiaries.**

McKesson Health Solutions has not had its accreditation status in any state for any product line adjusted down, suspended or revoked.

B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. **Include your organization's parent organization, affiliates, and subsidiaries.**

McKesson Health Solutions is not a health plan and therefore does not receive health plan report cards.

B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (**including your organization's parent organization, affiliates, and subsidiaries**) in response to the report.

No external quality review reports have been conducted. Quality improvement is a cornerstone of McKesson's programs and our annually revised Quality Improvement Program can be found in Attachment B.11 (e)_5.

B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. **Include your organization's parent organization, affiliates, and subsidiaries.**

McKesson Health Solutions provides its response to this question with respect to its Care Management division only.

To the best of McKesson Health Solutions' knowledge, it has not been the subject of any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity within the last 5 years.

McKesson Health Solutions is part of the McKesson Corporation, a fortune 15 company. See Form 10K/Q of McKesson Corporation for information about its business, legal proceedings, stock holder matters, financial statements, corporate governance and other similar items related to McKesson Corporation and its subsidiaries.

See Form 10K/Q of McKesson Corporation, which can be found in Attachment B.11

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

(e) 2: or at the following link:

<http://sec.gov/Archives/edgar/data/927653/000095012311045634/0000950123-11-045634-index.htm>

B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. **Include your organization's parent company, affiliates and subsidiaries.**

McKesson Health Solutions provides its response to this question with respect to its Care Management division only.

To the best of McKesson Health Solutions' knowledge, it has not been the subject of any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity within the last 5 years.

McKesson Health Solutions is part of the McKesson Corporation, a fortune 15 company. See Form 10K/Q of McKesson Corporation for information about its business, legal proceedings, stock holder matters, financial statements, corporate governance and other similar items related to McKesson Corporation and its subsidiaries.

See Form 10K/Q of McKesson Corporation, which can be found in Attachment B.11

(e) 2: or at the following link:

<http://sec.gov/Archives/edgar/data/927653/000095012311045634/0000950123-11-045634-index.htm>

B.27 Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

- a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:
 - Your/Subcontractor's name;
 - Geographic Service Area(s) for which the reference is being submitted;
 - Reference organization's name; and
 - Reference contact's name, title, telephone number, and email address.
- b. Send the form to each reference contact along with a new, sealable standard #10 envelope;

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

- c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;
- d. Instruct the reference contact to:
- Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);
 - Sign and date it;
 - Seal it in the provided envelope;
 - Sign the back of the envelope across the seal; and
 - Return it directly to you.
- e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.

Refer to Attachment B.11(e)_3: Sealed References for McKesson Health Solutions, LLC

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

Each completed questionnaire should include:

- Proposing Organization/Subcontractor's name;
- GSA (s) for which the reference is being submitted;
- Reference Organization's name;
- Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;
- Date reference form was completed; and
- Responses to numbered items in RFP Attachment # (as applicable).

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

**McKesson Corporation
Board of Directors**

Name	Title/Position	Work Address	Telephone Number
John H. Hammergren	Chairman, President and Chief Executive Officer	One Post Street, San Francisco, CA 94104	415-983-8826
Patrick J. Blake	Executive Vice President and Group President	One Post Street, San Francisco, CA 94104	415-983-9397
Jeffrey C. Campbell	Executive Vice President, Chief Financial Officer	One Post Street, San Francisco, CA 94104	415-983-8882
Jorge L. Figueredo Executive Vice President, Human Resources	Executive Vice President, Human Resources	One Post Street, San Francisco, CA 94104	415-983-8580
Paul C. Julian	Executive Vice President and Group President	One Post Street, San Francisco, CA 94104	415-983-7687
Marc E. Owen	Executive Vice President, Corporate Strategy and Business Development	One Post Street, San Francisco, CA 94104	415-983-9714
Laureen E. Seeger	Executive Vice President, General Counsel and Chief Compliance Officer	One Post Street, San Francisco, CA 94104	415-983-8727
Randall N. Spratt	Executive Vice President, Chief Technology Officer and Chief Information Officer	One Post Street, San Francisco, CA 94104	415-983-8881

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**UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549**

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended March 31, 2011

OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

Commission File Number 1-13252

McKESSON CORPORATION

(Exact name of registrant as specified in its charter)

Delaware

94-3207296

(State or other jurisdiction of incorporation or organization)

(I.R.S. Employer Identification No.)

One Post Street, San Francisco, California

94104

(Address of principal executive offices)

(Zip Code)

(415) 983-8300

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

(Title of each class)

(Name of each exchange on which registered)

Common Stock, \$0.01 par value

New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer," and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer

Accelerated filer

Non-accelerated filer

Smaller reporting company

(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes No

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, computed by reference to the closing price as of the last business day of the registrant's most recently completed second fiscal quarter, September 2010, was approximately \$15.5 billion.

Number of shares of common stock outstanding on April 29, 2011: 252,120,037

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for its 2011 Annual Meeting of Stockholders are incorporated by reference into Part III of this Annual Report on Form 10-K.

McKESSON CORPORATION

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McKESSON CORPORATION

PART I

Item 1. Business

General

McKesson Corporation (“McKesson,” the “Company,” the “Registrant” or “we” and other similar pronouns), is a Fortune 15 corporation that delivers medicines, pharmaceutical supplies, information and care management products and services designed to reduce costs and improve quality across the healthcare industry.

The Company’s fiscal year begins on April 1 and ends on March 31. Unless otherwise noted, all references in this document to a particular year shall mean the Company’s fiscal year.

Our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended (the “Exchange Act,”) are available free of charge on our website (www.mckesson.com under the “Investors – Financial Information – SEC Filings” caption) as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission (“SEC” or the “Commission”). The content on any website referred to in this Annual Report on Form 10-K is not incorporated by reference into this report, unless expressly noted otherwise.

The public may also read or copy any materials that we file with the SEC at the SEC’s Public Reference Room at 100 F Street, NE, Washington, D.C. 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. The SEC maintains a website that contains reports, proxy and information statements, and other information regarding issuers, including the Company, that file electronically with the SEC. The address of the website is <http://www.sec.gov>.

Business Segments

We operate in two segments. The McKesson Distribution Solutions segment distributes ethical and proprietary drugs, medical-surgical supplies and equipment and health and beauty care products throughout North America. This segment also provides specialty pharmaceutical solutions for biotech and pharmaceutical manufacturers, sells financial, operational and clinical solutions for pharmacies (retail, hospital, alternate site) and provides consulting, outsourcing and other services. This segment includes a 49% interest in Nadro, S.A. de C.V. (“Nadro”), one of the leading pharmaceutical distributors in Mexico, and a 39% interest in Parata Systems, LLC (“Parata”), which sells automated pharmacy and supply management systems and services to retail and institutional outpatient pharmacies.

The McKesson Technology Solutions segment delivers enterprise-wide clinical, patient care, financial, supply chain, strategic management software solutions, pharmacy automation for hospitals, as well as connectivity, outsourcing and other services, including remote hosting and managed services, to healthcare organizations. This segment also includes our Payer group of businesses, which includes our InterQual® clinical criteria solution, medical management tools, claims payment solutions and care management programs. The segment’s customers include hospitals, physicians, homecare providers, retail pharmacies and payers from North America, the United Kingdom, Ireland, other European countries and Israel.

Net revenues for our segments for the last three years were as follows:

<i>(Dollars in billions)</i>	2011		2010		2009	
Distribution Solutions	\$ 108.9	97%	\$ 105.6	97%	\$ 103.6	97%
Technology Solutions	3.2	3%	3.1	3%	3.0	3%
Total	\$ 112.1	100%	\$ 108.7	100%	\$ 106.6	100%

McKESSON CORPORATION

Distribution Solutions

McKesson Distribution Solutions consists of the following businesses: U.S. Pharmaceutical Distribution, McKesson Canada, Medical-Surgical Distribution, McKesson Pharmacy Systems and Automation and McKesson Specialty Care Solutions. This segment also includes our 49% interest in Nadro and 39% interest in Parata.

U.S. Pharmaceutical Distribution: This business supplies pharmaceuticals and/or other healthcare-related products to customers in three primary customer channels: (1) retail national accounts (including national and regional chains, food/drug combinations, mail order pharmacies and mass merchandisers); (2) independent retail pharmacies; and (3) institutional healthcare providers (including hospitals, health systems, integrated delivery networks, clinics and alternate site providers). This business also provides solutions and services to pharmaceutical manufacturers.

Our U.S. pharmaceutical distribution business operates and serves thousands of customer locations through a network of 28 distribution centers, as well as a primary redistribution center, a strategic redistribution center and two repackaging facilities, serving all 50 states and Puerto Rico. We invest in technology and other systems at all of our distribution centers to enhance safety, reliability and provide the best product availability for our customers. For example, in all of our distribution centers we use Acumax® Plus, an award-winning technology that integrates and tracks all internal inventory-related functions such as receiving, put-away and order fulfillment. Acumax® Plus uses bar code technology, wrist-mounted computer hardware and radio frequency signals to provide customers with real-time product availability and industry-leading order quality and fulfillment in excess of 99.9% adjusted accuracy. In addition, we offer Mobile ManagerSM, which integrates portable handheld technology with Acumax® Plus to give customers complete ordering and inventory control. We also offer McKesson ConnectSM, an Internet-based ordering system that provides item lookup and real-time inventory availability as well as ordering, purchasing, third-party reconciliation and account management functionality. Together, these features help ensure customers have the right products at the right time for their facilities and patients.

To maximize distribution efficiency and effectiveness, we follow the Six Sigma methodology — an analytical approach that emphasizes setting high-quality objectives, collecting data and analyzing results to a fine degree in order to improve processes, reduce costs and minimize errors. We continue to implement information systems to help achieve greater consistency and accuracy both internally and for our customers.

The major offerings of the McKesson U.S. Pharmaceutical Distribution business by customer group can be categorized as retail national accounts, independent retail pharmacies and institutional healthcare providers.

Retail National Accounts — Business solutions that help national account customers increase revenues and profitability. Solutions include:

- Central FillSM — Prescription refill service that enables pharmacies to more quickly refill prescriptions remotely, more accurately and at a lower cost, while reducing inventory levels and improving customer service.
- Redistribution Centers — Two facilities totaling over 500 thousand square feet that offer access to inventory for single source warehouse purchasing, including pharmaceuticals and biologicals. These distribution centers also provide the foundation for a two-tiered distribution network that supports best-in-class direct store delivery.
- EnterpriseRx® — A fully integrated and centrally hosted pharmacy management solution (software as a service model). EnterpriseRx® centralizes data, reporting, pricing and drug updates, providing the operational control, visibility and support needed to reduce costs and streamline administrative tasks.
- RxPakSM — Bulk-to-bottle repackaging service that leverages our purchasing scale and supplier relationships to provide pharmaceuticals at reduced prices, help increase inventory turns and reduce working capital investment.
- Inventory Management — An integrated solution comprising forecasting software and automated replenishment technologies that reduce inventory-carrying costs.
- McKesson OneStop Generics® — Generic pharmaceutical purchasing program that helps pharmacies maximize their cost savings with a broad selection of generic drugs, low pricing and one-stop shopping.

McKESSON CORPORATION

Independent Retail Pharmacies — Solutions for managed care contracting, branding and advertising, merchandising, purchasing, operational efficiency and automation that help independent pharmacists focus on patient care while improving profitability. Solutions include:

- Health Mart® — Health Mart® is a national network of more than 2,700 independently-owned pharmacies and is one of the industry's most comprehensive pharmacy franchise programs. Health Mart® provides franchisees with managed care that drives pharmacy benefit manager recognition, branding that drives consumer recognition, in-store programs that drive manufacturer and payer recognition and community advocacy programs that drive industry recognition. Health Mart® helps franchisees grow their businesses by focusing on the three principles of successful retailing:
 - Attract new customers;
 - Maximize the value of current customers; and
 - Enhance business efficiency.
- AccessHealth® — Comprehensive managed care and reconciliation assistance services that help independent pharmacies save time, access competitive reimbursement rates and improve cash flow.
- McKesson Reimbursement AdvantageSM (“MRA”) — MRA is one of the industry's most comprehensive reimbursement optimization packages, comprising financial services (automated claim resubmission), analytic services and customer care.
- McKesson OneStop Generics® — described above.
- EnterpriseRx® — described above.
- Sunmark® — Complete line of more than 1,000 products that provide retail independent pharmacies with value-priced alternatives to national brands.
- FrontEdgeTM — Strategic planning, merchandising and price maintenance program that helps independent pharmacies maximize store profitability.
- McKesson Home Health Care — Comprehensive line of more than 1,800 home health care products, including durable medical equipment, diabetes supplies, self-care supplies and disposables from national brands and the Sunmark® line.
- Central FillSM — described above.

Institutional Healthcare Providers — Electronic ordering/purchasing and supply chain management systems that help customers improve financial performance, increase operational efficiencies and deliver better patient care. Solutions include:

- McKesson Pharmacy Optimization® — An experienced group of pharmacy professionals providing consulting services and pharmacy practice resources. McKesson Pharmacy Optimization® develops customized and quantifiable solutions that help hospitals create and sustain financial, operational and clinical results.
- Fulfill-RxSM — Ordering and inventory management system that integrates McKesson pharmaceutical distribution services with our automation solutions, thus empowering hospitals to optimize the often complicated and disjointed processes related to unit-based cabinet replenishment and inventory management.
- Asset Management — Award-winning inventory optimization and purchasing management program that helps institutional providers lower costs while ensuring product availability.
- SKY Packaging — Blister-format packaging containing the most widely prescribed dosages and strengths in generic oral-solid medications. SKY Packaging enables acute care, long-term care and institutional pharmacies to provide cost-effective, uniform packaging.
- McKesson OneStop Generics® — Generic pharmaceutical purchasing program that enables acute care pharmacies to capture the full potential of purchasing generic pharmaceuticals. The Long-Term Care OneStop Generics program allows a long-term care pharmacy to capture savings on generic purchases.
- McKesson 340B Solution Suite — Solutions that help providers manage, track and report on medication replenishment associated with the federal 340B Drug Pricing Program.
- High Performance Pharmacy® — Framework that identifies and categorizes hospital pharmacy best practices to help improve clinical outcomes and financial results. The High Performance Pharmacy Assessment Tool enables hospital pharmacies to measure against comparable institutions and chart a step-by-step path to high performance.

McKESSON CORPORATION

McKesson Canada: McKesson Canada, a wholly-owned subsidiary, is one of the largest pharmaceutical distributors in Canada. McKesson Canada, through its network of 17 distribution centers, provides logistics and distribution to more than 800 manufacturers – delivering their products to retail pharmacies, hospitals, long-term care centers, clinics and institutions throughout Canada. Beyond pharmaceutical distribution, logistics and order fulfillment, McKesson Canada has automated over 2,500 retail pharmacies and is also active in hospital automation solutions, dispensing more than 100 million doses each year. In partnership with other McKesson businesses, McKesson Canada provides a full range of services to Canadian manufacturers and healthcare providers, contributing to the quality and safety of care for patients.

Medical–Surgical Distribution: This business provides medical-surgical supply distribution, equipment, logistics and other services to healthcare providers including physicians’ offices, surgery centers, extended care facilities, homecare and occupational health sites through a network of 28 distribution centers within the U.S. This business is a leading provider of supplies to the full range of alternate-site healthcare facilities, including physicians’ offices, clinics and surgery centers (primary care), long-term care, occupational health facilities and homecare sites (extended care). Through a variety of technology products and services geared towards the supply chain, our Medical-Surgical Distribution business is focused on helping its customers operate more efficiently while providing one of the industry’s most extensive product offerings, including our own private label line. This business also includes ZEE® Medical, one of the most extensive product offerings in the industry of first aid, safety and training solutions, providing services to industrial and commercial customers. This business offers an extensive line of products and services aimed at maximizing productivity and minimizing the liability and cost associated with workplace illnesses and injuries.

McKesson Pharmacy Systems and Automation: This business supplies integrated pharmacy management systems, automated dispensing systems and related services to retail, outpatient, central fill, specialty and mail order pharmacies. Its primary offering is EnterpriseRx®, a fully integrated and centrally hosted pharmacy management solution (software as a service model). EnterpriseRx® centralizes data, reporting, pricing and drug updates, providing the operational control, visibility and support needed to reduce costs and streamline administrative tasks. We also own a 39% interest in Parata, which sells automated pharmacy and supply management systems and services to retail and institutional pharmacies.

McKesson Specialty Care Solutions: This business provides solutions for patients with complex diseases and advances specialty care by facilitating collaboration among healthcare providers, drug manufacturers and payers through our expertise in specialty drug distribution and commercialization support. The business provides direct-to-physician specialty distribution services ensuring specialty drugs are received in manufacturer recommended conditions. This business also offers our industry leading Lynx® integrated technologies and clinical tools, which help provider organizations to improve their inventory management, business efficiencies and reimbursement processes. The business also works with manufacturers to optimize delivery of complex medication to patients through custom distribution and safety programs that support appropriate product utilization, as well as the development and management of reimbursement and patient access programs that help patients to gain cost effective access to needed therapies. On December 30, 2010, we acquired US Oncology Holdings, Inc. (“US Oncology”) of The Woodlands, Texas, an integrated oncology company, which expands our existing specialty pharmaceutical distribution business and adds practice management services for oncologists. US Oncology is affiliated with community-based oncologists, and works with patients, hospitals, payers and the broader medical industry across all phases of the cancer research and delivery continuum.

Technology Solutions

Our Technology Solutions segment provides a comprehensive portfolio of software, automation, support and services to help healthcare organizations improve quality and patient safety, reduce the cost and variability of care and better manage their resources and revenue stream. This segment also includes our InterQual® clinical criteria solution, medical management tools, claims payment solutions and care management programs. Technology Solutions markets its products and services to integrated delivery networks, hospitals, physician practices, home healthcare providers, retail pharmacies and payers. Our solutions and services are sold internationally through subsidiaries and/or distribution agreements in Canada, the United Kingdom, Ireland, other European countries and Israel.

McKESSON CORPORATION

The product portfolio for the Technology Solutions segment is designed to address a wide array of healthcare clinical and business performance needs ranging from medication safety and information access to revenue cycle management, resource utilization and physician adoption of electronic health records (“EHR”). Analytics software enables organizations to measure progress as they automate care processes for optimal clinical outcomes, business and operating results and regulatory compliance. To ensure that organizations achieve the maximum value for their information technology investment, we also offer a wide range of services to support the implementation and use of solutions as well as assist with business and clinical redesign, process re-engineering and staffing (both information technology and back-office).

Key solution areas are as follows:

Clinical and financial management: We provide comprehensive clinical and financial information systems for hospitals and health systems of all sizes. These systems are designed to improve the safety and quality of patient care and improve clinical, financial and operational performance. Clinical functionality includes a data repository, care planning, physician order entry and documentation, nursing documentation with bar-coded medication administration, laboratory, radiology, pharmacy, surgical management, emergency department and ambulatory EHR systems, a Web-based physician portal and a comprehensive solution for homecare. Revenue management solutions are designed to improve financial performance by reducing days in accounts receivable, preventing insurance claim denials, reducing costs and improving productivity. Solutions include online patient billing, contract management, electronic claims processing and coding compliance checking. These solutions streamline patient access and help organizations to forecast financial responsibility for constituents before and during care, allowing providers to collect their reimbursements more quickly and at a lower cost.

Enterprise imaging: In addition to document imaging to facilitate maintenance and access to complete medical records, we offer medical imaging and information management systems for healthcare enterprises, including a picture archiving communications system, a radiology information system and a comprehensive cardiovascular information system. Our enterprise-wide approach to medical imaging enables organizations to take advantage of specialty-specific workstations while building an integrated image repository that manages all of the images and information captured throughout the care continuum.

Performance management: Performance management solutions are designed to enhance an organization’s ability to plan and optimize quality care delivery. Enterprise visibility and performance analytics provide business intelligence that enables providers to manage capacity, outcomes, productivity and patient flow. Workforce management solutions assist caregivers with staffing and maintaining labor rule continuity between scheduling, time and attendance and payroll. A comprehensive supply chain management solution integrates enterprise resource planning applications, including financials, materials, human resources/payroll, with scheduling, point of use, surgical and anesthesia services and enterprise-wide analytics.

Automation: Automation solutions include technologies that help hospitals re-engineer and improve their medication use processes. Examples include centralized pharmacy automation for dispensing unit-dose medications, unit-based cabinet technologies for secure medication storage and rapid retrieval and an anesthesia cart for dispensing of medications in the operating room. Based on a foundation of bar-code scanning technology, these integrated solutions are designed to reduce errors and bring new levels of safety to patients.

Physician practice solutions: We provide a complete solution for physician practices of all sizes that includes software, revenue cycle outsourcing and connectivity services. Software solutions include practice management and EHR software for physicians of every size and specialty. Our physician practice offering also includes outsourced billing and collection services as well as services that connect physicians with their patients, hospitals, retail pharmacies and payers. Revenue cycle outsourcing enables physician groups to avoid the infrastructure investment and administrative costs of an in-house billing office. Services include clinical data collection, data input, medical coding, billing, contract management, cash collections, accounts receivable management and extensive reporting of metrics related to the physician practice.

McKESSON CORPORATION

Connectivity: Through our vendor-neutral RelayHealth® and its intelligent network, the Company provides health information exchange and revenue cycle management solutions that streamline clinical, financial and administrative communication between patients, providers, payers, pharmacies, manufacturers, government and financial institutions. RelayHealth® helps to accelerate the delivery of high-quality care and improve financial performance through online consultation of physicians by patients, electronic prescribing by physicians, point-of-service resolution of pharmacy claims by payers, pre-visit financial clearance of patients by providers and post-visit settlement of provider bills by payers and patients. RelayHealth® securely processes more than 14.8 billion financial and clinical transactions annually.

In addition to the product offerings described above, Technology Solutions offers a comprehensive range of services to help organizations derive greater value, enhance satisfaction and return on investment throughout the life of the solutions implemented. The range of services includes:

Technology Services: Technology services supports the smooth operation of numerous organizations' information systems by providing the technical infrastructure designed to maximize application accessibility, availability, security and performance.

Outsourcing Services: With these services, we help providers focus their resources on healthcare while their information technology or operations are supported through managed services, including outsourcing. Service options include remote hosting, managing hospital data processing operations, as well as strategic information systems planning and management, revenue cycle processes, payroll processing, business office administration and major system conversions.

Professional Services: Professional services help customers achieve business results from their software or automation investment. A wide array of service options is available, including consulting for business and/or clinical process improvement and re-design as well as implementation, project management, technical and education services relating to all products in the Technology Solutions segment.

Payer Group: The following suite of services and software products is marketed to payers, hospitals and government organizations to help manage the cost and quality of care:

- Disease management programs to improve the health status and health outcomes of patients with chronic conditions;
- Nurse advice services to provide health information and recommend appropriate levels of care;
- Clinical and analytical software to support utilization, case and disease management workflows;
- Business intelligence tools for measuring, reporting and improving clinical and financial performance;
- InterQual® Criteria for clinical decision support and utilization management; and
- Claims payment solutions to facilitate accurate and efficient medical claim payments.

Business Combinations and Discontinued Operation

We have undertaken strategic initiatives in recent years designed to further focus on our core healthcare businesses and enhance our competitive position. We expect to continue to undertake such strategic initiatives in the future. These initiatives are detailed in Financial Notes 2 and 6, "Business Combinations" and "Discontinued Operation," to the consolidated financial statements appearing in this Annual Report on Form 10-K.

Competition

In every area of healthcare distribution operations, our Distribution Solutions segment faces strong competition, both in price and service, from national, regional and local full-line, short-line and specialty wholesalers, service merchandisers, self-warehousing chains, manufacturers engaged in direct distribution, third-party logistics companies and large payer organizations. In addition, this segment faces competition from various other service providers and from pharmaceutical and other healthcare manufacturers as well as other potential customers of the segment, which may from time-to-time decide to develop, for their own internal needs, supply management capabilities that would otherwise be provided by the segment. Price, quality of service, and in some cases, convenience to the customer are generally the principal competitive elements in this segment.

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Our Technology Solutions segment experiences substantial competition from many firms, including other software services firms, consulting firms, shared service vendors, certain hospitals and hospital groups, payers, care management organizations, hardware vendors and internet-based companies with technology applicable to the healthcare industry. Competition varies in size from small to large companies, in geographical coverage and in scope and breadth of products and services offered.

Intellectual Property

The principal trademarks and service marks of the Distribution Solutions segment include: AccessHealth®, Acumax®, Central FillSM, Closed Loop DistributionSM, CypressSM, Cypress Plus®, Edwards Medical Supply®, Empowering Healthcare®, EnterpriseRx®, Expect More From MooreSM, FrontEdge™, Fulfill-RxSM, Health Mart®, High Performance Pharmacy®, LoyaltyScript®, Lynx®, Max Impact®, McKesson®, McKesson AdvantageSM, McKesson ConnectSM, McKesson Empowering Healthcare®, McKesson High Volume SolutionsSM, McKesson Max Rewards®, McKesson OneStop Generics®, McKesson Pharmacy CentralSM, McKesson Pharmacy Optimization®, McKesson Priority Express OTCSM, McKesson Reimbursement AdvantageSM, McKesson Supply ManagerSM, MediNet™, Medi-Pak®, Mobile ManagerSM, Moore Medical®, Moorebrand®, Northstarx®, Onmark®, OTN®, Pharma360®, PharmacyRx™, Pharmaserv®, RX PakSM, RxOwnership®, ServiceFirstSM, Staydry®, Sterling Medical Services®, Sunmark®, The Supply Experts®, Supply Management OnlineSM, TrialScript®, Valu-Rite®, XVIII B Medi Mart®, Zee Medical Service®, ZEE®, US Oncology®, United We WinSM, Triangle Design®, AccessMed®, OncologyRx Care Advantage®, Oncology TodaySM, Nexcura®, Innovent®, Comprehensive Strategic Alliance (CSA)SM, Advancing Cancer Care in America®, iKnowMedSM, Accessmed®, CaresRxSM, Research & Education®, Heal Living Well After Cancer®, Heart Profilers & Design®, Iknowchart™, Oncology Today Translating Knowledge Into Cancer Care®, Radmap™, Selectplus Oncology®, US Cancer AllianceSM, and Market FocusSM.

The substantial majority of technical concepts and codes embodied in our Technology Solutions segment's computer programs and program documentation are protected as trade secrets. The principal trademarks and service marks for this segment are: AcuDose-Rx®, ANSOS One-Staff™, Ask-A-Nurse®, Care Fully Connected™, CareEnhance®, Connect-RN™, Connect-Rx®, CRMS™, DataStat®, ePremis®, Episode Profiler™, E-Script™, Fulfill-RxSM, HealthQuest™, Horizon Admin-Rx™, Horizon Clinicals®, Horizon Enterprise Revenue Management™, HorizonWP®, InterQual®, Lytec®, MedCarousel®, Medisoft®, ORSOS One-Call™, PACMED™, PakPlus-Rx™, Paragon®, Pathways 2000®, Patterns Profiler™, Per-Se™, Per-Se Technologies®, PerYourHealth.com®, Practice Partner®, Premis®, ProIntercept®, ProMed®, ProPBM®, RelayHealth®, ROBOT-Rx®, SelfPace®, Series 2000™, STAR 2000™, SupplyScan™, TRENDSTAR® and WebVisit™.

We also own other registered and unregistered trademarks and service marks and similar rights used by our business segments. Many of the principal trademarks and service marks are registered in the United States, or registrations have been applied for with respect to such marks, in addition to certain other jurisdictions. The United States federal registrations of these trademarks have terms of ten or twenty years, depending on date of registration, and are subject to unlimited renewals. We believe that we have taken all necessary steps to preserve the registration and duration of our trademarks and service marks, although no assurance can be given that we will be able to successfully enforce or protect our rights thereunder in the event that they are subject to third-party infringement claims. We do not consider any particular patent, license, franchise or concession to be material to our business. We also hold copyrights in, and patents related to, many of our products.

Other Information about the Business

Customers: During 2011, sales to our ten largest customers accounted for approximately 51% of our total consolidated revenues. Sales to our two largest customers, CVS Caremark Corporation ("CVS") and Rite Aid Corporation ("Rite Aid"), accounted for approximately 14% and 11% of our total consolidated revenues. At March 31, 2011, accounts receivable from our ten largest customers were approximately 43% of total accounts receivable. Accounts receivable from CVS, Wal-Mart Stores, Inc. ("Walmart") and Rite Aid were approximately 13%, 10% and 9% of total accounts receivable. Substantially all of these revenues and accounts receivable are included in our Distribution Solutions segment.

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Suppliers: We obtain pharmaceutical and other products from manufacturers, none of which accounted for more than approximately 7% of our purchases in 2011. The loss of a supplier could adversely affect our business if alternate sources of supply are unavailable. We believe that our relationships with our suppliers on the whole are good. The ten largest suppliers in 2011 accounted for approximately 47% of our purchases.

A significant portion of our distribution arrangements with the manufacturers provides us compensation based on a percentage of our purchases. In addition, we have certain distribution arrangements with branded pharmaceutical manufacturers that include an inflation-based compensation component whereby we benefit when the manufacturers increase their prices as we sell our existing inventory at the new higher prices. For these manufacturers, a reduction in the frequency and magnitude of price increases, as well as restrictions in the amount of inventory available to us, could have a material adverse impact on our gross profit margin.

Research and Development: Our development expenditures primarily consist of our investment in software held for sale. We spent \$471 million, \$451 million and \$438 million for development activities in 2011, 2010 and 2009 and of these amounts, we capitalized 14%, 17% and 17%. Development expenditures are primarily incurred by our Technology Solutions segment. Our Technology Solutions segment's product development efforts apply computer technology and installation methodologies to specific information processing needs of hospitals and other customers. We believe that a substantial and sustained commitment to such expenditures is important to the long-term success of this business. Additional information regarding our development activities is included in Financial Note 1, "Significant Accounting Policies," to the consolidated financial statements appearing in this Annual Report on Form 10-K.

Environmental Regulation: Our operations are subject to regulation under various federal, state, local and foreign laws concerning the environment, including laws addressing the discharge of pollutants into the air and water, the management and disposal of hazardous substances and wastes and the cleanup of contaminated sites. We could incur substantial costs, including cleanup costs, fines and civil or criminal sanctions and third-party damage or personal injury claims, if in the future we were to violate or become liable under environmental laws.

We are committed to maintaining compliance with all environmental laws applicable to our operations, products and services and to reducing our environmental impact across all aspects of our business. We meet this commitment through an environmental strategy and sustainability program.

We sold our chemical distribution operations in 1987 and retained responsibility for certain environmental obligations. Agreements with the Environmental Protection Agency and certain states may require environmental assessments and cleanups at several closed sites. These matters are described further in Financial Note 17, "Other Commitments and Contingent Liabilities," to the consolidated financial statements appearing in this Annual Report on Form 10-K.

The liability for environmental remediation and other environmental costs is accrued when the Company considers it probable and can reasonably estimate the costs. Environmental costs and accruals, including that related to our legacy chemical distribution operations, are presently not material to our operations or financial position. Although there is no assurance that existing or future environmental laws applicable to our operations or products will not have a material adverse impact on our operations or financial condition, we do not currently anticipate material capital expenditures for environmental matters. Other than the expected expenditures that may be required in connection with our legacy chemical distribution operations, we do not anticipate making substantial capital expenditures either for environmental issues, or to comply with environmental laws and regulations in the future. The amount of our capital expenditures for environmental compliance was not material in 2011 and is not expected to be material in the next year.

Employees: On March 31, 2011, we employed approximately 36,400 persons compared to 32,500 on March 31, 2010 and 2009.

Financial Information About Foreign and Domestic Operations: Information as to foreign and domestic operations is included in Financial Notes 1 and 20, "Significant Accounting Policies" and "Segments of Business," to the consolidated financial statements appearing in this Annual Report on Form 10-K.

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Forward-Looking Statements

This Annual Report on Form 10-K, including “Management’s Discussion and Analysis of Financial Condition and Results of Operations” in Item 7 of Part II of this report and the “Risk Factors” in Item 1A of Part I of this report, contains forward-looking statements within the meaning of section 27A of the Securities Act of 1933, as amended and section 21E of the Securities Exchange Act of 1934, as amended. Some of these statements can be identified by use of forward-looking words such as “believes,” “expects,” “anticipates,” “may,” “will,” “should,” “seeks,” “approximately,” “intends,” “plans” or “estimates,” or the negative of these words, or other comparable terminology. The discussion of financial trends, strategy, plans or intentions may also include forward-looking statements. Forward-looking statements involve risks and uncertainties that could cause actual results to differ materially from those projected, anticipated, or implied. Although it is not possible to predict or identify all such risks and uncertainties, they may include, but are not limited to, the factors discussed in Item 1A of Part I of this report under “Risk Factors.” The reader should not consider the list to be a complete statement of all potential risks and uncertainties.

These and other risks and uncertainties are described herein and in other information contained in our publicly available SEC filings and press releases. Readers are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date such statements were first made. Except to the extent required by federal securities laws, we undertake no obligation to publicly release the result of any revisions to these forward-looking statements to reflect events or circumstances after the date hereof, or to reflect the occurrence of unanticipated events.

Item 1A. Risk Factors

The risks described below could have a material adverse impact on our financial position, results of operations, liquidity and cash flows. Although it is not possible to predict or identify all such risks and uncertainties, they may include, but are not limited to, the factors discussed below. Our business operations could also be affected by additional factors that are not presently known to us or that we currently consider not to be material to our operations. The reader should not consider this list to be a complete statement of all risks and uncertainties.

We are subject to legal proceedings that could have a material adverse impact on our financial position and results of operations.

From time-to-time and in the ordinary course of our business, we and certain of our subsidiaries may become involved in various legal proceedings involving antitrust, commercial, employment, environmental, intellectual property, regulatory, tort and other various claims. All such legal proceedings are inherently unpredictable, and the outcome can result in excessive verdicts and/or injunctive relief that may affect how we operate our business or we may enter into settlements of claims for monetary damages. In some cases, substantial non-economic remedies or punitive damages may be sought. For some complaints filed against the Company, we are currently unable to estimate the amount of possible losses that might be incurred should these legal proceedings be resolved against the Company.

The outcome of litigation and other legal matters is always uncertain and outcomes that are not justified by the evidence or existing law can occur. The Company believes that it has valid defenses to the legal matters pending against it and is defending itself vigorously. Nevertheless, it is possible that resolution of one or any combination of more than one legal matter could result in a material adverse impact on our financial position or results of operations. For example, we are involved in a number of legal proceedings described in Financial Note 17, “Other Commitments and Contingent Liabilities,” to the accompanying consolidated financial statements that could have such an impact, including class actions and other legal proceedings alleging that we engaged in illegal conduct that caused average wholesale prices to rise for certain prescription drugs during specified periods.

Litigation is costly, time-consuming and disruptive to normal business operations. The defense of these matters could also result in continued diversion of our management’s time and attention away from business operations, which could also harm our business. Even if these matters are not resolved against us, the uncertainty and expense associated with unresolved legal proceedings could harm our business and reputation. For additional information regarding certain of the legal proceedings in which we are involved, see Financial Note 17, “Other Commitments and Contingent Liabilities,” to the accompanying consolidated financial statements.

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Changes in the United States healthcare industry and regulatory environment could have a material adverse impact on our results of operations.

Our products and services are primarily intended to function within the structure of the healthcare financing and reimbursement system currently being used in the United States. In recent years, the healthcare industry in the United States has changed significantly in an effort to reduce costs. These changes have included increased use of managed care, cuts in Medicare and Medicaid reimbursement levels, consolidation of pharmaceutical and medical-surgical supply distributors and the development of large, sophisticated purchasing groups. We expect the healthcare industry in the United States to continue to change and for healthcare delivery models to evolve in the future.

Changes in the healthcare industry's or our pharmaceutical suppliers' pricing, selling, inventory, distribution or supply policies or practices could significantly reduce our revenues and net income. Due to the diverse range of healthcare supply management and healthcare information technology products and services that we offer, such changes could have a material adverse impact on our results of operations, while not affecting some of our competitors who offer a narrower range of products and services.

The majority of our U.S. pharmaceutical distribution business' agreements with manufacturers are structured to ensure that we are appropriately and predictably compensated for the services we provide; however, failure to successfully renew these contracts in a timely and favorable manner could have a material adverse impact on our results of operations. In addition, branded price inflation can be the partial economic basis of some of our distribution business agreements with pharmaceutical manufacturers. If the frequency or rate of branded price increases slows, it could have a material adverse impact on our results of operations.

In addition, we also distribute generic pharmaceuticals, which can be subject to both price deflation and price inflation. Healthcare and public policy trends indicate that the number of generic drugs will increase over the next few years as a result of the expiration of certain drug patents. In recent years, our financial results have improved from our generic drug offerings. An increase or a decrease in the availability or changes in pricing trends or reimbursement of these generic drugs could have a material adverse impact on our results of operations.

Generic drug manufacturers are increasingly challenging the validity or enforceability of patents on branded pharmaceutical products. During the pendency of these legal challenges, a generics manufacturer may begin manufacturing and selling a generic version of the branded product prior to the final resolution to its legal challenge over the branded product's patent. To the extent we source and distribute such generic products launched "at risk," the brand-name company could assert infringement claims against us. While we generally obtain indemnification against such claims from generic manufacturers as a condition of distributing their products, there can be no assurances that these rights will be adequate or sufficient to protect us.

In recent years, the pharmaceutical suppliers have been subject to increasing consolidation. As a result, a small number of very large companies control a significant share of the market. Accordingly, we depend on fewer suppliers for our products and therefore we may be less able to negotiate price terms with suppliers.

Many healthcare organizations also have consolidated to create larger healthcare enterprises with greater market power. If this consolidation trend continues, it could reduce the size of our target market and give the resulting enterprises greater bargaining power, which may lead to erosion of the prices for our products and services. In addition, when healthcare organizations combine they often consolidate infrastructure including IT systems, which in turn may erode our customer and revenue base.

The healthcare industry is highly regulated, and further regulation of our distribution businesses and computer-related products and services could impose increased costs, negatively impact our profit margins and the profit margins of our customers, delay the introduction or implementation of our new products, or otherwise negatively impact our business and expose the Company to litigation and regulatory investigations.

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Healthcare Fraud: We are subject to extensive and frequently changing local, state and federal laws and regulations relating to healthcare fraud, and the federal government continues to strengthen its position and scrutiny over practices involving fraud affecting Medicare, Medicaid and other government healthcare programs. Our relationships with pharmaceutical and medical-surgical product manufacturers and healthcare providers, as well as our provision of products and services to government entities, subject our business to laws and regulations on fraud and abuse, which among other things (1) prohibit persons from soliciting, offering, receiving or paying any remuneration in order to induce the referral of a patient for treatment or for inducing the ordering or purchasing of items or services that are in any way paid for by Medicare, Medicaid or other government-sponsored healthcare programs, (2) impose a number of restrictions upon referring physicians and providers of designated health services under Medicare and Medicaid programs, and (3) prohibit the knowing submission of a false or fraudulent claim for payment to a federal health care program such as Medicare and Medicaid. Many of the regulations applicable to us, including those relating to marketing incentives, are vague or indefinite and have not been interpreted by the courts. They may be interpreted or applied by a prosecutorial, regulatory, or judicial authority in a manner that could require us to make changes in our operations. If we fail to comply with applicable laws and regulations, we could suffer civil and criminal penalties, including the loss of licenses or our ability to participate in Medicare, Medicaid and other federal and state healthcare programs.

Reimbursements: Both our profit margins and the profit margins of our customers may be adversely affected by laws and regulations reducing reimbursement rates for pharmaceuticals, medical treatments and related services, or changing the methodology by which reimbursement levels are determined. For example, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively the “Affordable Care Act”), signed into law in 2010, revised the federal upper limits for Medicaid reimbursement for multiple source generic drugs available for purchase by retail community pharmacies on a nationwide basis to a limit of not less than 175% of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer price (“AMP”) using a smoothing process. In addition, Medicare, Medicaid and the State Children’s Health Insurance Program (“SCHIP”) Extension Act of 2007 requires the Centers for Medicare and Medicaid Services (“CMS”) to adjust the calculation of the Medicare Part B drug average sales price (“ASP”) to an actual sales volume basis. We expect that the use of an AMP benchmark and the revised ASP calculations would result in a reduction in the Medicaid reimbursement rates to our customers for certain generic pharmaceuticals, which could indirectly impact the prices that we can charge our customers and cause corresponding declines in our profitability. There can be no assurance that these changes would not have a material adverse impact on our results of operations.

Operating, Security and Licensure Standards: We are subject to the operating and security standards of the Drug Enforcement Administration (the “DEA”), the Food and Drug Administration (“FDA”), various state boards of pharmacy, state health departments, the U.S. Department of Health and Human Services (“HHS”), the CMS and other comparable agencies. Certain of our businesses may be required to register for permits and/or licenses with, and comply with operating and security standards of the DEA, FDA, HHS, CMS, various state boards of pharmacy, state health departments and/or comparable state agencies as well as foreign agencies and certain accrediting bodies, depending upon the type of operations and location of product distribution, manufacturing and sale. As part of these operating, security and licensure standards, we regularly receive requests for information and occasionally subpoenas from government authorities. Although we believe that we are in compliance in all material respects with applicable laws and regulations, there can be no assurance that a regulatory agency or tribunal would not reach a different conclusion concerning the compliance of our operations with applicable laws and regulations. In addition, there can be no assurance that we will be able to maintain or renew existing permits, licenses or any other regulatory approvals or obtain without significant delay future permits, licenses or other approvals needed for the operation of our businesses. Any noncompliance by us with applicable laws and regulations or the failure to maintain, renew or obtain necessary permits and licenses could have a material adverse impact on our results of operations.

Pedigree Tracking: There have been increasing efforts by various levels of government agencies, including state boards of pharmacy and comparable government agencies, to regulate the pharmaceutical distribution system in order to prevent the introduction of counterfeit, adulterated and/or mislabeled drugs into the pharmaceutical distribution system (“pedigree tracking”). Certain states have adopted or are considering laws and regulations that are intended to protect the integrity of the pharmaceutical distribution system, while other government agencies are currently evaluating their recommendations. For example, Florida has adopted pedigree tracking requirements and California has enacted a law requiring chain of custody technology using radio frequency tagging and electronic pedigrees, which will be effective for us in July 2016.

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Final regulations under the federal Prescription Drug Marketing Act requiring pedigree and chain of custody tracking in certain circumstances became effective December 1, 2006. This latter regulation has been challenged in a case brought by secondary distributors. A preliminary injunction was issued by the United States District Court for the Eastern District of New York that temporarily enjoined implementation of this regulation. This injunction was affirmed by the Court of Appeals for the Second Circuit in July 2008. In December 2008, both parties agreed to delay this litigation, pending the outcome of certain U.S. congressional legislative initiatives. In addition, the Food and Drug Administration Amendments Act of 2007 (“FDAA”), which went into effect on October 1, 2007, requires the FDA to establish standards and identify and validate effective technologies for the purpose of securing the pharmaceutical supply chain against counterfeit drugs. These standards may include any track-and-trace or authentication technologies, such as radio frequency identification devices and other similar technologies. On March 26, 2010, the FDA released the Serialized Numerical Identifier (“SNI”) guidance for manufacturers who serialize pharmaceutical packaging. We expect to be able to accommodate these SNI regulations in our distribution operations. Nonetheless, these pedigree tracking laws and regulations could increase the overall regulatory burden and costs associated with our pharmaceutical distribution business, and could have a material adverse impact on our results of operations.

Privacy: State, federal and foreign laws regulate the confidentiality of sensitive personal information, how that information may be used, and the circumstances under which such information may be released. These regulations govern the disclosure and use of confidential personal and patient medical record information and require the users of such information to implement specified privacy and security measures. Regulations currently in place, including regulations governing electronic health data transmissions, continue to evolve and are often unclear and difficult to apply. Although our policies, procedures and systems are being updated and modified to comply with the current requirements of applicable state and foreign laws, including the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the Health Information Technology for Economic and Clinical Health (“HITECH”) Act portion of the American Recovery and Reinvestment Act (“ARRA”) of 2009, evolving laws and regulations in this area could restrict the ability of our customers to obtain, use or disseminate patient information, or it could require us to incur significant additional costs to re-design our products in a timely manner, either of which could have a material adverse impact on our results of operations. In addition, the HITECH Act expanded HIPAA privacy and security requirements and increased financial penalties for violations. It also extended certain provisions of the federal privacy and security standards to us in our capacity as a business associate of our payer and provider customers. These standards may be interpreted by a regulatory authority in a manner that could require us to make a material change to our operations. Furthermore, failure to maintain confidentiality of sensitive personal information in accordance with applicable regulatory requirements could expose us to breach of contract claims, fines and penalties, costs for remediation and harm to our reputation.

Health Care Reform: The Affordable Care Act significantly expanded health insurance coverage to uninsured Americans and changed the way health care is financed by both governmental and private payers. Further federal and state proposals for healthcare reform are likely. While we do not currently anticipate that the Affordable Care Act will have a material impact on our business, financial condition and results of operations, given the scope of the changes made and the uncertainties associated with the its implementation, we cannot predict its full impact on the Company at this time.

Interoperability Standards: There is increasing demand among customers, industry groups and government authorities that healthcare software and systems provided by various vendors be compatible with each other. This need for interoperability is leading to the development of standards by various groups, and certain federal and state agencies are also developing standards that could become mandatory for systems purchased by these agencies. For example, the HITECH Act requires meaningful use of “certified” healthcare information technology products by healthcare providers in order to receive stimulus funds from the federal government. Effective September 27, 2010, CMS issued a rule that utilizes a staged approach for defining meaningful use criteria. In “Stage 1,” CMS defined the initial criteria for meaningful use, and has stated that it intends to update these initial criteria with additional “Stage 2” criteria by the end of calendar 2011, and with additional “Stage 3” criteria by the end of calendar 2013. We may incur increased development costs and delays in upgrading our customer software and systems to be in compliance with these varying and evolving standards. In addition, these new standards may lengthen our sales and implementation cycle and we may incur costs in periods prior to the corresponding recognition of revenue. To the extent these standards are narrowly construed or delayed in publication, or that we are delayed in achieving certification under these evolving standards for applicable products, our customers may postpone or cancel their decisions to purchase or implement our software and systems.

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FDA Regulation of Computer Products. The FDA has increasingly focused on the regulation of computer products and computer-assisted products as medical devices under the federal Food, Drug and Cosmetic Act. For example, effective April 18, 2011, the FDA issued a new rule regulating certain computer data systems as medical devices. If the FDA chooses to regulate any of our products as medical devices, it can impose extensive requirements upon us. If we fail to comply with the applicable requirements, the FDA could respond by imposing fines, injunctions or civil penalties, requiring recalls or product corrections, suspending production, refusing to grant pre-market clearance of products, withdrawing clearances and initiating criminal prosecution. Any additional FDA regulations governing computer products, once issued, may increase the cost and time to market new or existing products or may prevent us from marketing our products.

Standards for Submission of Health Care Claims: HHS has adopted two new rules that impact healthcare claims submitted for reimbursement. In the first rule, effective January 1, 2012, HHS has modified the standards for electronic health care transactions (*e.g.*, eligibility, claims submission and payment and electronic remittance) from Version 4010/4010A to Version 5010. In the second rule, effective October 1, 2013, HHS has updated and expanded the standard medical code sets for diagnosis and procedure coding from International Classification of Diseases, Ninth Revision (“ICD-9”) to International Classification of Diseases, Tenth Revision (“ICD-10”). Updating systems to Version 5010 is required for use of the ICD-10 code set. Generally, claims submitted not using Version 5010 and ICD-10 when required will not be processed, and health plans not accepting transactions using Version 5010 and ICD-10 may experience significant increases in customer service inquiries. We may incur increased development costs and delays in delivering solutions and upgrading our software and systems to be in compliance with these new standards. In addition, these standards may lengthen our sales and implementation cycle and we may incur costs in periods prior to the corresponding recognition of revenue. Delays in providing software and systems that are in compliance with the new standards may result in postponement or cancellation of our customers’ decisions to purchase our software and systems.

Claims Transmissions: Medical billing and collection activities are governed by numerous federal and state civil and criminal laws that pertain to companies that provide billing and collection services, or that provide consulting services in connection with billing and collection activities. In connection with these laws, we may be subjected to federal or state government investigations and possible penalties may be imposed upon us, false claims actions may have to be defended, private payers may file claims against us and we may be excluded from Medicare, Medicaid or other government-funded healthcare programs. Any such proceeding or investigation could have a material adverse impact on our results of operations.

Changes in the Canadian healthcare industry and regulatory environment could have a material adverse impact on our results of operations.

The provincial governments in Canada provide partial funding for the purchase of pharmaceuticals and independently regulate the sale and reimbursement of drugs. Similar to the United States, the Canadian healthcare industry has undergone significant changes in recent years in an effort to reduce program costs. For example, in 2006 the Ontario government significantly revised the drug reimbursement system with the passage of the Transparent Drug System for Patients Act. In recent years, to reduce the cost for taxpayers, various provinces took further steps to reform the rules regarding the sale of generic drugs. These changes include the significant lowering of prices for generic pharmaceuticals and, in some provinces, the elimination or reduction of professional allowances paid to pharmacists by generic manufacturers. These reforms may adversely affect the distribution of drugs as well as the pricing for prescription drugs for the Company’s operations in Canada. Other provinces are considering similar changes, which would also lower pharmaceutical pricing and service fees. Individually or in combination, such changes in the Canadian healthcare environment may significantly reduce our Canadian revenue and operating profit.

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Competition may erode our profit.

In every area of healthcare distribution operations, our Distribution Solutions segment faces strong competition, both in price and service, from national, regional and local full-line, short-line and specialty wholesalers, service merchandisers, self-warehousing chains, manufacturers engaged in direct distribution, third-party logistics companies and large payer organizations. In addition, this segment faces competition from various other service providers and from pharmaceutical and other healthcare manufacturers as well as other potential customers of the segment, which may from time-to-time decide to develop, for their own internal needs, supply management capabilities that would otherwise be provided by the segment. Price, quality of service, and in some cases, convenience to the customer are generally the principal competitive elements in this segment.

Our Technology Solutions segment experiences substantial competition from many firms, including other software services firms, consulting firms, shared service vendors, certain hospitals and hospital groups, payers, care management organizations, hardware vendors and internet-based companies with technology applicable to the healthcare industry. Competition varies in size from small to large companies, in geographical coverage and in scope and breadth of products and services offered. These competitive pressures could have a material adverse impact on our results of operations.

A material reduction in purchases or the loss of a large customer or group purchasing organization, as well as substantial defaults in payment by a large customer or group purchasing organization, could have a material adverse impact on our financial condition, results of operations and liquidity.

In recent years, a significant portion of our revenue growth has been with a limited number of large customers. During 2011, sales to our ten largest customers accounted for approximately 51% of our total consolidated revenues. Sales to our two largest customers, CVS and Rite Aid, accounted for approximately 14% and 11% of our total consolidated revenues. At March 31, 2011, accounts receivable from our ten largest customers were approximately 43% of total accounts receivable. Accounts receivable from CVS, Walmart and Rite Aid were approximately 13%, 10% and 9% of total accounts receivable. As a result, our sales and credit concentration is significant. We also have agreements with group purchasing organizations (“GPOs”), each of which functions as a purchasing agent on behalf of member hospitals, pharmacies and other healthcare providers, as well as with government entities and agencies. A material default in payment, change in our customer mix, reduction in purchases, or the loss of a large customer or GPO could have a material adverse impact on our financial condition, results of operations and liquidity.

We generally sell our products and services to customers on credit that is short-term in nature and unsecured. Any adverse change in general economic conditions can adversely reduce sales to our customers, affect consumer buying practices or cause our customers to delay or be unable to pay accounts receivable owed to us, which may in turn materially reduce our revenue growth and cause a material decrease in our profitability and cash flow. Further, interest rate fluctuations and changes in capital market conditions may also affect our customers’ ability to obtain credit to finance their business under acceptable terms, which in turn may materially reduce our revenue growth and cause a decrease in our profitability.

Contracts with the U.S. federal government and other governments and their agencies pose additional risks relating to future funding and compliance.

Contracts with the U.S. federal government and other governments and their agencies are subject to various uncertainties, restrictions and regulations, including oversight audits by various government authorities and profit and cost controls. Government contracts also are exposed to uncertainties associated with funding. Contracts with the U.S. federal government, for example, are subject to the uncertainties of Congressional funding. Governments are typically under no obligation to maintain funding at any specific level, and funds for government programs may even be eliminated. As a result, our government clients may terminate our contracts for convenience or decide not to renew our contracts with little or no prior notice. The loss of such contracts could have a material adverse impact on our results of operations.

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In addition, since government contracts are subject to specific procurement regulations and a variety of other socio-economic requirements, we must comply with such requirements. For example, for contracts with the U.S. federal government, we must comply with the Federal Acquisition Regulation, the Truth in Negotiations Act, and the Cost Accounting Standards. We must also comply with various other government regulations and requirements as well as various statutes related to employment practices, environmental protection, recordkeeping and accounting. These regulations and requirements affect how we transact business with our clients and, in some instances, impose additional costs on our business operations. Government contracts also contain terms that expose us to higher levels of risk and potential liability than non-government contracts.

We also are subject to government audits, investigations, and proceedings. For example, government agencies routinely review and audit government contractors to determine whether allowable costs are in accordance with applicable government regulations. These audits can result in adjustments to the amount of contract costs we believe are reimbursable by the agencies and the amount of our overhead costs allocated to the agencies.

If we violate these rules or regulations, fail to comply with a contractual or other requirement or do not satisfy an audit, a variety of penalties can be imposed by the government including monetary damages and criminal and civil penalties. In addition, any or all of our government contracts could be terminated, we could be suspended or debarred from all government contract work, or payment of our costs could be disallowed. The occurrence of any of these actions could harm our reputation and could have a material adverse impact on our results of operations.

Our future results could be materially affected by a number of public health issues whether occurring in the United States or abroad.

Public health issues, whether occurring in the United States or abroad, could disrupt our operations, disrupt the operations of suppliers or customers, or have a broader adverse impact on consumer spending and confidence levels that would negatively affect our suppliers and customers. We have developed contingency plans to address infectious disease scenarios and the potential impact on our operations, and we will continue to update these plans as necessary. However, there can be no assurance that these plans will be effective in eliminating the negative impact of any such diseases on the Company's operating results. We may be required to suspend operations in some or all of our locations, which could have a material adverse impact on our business, financial condition and results of operations.

Our Distribution Solutions segment is dependent upon sophisticated information systems. The implementation delay, malfunction, or failure of these systems for any extended period of time could have a material adverse impact on our business.

We rely on sophisticated information systems in our business to obtain, rapidly process, analyze and manage data to (1) facilitate the purchase and distribution of thousands of inventory items from numerous distribution centers, (2) receive, process and ship orders and handle other product and services on a timely basis, (3) manage the accurate billing and collections for thousands of customers, and (4) process payments to suppliers. If these systems are interrupted, damaged by an unforeseen event or actions of a third party, or fail for any extended period of time, we could have a material adverse impact on our results of operations.

We could experience losses or liability not covered by insurance.

In order to provide prompt and complete service to our major Distribution Solutions segment's customers, we maintain significant product inventory at certain of our distribution centers. While we seek to maintain property insurance coverage in amounts sufficient for our business, there can be no assurance that our property insurance will be adequate or available on acceptable terms. One or more large casualty losses caused by fire, earthquake or other natural disaster in excess of our coverage limits could have a material adverse impact on our results of operations.

McKESSON CORPORATION

Our business exposes us to risks that are inherent in the distribution, manufacturing, dispensing of pharmaceuticals and medical-surgical supplies, the provision of ancillary services, the conduct of our payer businesses (which include disease management programs and our nurse triage services) and the provision of products that assist clinical decision-making and relate to patient medical histories and treatment plans. If customers assert liability claims against our products and/or services, any ensuing litigation, regardless of outcome, could result in a substantial cost to us, divert management's attention from operations and decrease market acceptance of our products. We attempt to limit our liability to customers by contract; however, the limitations of liability set forth in the contracts may not be enforceable or may not otherwise protect us from liability for damages. Additionally, we may be subject to claims that are not explicitly covered by contract, such as a claim directly by a patient. We also maintain general liability coverage; however, this coverage may not continue to be available on acceptable terms, may not be available in sufficient amounts to cover one or more large claims against us and may include larger self-insured retentions or exclusions for certain products. In addition, the insurer might disclaim coverage as to any future claim. A successful product or professional liability claim not fully covered by our insurance could have a material adverse impact on our results of operations.

The failure of our healthcare technology businesses to attract and retain customers due to challenges in software product integration or to keep pace with technological advances may significantly reduce our results of operations.

Our healthcare technology businesses, the bulk of which resides in our Technology Solutions segment, deliver enterprise-wide clinical, patient care, financial, supply chain, strategic management software solutions and pharmacy automation to hospitals, physicians, homecare providers, retail and mail order pharmacies and payers. Challenges integrating software products could impair our ability to attract and retain customers, and it could have a material adverse impact on our consolidated results of operations and a disproportionate impact on the results of operations of our Technology Solutions segment.

Future advances in the healthcare information systems industry could lead to new technologies, products or services that are competitive with the technology products and services offered by our various businesses. Such technological advances could also lower the cost of such products and services or otherwise result in competitive pricing pressure or render our products obsolete.

The success of our technology businesses will depend, in part, on our ability to be responsive to technological developments, pricing pressures and changing business models. To remain competitive in the evolving healthcare information systems marketplace, our technology businesses must also develop new products on a timely basis. The failure to develop competitive products and to introduce new products on a timely basis could curtail the ability of our technology businesses to attract and retain customers, and thereby it could have a material adverse impact on our results of operations.

Proprietary technology protections may not be adequate and products may be found to infringe the rights of third parties.

We rely on a combination of trade secret, patent, copyright and trademark laws, nondisclosure and other contractual provisions and technical measures to protect our proprietary rights in our products and solutions. There can be no assurance that these protections will be adequate or that our competitors will not independently develop technologies that are equivalent or superior to our technology. In addition, despite protective measures, we may be subject to unauthorized use of our technology due to copying, reverse-engineering or other infringement. Although we believe that our products do not infringe the proprietary rights of third parties, from time-to-time third parties have asserted infringement claims against us and there can be no assurance that third parties will not assert infringement claims against us in the future. If we were found to be infringing others' rights, we may be required to pay substantial damage awards and forced to develop non-infringing products or technology, obtain a license or cease selling the products that contain the infringing technology. Additionally, we may find it necessary to initiate litigation to protect our trade secrets, to enforce our patent, copyright and trademark rights and to determine the scope and validity of the proprietary rights of others. These types of litigation can be costly and time consuming. These litigation expenses, damage payments or costs of developing replacement products or technology could have a material adverse impact on our results of operations.

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System errors or failures of our products to conform to specifications could cause unforeseen liabilities or injury, harm our reputation and have a material adverse impact on our results of operations.

The software and software systems (“systems”) that we sell or operate are very complex. As with complex systems offered by others, our systems may contain errors, especially when first introduced. For example, our Technology Solutions segment’s business systems are intended to provide information for healthcare providers in providing patient care. Therefore, users of our systems have a greater sensitivity to errors than the general market for software products. If our software or systems lead to faulty clinical decisions or injury to patients, we could be subject to claims or litigation by our clients, clinicians or patients. In addition, such failures could damage our reputation and could negatively affect future sales.

Failure of a client’s system to perform in accordance with our documentation could constitute a breach of warranty and could require us to incur additional expense in order to make the system comply with the documentation. If such failure is not remedied in a timely manner, it could constitute a material breach under a contract, allowing the client to cancel the contract, obtain refunds of amounts previously paid or assert claims for significant damages.

Various risks could interrupt customers’ access to their data residing in our service center, exposing us to significant costs.

We provide remote hosting services that involve operating both our software and the software of third-party vendors for our customers. The ability to access the systems and the data that we host and support on demand is critical to our customers. Our operations and facilities are vulnerable to interruption and/or damage from a number of sources, many of which are beyond our control, including, without limitation (1) power loss and telecommunications failures, (2) fire, flood, hurricane and other natural disasters, (3) software and hardware errors, failures or crashes, and (4) computer viruses, hacking and similar disruptive problems. We attempt to mitigate these risks through various means including disaster recovery plans, separate test systems and change control and system security measures, but our precautions may not protect against all problems. If customers’ access is interrupted because of problems in the operation of our facilities, we could be exposed to significant claims, particularly if the access interruption is associated with problems in the timely delivery of medical care. We must maintain disaster recovery and business continuity plans that rely upon third-party providers of related services and if those vendors fail us at a time that our center is not operating correctly, we could incur a loss of revenue and liability for failure to fulfill our contractual service commitments. Any significant instances of system downtime could negatively affect our reputation and ability to sell our remote hosting services.

The length of our sales and implementation cycles for our Technology Solutions segment could have a material adverse impact on our future results of operations.

Many of the solutions offered by our Technology Solutions segment have long sales and implementation cycles, which could range from a few months to two years or more from initial contact with the customer to completion of implementation. How and when to implement, replace, or expand an information system, or modify or add business processes, are major decisions for healthcare organizations. Many of the solutions we provide typically require significant capital expenditures and time commitments by the customer. Any decision by our customers to delay or cancel implementation could have a material adverse impact on our results of operations. Furthermore, delays or failures to meet milestones established in our agreements may result in a breach of contract, termination of the agreement, damages and/or penalties as well as a reduction in our margins or a delay in our ability to recognize revenue.

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We may be required to record a significant charge to earnings if our goodwill or intangible assets become impaired.

We are required under U.S. generally accepted accounting principles (“GAAP”) to test our goodwill for impairment, annually or more frequently if indicators for potential impairment exist. Indicators that are considered include significant changes in performance relative to expected operating results, significant changes in the use of the assets, significant negative industry, or economic trends or a significant decline in the Company’s stock price and/or market capitalization for a sustained period of time. In addition, we periodically review our intangible assets for impairment when events or changes in circumstances indicate the carrying value may not be recoverable. Factors that may be considered a change in circumstances indicating that the carrying value of our intangible assets may not be recoverable include slower growth rates and the loss of a significant customer. We may be required to record a significant charge to earnings in our consolidated financial statements during the period in which any impairment of our goodwill or intangible assets is determined. This could have a material adverse impact on our results of operations. There are inherent uncertainties in management’s estimates, judgments and assumptions used in assessing recoverability of goodwill and intangible assets. Any changes in key assumptions, including failure to meet business plans, a further deterioration in the market or other unanticipated events and circumstances, may affect the accuracy or validity of such estimates and could potentially result in an impairment charge.

Our foreign operations may subject us to a number of operating, economic, political and regulatory risks that may have a material adverse impact on our financial condition and results of operations.

We have operations based in foreign countries, including Canada, the United Kingdom, Ireland, other European countries and Israel and we have a large investment in Mexico. In the future, we look to continue to grow our foreign operations both organically and through acquisitions and investments; however, increasing our foreign operations carries additional risks. Operations outside of the United States may be affected by changes in trade protection laws, policies, measures and other regulatory requirements affecting trade and investment; unexpected changes in regulatory requirements for software, social, political, labor or economic conditions in a specific country or region; import/export regulations in both the United States and foreign countries and difficulties in staffing and managing foreign operations. Political changes and natural disasters, some of which may be disruptive, can interfere with our supply chain, our customers and all of our activities in a particular location. Additionally, foreign operations expose us to foreign currency fluctuations that could adversely impact our results of operations based on the movements of the applicable foreign currency exchange rates in relation to the U.S. dollar.

Foreign operations are also subject to risks of violations of laws prohibiting improper payments and bribery, including the U.S. Foreign Corrupt Practices Act and similar regulations in foreign jurisdictions. Failure to comply with these laws could subject us to civil and criminal penalties that could have a material adverse impact on our financial condition and results of operations.

We also may experience difficulties and delays inherent in sourcing products and contract manufacturing from foreign countries, including but not limited to (1) difficulties in complying with the requirements of applicable federal, state and local governmental authorities in the United States and of foreign regulatory authorities, (2) inability to increase production capacity commensurate with demand or the failure to predict market demand (3) other manufacturing or distribution problems including changes in types of products produced, limits to manufacturing capacity due to regulatory requirements or physical limitations that could impact continuous supply, and (4) damage to our reputation due to real or perceived quality issues. Manufacturing difficulties could result in production shutdowns, product shortages and other similar delays in product manufacturing that could have a material adverse impact on our financial condition and results of operations.

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Tax legislation initiatives or challenges to our tax positions could have a material adverse impact on our results of operations.

We are a large multinational corporation with operations in the United States and international jurisdictions. As such, we are subject to the tax laws and regulations of the United States federal, state and local governments and of many international jurisdictions. From time-to-time, various legislative initiatives may be proposed that could adversely affect our tax positions. There can be no assurance that our effective tax rate will not be adversely affected by these initiatives. In addition, United States federal, state and local, as well as international, tax laws and regulations are extremely complex and subject to varying interpretations. Although we believe that our historical tax positions are sound and consistent with applicable laws, regulations and existing precedent, there can be no assurance that these tax positions will not be challenged by relevant tax authorities or that we would be successful in any such challenge.

Our business could be hindered if we are unable to complete and integrate acquisitions successfully.

An element of our strategy is to identify, pursue and consummate acquisitions that either expand or complement our business. Since 2008, we have completed approximately \$3 billion of business acquisitions. Integration of acquisitions involves a number of significant risks, including the diversion of management's attention to the assimilation of the operations of businesses we have acquired; difficulties in the integration of operations and systems; the realization of potential operating synergies; the assimilation and retention of the personnel of the acquired companies; accounting, regulatory or compliance issues that could arise, including internal control over financial reporting; challenges in retaining the customers, including physician affiliates, of the combined businesses. Further, acquisitions may have a material adverse impact on our operating results if unanticipated expenses or charges to earnings were to occur, including unanticipated depreciation and amortization expenses over the useful lives of certain assets acquired, as well as costs related to potential impairment charges, assumed litigation and unknown liabilities. In addition, we may potentially require additional financing in order to fund future acquisitions, which may or may not be attainable and is subject to potential volatility in the credit markets. If we are unable to successfully complete and integrate strategic acquisitions in a timely manner, our business and our growth strategies could be negatively affected.

Volatility and disruption to the global capital and credit markets may adversely affect our ability to access credit, our cost of credit and the financial soundness of our customers and suppliers.

Volatility and disruption in the global capital and credit markets, including the bankruptcy or restructuring of certain financial institutions, reduced lending activity by other financial institutions, decreased liquidity and increased costs in the commercial paper market and the reduced market for securitizations, may adversely affect the availability and cost of credit already arranged and the availability, terms and cost of credit in the future, including any arrangements to renew or replace our current credit or financing arrangements. Although we believe that our operating cash flow, financial assets, current access to capital and credit markets, including our existing credit and sales facilities, will give us the ability to meet our financing needs for the foreseeable future, there can be no assurance that continued or increased volatility and disruption in the global capital and credit markets will not impair our liquidity or increase our costs of borrowing.

Our \$1.35 billion accounts receivable sales facility is generally renewed annually and will expire in May 2011. Although we did not use this facility in 2010 or 2011, we have historically used it to fund working capital requirements, as needed. We anticipate renewing this facility before its expiration. Although we believe we will be able to renew this facility, there is no assurance that we will be able to do so.

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Our business could also be negatively impacted if our customers or suppliers experience disruptions resulting from tighter capital and credit markets or a slowdown in the general economy. As a result, customers may modify, delay or cancel plans to purchase or implement our products or services and suppliers may increase their prices, reduce their output or change their terms of sale. Additionally, if customers' or suppliers' operating and financial performance deteriorates or if they are unable to make scheduled payments or obtain credit, customers may not be able to pay, or may delay payment of accounts receivable owed to us and suppliers may restrict credit, impose different payment terms or be unable to make payments due to us for fees, returned products or incentives. Any inability of customers to pay us for our products and services or any demands by suppliers for different payment terms may have a material adverse impact on our results of operations and cash flow.

Changes in accounting standards issued by the Financial Accounting Standards Board ("FASB") or other standard-setting bodies may adversely affect our financial statements.

Our financial statements are subject to the application of U.S. GAAP, which is periodically revised and/or expanded. Accordingly, from time-to-time we are required to adopt new or revised accounting standards issued by recognized authoritative bodies, including the FASB and the SEC. It is possible that future accounting standards we are required to adopt could change the current accounting treatment that we apply to our consolidated financial statements and that such changes could have a material adverse impact on our results of operations and financial condition.

Item 1B. Unresolved Staff Comments

Not applicable.

Item 2. Properties

Because of the nature of our principal businesses, our plant, warehousing, office and other facilities are operated in widely dispersed locations, mostly throughout the U.S. and Canada. The warehouses are typically owned or leased on a long-term basis. We consider our operating properties to be in satisfactory condition and adequate to meet our needs for the next several years without making capital expenditures materially higher than historical levels. Information as to material lease commitments is included in Financial Note 15, "Lease Obligations," to the consolidated financial statements appearing in this Annual Report on Form 10-K.

Item 3. Legal Proceedings

Certain legal proceedings in which we are involved are discussed in Financial Note 17, "Other Commitments and Contingent Liabilities," to the consolidated financial statements appearing in this Annual Report on Form 10-K.

Item 4. Reserved

Not applicable.

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Executive Officers of the Registrant

The following table sets forth information regarding the executive officers of the Company, including their principal occupations during the past five years. The number of years of service with the Company includes service with predecessor companies.

There are no family relationships between any of the executive officers or directors of the Company. The executive officers are elected on an annual basis generally and their term expires at the first meeting of the Board of Directors (“Board”) following the annual meeting of stockholders, or until their successors are elected and have qualified, or until death, resignation or removal, whichever is sooner.

<u>Name</u>	<u>Age</u>	<u>Position with Registrant and Business Experience</u>
John H. Hammergren	52	Chairman of the Board since July 2002; President and Chief Executive Officer since April 2001; and a director since July 1999. Service with the Company – 15 years.
Jeffrey C. Campbell.....	50	Executive Vice President and Chief Financial Officer since April 2004; Senior Vice President and Chief Financial Officer from December 2003 to April 2004. Service with the Company – 7 years.
Patrick J. Blake.....	47	Executive Vice President and Group President since June 2009; President of McKesson Specialty Care Solutions from April 2006 to June 2009; President of Customer Operations for McKesson U.S. Pharmaceutical from October 2000 to April 2006. Service with the Company – 15 years.
Jorge L. Figueredo.....	50	Executive Vice President, Human Resources since May 2008; Senior Vice President, Human Resources, Dow Jones, Inc. from February 2007 to January 2008; President, International, Liz Claiborne Inc. from October 1984 to May 2006. Service with the Company – 3 years.
Paul C. Julian.....	55	Executive Vice President and Group President since April 2004; Senior Vice President from August 1999 to April 2004. Service with the Company – 15 years.
Marc E. Owen.....	51	Executive Vice President, Corporate Strategy and Business Development since April 2004; Senior Vice President, Corporate Strategy and Business Development from September 2001 to April 2004. Service with the Company – 10 years.
Laureen E. Seeger.....	49	Executive Vice President, General Counsel and Chief Compliance Officer since April 2010 (functionally has served as chief compliance officer since March 2006); Executive Vice President and General Counsel from July 2009 to April 2010; Executive Vice President, General Counsel and Secretary from March 2006 to July 2009; Vice President and General Counsel of McKesson Provider Technologies from February 2000 to March 2006. Service with the Company – 11 years.
Randall N. Spratt	59	Executive Vice President, Chief Technology Officer and Chief Information Officer since April 2009; Executive Vice President, Chief Information Officer from July 2005 to April 2009; Senior Vice President, Chief Process Officer, McKesson Provider Technologies from April 2003 to July 2005. Service with the Company – 25 years.

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PART II

Item 5. Market for the Registrant’s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

- (a) *Market Information:* The principal market on which the Company’s common stock is traded is the New York Stock Exchange (“NYSE”).

The following table sets forth the high and low sales prices for our common stock as reported on NYSE for each quarterly period of the two most recently completed fiscal years:

	2011		2010	
	<u>High</u>	<u>Low</u>	<u>High</u>	<u>Low</u>
First quarter	\$71.49	\$62.94	\$45.27	\$33.13
Second quarter	\$69.48	\$57.81	\$59.95	\$42.61
Third quarter	\$71.09	\$59.54	\$64.98	\$55.82
Fourth quarter	\$81.00	\$70.44	\$66.98	\$57.23

- (b) *Holder:* The number of record holders of the Company’s common stock at March 31, 2011 was approximately 8,150.
- (c) *Dividends:* In May 2010, the Company’s Board of Directors (the “Board”) approved a change in the Company’s dividend policy by increasing the amount of the Company’s quarterly dividend from \$0.12 to \$0.18 per share, applicable to ensuing quarterly dividend declarations. We declared regular cash dividends of \$0.72 per share (or \$0.18 per share per quarter) in the year ended March 31, 2011 and \$0.48 per share (or \$0.12 per share per quarter) in the year ended March 31, 2010. In April 2011, the Board approved an increase in the quarterly dividend from \$0.18 to \$0.20 per share, applicable to ensuing quarterly dividend declarations.

The Company anticipates that it will continue to pay quarterly cash dividends in the future. However, the payment and amount of future dividends remain within the discretion of the Board and will depend upon the Company’s future earnings, financial condition, capital requirements and other factors.

- (d) *Securities Authorized for Issuance under Equity Compensation Plans:* Information relating to this item is provided under Part III, Item 12, to this Annual Report on Form 10-K.
- (e) *Share Repurchase Plans:* The following table provides information on the Company’s share repurchases during the fourth quarter of 2011:

	Share Repurchases ⁽¹⁾			
	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs
<i>(In millions, except price per share)</i>				
January 1, 2011 – January 31, 2011	—	\$ —	—	\$ 1,000
February 1, 2011 – February 28, 2011	—	—	—	1,000
March 1, 2011 – March 31, 2011	6	79.34	6	500
Total	6	79.34	6	500

- (1) This table does not include shares tendered to satisfy the exercise price in connection with cashless exercises of employee stock options or shares tendered to satisfy tax-withholding obligations in connection with employee equity awards.

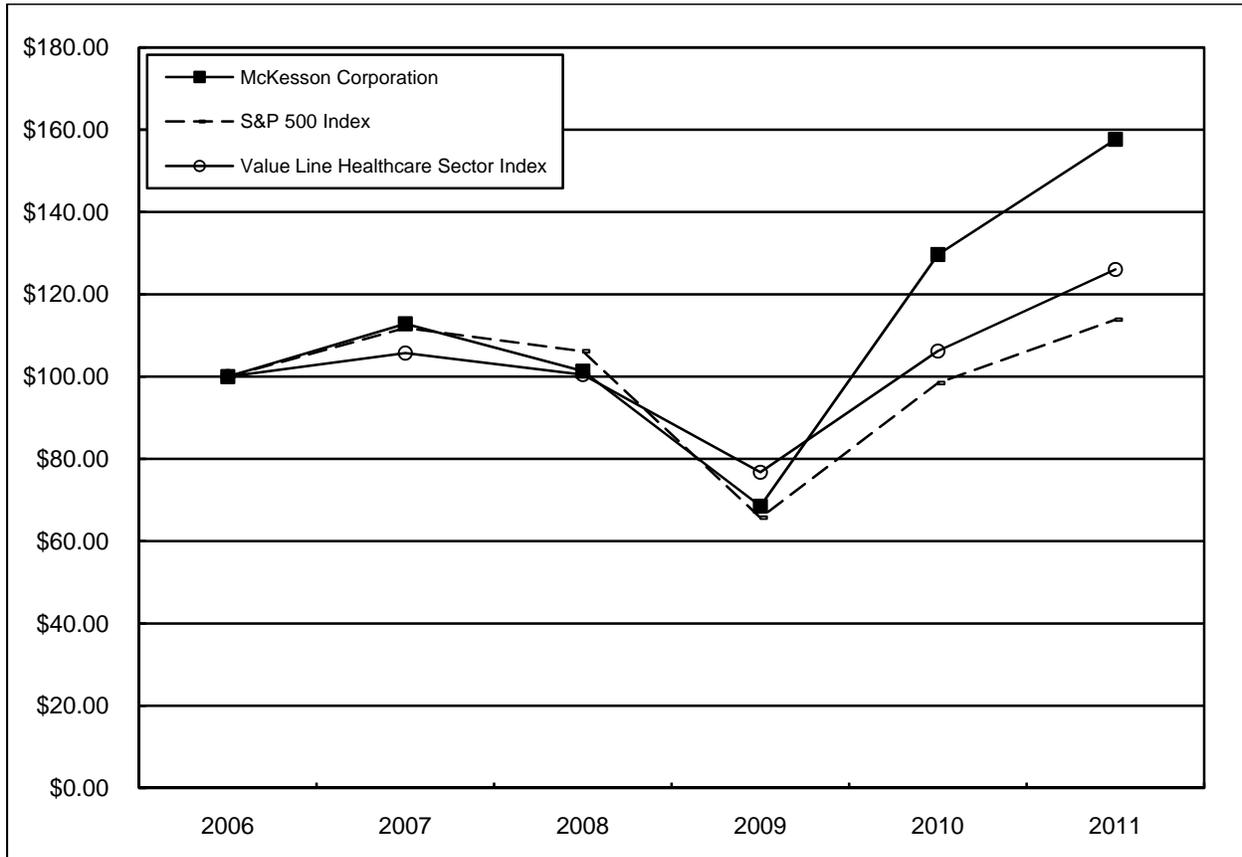
McKESSON CORPORATION

In October 2010, the Board approved a plan to repurchase up to \$1.0 billion of the Company's common stock of which \$500 million remained available for future repurchases as of March 31, 2011. In March 2011, we entered into an accelerated share repurchase ("ASR") program with a third party financial institution to repurchase \$275 million of the Company's common stock. The program was funded with cash on hand. As of March 31, 2011, we had received 3.1 million shares representing the minimum number of shares due under the program. The ASR program was completed on May 2, 2011 and we received 0.4 million additional shares on May 5, 2011. The total number of shares repurchased under the ASR program was 3.5 million shares at an average price per share of \$79.65. In addition, we repurchased 2.8 million shares for \$225 million during the fourth quarter of 2011 through regular open market transactions at an average price per share of \$79.00. In April 2011, the Board authorized the repurchase of up to an additional \$1.0 billion of the Company's common stock.

Stock repurchases may be made from time-to-time in open market transactions, privately negotiated transactions, through accelerated share repurchase programs, or by any combination of such methods. The timing of any repurchases and the actual number of shares repurchased will depend on a variety of factors, including our stock price, corporate and regulatory requirements, restrictions under our debt obligations and other market and economic conditions.

McKESSON CORPORATION

(f) *Stock Price Performance Graph**: The following graph compares the cumulative total stockholder return on the Company's common stock for the periods indicated with the Standard & Poor's 500 Index and the Value Line Healthcare Sector Index (composed of 162 companies in the health care industry, including the Company).



	March 31,					
	2006	2007	2008	2009	2010	2011
McKesson Corporation	\$ 100.00	\$ 112.83	\$ 101.33	\$ 68.52	\$ 129.66	\$ 157.65
S&P 500 Index	\$ 100.00	\$ 111.83	\$ 106.15	\$ 65.72	\$ 98.43	\$ 113.83
Value Line Healthcare Sector Index	\$ 100.00	\$ 105.72	\$ 100.47	\$ 76.75	\$ 106.21	\$ 126.05

* Assumes \$100 invested in McKesson's common stock and in each index on March 31, 2006 and that all dividends are reinvested.

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Item 6. Selected Financial Data

FIVE-YEAR HIGHLIGHTS

	As of and for the Years Ended March 31,				
<i>(In millions, except per share data and ratios)</i>	2011	2010	2009	2008	2007
Operating Results					
Revenues	\$ 112,084	\$ 108,702	\$ 106,632	\$ 101,703	\$ 92,977
Percent change	3.1%	1.9%	4.8%	9.4%	6.9%
Gross profit	5,970	5,676	5,378	5,009	4,332
Income from continuing operations before income taxes	1,635	1,864	1,064	1,457	1,297
Income after income taxes					
Continuing operations	1,130	1,263	823	989	968
Discontinued operations	72	—	—	1	(55)
Net income	1,202	1,263	823	990	913
Financial Position					
Working capital	3,631	4,492	3,065	2,438	2,730
Days sales outstanding for: ⁽¹⁾					
Customer receivables	25	25	24	22	21
Inventories	31	34	31	33	32
Drafts and accounts payable	47	48	43	44	43
Total assets	30,886	28,189	25,267	24,603	23,943
Total debt, including capital lease obligations	4,004	2,297	2,512	1,797	1,958
Stockholders' equity	7,220	7,532	6,193	6,121	6,273
Property acquisitions	233	199	195	195	126
Acquisitions of businesses, net	292	18	358	610	1,938
Common Share Information					
Common shares outstanding at year-end	252	271	271	277	295
Shares on which earnings per common share were based					
Diluted	263	273	279	298	305
Basic	258	269	275	291	298
Diluted earnings per common share ⁽²⁾					
Continuing operations	\$ 4.29	\$ 4.62	\$ 2.95	\$ 3.32	\$ 3.17
Discontinued operations	0.28	—	—	—	(0.18)
Total	4.57	4.62	2.95	3.32	2.99
Cash dividends declared	188	131	134	70	72
Cash dividends declared per common share	0.72	0.48	0.48	0.24	0.24
Book value per common share ⁽²⁾⁽³⁾	28.65	27.79	22.87	22.10	21.26
Market value per common share – year end	79.05	65.72	35.04	52.37	58.54
Supplemental Data					
Capital employed ⁽⁴⁾	11,224	9,829	8,705	7,918	8,231
Debt to capital ratio ⁽⁵⁾	35.7%	23.4%	28.9%	22.7%	23.8%
Net debt to net capital employed ⁽⁶⁾	5.1%	(23.5)%	6.1%	6.6%	0.1%
Average stockholders' equity ⁽⁷⁾	7,105	6,768	6,214	6,344	6,022
Return on stockholders' equity ⁽⁸⁾	16.9%	18.7%	13.2%	15.6%	15.2%

Footnotes to Five-Year Highlights:

- (1) Based on year-end balances and sales or cost of sales for the last 90 days of the year.
- (2) Certain computations may reflect rounding adjustments.
- (3) Represents stockholders' equity divided by year-end common shares outstanding.
- (4) Consists of total debt and stockholders' equity.
- (5) Ratio is computed as total debt divided by capital employed.
- (6) Ratio is computed as total debt, net of cash and cash equivalents ("net debt"), divided by net debt and stockholders' equity ("net capital employed").
- (7) Represents a five-quarter average of stockholders' equity.
- (8) Ratio is computed as net income divided by a five-quarter average of stockholders' equity.

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FINANCIAL REVIEW

Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations

GENERAL

Management’s discussion and analysis of financial condition and results of operations, referred to as the Financial Review, is intended to assist the reader in the understanding and assessment of significant changes and trends related to the results of operations and financial position of the Company together with its subsidiaries. This discussion and analysis should be read in conjunction with the consolidated financial statements and accompanying financial notes in Item 8 of Part II of this Annual Report on Form 10-K. The Company’s fiscal year begins on April 1 and ends on March 31. Unless otherwise noted, all references in this document to a particular year shall mean the Company’s fiscal year.

Certain statements in this report constitute forward-looking statements. See Item 1 – Business – Forward-Looking Statements in Part I of this Annual Report on Form 10-K for additional factors relating to these statements; also see Item 1A – Risk Factors in Part I of this Annual Report on Form 10-K for a list of certain risk factors applicable to our business, financial condition and results of operations.

We conduct our business through two operating segments: Distribution Solutions and Technology Solutions. See Financial Note 20, “Segments of Business,” to the consolidated financial statements appearing in this Annual Report on Form 10-K for a description of these segments.

RESULTS OF OPERATIONS

Overview:

<i>(In millions, except per share data)</i>	Years Ended March 31,		
	2011	2010	2009
Revenues	\$ 112,084	\$ 108,702	\$ 106,632
Gross Profit	5,970	5,676	5,378
Operating Expenses ⁽¹⁾	(4,149)	(3,668)	(4,182)
Other Income, Net	36	43	12
Interest Expense	(222)	(187)	(144)
Income from Continuing Operations Before Income Taxes	1,635	1,864	1,064
Income Tax Expense	(505)	(601)	(241)
Income from Continuing Operations	1,130	1,263	823
Discontinued Operation – gain on sale, net of tax	72	—	—
Net Income	\$ 1,202	\$ 1,263	\$ 823
Diluted Earnings Per Common Share			
Continuing Operations	\$ 4.29	\$ 4.62	\$ 2.95
Discontinued Operation	0.28	—	—
Total	\$ 4.57	\$ 4.62	\$ 2.95
Weighted Average Diluted Common Shares	263	273	279

(1) Includes pre-tax litigation charges (credit) of \$213 million, \$(20) million and \$493 million for 2011, 2010 and 2009.

Revenues increased 3% to \$112.1 billion in 2011 and 2% to \$108.7 billion in 2010. The increase in revenues primarily reflects market growth in our Distribution Solutions segment, which accounted for approximately 97% of our consolidated revenues. Additionally, revenues for 2011 benefited from our December 30, 2010 acquisition of US Oncology Holdings, Inc. (“US Oncology”) of The Woodlands, Texas and revenues for 2010 benefited to a lesser extent from an increase in demand related to the flu season. Partially offsetting the 2010 increases, revenues for that year were affected by the loss of several customers in late 2009.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

Gross profit increased 5% to \$6.0 billion in 2011 and 6% to \$5.7 billion in 2010. As a percentage of revenues, gross profit increased 11 basis points (“bp”) to 5.33% and 18 bp to 5.22% in 2011 and 2010. The increase in our 2011 gross profit margin was primarily due to an increase in buy margin and increased sales of higher margin generic drugs in our Distribution Solutions segment. These increases were partially offset by a decline in our Technology Solutions segment margin which included a \$72 million asset impairment charge. The increase in our 2010 gross profit margin was primarily due to an improved mix of higher margin revenues in both our Distribution Solutions and Technology Solutions segments.

Operating expenses were \$4.1 billion, \$3.7 billion and \$4.2 billion in 2011, 2010 and 2009. Operating expenses include pre-tax charges (credit) of \$213 million, \$(20) million and \$493 million relating to our securities and Average Wholesale Price (“AWP”) litigation matters. Excluding these charges (credit), operating expenses increased in 2011 primarily reflecting higher employee compensation costs including expenses associated with our Profit Sharing Investment Plan (“PSIP”) as well as due to our acquisition of US Oncology. Excluding these charges (credit), operating expenses in 2010 approximated the same period a year ago primarily due to lower PSIP expenses and the sale of two businesses during the first and third quarters of 2009. These decreases were partially offset by an increase in expenses associated with employee compensation and benefit costs, our 2009 business acquisitions and other business initiatives. Our litigation charges (credit) and PSIP expense are more fully described under the caption “Operating Expenses” in this Financial Review.

Other income, net was \$36 million, \$43 million and \$12 million in 2011, 2010 and 2009. In 2009, other income, net included a pre-tax impairment charge of \$63 million (\$60 million after-tax) on two equity-held investments and a pre-tax gain of \$24 million (\$14 million after tax) from the sale of an equity-held investment.

Interest expense increased 19% to \$222 million in 2011 and 30% to \$187 million in 2010. Interest expense increased in 2011 primarily due to bridge loan fees incurred for our acquisition of US Oncology and interest expense associated with the assumed debt and the subsequent refinancing of the debt. These increases were partially offset by the repayment of \$215 million of long-term debt in March 2010. Interest expense increased in 2010 primarily due to our issuance of \$700 million of long-term debt in February 2009.

Our reported income tax rates were 30.9%, 32.2% and 22.7% in 2011, 2010 and 2009. In 2011, income tax expense included \$34 million of net income tax benefits for discrete items which primarily relates to the recognition of previously unrecognized tax benefits and accrued interest. In 2009, current income tax expense included \$111 million of net income tax benefits for discrete items of which \$87 million represents a non-cash benefit. These benefits primarily relate to the recognition of previously unrecognized tax benefits and related accrued interest.

Net income was \$1,202 million, \$1,263 million and \$823 million in 2011, 2010 and 2009, and diluted earnings per common share were \$4.57, \$4.62, and \$2.95. Diluted earnings per common share were favorably affected by decreases in our weighted average shares outstanding due to the cumulative effect of share repurchases over the past three years. Net income for 2011 includes a \$72 million after-tax gain (or \$0.28 per diluted share) on the sale of our Technology Solutions segment’s wholly-owned subsidiary, McKesson Asia Pacific Pty Limited (“MAP”), which was sold in July 2010. Historical financial results for this subsidiary were not material.

McKESSON CORPORATION
FINANCIAL REVIEW (Continued)

Revenues:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Distribution Solutions			
Direct distribution & services	\$ 77,554	\$ 72,210	\$ 66,876
Sales to customers' warehouses	18,631	21,435	25,809
Total U.S. pharmaceutical distribution & services	96,185	93,645	92,685
Canada pharmaceutical distribution & services	9,784	9,072	8,225
Medical-Surgical distribution & services	2,920	2,861	2,658
Total Distribution Solutions	108,889	105,578	103,568
Technology Solutions			
Services	2,483	2,439	2,337
Software & software systems	590	571	572
Hardware	122	114	155
Total Technology Solutions	3,195	3,124	3,064
Total Revenues	\$ 112,084	\$ 108,702	\$ 106,632

Revenues increased 3% to \$112.1 billion in 2011 and 2% to \$108.7 billion in 2010. The increase in revenues primarily reflects market growth in our Distribution Solutions segment, which accounted for approximately 97% of our consolidated revenues.

Direct distribution and services revenues increased in 2011 compared to 2010 primarily due to market growth, which includes price increases and increased volume from new and existing customers, the effect of a shift from sales to customers' warehouses to direct store delivery, the lapsing of which was completed in the third quarter of 2011, and due to our acquisition of US Oncology. These increases were partially offset by a decline in demand associated with the flu season and price deflation associated with brand to generic drug conversions. Direct distribution and services revenues increased in 2010 compared to 2009 primarily due to a shift of revenues from sales to customers' warehouses to direct store delivery and market growth, partially offset by greater sales of lower priced generic drugs and the loss of several customers in late 2009. Revenues for 2010 benefited to a lesser extent from an increase in demand associated with the flu season.

Sales to customers' warehouses for 2011 decreased compared to 2010 primarily reflecting reduced revenues associated with existing customers, the effect of a shift of revenues to direct store delivery, the lapsing of which was completed in the third quarter of 2011, and the impact of brand to generic conversions. Sales to customers' warehouses for 2010 decreased compared to 2009 primarily due to a shift of revenues to direct store delivery, reduced revenues associated with a large customer and the loss of a large customer in mid-2009, partially offset by expanded business with existing customers.

Sales to retail customers' warehouses represent large volume sales of pharmaceuticals primarily to a limited number of large self-warehousing retail chain customers whereby we order bulk product from the manufacturer, receive and process the product through our central distribution facility and subsequently deliver the bulk product (generally in the same form as received from the manufacturer) directly to our customers' warehouses. This distribution method is typically not marketed or sold by the Company as a stand-alone service; rather, it is offered as an additional distribution method for our large retail chain customers that have an internal self-warehousing distribution network. Sales to customers' warehouses provide a benefit to these customers because they can utilize the Company as one source for both their direct-to-store business and their warehouse business. We generally have significantly lower gross profit margins on sales to customers' warehouses as we pass much of the efficiency of this low cost-to-serve model on to the customer. These sales do, however, contribute to our gross profit dollars.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

The customer mix of our U.S. pharmaceutical distribution revenues was as follows:

	Years Ended March 31,		
	2011	2010	2009
Direct Sales			
Independents	12%	12%	13%
Institutions	34	32	32
Retail Chains	33	32	26
Subtotal	79	76	71
Sales to retail customers' warehouses	21	24	29
Total	100%	100%	100%

As previously described, a limited number of our large retail chain customers purchase products through both our direct and warehouse distribution methods, the latter of which generally has a significantly lower gross profit margin due to the low cost-to-serve model. When evaluating and pricing customer contracts, we do so based on our assessment of total customer profitability. As a result, we do not evaluate our performance or allocate resources based on sales to customers' warehouses or gross profit associated with such sales.

Canadian pharmaceutical distribution and services revenues for 2011 increased compared to 2010 primarily due to a change in the foreign currency exchange rate of 7%. On a constant currency basis, revenues increased 1% in 2011. Canadian revenues for 2011 increased due to market growth, offset by a government-imposed price reduction for generic pharmaceuticals in certain provinces and brand to generic conversions. Canadian pharmaceutical distribution and services revenues for 2010 increased compared to 2009 primarily due to market growth and a favorable change in the foreign currency exchange rate of 3%. On a constant currency basis, revenues increased by 7% in 2010.

Medical-Surgical distribution and services revenues increased in 2011 compared to 2010 primarily due to market growth, partially offset by the decrease in demand associated with the flu season. Medical-Surgical distribution and services revenues increased in 2010 compared to 2009 reflecting an increase in demand related to the flu season, acquisitions and increased volume from new and existing customers.

Technology Solutions revenues increased slightly in 2011 compared to 2010 primarily due to an increase in maintenance revenues from new and existing customers, increased revenues associated with the sale and installation of our software products and growth in our outsourcing services, partially offset by the sale of MAP in July 2010. Technology Solutions revenues increased in 2010 compared to 2009 primarily due to higher services revenues associated with increases in outsourcing revenues for claims processing and other services and software maintenance reflecting the segment's expanded customer base. These increases were partially offset by a shift to products that have higher software revenue deferral rates and lower hardware sales.

McKESSON CORPORATION
FINANCIAL REVIEW (Continued)

Gross Profit:

<i>(Dollars in millions)</i>	Years Ended March 31,		
	2011	2010	2009
Gross Profit			
Distribution Solutions ⁽¹⁾	\$ 4,565	\$ 4,219	\$ 3,955
Technology Solutions ⁽²⁾	1,405	1,457	1,423
Total	\$ 5,970	\$ 5,676	\$ 5,378
Gross Profit Margin			
Distribution Solutions	4.19%	4.00%	3.82%
Technology Solutions	43.97	46.64	46.44
Total	5.33	5.22	5.04

- (1) Gross profit of our Distribution Solutions segment for 2011 includes a credit of \$51 million representing our share of a settlement of an antitrust class action lawsuit brought against a drug manufacturer, which was recorded as a reduction to cost of sales.
- (2) Gross profit of our Technology Solutions segment for 2011 includes a \$72 million asset impairment charge for capitalized software held for sale.

Gross profit increased 5% to \$6.0 billion in 2011 and 6% to \$5.7 billion in 2010. As a percentage of revenues, gross profit increased by 11 bp in 2011 and 18 bp in 2010. Gross profit margin increased in 2011 primarily reflecting higher gross profit margin from our Distribution Solutions segment and increased in 2010 primarily due to an improved mix of higher margin revenues in both of our operating segments.

In 2011, our Distribution Solutions segment's gross profit margin increased compared to 2010 primarily reflecting higher buy margin, increased sales of higher margin generic drugs and due to our acquisition of US Oncology, partially offset by a decline in demand associated with the flu season and a decrease in sell margin. Buy margin primarily reflects volume and timing of compensation from branded pharmaceutical manufacturers. Our Distribution Solutions segment's 2011 gross profit margin was also favorably affected by a credit of \$51 million representing our share of a settlement of an antitrust class action lawsuit.

In 2010, our Distribution Solutions segment's gross profit margin increased compared to 2009 primarily due to an improved mix of higher margin revenues stemming from increased flu-related demand across our distribution businesses. Gross profit margin was also favorably affected by a higher buy margin and increased sales of higher margin generic drugs. These benefits were partially offset by a decline in sell margin.

Our last-in, first-out ("LIFO") net inventory expense was \$3 million in 2011 and \$8 million for 2010 and 2009. Our Distribution Solutions segment uses the LIFO method of accounting for the majority of its inventories, which results in cost of sales that more closely reflects replacement cost than under other accounting methods. The practice in the Distribution Solutions segment's distribution businesses is to pass on to customers published price changes from suppliers. Manufacturers generally provide us with price protection, which limits price-related inventory losses. Price declines on many generic pharmaceutical products in this segment over the last few years have moderated the effects of inflation in other product categories, which resulted in minimal overall price changes in those years. Additional information regarding our LIFO accounting is included under the caption "Critical Accounting Policies and Estimates," included in this Financial Review.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

In 2011, our Technology Solutions segment's gross profit margin decreased compared to 2010 primarily due to a \$72 million asset impairment charge, the sale of MAP and continued investment in our clinical and enterprise revenue management solutions products. These decreases were partially offset by a shift to higher margin revenue. In 2010, our Technology Solutions segment's gross profit margin increased compared to 2009 primarily due to a favorable change in revenue mix, partially offset by a higher software revenue deferral rate.

Our capitalized software held for sale is amortized over three years. At each balance sheet date, or earlier if an indicator of an impairment exists, we evaluate the recoverability of unamortized capitalized software costs based on estimated future undiscounted revenues, net of estimated related costs over the remaining amortization period. In October 2010, we decreased our estimated revenues over the next 24 months for our Horizon Enterprise Revenue Management™ ("HzERM") software product and as a result, concluded that the estimated future revenues, net of estimated related costs, were insufficient to recover its carrying value. Accordingly, we recorded a \$72 million non-cash impairment charge in the second quarter of 2011 within our Technology Solutions segment's cost of sales to reduce the carrying value of the software product to its net realizable value.

Operating Expenses:

<i>(Dollars in millions)</i>	Years Ended March 31,		
	2011	2010	2009
Operating Expenses			
Distribution Solutions ⁽¹⁾	\$ 2,673	\$ 2,260	\$ 2,777
Technology Solutions	1,108	1,077	1,096
Corporate	368	351	309
Subtotal	4,149	3,688	4,182
Litigation (credit), net	—	(20)	—
Total	\$ 4,149	\$ 3,668	\$ 4,182
Operating Expenses as a Percentage of Revenues			
Distribution Solutions	2.45%	2.14%	2.68%
Technology Solutions	34.68	34.48	35.77
Total	3.70	3.37	3.92

(1) Operating expenses for 2011 and 2009 include \$213 million and \$493 million of AWP litigation charges.

Operating expenses increased 13% to \$4.1 billion in 2011 and decreased 12% to \$3.7 billion in 2010. Excluding the 2011, 2010 and 2009 litigation charges (credit) of \$213 million, \$(20) million and \$493 million, operating expenses increased 7% in 2011 and remained flat in 2010. Excluding the litigation charges (credit), operating expenses for 2011 increased compared to 2010 primarily due to higher costs associated with employee compensation and benefits including the McKesson Corporation Profit Sharing Investment Plan ("PSIP") and the addition of US Oncology.

Excluding the litigation charges (credit), operating expenses for 2010 approximated 2009 primarily due to lower PSIP expense, cost containment efforts and the sale of two businesses during 2009. These decreases were partially offset by an increase in expenses associated with employee compensation and benefit costs, our 2009 business acquisitions and other business initiatives.

The McKesson Corporation PSIP was a member of the settlement class in the Consolidated Securities Litigation Action. On April 27, 2009, the court issued an order approving the distribution of the settlement funds. On October 9, 2009, the PSIP received approximately \$119 million of the Consolidated Securities Litigation Action proceeds. Approximately \$42 million of the proceeds were attributable to the allocated shares of McKesson common stock owned by the PSIP participants during the Consolidated Securities Litigation Action class-holding period and were allocated to the respective participants on that basis in the third quarter of 2010. Approximately \$77 million of the proceeds were attributable to the unallocated shares (the "Unallocated Proceeds") of McKesson common stock owned by the PSIP in an employee stock ownership plan ("ESOP") suspense account. In accordance with the plan terms, the PSIP distributed all of the Unallocated Proceeds to current PSIP participants after the close of the plan year in April 2010. The receipt of the Unallocated Proceeds by the PSIP was reimbursement for the loss in value of the Company's common stock held by the PSIP in its ESOP suspense account during the Consolidated Securities Litigation Action class-holding period and was not a contribution made by the Company to the PSIP or ESOP.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

Accordingly, there were no accounting consequences to the Company's financial statements relating to the receipt of the Unallocated Proceeds by the PSIP.

As a result of the PSIP's receipt of the Unallocated Proceeds, in 2010 the Company contributed \$1 million to the PSIP. Accordingly, PSIP expense for 2010 was nominal. In 2011, the Company resumed its contributions to the PSIP.

PSIP expense by segment for the last three years was as follows:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Distribution Solutions	\$ 23	\$ —	\$ 23
Technology Solutions	32	1	28
Corporate	4	—	2
PSIP expense	<u>\$ 59</u>	<u>\$ 1</u>	<u>\$ 53</u>
Cost of sales ⁽¹⁾	\$ 17	\$ —	\$ 12
Operating expenses	42	1	41
PSIP expense	<u>\$ 59</u>	<u>\$ 1</u>	<u>\$ 53</u>

(1) Amounts recorded to cost of sales pertain solely to our McKesson Technology Solutions segment.

On a segment basis, Distribution Solutions segment's operating expenses increased in 2011 and decreased in 2010 primarily due to the AWP litigation charges of \$213 million and \$493 million in 2011 and 2009. Excluding the AWP charge, operating expenses and operating expenses as a percentage of revenues increased in 2011 compared to 2010 primarily due to higher costs associated with employee compensation and benefits including PSIP expenses and the addition of US Oncology. Operating expenses in 2011 also increased as a result of changes in foreign currency exchange rates.

Excluding the AWP charge, Distribution Solutions segment's operating expenses and operating expenses as a percentage of revenues decreased in 2010 compared to 2009 primarily due to the sale of two businesses during 2009, lower PSIP expense in 2010 and our continued focus on cost containment. These decreases were partially offset by increased expenses associated with our 2009 business acquisitions.

As previously reported, in 2009 we reached an agreement to settle all private party claims relating to First DataBank, Inc.'s published drug reimbursement benchmarks for \$350 million. We also recorded an accrual of \$143 million for pending and expected AWP claims by public payers. The combination of the settlement for all AWP private party claims and the decision by us to establish an estimated accrual for the pending and expected AWP claims by public payers resulted in a pre-tax, non-cash charge of \$493 million in the third quarter of 2009. In the second quarter of 2011, we recorded a pre-tax charge of \$24 million for the settlement with the State of Connecticut relating to AWP claims. The settlement included an express denial of liability and a release by Connecticut of the Company as to all matters alleged or which could have been alleged in the action. A cash payment of \$26 million was made in the third quarter of 2011 for this settlement. During the third quarter of 2011, following a review of the reserve for estimated probable losses from current and possible future public entity AWP claims, which review included consideration of the pace and progress of settlement discussions during and after the third quarter relating to state and federal Medicaid claims, we recorded a pre-tax charge of \$189 million. All AWP litigation charges were included in our Distribution Solutions segment's operating expenses. As of March 31, 2011, the reserve relating to AWP public entity claims was \$330 million and was included in other current liabilities in our consolidated balance sheet. Refer to Financial Note 17, "Other Commitments and Contingent Liabilities," to the consolidated financial statements appearing in this Annual Report on Form 10-K for further information.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

As a result of our acquisition of US Oncology, we incurred a net \$52 million of acquisition-related expenses as follows:

<i>(In millions)</i>	Distribution Solutions	Corporate & Interest Expense	Total
Operating expenses:			
Transaction closing expenses	\$ 22	\$ —	\$ 22
Severance and relocation	9	—	9
Other integration expenses	10	2	12
Total operating expenses	41	2	43
Other income: reimbursement of post-acquisition interest expense from former shareholders	—	(16)	(16)
Interest expense: bridge loan fees	—	25	25
Total acquisition-related expenses	\$ 41	\$ 11	\$ 52

We anticipate incurring additional acquisition-related expenses in 2012 as we continue to integrate US Oncology.

Technology Solutions segment's operating expenses and operating expenses as a percentage of revenues increased in 2011 and decreased in 2010. The growth in 2011 reflects our increased investment in research and development activities and higher employee compensation and benefit costs, which includes PSIP expense, partially offset by the sale of MAP in the second quarter of 2011. Operating expenses and operating expenses as a percentage of revenues for 2010 benefited from lower PSIP expense, cost containment efforts and reduction in workforce plans implemented in 2009, partially offset by our continued investment in research and development activities.

Corporate expenses for 2011 increased compared to 2010 primarily due to higher compensation and benefits costs and an asset impairment charge for certain tangible property, partially offset by lower fees associated with our accounts receivable facility. As a result of our adoption of a new accounting standard for transfers of financial assets on April 1, 2010, fees associated with our accounts receivable sales facility are now recorded in interest expense. Prior to 2011, these fees were recorded in Corporate administrative expenses. Corporate expenses for 2010 increased compared to 2009 primarily due to higher compensation and benefits costs, other business initiatives and legal settlement charges.

In 2010, we recorded net credits of \$20 million relating to settlements for the securities litigation, which were recorded in Corporate expenses.

Other Income, net:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
By Segment			
Distribution Solutions	\$ 5	\$ 29	\$ (20)
Technology Solutions	4	5	7
Corporate	27	9	25
Total	\$ 36	\$ 43	\$ 12

In 2011, other income, net included a credit of \$16 million representing the reimbursement of post-acquisition interest expense by the former shareholders of US Oncology, which is recorded in Corporate. Interest income was \$18 million, \$16 million and \$31 million in 2011, 2010 and 2009.

In 2010, other income, net included a \$17 million pre-tax gain (\$14 million after-tax) from the sale of our 50% equity interest in McKesson Logistic Solutions, LLC ("MLS"). The gain on sale of our investment in MLS was recorded within our Distribution Solutions segment. This increase was partially offset by a decrease in interest income due to lower interest rates.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

In 2009, other income, net included a pre-tax impairment charge of \$63 million (\$60 million after-tax) on two equity-held investments (as further described below) and a pre-tax gain of \$24 million (\$14 million after-tax) from the sale of our 42% equity interest in Verispan, LLC (“Verispan”). The impairment charge and the gain on sale of our investment in Verispan were both recorded within our Distribution Solutions segment.

We evaluate our investments for impairment when events or changes in circumstances indicate that the carrying values of such investment may have experienced an other-than-temporary decline in value. In 2009, we determined that the fair value of our interest in Parata Systems, LLC (“Parata”) was lower than its carrying value and that such impairment was other-than-temporary. Fair value was determined using a discounted cash flow analysis based on estimated future results and market capitalization rates. We determined the impairment was other-than-temporary based on our assessment of all relevant factors including deterioration in the investee’s financial condition and weak market conditions. As a result, we recorded a pre-tax impairment of \$58 million (\$55 million after-tax) on this investment which is recorded as other income, net in the consolidated statements of operations within our Distribution Solutions segment. Our investment in Parata is accounted for under the equity method of accounting.

In 2009, we also recorded a pre-tax impairment of \$5 million (\$5 million after-tax) on another equity-held investment within our Distribution Solutions segment.

Segment Operating Profit and Corporate Expenses:

<i>(Dollars in millions)</i>	Years Ended March 31,		
	2011	2010	2009
Segment Operating Profit ⁽¹⁾			
Distribution Solutions ⁽²⁾	\$ 1,897	\$ 1,988	\$ 1,158
Technology Solutions	301	385	334
Subtotal	2,198	2,373	1,492
Corporate Expenses, Net	(341)	(342)	(284)
Litigation Credit, Net	—	20	—
Interest Expense	(222)	(187)	(144)
Income from Continuing Operations Before Income Taxes	\$ 1,635	\$ 1,864	\$ 1,064
Segment Operating Profit Margin			
Distribution Solutions	1.74%	1.88%	1.12%
Technology Solutions	9.42	12.32	10.90

(1) Segment operating profit includes gross profit, net of operating expenses, plus other income (expense), net for our two operating segments.

(2) Operating expenses for 2011 and 2009 for our Distribution Solutions segment included \$213 million and \$493 million of AWP litigation charges.

Operating profit margin for our Distribution Solutions segment decreased in 2011 compared to 2010 primarily due to higher operating expenses as a percentage of revenue, including a \$213 million AWP litigation charge, partially offset by a higher gross profit margin, which included a \$51 million antitrust settlement.

Operating profit margin for our Distribution Solutions segment increased in 2010 compared to 2009 primarily due to a higher gross profit margin, lower operating expenses as a percentage of revenues and higher other income. Results for 2010 included the \$17 million gain on sale of MLS. Results for 2009 included the \$493 million AWP litigation charge, \$63 million of charges to write-down two equity-held investments and a \$24 million gain on the sale of the segment’s 42% equity investment in Verispan.

Operating profit margin in our Technology Solutions segment decreased in 2011 compared to 2010 primarily reflecting a decrease in gross profit margin, which included the \$72 million asset impairment charge and an increase in operating expenses as a percentage of revenues. Operating profit margin in our Technology Solutions segment increased in 2010 compared to 2009 primarily due to lower operating expenses as a percentage of revenues and an improvement in gross profit margin.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

Corporate expenses, net of other income were flat in 2011 compared to 2010 primarily due to an increase in operating expenses which were fully offset by an increase in other income, including the \$16 million benefit associated with the reimbursement of post-acquisition interest expense by the former shareholders of US Oncology. Corporate expenses, net of other income increased in 2010 compared to 2009 primarily due to an increase in operating expenses and a decrease in interest income.

Interest Expense: Interest expense increased in 2011 compared to 2010 primarily due to \$25 million of bridge loan fees related to the acquisition of US Oncology, interest expense associated with the assumed debt and the subsequent refinancing of the debt, and fees from our accounts receivable sales facility which are recorded in interest expense commencing in 2011. These increases were partially offset by lower interest expense due to the repayment of \$215 million of our long-term debt in March 2010. Interest expense increased in 2010 compared to 2009 primarily due to our issuance of \$700 million of long-term debt in February 2009. Refer to our discussion under the caption "Credit Resources" within this Financial Review for additional information regarding our financing activities.

Income Taxes: Our reported tax rates were 30.9%, 32.2% and 22.7% in 2011, 2010 and 2009. In addition to the items noted below, fluctuations in our reported tax rate are primarily due to changes within our business mix, including varying proportions of income attributable to foreign countries that have lower income tax rates.

In 2011, income tax expense included \$34 million of net income tax benefits for discrete items, which primarily relates to the recognition of previously unrecognized tax benefits and accrued interest.

In 2009, income tax expense included \$111 million of net income tax benefits for discrete items of which \$87 million represents a non-cash benefit. These benefits primarily relate to the recognition of previously unrecognized tax benefits and related accrued interest. The recognition of these discrete items was primarily due to the lapsing of the statutes of limitations.

The U.S. Internal Revenue Service ("IRS") is currently examining our fiscal years 2003 through 2006 and we anticipate the field work will be completed and they will issue the Revenue Agent Report in our first quarter of fiscal 2012. We have received assessments from the Canada Revenue Agency ("CRA") for a total of \$169 million related to transfer pricing for 2003 through 2007. Payments of most of the assessments to the CRA have been made to stop the accrual of interest. We have appealed the assessment for 2003 to the Tax Court of Canada and have filed a notice of objection for 2004 through 2007. If we are not successful in resolving these issues with the CRA, a trial date has been set for October 17, 2011 with the Tax Court of Canada. We believe that we have adequately provided for any potential adverse results relating to the IRS and CRA examinations. However, the final resolution of these issues could result in an increase or decrease to income tax expense.

Discontinued Operation: In July 2010, our Technology Solutions segment sold MAP, a provider of phone and web-based healthcare services in Australia and New Zealand, for net sales proceeds of \$109 million. The divestiture generated a pre-tax and after-tax gain of \$95 million and \$72 million. As a result of the sale, we were able to utilize capital loss carry-forwards for which we previously recorded a valuation allowance of \$15 million. The release of the valuation allowance is included as a tax benefit in our after-tax gain on the divestiture. The after-tax gain on disposition was recorded as a discontinued operation in our statement of operations in 2011. The historical financial operating results and net assets of MAP were not material to our consolidated financial statements for all periods presented.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

Net Income: Net income was \$1,202 million, \$1,263 million and \$823 million in 2011, 2010 and 2009 and diluted earnings per common share were \$4.57, \$4.62 and \$2.95. The net income and diluted earnings per common share for 2011 included a pre-tax charge of \$213 million (\$149 million after-tax). Net income and diluted earnings per common share for 2011 also included an after-tax gain of \$72 million (or \$0.28 per diluted share) relating to our sale of MAP. The net income and diluted earnings per common share for 2009 included a pre-tax charge of \$493 million (\$311 million after-tax) for the AWP litigation.

Weighted Average Diluted Common Shares Outstanding: Diluted earnings per common share was calculated based on a weighted average number of shares outstanding of 263 million, 273 million and 279 million for 2011, 2010 and 2009. The decrease in the number of weighted average diluted common shares outstanding over the past two years primarily reflects a decrease in the number of shares outstanding as a result of stock repurchased, partially offset by the exercise/settlement of share-based awards.

International Operations

International operations accounted for 8.9%, 8.6% and 7.9% of 2011, 2010 and 2009 consolidated revenues. International operations are subject to certain risks, including currency fluctuations. We monitor our operations and adopt strategies responsive to changes in the economic and political environment in each of the countries in which we operate. Additional information regarding our international operations is also included in Financial Note 20, "Segments of Business," to the consolidated financial statements appearing in this Annual Report on Form 10-K.

Business Combinations

On December 30, 2010, we acquired all of the outstanding shares of US Oncology for approximately \$2.1 billion, consisting of cash consideration of \$0.2 billion, net of cash acquired, and the assumption of liabilities with a fair value of \$1.9 billion. As an integrated oncology company, US Oncology is affiliated with community-based oncologists, and works with patients, hospitals, payers and the medical industry across all phases of the cancer research and delivery continuum. The acquisition of US Oncology expands our existing specialty pharmaceutical distribution business and adds practice management services for oncologists. The cash paid at acquisition was funded from cash on hand.

Included in the purchase price allocation are acquired identifiable intangibles of \$1.0 billion, which primarily consist of \$0.7 billion of service agreements and \$0.2 billion of customer lists. The estimated weighted average lives of the service agreements, customer lists and total acquired intangibles are 18 years, 10 years and 16 years. The excess of the purchase price over the net tangible and intangible assets of approximately \$808 million was recorded as goodwill, which primarily reflects the expected future benefits to be realized upon integrating the business. Due to the recent timing of the acquisition, the fair value measurements of assets and liabilities assumed as of the acquisition date are subject to change within the measurement period as our fair value assessments are finalized. Financial results for US Oncology have been included in the results of operations within our Distribution Solutions segment beginning in the fourth quarter of 2011.

On May 21, 2008, we acquired McQueary Brothers of Springfield, Missouri for approximately \$190 million. McQueary Brothers is a regional distributor of pharmaceutical, health and beauty products to independent and regional chain pharmacies in the Midwestern U.S. This acquisition expanded our existing U.S. pharmaceutical distribution business. The acquisition was funded with cash on hand. Financial results for McQueary Brothers have been included within our Distribution Solutions segment since the date of acquisition. During the first quarter of 2010, the fair value measurements of assets acquired and liabilities assumed as of the acquisition date were completed. The excess of the purchase price over the net tangible and intangible assets of approximately \$126 million was recorded as goodwill, which primarily reflected the expected future benefits from synergies to be realized upon integrating the business. Included in the purchase price allocation were acquired identifiable intangibles of \$61 million primarily representing a customer relationship with a useful life of 7 years, a trade name of \$2 million with a useful life of less than one year and a not-to-compete agreement of \$4 million with a useful life of 4 years.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

During the last three years, we also completed a number of other smaller acquisitions within both of our operating segments. Financial results for our business acquisitions have been included in our consolidated financial statements since their respective acquisition dates. Purchase prices for our business acquisitions have been allocated based on estimated fair values at the date of acquisition.

Goodwill recognized for our business acquisitions is generally not expected to be deductible for tax purposes. Pro forma results of operations for our business acquisitions have not been presented because the effects were not material to the consolidated financial statements on either an individual or an aggregate basis. Refer to Financial Notes 2 and 11, "Business Combinations" and "Debt and Financing Activities," to the consolidated financial statements appearing in this Annual Report on Form 10-K for additional information.

2012 Outlook

Information regarding the Company's 2012 outlook is contained in our Form 8-K dated May 3, 2011. This Form 8-K should be read in conjunction with the sections Item 1 – Business – Forward-Looking Statements and Item 1A – Risk Factors in Part 1 of this Annual Report on Form 10-K.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

CRITICAL ACCOUNTING POLICIES AND ESTIMATES

We consider an accounting estimate to be critical if the estimate requires us to make assumptions about matters that were uncertain at the time the accounting estimate was made and if different estimates that we reasonably could have used in the current period, or changes in the accounting estimate that are reasonably likely to occur from period to period, could have a material impact on our financial condition or results from operations. Below are the estimates that we believe are critical to the understanding of our operating results and financial condition. Other accounting policies are described in Financial Note 1, "Significant Accounting Policies," to the consolidated financial statements appearing in this Annual Report on Form 10-K. Because of the uncertainty inherent in such estimates, actual results may differ from these estimates.

Allowance for Doubtful Accounts: We provide short-term credit and other customer financing arrangements to customers who purchase our products and services. Other customer financing primarily relates to guarantees provided to our customers, or their creditors, regarding the repurchase of inventories. We also provide financing to certain customers related to the purchase of pharmacies, which serve as collateral for the loans. We estimate the receivables for which we do not expect full collection based on historical collection rates and specific knowledge regarding the current creditworthiness of our customers and record an allowance in our consolidated financial statements for these amounts.

In determining the appropriate allowance for doubtful accounts, which includes portfolio and specific reserves, the Company reviews accounts receivable aging, industry trends, customer financial strength, credit standing, historical write-off trends and payment history to assess the probability of collection. If the frequency and severity of customer defaults due to our customers' financial condition or general economic conditions change, our allowance for uncollectible accounts may require adjustment. As a result, we continuously monitor outstanding receivables and other customer financing and adjust allowances for accounts where collection may be in doubt. During 2011, sales to our ten largest customers accounted for approximately 51% of our total consolidated revenues. Sales to our two largest customers, CVS Caremark Corporation ("CVS") and Rite Aid Corporation ("Rite Aid"), accounted for approximately 14% and 11% of our total consolidated revenues. At March 31, 2011, accounts receivable from our ten largest customers were approximately 43% of total accounts receivable. Accounts receivable from CVS, Wal-Mart Stores, Inc. ("Walmart") and Rite Aid were approximately 13%, 10% and 9% of total accounts receivable. As a result, our sales and credit concentration is significant. A default in payments, a material reduction in purchases from these, or any other large customer or the loss of a large customer could have a material adverse impact on our financial condition, results of operations and liquidity.

Reserve methodologies are assessed annually based on historical losses and economic, business and market trends. In addition, reserves are reviewed quarterly and updated if unusual circumstances or trends are present. We believe the reserves maintained and expenses recorded in 2011 are appropriate and consistent with historical methodologies employed. At this time, we are not aware of any internal process or customer issues that might lead to a significant increase in the foreseeable future in our allowance for doubtful accounts as a percentage of net revenue.

At March 31, 2011, trade and notes receivables were \$8,108 million prior to allowances of \$124 million. In 2011, 2010 and 2009 our provision for bad debts was \$18 million, \$17 million and \$29 million. At March 31, 2011 and 2010, the allowance as a percentage of trade and notes receivables was 1.5% and 1.8%. An increase or decrease of a hypothetical 0.1% in the 2011 allowance as a percentage of trade and notes receivables would result in an increase or decrease in the provision for bad debts of approximately \$8 million. The selected 0.1% hypothetical change does not reflect what could be considered the best or worst case scenarios. Additional information concerning our allowance for doubtful accounts may be found in Schedule II included in this Annual Report on Form 10-K.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

Inventories: We report inventories at the lower of cost or market (“LCM”). Inventories for our Distribution Solutions segment consist of merchandise held for resale. For our Distribution Solutions segment, the majority of the cost of domestic inventories is determined using the LIFO method and the cost of Canadian inventories is determined using the first-in, first-out (“FIFO”) method. Technology Solutions segment inventories consist of computer hardware with cost determined by the standard cost method. Rebates, fees, cash discounts, allowances, chargebacks and other incentives received from vendors are generally accounted for as a reduction in the cost of inventory and are recognized when the inventory is sold. Total inventories were \$9.2 billion and \$9.4 billion at March 31, 2011 and 2010.

The LIFO method was used to value approximately 87% of our inventories at March 31, 2011 and 2010. At March 31, 2011 and 2010, our LIFO reserves, net of LCM adjustments, were \$96 million and \$93 million. LIFO reserves include both pharmaceutical and non-pharmaceutical products. In 2011, 2010, and 2009, we recognized net LIFO expense of \$3 million, \$8 million and \$8 million within our consolidated statements of operations. In 2011, our \$3 million net LIFO expense related to our non-pharmaceutical products. A LIFO expense is recognized when the net effect of price increases on branded pharmaceuticals and non-pharmaceutical products held in inventory exceeds the impact of price declines and shifts towards generic pharmaceuticals, including the effect of branded pharmaceutical products that have lost market exclusivity. A LIFO credit is recognized when the net effect of price declines and shifts towards generic pharmaceuticals exceeds the impact of price increases on branded pharmaceuticals and non-pharmaceutical products held in inventory.

We believe that the FIFO inventory costing method provides a reasonable estimation of the current cost of replacing inventory (i.e., “market”). As such, our LIFO inventory is valued at the lower of LIFO or inventory as valued under FIFO. Primarily due to continued net deflation in generic pharmaceutical inventories, pharmaceutical inventories at LIFO were \$156 million and \$112 million higher than FIFO as of March 31, 2011 and 2010. As a result, in 2011 and 2010, we recorded LCM charges of \$44 million and \$5 million within our consolidated statements of operations to adjust our LIFO inventories to market. As deflation in generic pharmaceuticals continues, we anticipate that LIFO credits from the valuation of our pharmaceutical products will be fully offset by LCM reserves.

In determining whether inventory valuation issues exist, we consider various factors including estimated quantities of slow-moving inventory by reviewing on-hand quantities, outstanding purchase obligations and forecasted sales. Shifts in market trends and conditions, changes in customer preferences due to the introduction of generic drugs or new pharmaceutical products or the loss of one or more significant customers are factors that could affect the value of our inventories. We provide reserves for excess and obsolete inventory, if indicated, as a result of these reviews. These factors could make our estimates of inventory valuation differ from actual results.

Business Combinations: We account for acquired businesses using the acquisition method of accounting, which requires that the assets acquired and liabilities assumed be recorded at the date of acquisition at their respective fair values. Any excess of the purchase price over the estimated fair values of the net assets acquired is recorded as goodwill. Effective April 1, 2009, acquisition-related expenses and restructuring costs are recognized separately from the business combinations and are expensed as incurred. Acquisition-related expenses totaled \$52 million in 2011 and were not material in 2010.

Several methods may be used to determine the fair value of assets acquired and liabilities assumed. For intangible assets, we typically use the income method. This method starts with a forecast of all of the expected future net cash flows for each asset or liability acquired. These cash flows are then adjusted to present value by applying an appropriate discount rate that reflects the risk factors associated with the cash flow streams. Some of the more significant estimates and assumptions inherent in the income method or other methods include the amount and timing of projected future cash flows, the discount rate selected to measure the risks inherent in the future cash flows and the assessment of the asset’s life cycle and the competitive trends impacting the asset, including consideration of any technical, legal, regulatory, or economic barriers to entry. Determining the useful life of an intangible asset also requires judgment as different types of intangible assets will have different useful lives and certain assets may even be considered to have indefinite useful lives. Refer to Financial Note 2, “Business Combinations,” to the consolidated financial statements appearing in this Annual Report on Form 10-K for additional information regarding our acquisitions.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

Goodwill: As a result of acquiring businesses, we have \$4,364 million and \$3,568 million of goodwill at March 31, 2011 and 2010. We maintain goodwill assets on our books unless the assets are considered to be impaired. We perform an impairment test on goodwill balances annually in the fourth quarter or more frequently if indicators for potential impairment exist. Indicators that are considered include significant changes in performance relative to expected operating results, significant changes in the use of the assets, significant negative industry, or economic trends or a significant decline in the Company's stock price and/or market capitalization for a sustained period of time.

Impairment testing is conducted at the reporting unit level, which is generally defined as a component – one level below our Distribution Solutions and Technology Solutions operating segments, for which discrete financial information is available and segment management regularly reviews the operating results of that unit. Components that have essentially similar operations, products, services and customers are aggregated as a single reporting unit. Management judgment is involved in determining which components may be combined and changes in these combinations could affect the outcome of the testing.

Impairment tests require that we first compare the carrying value of net assets to the estimated fair value of net assets for the reporting units. If the carrying value exceeds the fair value, a second step would be performed to calculate the amount of impairment, which would be recorded as a charge in our consolidated statements of operations. Fair values can be determined using the market, income or cost approach. To estimate the fair value of our reporting units, we use a combination of the market approach and the income approach. Under the market approach, we estimate fair value by comparing the business to similar businesses, or guideline companies whose securities are actively traded in public markets. Under the income approach, we use a discounted cash flow model in which cash flows anticipated over several periods, plus a terminal value at the end of that time horizon, are discounted to their present value using an appropriate rate of return. In addition, we compare the aggregate fair value of our reporting units to our market capitalization as further corroboration of the fair value.

Some of the more significant estimates and assumptions inherent in the goodwill impairment estimation process using the market approach include the selection of appropriate guideline companies, the determination of market value multiples for both the guideline companies and the reporting unit, the determination of applicable premiums and discounts based on any differences in marketability between the business and the guideline companies and for the income approach, the required rate of return used in the discounted cash flow method, which reflects capital market conditions and the specific risks associated with the business. Other estimates inherent in both the market and income approaches include long-term growth rates, projected revenues and earnings and cash flow forecasts for the reporting units.

Estimates of fair value result from a complex series of judgments about future events and uncertainties and rely heavily on estimates and assumptions at a point in time. The judgments made in determining an estimate of fair value may materially impact our results of operations. The valuations are based on information available as of the impairment review date and are based on expectations and assumptions that have been deemed reasonable by management. Any changes in key assumptions, including failure to meet business plans, a further deterioration in the market or other unanticipated events and circumstances, may affect the accuracy or validity of such estimates and could potentially result in an impairment charge.

In 2011, 2010 and 2009, we concluded that there were no impairments of goodwill as the fair value of each reporting unit exceeded its carrying value.

Supplier Incentives: Fees for service and other incentives received from suppliers, relating to the purchase or distribution of inventory, are generally reported as a reduction to cost of goods sold. We consider these fees and other incentives to represent product discounts and as a result, the amounts are recorded as a reduction of product cost and are recognized through cost of goods sold upon the sale of the related inventory.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

Supplier Reserves: We establish reserves against amounts due from suppliers relating to various price and rebate incentives, including deductions or billings taken against payments otherwise due to them. These reserve estimates are established based on judgment after considering the status of current outstanding claims, historical experience with the suppliers, the specific incentive programs and any other pertinent information available. We evaluate the amounts due from suppliers on a continual basis and adjust the reserve estimates when appropriate based on changes in factual circumstances. As of March 31, 2011 and 2010, supplier reserves were \$102 million and \$89 million. The ultimate outcome of any amounts due from our suppliers may be different from our estimate. All of the supplier reserves at March 31, 2011 and 2010 pertain to our Distribution Solutions segment. An increase or decrease in the supplier reserve as a hypothetical 0.1% of trade payables at March 31, 2011 would result in an increase or decrease in the cost of sales of approximately \$14 million in 2011. The selected 0.1% hypothetical change does not reflect what could be considered the best or worst case scenarios.

Income Taxes: Our income tax expense and deferred tax assets and liabilities reflect management's best assessment of estimated current and future taxes to be paid. We are subject to income taxes in the U.S. and numerous foreign jurisdictions. Significant judgments and estimates are required in determining the consolidated income tax provision and in evaluating income tax uncertainties. We review our tax positions at the end of each quarter and adjust the balances as new information becomes available.

Deferred income taxes arise from temporary differences between the tax and financial statement recognition of revenue and expense. In evaluating our ability to recover our deferred tax assets, we consider all available positive and negative evidence including our past operating results, the existence of cumulative net operating losses in the most recent years and our forecast of future taxable income. In estimating future taxable income, we develop assumptions including the amount of future federal, state and foreign pre-tax operating income, the reversal of temporary differences and the implementation of feasible and prudent tax planning strategies. These assumptions require significant judgment about the forecasts of future taxable income and are consistent with the plans and estimates we use to manage the underlying businesses. We had deferred income tax assets (net of valuation allowances) of \$1,297 million and \$1,187 million at March 31, 2011 and 2010 and deferred tax liabilities of \$2,261 million and \$1,845 million. Deferred tax assets primarily consist of net loss and credit carryforwards and timing differences on our compensation and benefit related accruals. Deferred tax liabilities primarily consist of basis differences for inventory valuation (including inventory valued at LIFO) and other assets. We established valuation allowances of \$99 million against certain deferred tax assets, which primarily relate to federal, state and foreign loss carryforwards for which the ultimate realization of future benefits is uncertain. Changes in tax laws and rates could also affect recorded deferred tax assets and liabilities in the future. Should tax laws change, including those laws pertaining to LIFO, our cash flows could be materially impacted.

If our assumptions and estimates described above were to change, an increase/decrease of 1% in our effective tax rate as applied to income from continuing operations would have increased/decreased tax expense by approximately \$16 million, or \$0.06 per diluted share, for 2011.

Share-Based Compensation: Our compensation programs include share-based compensation. We account for all share-based compensation transactions using a fair-value based measurement method. The share-based compensation expense is recognized, for the portion of the awards that is ultimately expected to vest, on a straight-line basis over the requisite service period for those awards with graded vesting and service conditions. For awards with performance conditions and multiple vest dates, we recognize the expense on a graded vesting basis. For awards with performance conditions and a single vest date, we recognize the expense on a straight-line basis.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

We estimate the grant-date fair value of employee stock options using the Black-Scholes options-pricing model. We believe that it is difficult to accurately measure the value of an employee stock option. Our estimates of employee stock option values rely on estimates of factors we input into the model. The key factors involve an estimate of future uncertain events. The key factors influencing the estimation process, among others, are the expected life of the option, the expected stock price volatility factor and the expected dividend yield. In determining the expected life of the option, we primarily use historical experience as our best estimate of future exercise patterns. We use a combination of historical and implied market volatility to determine the expected stock price volatility factor. We believe that this market-based input provides a better estimate of our future stock price movements and is consistent with employee stock option valuation considerations. Once the fair values of employee stock options are determined, current accounting practices do not permit them to be changed, even if the estimates used are different from actual experience.

In addition, we develop an estimate of the number of share-based awards, which will ultimately vest primarily based on historical experience. Changes in the estimated forfeiture rate can have a material effect on share-based compensation expense. If the actual forfeiture rate is higher than the estimated forfeiture rate, then an adjustment is made to increase the estimated forfeiture rate, which will result in a decrease to the expense recognized in the financial statements. If the actual forfeiture rate is lower than the estimated forfeiture rate, then an adjustment is made to decrease the estimated forfeiture rate, which will result in an increase to the expense recognized in the financial statements. We re-assess the estimated forfeiture rate established upon grant periodically throughout the requisite service period. Such estimates are revised if they differ materially from actual forfeitures. As required, the forfeiture estimates will be adjusted to reflect actual forfeitures when an award vests. The actual forfeitures in future reporting periods could be materially higher or lower than our current estimates.

Our assessments of estimated share-based compensation charges are affected by our stock price as well as assumptions regarding a number of complex and subjective variables and the related tax impact. These variables include the volatility of our stock price, employee stock option exercise behavior, timing, number and types of annual share-based awards and the attainment of performance goals. As a result, the future share-based compensation expense may differ from the Company's historical amounts.

Loss Contingencies: We are subject to various claims, other pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of our business. When a loss is considered probable and reasonably estimable, we record a liability in the amount of our best estimate for the ultimate loss. However, the likelihood of a loss with respect to a particular contingency is often difficult to predict and determining a meaningful estimate of the loss or a range of loss may not be practicable based on the information available and the potential effect of future events and decisions by third parties that will determine the ultimate resolution of the contingency. Moreover, it is not uncommon for such matters to be resolved over many years, during which time relevant developments and new information must be reevaluated at least quarterly to determine both the likelihood of potential loss and whether it is possible to reasonably estimate a range of possible loss. When a loss is probable but a reasonable estimate cannot be made, disclosure of the proceeding is provided.

Disclosure also is provided when it is reasonably possible that a loss will be incurred or when it is reasonably possible that the amount of a loss will exceed the recorded provision. We review all contingencies at least quarterly to determine whether the likelihood of loss has changed and to assess whether a reasonable estimate of the loss or range of the loss can be made. As discussed above, development of a meaningful estimate of loss or a range of potential loss is complex when the outcome is directly dependent on negotiations with or decisions by third parties, such as regulatory agencies, the court system and other interested parties. Such factors bear directly on whether it is possible to reasonably estimate a range of potential loss and boundaries of high and low estimate.

FINANCIAL CONDITION, LIQUIDITY AND CAPITAL RESOURCES

We expect our available cash generated from operations, together with our existing sources of liquidity from our accounts receivable sales facility and short-term borrowings under the revolving credit facility and commercial paper, will be sufficient to fund our long-term and short-term capital expenditures, working capital and other cash requirements. In addition, from time-to-time, we may access the long-term debt capital markets to discharge our other liabilities.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

Net cash flow from operating activities was \$2,338 million in 2011 compared to \$2,316 million in 2010 and \$1,351 million in 2009. Operating activities for 2011 included a non-cash charge of \$213 million and the related income tax benefit of \$64 million for the AWP litigation charge. Operating activities for 2011 also reflect an increase in receivables primarily associated with revenue growth, partially offset by improved management of inventories and longer payment terms for certain purchases. Cash flows from operations can also be significantly affected by factors such as the timing of receipts from customers and payments to vendors.

Operating activities for 2010 were primarily affected by improved management of drafts and accounts payable, partially offset by an increase in inventories due to our revenue growth and the AWP litigation private payer settlement payments of \$350 million.

Operating activities for 2009 included a non-cash charge of \$493 million and the related income tax benefit of \$182 million for the AWP litigation charge. Operating activities for 2009 also reflect an increase in receivables primarily associated with our revenue growth as well as longer payment terms for certain customers and improvement in our net financial inventory (inventory, net of drafts and accounts payable).

Net cash used in investing activities was \$624 million in 2011 compared to \$309 million in 2010 and \$727 million in 2009. Investing activities for 2011 included \$292 million of cash payments for business acquisitions, including approximately \$244 million for our acquisition of US Oncology, and \$109 million of cash received from the sale of MAP. Investing activities in 2011 also included \$233 million and \$155 million in capital expenditures for property acquisitions and capitalized software. Investing activities for 2010 included \$199 million and \$179 million in capital expenditures for property acquisitions and capitalized software and the release of \$55 million of restricted cash from escrow related to the AWP private litigation settlement payments. Investing activities for 2009 included \$358 million of cash payments for business acquisitions, including the McQueary Brothers acquisition for approximately \$190 million.

Financing activities utilized cash of \$1,841 million in 2011 and \$421 million in 2010, and provided cash of \$178 million in 2009. Financing activities for 2011 reflect \$1,689 million of cash received from the issuance of long-term debt. In February 2011 we issued \$600 million of 3.25% notes due 2016, \$600 million of 4.75% notes due 2021, and \$500 million of 6.00% notes due 2041. Net proceeds from the issuance of the long-term notes, after discounts and offering expenses, were used to pay off the \$1,730 million of debt assumed as part of the acquisition of US Oncology. Also as part of our acquisition of US Oncology, we borrowed \$1,000 million for bridge financing which was fully repaid by February 2011. Financing activities for 2011 also included \$2,050 million of cash paid for share repurchases, \$171 million of dividends paid and \$367 million of cash receipts from employees' exercises of stock options.

Financing activities for 2010 included \$323 million in cash paid for share repurchases and \$218 million in cash paid on our long-term debt, which primarily consisted of \$215 million paid on the maturity of our 9.13% Series C Senior Notes in March 2010. Financing activities for 2010 also included \$323 million of cash paid for share repurchases, \$131 million of dividends paid and \$212 million of cash receipts from employees' exercises of stock options.

Financing activities for 2009 included our February 2009 issuance of \$350 million of 6.50% notes due 2014 and \$350 million of 7.50% notes due 2019. Net proceeds of \$693 million from the issuance of the notes, after discounts and offering expenses, were used by the Company for general corporate purposes. Financing activities for 2009 also included \$502 million of cash paid for share repurchases, \$116 million of dividends paid and \$97 million of cash receipts from employees' exercises of stock options.

The Company's Board has authorized the repurchase of McKesson's common stock from time-to-time in open market transactions, privately negotiated transactions, through accelerated share repurchase programs, or by any combination of such methods. The timing of any repurchases and the actual number of shares repurchased will depend on a variety of factors, including our stock price, corporate and regulatory requirements, restrictions under our debt obligations and other market and economic conditions. As of March 31, 2011, \$500 million remained available for future repurchases under the October 2010 Board approved share repurchase plan. In April 2011, the Board authorized the repurchase of up to an additional \$1.0 billion of the Company's common stock.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

In July 2008, the Board authorized the retirement of shares of the Company's common stock that may be repurchased from time-to-time pursuant to its stock repurchase program. During the second quarter of 2009, all of the 4 million repurchased shares, which we purchased for \$204 million, were formally retired by the Company. The retired shares constitute authorized but unissued shares. We elected to allocate any excess of share repurchase price over par value between additional paid-in capital and retained earnings. As such, \$165 million was recorded as a decrease to retained earnings.

The Company anticipates that it will continue to pay quarterly cash dividends in the future. However, the payment and amount of future dividends remain within the discretion of the Board and will depend upon the Company's future earnings, financial condition, capital requirements and other factors.

Although we believe that our operating cash flow, financial assets, current access to capital and credit markets, including our existing credit and sales facilities, will give us the ability to meet our financing needs for the foreseeable future, there can be no assurance that continued or increased volatility and disruption in the global capital and credit markets will not impair our liquidity or increase our costs of borrowing.

Selected Measures of Liquidity and Capital Resources:

<i>(Dollars in millions)</i>	March 31,		
	2011	2010	2009
Cash and cash equivalents	\$ 3,612	\$ 3,731	\$ 2,109
Working capital	3,631	4,492	3,065
Debt, net of cash and cash equivalents	392	(1,434)	403
Debt to capital ratio ⁽¹⁾	35.7%	23.4%	28.9%
Net debt to net capital employed ⁽²⁾	5.1%	(23.5)%	6.1%
Return on stockholders' equity ⁽³⁾	16.9%	18.7%	13.2%

(1) Ratio is computed as total debt divided by total debt and stockholders' equity.

(2) Ratio is computed as total debt, net of cash and cash equivalents ("net debt"), divided by net debt and stockholders' equity ("net capital employed").

(3) Ratio is computed as net income, divided by a five-quarter average of stockholders' equity.

Our cash and equivalents balance as of March 31, 2011, included approximately \$1.8 billion of cash held by our subsidiaries outside of the United States. Our intent is to utilize this cash in the foreign operations as well as to fund certain research and development activities for an indefinite period of time. Although the vast majority of cash held outside the United States is available for repatriation, doing so could subject us to U.S. federal, state and local income tax. During the fourth quarter of 2011 and pursuant to IRS regulations, we temporarily borrowed and repaid \$1.0 billion of cash held by our subsidiaries outside the United States. The duration of this temporary loan to the United States was less than 60 days.

Working capital primarily includes cash and cash equivalents, receivables and inventories, net of drafts and accounts payable, deferred revenue and other current liabilities. Our Distribution Solutions segment requires a substantial investment in working capital that is susceptible to large variations during the year as a result of inventory purchase patterns and seasonal demands. Inventory purchase activity is a function of sales activity and customer requirements.

Consolidated working capital decreased at March 31, 2011 compared to March 31, 2010, primarily due to increases in drafts and accounts payables, accrued liabilities and the current portion of long-term debt, partially offset by an increase in receivables. Consolidated working capital increased at March 31, 2010 compared to March 31, 2009, primarily due to increases in cash and cash equivalents, partially offset by an increase in net financial inventory and repayment of \$215 million of our long-term debt in March 2010.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

Our ratio of net debt to net capital employed increased at March 31, 2011, compared to March 31, 2010, primarily due to an increase in total debt as a result of the US Oncology acquisition. This ratio decreased at March 31, 2010, compared to March 31, 2009, primarily reflecting an increase in cash and cash equivalents and repayment of \$215 million of our long-term debt in March 2010.

The Company paid quarterly cash dividends at the rate of \$0.06 per share on its common stock from the fourth quarter of 1999 through the fourth quarter of 2008. In April 2008, the quarterly dividend was raised from \$0.06 to \$0.12 per share and in May 2010, the quarterly dividend was raised to \$0.18 per common share. In April 2011, the Board approved an increase in the quarterly dividend from \$0.18 to \$0.20 per share, applicable to ensuing quarterly dividend declarations. The Company anticipates that it will continue to pay quarterly cash dividends in the future. However, the payment and amount of future dividends remain within the discretion of the Board and will depend upon the Company's future earnings, financial condition, capital requirements and other factors. In 2011, 2010 and 2009, we paid total cash dividends of \$171 million, \$131 million and \$116 million.

Contractual Obligations:

The table below presents our significant financial obligations and commitments at March 31, 2011:

<i>(In millions)</i>	Total	Years			
		Within 1	Over 1 to 3	Over 3 to 5	After 5
On balance sheet					
Long-term debt ⁽¹⁾	\$ 4,004	\$ 417	\$ 861	\$ 606	\$ 2,120
Other ⁽²⁾	413	32	83	162	136
Off balance sheet					
Interest on borrowings ⁽³⁾	2,012	224	361	293	1,134
Purchase obligations ⁽⁴⁾	3,730	3,610	89	31	—
Operating lease obligations ⁽⁵⁾	844	178	258	167	241
Customer guarantees ⁽⁶⁾	176	119	24	5	28
Total	\$ 11,179	\$ 4,580	\$ 1,676	\$ 1,264	\$ 3,659

- (1) Represents maturities of the Company's long-term obligations including an immaterial amount of capital lease obligations.
- (2) Represents our estimated benefit payments for the unfunded benefit plans and minimum funding requirements for the pension plans.
- (3) Primarily represents interest that will become due on our fixed rate long-term debt obligations.
- (4) A purchase obligation is defined as an arrangement to purchase goods or services that is enforceable and legally binding on the Company. These obligations primarily relate to inventory purchases, capital commitments and service agreements.
- (5) Represents minimum rental payments for operating leases.
- (6) Represents primarily agreements with certain of our Canadian customers' financial institutions under which we have guaranteed the repurchase of our customers' inventory or our customers' debt in the event these customers are unable to meet their obligations to those financial institutions. We also have an agreement with one software customer that, under limited circumstances, may require us to secure standby financing. Because the amount of the standby financing is not explicitly stated, the overall amount of this guarantee cannot reasonably be estimated. At March 31, 2011, the maximum amounts of inventory repurchase guarantees and customers' debt guarantees were \$138 million and \$38 million, none of which had been accrued.

At March 31, 2011, the liability recorded for uncertain tax positions, excluding associated interest and penalties, was approximately \$485 million. Since the ultimate amount and timing of any future cash settlements cannot be predicted with reasonable certainty, the estimated liability has been excluded from the contractual obligations table.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

In addition, at March 31, 2011, our banks and insurance companies have issued \$128 million of standby letters of credit and surety bonds, which were issued on our behalf mostly related to our customer contracts and in order to meet the security requirements for statutory licenses and permits, court and fiduciary obligations and our workers' compensation and automotive liability programs.

Credit Resources:

We fund our working capital requirements primarily with cash and cash equivalents, our accounts receivable sales facility, short-term borrowings under the revolving credit facility and commercial paper.

Senior Bridge Term Loan Facility

In connection with our execution of an agreement to acquire US Oncology, in November 2010, we entered into a \$2.0 billion unsecured Senior Bridge Term Loan Agreement ("Bridge Loan"). In December 2010, we reduced the Bridge Loan commitment to \$1.0 billion. On January 31, 2011, we borrowed \$1.0 billion under the Bridge Loan. On February 28, 2011, we repaid the funds obtained under the Bridge Loan with long-term debt, as further described below, and the Senior Bridge Term Loan Agreement was terminated. During the time it was outstanding, the Bridge Loan bore interest of 1.76%, which was based on the London Interbank Offered Rate plus a margin based on the Company's credit rating. Bridge Loan fees of \$25 million were included in Corporate interest expense.

US Oncology Debt Acquired

Upon our purchase of US Oncology in December 2010, we assumed the outstanding debt of US Oncology Holdings, Inc. and its wholly-owned subsidiary US Oncology, Inc. Immediately prior to our acquisition, US Oncology Holdings, Inc. called for redemption all of its outstanding Senior Unsecured Floating Rate Toggle Notes due 2012, and US Oncology, Inc. called for redemption all of its outstanding 9.125% Senior Secured Notes due 2017 and 10.75% Senior Subordinated Notes due 2014. In the fourth quarter of 2011, we paid interest of \$50 million and redeemed these notes, including the remaining accrued interest, for \$1,738 million using cash on hand and borrowings under our Bridge Loan.

Long-Term Debt

On February 28, 2011, we issued 3.25% notes due March 1, 2016 in an aggregate principal amount of \$600 million, 4.75% notes due March 1, 2021 in an aggregate principal amount of \$600 million and 6.00% notes due March 1, 2041 in an aggregate principal amount of \$500 million. Interest is payable on March 1 and September 1 of each year beginning on September 1, 2011. We utilized net proceeds, after discounts and offering expenses, of \$1,673 million from the issuance of these notes for general corporate purposes, including the repayment of borrowings under the Bridge Loan. On February 12, 2009, we issued 6.50% notes due February 15, 2014, in an aggregate principal amount of \$350 million and 7.50% notes due February 15, 2019, in an aggregate principal amount of \$350 million. Interest is payable on February 15 and August 15 of each year. We utilized net proceeds, after discounts and offering expenses, of \$693 million from the issuance of these notes for general corporate purposes.

In March 2010, we repaid our \$215 million 9.13% Series C Senior notes, which had matured.

Accounts Receivable Sales Facility

In May 2010, we renewed our accounts receivable sales facility (the "Facility") for an additional one year period under terms substantially similar to those previously in place, and in doing so we increased our committed balance from \$1.1 billion to \$1.35 billion. From time-to-time, the available amount of the Facility may be less than \$1.35 billion based on accounts receivable concentration limits and other eligibility requirements. The renewed Facility will expire in May 2011. We anticipate renewing this Facility before its expiration. At March 31, 2011, there were no securitized accounts receivable balances or secured borrowings outstanding under the Facility. As of March 31, 2010, there were no accounts receivable sold under the Facility. Additionally, there were no sales of interests to third-party purchaser groups in the year ended March 31, 2011.

McKESSON CORPORATION

FINANCIAL REVIEW (Continued)

Additional information regarding our accounts receivable sales facility is included in Financial Notes 1 and 11, “Significant Accounting Policies” and “Debt and Financing Activities,” to the consolidated financial statements appearing in this Annual Report on Form 10-K.

Revolving Credit Facility

We have a syndicated \$1.3 billion five-year senior unsecured revolving credit facility, which expires in June 2012. Borrowings under this credit facility bear interest based upon either a Prime rate or the London Interbank Offered Rate. There were no borrowings under this facility in 2011 and 2010 and \$279 million for 2009. As of March 31, 2011 and 2010, there were no amounts outstanding under this facility.

Commercial Paper

There were no commercial paper issuances during 2011 and 2010 and no amount outstanding at March 31, 2011 and 2010. We issued and repaid \$3.3 billion of commercial paper in 2009.

Debt Covenant

Our various borrowing facilities and long-term debt are subject to certain covenants. Our principal debt covenant is our debt to capital ratio under our unsecured revolving credit facility, which cannot exceed 56.5%. If we exceed this ratio, repayment of debt outstanding under the revolving credit facility could be accelerated. As of March 31, 2011, this ratio was 35.7% and we were in compliance with our other financial covenants. A reduction in our credit ratings, or the lack of compliance with our covenants, could negatively impact our ability to finance operations or issue additional debt at acceptable interest rates.

Funds necessary for future debt maturities and our other cash requirements are expected to be met by existing cash balances, cash flow from operations, existing credit sources and other capital market transactions.

RELATED PARTY BALANCES AND TRANSACTIONS

Information regarding our related party balances and transactions is included in Financial Note 19, “Related Party Balances and Transactions,” to the consolidated financial statements appearing in this Annual Report on Form 10-K.

NEW ACCOUNTING PRONOUNCEMENTS

New accounting pronouncements that we have recently adopted, as well as those that have been recently issued but not yet adopted by us, are included in Financial Note 1, “Significant Accounting Policies,” to the consolidated financial statements appearing in this Annual Report on Form 10-K.

McKESSON CORPORATION

FINANCIAL REVIEW (Concluded)

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

Interest rate risk: Our long-term debt bears interest predominately at fixed rates, whereas our short-term borrowings are at variable interest rates. If the underlying weighted average interest rate on our variable rate debt were to have changed by a hypothetical 50 bp in 2011, interest expense would not have been materially different from that reported.

Our cash and cash equivalents balances earn interest at variable rates. Should interest rates decline, our interest income may be negatively impacted. If the underlying weighted average interest rate on our cash and cash equivalents balances changed by 50 bp in 2011, interest income would have increased or decreased by approximately \$17 million. The selected hypothetical change in interest rates does not reflect what could be considered the best or worst case scenarios.

As of March 31, 2011 and 2010, the net fair value liability of financial instruments with exposure to interest rate risk was approximately \$4.3 billion and \$2.5 billion. The estimated fair value of our long-term debt and other financing was determined using quoted market prices and other inputs that were derived from available market information and may not be representative of actual values that could have been realized or that will be realized in the future. Fair value is subject to fluctuations based on our performance, our credit ratings, changes in the value of our stock and changes in interest rates for debt securities with similar terms.

Foreign exchange risk: We derive revenues and earnings from Canada, the United Kingdom, Ireland, other European countries, Israel and Mexico, which exposes us to changes in foreign exchange rates. We seek to manage our foreign exchange risk in part through operational means, including managing same currency revenues in relation to same currency costs, and same currency assets in relation to same currency liabilities. Foreign exchange risk is also managed through the use of foreign currency forward-exchange contracts. These contracts are used to offset the potential earnings effects from mostly intercompany foreign currency investments and loans. As of March 31, 2011, a hypothetical adverse 10% change in quoted foreign currency exchange rates would not have had a material impact on our net fair value of financial instruments that have exposure to foreign currency risk.

McKESSON CORPORATION

Item 8. Financial Statements and Supplementary Data

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McKESSON CORPORATION

MANAGEMENT'S ANNUAL REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

The management of McKesson Corporation is responsible for establishing and maintaining an adequate system of internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). With the participation of the Chief Executive Officer and the Chief Financial Officer, our management conducted an assessment of the effectiveness of our internal control over financial reporting based on the framework and criteria established in *Internal Control—Integrated Framework*, issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on this assessment, our management has concluded that our internal control over financial reporting was effective as of March 31, 2011.

Deloitte & Touche LLP, an independent registered public accounting firm, audited the financial statements included in this Annual Report on Form 10-K and has also audited the effectiveness of the Company's internal control over financial reporting as of March 31, 2011. This audit report appears on page 53 of this Annual Report on Form 10-K.

May 5, 2011

/s/ John H. Hammergren

John H. Hammergren

Chairman, President and Chief Executive Officer

(Principal Executive Officer)

/s/ Jeffrey C. Campbell

Jeffrey C. Campbell

Executive Vice President and Chief Financial Officer

(Principal Financial Officer)

McKESSON CORPORATION

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of McKesson Corporation:

We have audited the accompanying consolidated balance sheets of McKesson Corporation and subsidiaries (the "Company") as of March 31, 2011 and 2010, and the related consolidated statements of operations, stockholders' equity and cash flows for each of the three fiscal years in the period ended March 31, 2011. Our audits also included the consolidated financial statement schedule ("financial statement schedule") listed in the Index at Item 15(a). We also have audited the Company's internal control over financial reporting as of March 31, 2011, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for these financial statements and financial statement schedule, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying *Management's Annual Report on Internal Control Over Financial Reporting*. Our responsibility is to express an opinion on these financial statements and financial statement schedule, and an opinion on the Company's internal control over financial reporting based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of McKesson Corporation and subsidiaries as of March 31, 2011 and 2010, and the results of their operations and their cash flows for each of the three fiscal years in the period ended March 31, 2011, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein. Also, in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of March 31, 2011, based on the criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

/s/ Deloitte & Touche LLP
San Francisco, California
May 5, 2011

McKESSON CORPORATION

CONSOLIDATED STATEMENTS OF OPERATIONS
(In millions, except per share amounts)

	Years Ended March 31,		
	2011	2010	2009
Revenues	\$ 112,084	\$ 108,702	\$ 106,632
Cost of Sales	106,114	103,026	101,254
Gross Profit	<u>5,970</u>	<u>5,676</u>	<u>5,378</u>
Operating Expenses			
Selling	767	746	743
Distribution	920	882	943
Research and development	407	376	364
Administrative	1,842	1,684	1,639
Litigation charge (credit), net	213	(20)	493
Total Operating Expenses	<u>4,149</u>	<u>3,668</u>	<u>4,182</u>
Operating Income	1,821	2,008	1,196
Other Income, Net	36	43	12
Interest Expense	<u>(222)</u>	<u>(187)</u>	<u>(144)</u>
Income from Continuing Operations Before Income Taxes	1,635	1,864	1,064
Income Tax Expense	<u>(505)</u>	<u>(601)</u>	<u>(241)</u>
Income from Continuing Operations	1,130	1,263	823
Discontinued Operation – gain on sale, net of tax	72	—	—
Net Income	<u>\$ 1,202</u>	<u>\$ 1,263</u>	<u>\$ 823</u>
Earnings Per Common Share			
Diluted			
Continuing operations	\$ 4.29	\$ 4.62	\$ 2.95
Discontinued operation – gain on sale	0.28	—	—
Total	<u>\$ 4.57</u>	<u>\$ 4.62</u>	<u>\$ 2.95</u>
Basic			
Continuing operations	\$ 4.37	\$ 4.70	\$ 2.99
Discontinued operation – gain on sale	0.28	—	—
Total	<u>\$ 4.65</u>	<u>\$ 4.70</u>	<u>\$ 2.99</u>
Weighted Average Common Shares			
Diluted	263	273	279
Basic	258	269	275

See Financial Notes

McKESSON CORPORATION

CONSOLIDATED BALANCE SHEETS
(In millions, except per share amounts)

	March 31,	
	2011	2010
ASSETS		
Current Assets		
Cash and cash equivalents	\$ 3,612	\$ 3,731
Receivables, net	9,187	8,075
Inventories, net	9,225	9,441
Prepaid expenses and other	333	257
Total	22,357	21,504
Property, Plant and Equipment, Net	991	851
Capitalized Software Held for Sale, Net	152	234
Goodwill	4,364	3,568
Intangible Assets, Net	1,456	551
Other Assets	1,566	1,481
Total Assets	\$ 30,886	\$ 28,189
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current Liabilities		
Drafts and accounts payable	\$ 14,090	\$ 13,255
Deferred revenue	1,321	1,218
Deferred tax liabilities	1,037	977
Current portion of long-term debt	417	3
Other accrued liabilities	1,861	1,559
Total	18,726	17,012
Long-Term Debt	3,587	2,293
Other Noncurrent Liabilities	1,353	1,352
Other Commitments and Contingent Liabilities (Note 17)		
Stockholders' Equity		
Preferred stock, \$0.01 par value, 100 shares authorized, no shares issued or outstanding	—	—
Common stock, \$0.01 par value		
Shares authorized: 2011 and 2010 – 800		
Shares issued: 2011 – 369, 2010 – 359	4	4
Additional Paid-in Capital	5,339	4,756
Retained Earnings	8,250	7,236
Accumulated Other Comprehensive Income	87	6
Other	10	(12)
Treasury Shares, at Cost, 2011 – 117 and 2010 – 88	(6,470)	(4,458)
Total Stockholders' Equity	7,220	7,532
Total Liabilities and Stockholders' Equity	\$ 30,886	\$ 28,189

See Financial Notes

McKESSON CORPORATION

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
 Years Ended March 31, 2011, 2010 and 2009
 (In millions, except per share amounts)

	Common Stock		Additional Paid-in Capital	Other Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	ESOP Notes and Guarantee	Treasury		Stockholders' Equity	Other Comprehensive Income (Loss)
	Shares	Amount						Common Shares	Amount		
Balances, March 31, 2008	351	\$ 4	\$ 4,252	\$ (10)	\$ 5,586	\$ 152	\$ (3)	(74)	\$ (3,860)	\$ 6,121	
Issuance of shares under employee plans	4		97						(19)	78	
ESOP funding									15	15	
Share-based compensation			99							99	
Tax benefit related to issuance of shares under employee plans			8							8	
ESOP note collections							2			2	
Translation adjustments						(273)				(273)	(273)
Unrealized net loss and other components of benefit plans, net of tax benefit of \$33										(57)	(57)
Net income					823					823	823
Repurchase and retirement of common stock	(4)		(39)		(165)			(6)	(280)	(484)	
Cash dividends declared, \$0.48 per common share					(134)					(134)	
Other				3	(7)	(1)				(5)	
Balances, March 31, 2009	351	\$ 4	\$ 4,417	\$ (7)	\$ 6,103	\$ (179)	\$ (1)	(80)	\$ (4,144)	\$ 6,193	\$ 493
Issuance of shares under employee plans	8		218					(1)	(24)	194	
Share-based compensation			114							114	
Tax benefit related to issuance of shares under employee plans			11							11	
ESOP note collections							1			1	
Translation adjustments						238				238	238
Unrealized net loss and other components of benefit plans, net of tax benefit of \$32										(53)	(53)
Net income					1,263					1,263	1,263
Repurchase of common stock								(7)	(299)	(299)	
Cash dividends declared, \$0.48 per common share					(131)					(131)	
Other			(4)	(5)	1				9	1	
Balances, March 31, 2010	359	\$ 4	\$ 4,756	\$ (12)	\$ 7,236	\$ 6	\$ —	(88)	\$ (4,458)	\$ 7,532	\$ 1,448
Issuance of shares under employee plans	10		370						(17)	353	
Share-based compensation			137							137	
Tax benefit related to issuance of shares under employee plans			113							113	
Translation adjustments						76				76	76
Net income					1,202					1,202	1,202
Repurchase of common stock			(37)					(29)	(1,995)	(2,032)	
Cash dividends declared, \$0.72 per common share					(188)					(188)	
Other				22		5				27	5
Balances, March 31, 2011	369	\$ 4	\$ 5,339	\$ 10	\$ 8,250	\$ 87	\$ —	(117)	\$ (6,470)	\$ 7,220	\$ 1,283

See Financial Notes

McKESSON CORPORATION

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In millions)

	Years Ended March 31,		
	2011	2010	2009
Operating Activities			
Net income	\$ 1,202	\$ 1,263	\$ 823
Discontinued operation – gain on sale, net of tax	(72)	—	—
Adjustments to reconcile to net cash provided by operating activities:			
Depreciation	139	148	133
Amortization	357	326	308
Provision for bad debts	18	17	29
Other deferred taxes	184	161	320
Share-based compensation expense	137	114	99
Impairment of capitalized software held for sale	72	—	—
Impairment of investments	—	—	63
Other non-cash items	12	(20)	(99)
Changes in operating assets and liabilities, net of business acquisitions:			
Receivables	(673)	(133)	(708)
Inventories	367	(782)	370
Drafts and accounts payable	533	1,340	(189)
Deferred revenue	42	27	(55)
Taxes	33	88	(47)
Litigation charge (credit)	213	(20)	493
Litigation settlement payments	(26)	(350)	—
Deferred tax (benefit) expense on litigation	(56)	116	(172)
Other	(144)	21	(17)
Net cash provided by operating activities	<u>2,338</u>	<u>2,316</u>	<u>1,351</u>
Investing Activities			
Property acquisitions	(233)	(199)	(195)
Capitalized software expenditures	(155)	(179)	(197)
Acquisitions of businesses, less cash and cash equivalents acquired	(292)	(18)	(358)
Proceeds from sale of businesses	109	1	63
Restricted cash for litigation charge, net	—	55	(55)
Other	(53)	31	15
Net cash used in investing activities	<u>(624)</u>	<u>(309)</u>	<u>(727)</u>
Financing Activities			
Proceeds from short-term borrowings	1,000	5	3,630
Repayments of short-term borrowings	(1,000)	(6)	(3,630)
Proceeds from issuances of long-term debt	1,689	—	699
Repayments of long-term debt	(1,730)	(218)	(4)
Common stock transactions:			
Issuances	367	212	97
Share repurchases, including shares surrendered for tax withholding	(2,050)	(323)	(298)
Share repurchases, retirements	—	—	(204)
Dividends paid	(171)	(131)	(116)
Other	54	40	4
Net cash provided by (used in) financing activities	<u>(1,841)</u>	<u>(421)</u>	<u>178</u>
Effect of exchange rate changes on cash and cash equivalents	8	36	(55)
Net increase (decrease) in cash and cash equivalents	(119)	1,622	747
Cash and cash equivalents at beginning of year	3,731	2,109	1,362
Cash and cash equivalents at end of year	<u>\$ 3,612</u>	<u>\$ 3,731</u>	<u>\$ 2,109</u>
Supplemental Cash Flow Information			
Cash paid for:			
Interest	\$ 244	\$ 188	\$ 139
Income taxes, net of refunds	347	234	235
Non-cash item:			
Fair value of acquisition debt assumed	\$ (1,891)	\$ —	\$ —

See Financial Notes

McKESSON CORPORATION

FINANCIAL NOTES

1. Significant Accounting Policies

Nature of Operations: McKesson Corporation (“McKesson,” the “Company,” or “we” and other similar pronouns) is a corporation that delivers medicines, pharmaceutical supplies, information and care management products and services designed to reduce costs and improve quality across the healthcare industry. We conduct our business through two operating segments, McKesson Distribution Solutions and McKesson Technology Solutions, as further described in Financial Note 20, “Segments of Business.”

Basis of Presentation: The consolidated financial statements and accompanying notes are prepared in accordance with U. S. generally accepted accounting principles (“GAAP”). The consolidated financial statements of McKesson include the financial statements of all wholly-owned subsidiaries and majority-owned or controlled companies. We evaluate our ownership, contractual and other interests in entities to determine if they are variable interest entities (“VIEs”), if we have a variable interest in those entities and the nature and extent of those interests. These evaluations are highly complex and involve judgment and the use of estimates and assumptions based on available historical information and management’s judgment, among other factors. Intercompany transactions and balances have been eliminated.

Fiscal Period: The Company’s fiscal year begins on April 1 and ends on March 31. Unless otherwise noted, all references to a particular year shall mean the Company’s fiscal year.

Reclassifications: Certain prior year amounts have been reclassified to conform to the current year presentation.

Use of Estimates: The preparation of financial statements in conformity with U.S. GAAP requires that we make estimates and assumptions that affect the reported amounts in the consolidated financial statements and accompanying notes. Actual amounts could differ from those estimated amounts.

Cash and Cash Equivalents: All highly liquid debt instruments purchased with original maturity of three months or less at the date of acquisition are included in cash and cash equivalents.

We maintain cash and cash equivalents with several financial institutions. Bank deposits may exceed the amount of federal deposit insurance; however, domestic non-interest bearing deposit transaction amounts are fully insured by the Federal Deposit Insurance Corporation regardless of the dollar amount. Cash equivalents may be invested in money market funds. We mitigate the risk of our short-term investment portfolio by investing the majority of funds in U.S. government securities, depositing funds with reputable financial institutions and monitoring risk profiles and investment strategies of money market funds.

Restricted Cash: Cash that is subject to legal restrictions or is unavailable for general operating purposes is classified as restricted cash and is included within prepaid expenses and other in the consolidated balance sheets. At March 31, 2011 and 2010, restricted cash was not material.

Marketable Securities Available for Sale: We carry our marketable securities, which are available for sale, at fair value and they are included in prepaid expenses and other in the consolidated balance sheets. The net unrealized gains and losses, net of the related tax effect, computed in marking these securities to market have been reported within stockholders’ equity. At March 31, 2011 and 2010, marketable securities were not material.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Concentrations of Credit Risk and Receivables: Our trade receivables are subject to a concentration of credit risk with customers primarily in our Distribution Solutions segment. During 2011, sales to our ten largest customers accounted for approximately 51% of our total consolidated revenues. Sales to our two largest customers, CVS Caremark Corporation (“CVS”) and Rite Aid Corporation (“Rite Aid”), accounted for approximately 14% and 11% of our total consolidated revenues. At March 31, 2011, accounts receivable from our ten largest customers were approximately 43% of total accounts receivable. Accounts receivable from CVS, Wal-Mart Stores, Inc. (“Walmart”) and Rite Aid were approximately 13%, 10% and 9% of total accounts receivable. As a result, our sales and credit concentration is significant. A default in payment, a material reduction in purchases from these, or any other large customers or the loss of a large customer could have a material adverse impact on our financial condition, results of operations and liquidity. In addition, trade receivables are subject to a concentration of credit risk with customers in the institutional, retail and healthcare provider sectors, which can be affected by a downturn in the economy and changes in reimbursement policies. This credit risk is mitigated by the size and diversity of the customer base as well as its geographic dispersion. We estimate the receivables for which we do not expect full collection based on historical collection rates and ongoing evaluations of the creditworthiness of our customers. An allowance is recorded in our consolidated financial statements for these amounts.

Financing Receivables: We assess and monitor credit risk associated with financing receivables, namely lease and notes receivables, through regular review of our collection experience in determining our allowance for loan losses. On an ongoing basis, we also evaluate credit quality of our financing receivables utilizing aging of receivables and write-offs, as well as consider existing economic conditions, to determine if an allowance is necessary. As of March 31, 2011, financing receivables and the related allowance were not material to our consolidated financial statements.

Inventories: We report inventories at the lower of cost or market (“LCM”). Inventories for our Distribution Solutions segment consist of merchandise held for resale. For our Distribution Solutions segment, the majority of the cost of domestic inventories is determined using the last-in, first-out (“LIFO”) method and the cost of Canadian inventories is determined using the first-in, first-out (“FIFO”) method. Technology Solutions segment inventories consist of computer hardware with cost determined by the standard cost method. Rebates, fees, cash discounts, allowances, chargebacks and other incentives received from vendors are generally accounted for as a reduction in the cost of inventory and are recognized when the inventory is sold.

The LIFO method was used to value approximately 87% of our inventories at March 31, 2011 and 2010. At March 31, 2011 and 2010, our LIFO reserves, net of LCM adjustments, were \$96 million and \$93 million. LIFO reserves include both pharmaceutical and non-pharmaceutical products. In 2011, 2010 and 2009, we recognized net LIFO expense of \$3 million, \$8 million and \$8 million within our consolidated statements of operations. In 2011, our \$3 million net LIFO expense related to our non-pharmaceutical products. A LIFO expense is recognized when the net effect of price increases on branded pharmaceuticals and non-pharmaceutical products held in inventory exceeds the impact of price declines and shifts towards generic pharmaceuticals, including the effect of branded pharmaceutical products that have lost market exclusivity. A LIFO credit is recognized when the net effect of price declines and shifts towards generic pharmaceuticals exceeds the impact of price increases on branded pharmaceuticals and non-pharmaceutical products held in inventory.

We believe that the FIFO inventory costing method provides a reasonable estimation of the current cost of replacing inventory (i.e., “market”). As such, our LIFO inventory is valued at the lower of LIFO or inventory as valued under FIFO. Primarily due to continued net deflation in generic pharmaceutical inventories, pharmaceutical inventories at LIFO were \$156 million and \$112 million higher than FIFO as of March 31, 2011 and 2010. As a result, in 2011 and 2010, we recorded LCM charges of \$44 million and \$5 million in cost of sales within our consolidated statements of operations to adjust our LIFO inventories to market.

Shipping and Handling Costs: We include all costs to warehouse, pick, pack and deliver inventory to our customers in distribution expenses.

Property, Plant and Equipment: We state our property, plant and equipment at cost and depreciate them under the straight-line method at rates designed to distribute the cost of properties over estimated service lives ranging from one to 30 years.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Capitalized Software Held for Sale: Development costs for software held for sale, which primarily pertain to our Technology Solutions segment, are capitalized once a project has reached the point of technological feasibility. Completed projects are amortized after reaching the point of general availability using the straight-line method based on an estimated useful life of approximately three years. At each balance sheet date, or earlier if an indicator of an impairment exists, we evaluate the recoverability of unamortized capitalized software costs based on estimated future undiscounted revenues net of estimated related costs over the remaining amortization period. At the end of the second quarter of 2010, our Horizon Enterprise Revenue Management™ (“HzERM”) software product became generally available. In October 2010, we decreased our estimated revenues over the next 24 months for our HzERM software product and as a result, concluded that the estimated future revenues, net of estimated related costs, were insufficient to recover its carrying value. Accordingly, we recorded a \$72 million non-cash impairment charge in the second quarter of 2011 within our Technology Solutions segment’s cost of sales to reduce the carrying value of the software product to its net realizable value.

Additional information regarding our capitalized software expenditures is as follows:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Amounts capitalized	\$ 64	\$ 75	\$ 74
Amortization expense	75	67	50
Impairment charge	72	—	—
Third-party royalty fees paid	72	63	50

Goodwill: Goodwill is tested for impairment on an annual basis or more frequently if indicators for potential impairment exist. Impairment testing is conducted at the reporting unit level, which is generally defined as a component - one level below our Distribution Solutions and Technology Solutions operating segments, for which discrete financial information is available and segment management regularly reviews the operating results of that unit. Components that have essentially similar operations, products, services and customers are aggregated as a single reporting unit.

Impairment tests require that we first compare the carrying value of our reporting units to the estimated fair value of the reporting units. If the carrying value exceeds the fair value, a second step is performed to calculate the amount of impairment, which would be recorded as a charge in the consolidated statements of operations. The fair value of a reporting unit is based upon a number of considerations including projections of revenues, earnings and discounted cash flows and determination of market value multiples for similar businesses or guideline companies whose securities are actively traded in public markets. The discount rate used for cash flows reflects capital market conditions and the specific risks associated with the business. In addition, we compare the aggregate of the reporting units’ fair value to the Company’s market capitalization as a further corroboration of the fair value. The testing requires a complex series of assumptions and judgment by management in projecting future operating results, selecting guideline companies for comparisons and assessing risks. The use of alternative assumptions and estimates could affect the fair values and change the impairment determinations. There were no goodwill impairments during 2011, 2010, or 2009.

Intangible assets: Currently all of our intangible assets are subject to amortization and are generally amortized on a straight line basis over their estimated useful lives, ranging from one to twenty years. We review identifiable amortizable intangible assets for impairment whenever events or changes in circumstances indicate that the carrying value of the assets may not be recoverable. Determination of recoverability is based on the lowest level of identifiable estimated undiscounted cash flows resulting from use of the asset and its eventual disposition. Measurement of any impairment loss is based on the excess of the carrying value of the asset over its fair value. There were no material impairments of intangible assets during 2011, 2010 or 2009.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Capitalized Software Held for Internal Use: We capitalize costs of software held for internal use during the application development stage of a project and amortize those costs over the assets' estimated useful lives ranging from one to ten years. As of March 31, 2011 and 2010, capitalized software held for internal use was \$446 million and \$483 million, net of accumulated amortization of \$778 million and \$665 million, and was included in other assets in the consolidated balance sheets.

Insurance Programs: Under our insurance programs, we seek to obtain coverage for catastrophic exposures as well as those risks required to be insured by law or contract. It is our policy to retain a significant portion of certain losses primarily related to workers' compensation and comprehensive general, product and vehicle liability. Provisions for losses expected under these programs are recorded based upon our estimate of the aggregate liability for claims incurred as well as for claims incurred but not yet reported. Such estimates utilize certain actuarial assumptions followed in the insurance industry.

Revenue Recognition: Revenues for our Distribution Solutions segment are recognized when product is delivered and title passes to the customer or when services have been rendered and there are no further obligations to customers.

Revenues are recorded net of sales returns, allowances, rebates and other incentives. Our sales return policy generally allows customers to return products only if they can be resold for value or returned to suppliers for full credit. Sales returns are accrued based on estimates at the time of sale to the customer. Sales returns from customers were approximately \$1.4 billion in 2011, and \$1.2 billion in 2010 and 2009. Taxes collected from customers and remitted to governmental authorities are presented on a net basis; that is, they are excluded from revenues.

The revenues for our Distribution Solutions segment include large volume sales of pharmaceuticals to a limited number of large customers who warehouse their own product. We order bulk product from the manufacturer, receive and process the product through our central distribution facility and deliver the bulk product (generally in the same form as received from the manufacturer) directly to our customers' warehouses. Sales to customers' warehouses amounted to \$18.6 billion in 2011, \$21.4 billion in 2010, and \$25.8 billion in 2009. We also record revenues for direct store deliveries from most of these same customers. Direct store deliveries are shipments from the manufacturer to our customers of a limited category of products that require special handling. We assume the primary liability to the manufacturer for these products.

Revenues are recorded gross when we are the primary party obligated in the transaction, take title to and possession of the inventory, are subject to inventory risk, have latitude in establishing prices, assume the risk of loss for collection from customers as well as delivery or return of the product, are responsible for fulfillment and other customer service requirements, or the transactions have several but not all of these indicators.

Our Distribution Solutions segment also engages in multiple-element arrangements, which may contain a combination of various products and services. Revenue from a multiple element arrangement is allocated to the separate elements based on estimates of fair value and recognized in accordance with the revenue recognition criteria applicable to each element. If fair value cannot be established for any undelivered element, all of the arrangement's revenue is deferred until delivery of the last element has occurred and services have been performed or until fair value can objectively be determined for any remaining undelivered elements.

Revenues for our Technology Solutions segment are generated primarily by licensing software and software systems (consisting of software, hardware and maintenance support), and providing outsourcing and professional services. Revenue for this segment is recognized as follows:

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Software systems are marketed under information systems agreements as well as service agreements. Perpetual software arrangements are recognized at the time of delivery or under the percentage-of-completion method based on the terms and conditions in the contract. Contracts accounted for under the percentage-of-completion method are generally measured based on the ratio of labor costs incurred to date to total estimated labor costs to be incurred. Changes in estimates to complete and revisions in overall profit estimates on these contracts are charged to earnings in the period in which they are determined. We accrue for contract losses if and when the current estimate of total contract costs exceeds total contract revenue.

Hardware revenues are generally recognized upon delivery. Revenue from multi-year software license agreements is recognized ratably over the term of the agreement. Software implementation fees are recognized as the work is performed or under the percentage-of-completion method. Maintenance and support agreements are marketed under annual or multi-year agreements and are recognized ratably over the period covered by the agreements. Subscription, content and transaction processing fees are generally marketed under annual and multi-year agreements and are recognized ratably over the contracted terms beginning on the service start date for fixed fee arrangements and recognized as transactions are performed beginning on the service start date for per-transaction fee arrangements. Remote processing service fees are recognized monthly as the service is performed. Outsourcing service revenues are recognized as the service is performed.

We also offer certain products on an application service provider basis, making our software functionality available on a remote hosting basis from our data centers. The data centers provide system and administrative support, as well as hosting services. Revenue on products sold on an application service provider basis is recognized on a monthly basis over the term of the contract beginning on the service start date of products hosted.

This segment also engages in multiple-element arrangements, which may contain any combination of software, hardware, implementation or consulting services, or maintenance services. When some elements are delivered prior to others in an arrangement and vendor-specific objective evidence of fair value ("VSOE") exists for the undelivered elements, revenue for the delivered elements is recognized upon delivery of such items. The segment establishes VSOE for hardware and implementation and consulting services based on the price charged when sold separately, and for maintenance services, based on renewal rates offered to customers. Revenue for the software element is recognized under the residual method only when fair value has been established for all of the undelivered elements in an arrangement. If fair value cannot be established for any undelivered element, all of the arrangement's revenue is deferred until the delivery of the last element or until the fair value of the undelivered element is determinable.

Our Technology Solutions segment also includes revenues from disease management programs provided to various states' Medicaid programs. These service contracts include provisions for achieving certain cost-savings and clinical targets. If the targets are not met for certain of these contracts, a portion, or all, of the revenue must be refunded to the customer. We recognize revenue during the term of the contract by assessing actual performance against contractual targets and then determining the amount the customer would be legally obligated to pay if the contract terminated as of the measurement date. These assessments include estimates of medical claims and other data in accordance with the contract methodology. Because complete data is unavailable until six to nine months after the measurement period, there is generally a significant time delay between recording the accrual and the final settlement of the contract. If data is insufficient to assess performance or we have not met the targets, we defer recognition of the revenue. As of March 31, 2011 and 2010, we had deferred \$25 million and \$26 million related to these types of contracts, which was included in deferred revenue in the consolidated balance sheets. We generally have been successful in achieving performance targets under these agreements.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Supplier Incentives: Fees for service and other incentives received from suppliers, relating to the purchase or distribution of inventory, are generally reported as a reduction to cost of goods sold. We consider these fees and other incentives to represent product discounts and as a result, the amounts are recorded as a reduction of product cost and are recognized through cost of goods sold upon the sale of the related inventory.

Supplier Reserves: We establish reserves against amounts due from suppliers relating to various price and rebate incentives, including deductions or billings taken against payments otherwise due to them. These reserve estimates are established based on judgment after considering the status of current outstanding claims, historical experience with the suppliers, the specific incentive programs and any other pertinent information available. We evaluate the amounts due from suppliers on a continual basis and adjust the reserve estimates when appropriate based on changes in factual circumstances. As of March 31, 2011 and 2010, supplier reserves were \$102 million and \$89 million. The ultimate outcome of any outstanding claim may be different than our estimate. All of the supplier reserves at March 31, 2011 and 2010 pertain to our Distribution Solutions segment.

Income Taxes: We account for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the financial statements. Under this method, deferred tax assets and liabilities are determined based on the difference between the financial statements and the tax basis of assets and liabilities using enacted tax rates in effect for the year in which the differences are expected to reverse. Tax benefits from uncertain tax positions are recognized when it is more likely than not that the position will be sustained upon examination, including resolutions of any related appeals or litigation processes, based on the technical merits. The amount recognized is measured as the largest amount of tax benefit that is greater than 50 percent likely of being realized upon effective settlements. Deferred taxes are not provided on undistributed earnings of our foreign operations that are considered to be permanently reinvested.

Foreign Currency Translation: Our international subsidiaries generally consider their local currency to be their functional currency. Assets and liabilities of these international subsidiaries are translated into U.S. dollars at year-end exchange rates and revenues and expenses are translated at average exchange rates during the year. Cumulative currency translation adjustments are included in accumulated other comprehensive income or losses in the stockholders' equity section of the consolidated balance sheets. Realized gains and losses from currency exchange transactions are recorded in operating expenses in the consolidated statements of operations and were not material to our consolidated results of operations in 2011, 2010 or 2009.

Derivative Financial Instruments: Derivative financial instruments are used principally in the management of foreign currency and interest rate exposures and are recorded on the consolidated balance sheets at fair value. If a derivative is designated as a fair value hedge, the changes in the fair value of the derivative and of the hedged item attributable to the hedged risk are recognized as a charge or credit to earnings. If the derivative is designated as a cash flow hedge, the effective portions of changes in the fair value of the derivative are recorded in accumulated other comprehensive income or losses and are recognized in the consolidated statements of operations when the hedged item affects earnings. We periodically evaluate hedge effectiveness and ineffective portions of changes in the fair value of cash flow hedges are recognized as a charge or credit to earnings. Derivative instruments not designated as hedges are marked-to-market at the end of each accounting period with the change included in earnings. The volume of activity related to derivative financial instruments was not material for 2011, 2010 and 2009.

Accounts Receivable Sales: At March 31, 2011, we had a \$1.35 billion accounts receivable sales facility ("the Facility"). Through this Facility, McKesson Corporation, the parent company, transfers certain U.S. pharmaceutical trade accounts receivable on a non-recourse basis to a wholly-owned and consolidated subsidiary, which then sells these receivables to a special purpose entity ("SPE"), which is a wholly-owned, bankruptcy-remote subsidiary of McKesson Corporation that is consolidated in our financial statements. This SPE then sells undivided interests in the pool of accounts receivable to third-party purchaser groups, (the "Purchaser Groups"), which include financial institutions and commercial paper conduits.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Prior to April 1, 2010, sales of undivided interests in the receivables by the SPE to the Purchaser Groups were accounted for as sales because we had relinquished control of the receivables. Accounts receivable sold under these transactions were excluded from receivables, net in the accompanying consolidated balance sheets. Fee charges from the Purchaser Groups were recorded within administrative expenses in the consolidated statements of operations.

On April 1, 2010, we adopted amended accounting guidance for transfers of financial assets, including securitization transactions, in which entities have continued exposure to risks related to transferred financial assets. This amendment changed the requirements for derecognizing financial assets and expanded the disclosure requirements for such transactions. The operations of the Facility did not change, however as a result of the amended accounting guidance from April 1, 2010 forward, accounts receivable transactions under our Facility are accounted for as secured borrowings rather than asset sales. Accounts receivable continue to be recognized on our consolidated balance sheet and proceeds from the Purchaser groups are shown as secured borrowings. Commencing in 2011, fee charges from the Purchaser Groups are recorded as interest expense in the consolidated statements of operations.

Share-Based Compensation: We account for all share-based compensation transactions using a fair-value based measurement method. The share-based compensation expense is recognized, for the portion of the awards that is ultimately expected to vest, on a straight-line basis over the requisite service period for those awards with graded vesting and service conditions. For awards with performance conditions and multiple vest dates, we recognize the expense on a graded vesting basis. For awards with performance conditions and a single vest date, we recognize the expense on a straight-line basis. The compensation expense recognized has been classified in the consolidated statements of operations or capitalized on the consolidated balance sheets in the same manner as cash compensation paid to our employees.

Loss Contingencies: We are subject to various claims, other pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of our business. When a loss is considered probable and reasonably estimable, we record a liability in the amount of our best estimate for the ultimate loss. However, the likelihood of a loss with respect to a particular contingency is often difficult to predict and determining a meaningful estimate of the loss or a range of loss may not be practicable based on the information available and the potential effect of future events and decisions by third parties that will determine the ultimate resolution of the contingency. Moreover, it is not uncommon for such matters to be resolved over many years, during which time relevant developments and new information must be reevaluated at least quarterly to determine both the likelihood of potential loss and whether it is possible to reasonably estimate a range of possible loss. When a loss is probable but a reasonable estimate cannot be made, disclosure of the proceeding is provided.

Disclosure also is provided when it is reasonably possible that a loss will be incurred or when it is reasonably possible that the amount of a loss will exceed the recorded provision. We review all contingencies at least quarterly to determine whether the likelihood of loss has changed and to assess whether a reasonable estimate of the loss or range of the loss can be made. As discussed above, development of a meaningful estimate of loss or a range of potential loss is complex when the outcome is directly dependent on negotiations with or decisions by third parties, such as regulatory agencies, the court system and other interested parties. Such factors bear directly on whether it is possible to reasonably estimate a range of potential loss and boundaries of high and low estimate.

Business Combinations: We account for acquired businesses using the acquisition method of accounting, which requires that the assets acquired and liabilities assumed be recorded at the date of acquisition at their respective fair values. Any excess of the purchase price over the estimated fair values of the net assets acquired is recorded as goodwill. Effective April 1, 2009, acquisition-related expenses and restructuring costs are recognized separately from the business combinations and are expensed as incurred. Acquisition-related expenses totaled \$52 million in 2011 and were not material in 2010.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Recently Adopted Accounting Pronouncements

Accounting for Transfers of Financial Assets: On April 1, 2010, we adopted amended accounting guidance for transfers of financial assets, including securitization transactions, in which entities have continued exposure to risks related to transferred financial assets. This amendment changed the requirements for derecognizing financial assets and expanded the disclosure requirements for such transactions. As a result of the amended accounting guidance, from April 1, 2010 forward, accounts receivable transactions under our accounts receivable sales facility are accounted for as secured borrowings rather than asset sales.

Consolidations: On April 1, 2010, we adopted amended accounting guidance for consolidation of VIEs. The new guidance eliminates the quantitative approach previously required for determining the primary beneficiary of a VIE and requires ongoing qualitative reassessments of whether an enterprise is the primary beneficiary, including ongoing assessments of control over such entities. The adoption of this amended guidance did not have a material effect on our consolidated financial statements.

Financing Receivables: On October 1, 2010, we adopted amended accounting guidance which expands disclosures regarding credit quality and the related allowance for credit losses of financing receivables. On January 1, 2011, we adopted additional disclosure requirements regarding activity during a reporting period. The adoption of the amended guidance did not have an impact on our consolidated financial results as these changes relate only to disclosures. Because our financing receivables are not material to our consolidated financial statements, the disclosures required under the new accounting guidance have been omitted from our Financial Notes with the exception of certain accounting policy disclosures which describe how we assess and monitor credit risk associated with our financing receivables.

Fair Value Measurements and Disclosures: In January 2010, the Financial Accounting Standards Board (“FASB”) issued amended standards that clarify and provide additional disclosure requirements related to recurring and non-recurring fair value measurements of assets and liabilities. These standards also amend requirements for employer’s disclosure about post retirement benefit plan assets to conform to the fair value disclosure requirement. On January 1, 2010, we adopted the amended standards, except for the disclosures about the roll-forward of activity in Level 3 (measurement using significant unobservable inputs) fair value measurements, which are effective for us on April 1, 2011. The adoption of the amended guidance did not have a material effect on our consolidated financial statements.

Newly Issued Accounting Pronouncements

Revenue Recognition: In October 2009, the FASB issued amended accounting guidance for multiple-element arrangements. The amended guidance eliminates the use of the residual method and incorporates the use of an estimated selling price to allocate arrangement consideration. The amended guidance will become effective for us for multiple-element arrangements entered into or materially modified on or after April 1, 2011. We do not anticipate the adoption of the amended guidance to have a material effect on our consolidated financial statements.

In October 2009, the FASB issued amended guidance for certain revenue arrangements that include software elements. The guidance amends pre-existing software revenue guidance by removing from its scope tangible products that contain both software and non-software components that function together to deliver the product’s functionality. The amended guidance will become effective for us for revenue arrangements entered into or materially modified on or after April 1, 2011. We do not anticipate the adoption of the amended guidance to have a material effect on our consolidated financial statements.

In April 2010, the FASB issued amended accounting guidance for vendors who apply the milestone method of revenue recognition to research and development arrangements. The amended guidance applies to arrangements with payments that are contingent, at inception, upon achieving substantively uncertain future events or circumstances. The amended guidance is effective on a prospective basis for us for milestones achieved on or after April 1, 2011. We do not anticipate the adoption of the amended guidance to have a material effect on our consolidated financial statements.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

2. Business Combinations

On December 30, 2010, we acquired all of the outstanding shares of US Oncology Holdings, Inc. (“US Oncology”) of The Woodlands, Texas for approximately \$2.1 billion, consisting of cash consideration of \$0.2 billion, net of cash acquired, and the assumption of liabilities with a fair value of \$1.9 billion. As an integrated oncology company, US Oncology is affiliated with community-based oncologists, and works with patients, hospitals, payers and the medical industry across all phases of the cancer research and delivery continuum. The acquisition of US Oncology expands our existing specialty pharmaceutical distribution business and adds practice management services for oncologists. The cash paid at acquisition was funded from cash on hand.

The following table summarizes the preliminary recording of the fair values of the assets acquired and liabilities assumed as of the acquisition date:

<i>(In millions)</i>	Amounts Previously Recognized as of Acquisition Date (Provisional) ⁽¹⁾	Measurement Period Adjustments	Amounts Recognized as of Acquisition Date (Provisional as Adjusted)
Current assets, net of cash acquired	\$ 546	\$ 116	\$ 662
Goodwill	774	34	808
Intangible assets	1,099	(92)	1,007
Other long-term assets	396	(42)	354
Current liabilities	(535)	46	(489)
Current portion of long-term debt	(1,751)	16	(1,735)
Other long-term liabilities	(270)	(68)	(338)
Other stockholders' equity	(15)	(10)	(25)
Net assets acquired, less cash and cash equivalents	\$ 244	\$ —	\$ 244

(1) Represents amounts reported in our Form 10-Q for the quarter ended December 31, 2010.

During the fourth quarter of 2011, the fair value measurements of assets acquired and liabilities assumed as of the acquisition date were revised. Due to the recent timing of the acquisition, these amounts are subject to change within the measurement period as our fair value assessments are finalized.

Included in the purchase price allocation are acquired identifiable intangibles of \$1.0 billion, the fair value of which was determined by using Level 3 inputs, which are estimated using significant unobservable inputs. Acquired intangibles primarily consist of \$0.7 billion of service agreements and \$0.2 billion of customer lists. The estimated weighted average lives of the service agreements, customer lists and total acquired intangibles are 18 years, 10 years and 16 years. The fair value of the debt acquired was determined primarily by using Level 3 inputs, which are estimated using significant unobservable inputs. Refer to Financial Note 11, “Debt and Financing Activities,” for additional information on the assumption and funding of acquired debt. The excess of the purchase price over the net tangible and intangible assets of approximately \$808 million was recorded as goodwill, which primarily reflects the expected future benefits to be realized upon integrating the business.

Financial results for US Oncology have been included in the results of operations within our Distribution Solutions segment beginning in the fourth quarter of 2011. We recorded \$52 million of net acquisition-related expenses in 2011 as follows:

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

<i>(In millions)</i>	Distribution Solutions	Corporate & Interest Expense	Total
Operating expenses:			
Transaction closing expenses	\$ 22	\$ —	\$ 22
Severance and relocation	9	—	9
Other integration expenses	10	2	12
Total operating expenses	41	2	43
Other income: reimbursement of post-acquisition interest expense from former shareholders	—	(16)	(16)
Interest expense: bridge loan fees	—	25	25
Total acquisition-related expenses	\$ 41	\$ 11	\$ 52

On May 21, 2008, we acquired McQueary Brothers Drug Company (“McQueary Brothers”) of Springfield, Missouri for approximately \$190 million. McQueary Brothers is a regional distributor of pharmaceutical, health and beauty products to independent and regional chain pharmacies in the Midwestern U.S. This acquisition expanded our existing U.S. pharmaceutical distribution business. The acquisition was funded with cash on hand. Financial results for McQueary Brothers have been included within our Distribution Solutions segment since the date of acquisition.

The following table summarizes the fair values of the assets acquired and liabilities assumed as of the acquisition date:

<i>(In millions)</i>	
Goodwill	\$ 126
Intangible assets	67
Other assets	89
Accounts payable and other liabilities	(92)
Net assets acquired, less cash and cash equivalents	\$ 190

During the first quarter of 2010, the fair value measurements of assets acquired and liabilities assumed as of the acquisition date were completed. The excess of the purchase price over the net tangible and intangible assets of approximately \$126 million was recorded as goodwill, which primarily reflected the expected future benefits from synergies to be realized upon integrating the business. Included in the purchase price allocation were acquired identifiable intangibles of \$61 million primarily representing a customer relationship with a useful life of 7 years, a trade name of \$2 million with a useful life of less than one year and a not-to-compete agreement of \$4 million with a useful life of 4 years.

During the last three years, we also completed a number of other smaller acquisitions within both of our operating segments. Financial results for our business acquisitions have been included in our consolidated financial statements since their respective acquisition dates. Purchase prices for our business acquisitions have been allocated based on estimated fair values at the date of acquisition.

Goodwill recognized for our business acquisitions is generally not expected to be deductible for tax purposes. Pro forma results of operations for our business acquisitions have not been presented because the effects were not material to the consolidated financial statements on either an individual or an aggregate basis.

3. Share-Based Compensation

We provide share-based compensation for our employees, officers and non-employee directors, including stock options, an employee stock purchase plan, restricted stock units (“RSUs”) and performance-based restricted stock units (“PeRSUs”) (collectively, “share-based awards.”) Most of our share-based awards are granted in the first quarter of each fiscal year.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Compensation expense for the share-based awards is recognized for the portion of awards ultimately expected to vest. We estimate the number of share-based awards, which will ultimately vest primarily based on historical experience. The estimated forfeiture rate established upon grant is re-assessed throughout the requisite service period. As required, the forfeiture estimates are adjusted to reflect actual forfeitures when an award vests. The actual forfeitures in future reporting periods could be higher or lower than current estimates. The weighted-average forfeiture rate was approximately 5% at March 31, 2011.

The compensation expense recognized has been classified in the consolidated statements of operations or capitalized on the consolidated balance sheets in the same manner as cash compensation paid to our employees. There was no material share-based compensation expense capitalized as part of the cost of an asset in 2011, 2010 and 2009.

Impact on Net Income

The components of share-based compensation expense and related tax benefits are as follows:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
RSUs ⁽¹⁾	\$ 79	\$ 47	\$ 60
PeRSUs ⁽²⁾	27	39	13
Stock options	22	19	18
Employee stock purchase plan	9	9	8
Share-based compensation expense	137	114	99
Tax benefit for share-based compensation expense ⁽³⁾	(48)	(41)	(34)
Share-based compensation expense, net of tax	\$ 89	\$ 73	\$ 65

- (1) This expense was primarily the result of PeRSUs awarded in prior years, which converted to RSUs due to the attainment of goals during the applicable years' performance period.
- (2) Represents estimated compensation expense for PeRSUs that are conditional upon attaining performance objectives during the current year's performance period.
- (3) Income tax expense is computed using the tax rates of applicable tax jurisdictions. Additionally, a portion of pre-tax compensation expense is not tax-deductible.

Stock Plans

The 2005 Stock Plan provides our employees, officers and non-employee director's share-based long-term incentives. The 2005 Stock Plan permits the granting of up to 42.5 million shares in the form of stock options, restricted stock, RSUs, PeRSUs and other share-based awards. As of March 31, 2011, 13 million shares remain available for future grant under the 2005 Stock Plan.

Stock Options

Stock options are granted at no less than fair market value and those options granted under the 2005 Stock Plan generally have a contractual term of seven years and follow a four-year vesting schedule.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Compensation expense for stock options is recognized on a straight-line basis over the requisite service period and is based on the grant-date fair value for the portion of the awards that is ultimately expected to vest. We continue to use the Black-Scholes options-pricing model to estimate the fair value of our stock options. Once the fair value of an employee stock option is determined, current accounting practices do not permit it to be changed, even if the estimates used are different from actual. The options-pricing model requires the use of various estimates and assumptions as follows:

- Expected stock price volatility is based on a combination of historical volatility of our common stock and implied market volatility. We believe that this market-based input provides a better estimate of our future stock price movements and is consistent with employee stock option valuation considerations.
- Expected dividend yield is based on historical experience and investors' current expectations.
- The risk-free interest rate for periods within the expected life of the option is based on the constant maturity U.S. Treasury rate in effect at the time of grant.
- Expected life of the options is based primarily on historical employee stock option exercise and other behavior data and reflects the impact of changes in contractual life of current option grants compared to our historical grants.

Weighted-average assumptions used to estimate the fair value of employee stock options were as follows:

	Years Ended March 31,		
	2011	2010	2009
Expected stock price volatility	29%	33%	27%
Expected dividend yield	1.1%	0.7%	0.6%
Risk-free interest rate	3%	2%	3%
Expected life (in years)	5	5	5

The following is a summary of options outstanding at March 31, 2011:

Range of Exercise Prices	Options Outstanding			Options Exercisable	
	Number of Options Outstanding At Year End (In millions)	Weighted- Average Remaining Contractual Life (Years)	Weighted- Average Exercise Price	Number of Options Exercisable at Year End (In millions)	Weighted- Average Exercise Price
\$ 27.35 - \$ 41.02	4	3	\$ 37.26	3	\$ 35.28
\$ 41.03 - \$ 54.70	1	2	45.89	1	46.06
\$ 54.71 - \$ 68.37	4	5	62.76	1	59.95
	9			5	

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

The following table summarizes stock option activity during 2011, 2010 and 2009:

<i>(In millions, except per share data and years)</i>	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value⁽²⁾
Outstanding, March 31, 2008	26	\$ 48.59	3	\$ 298
Granted	1	57.81		
Exercised	(1)	33.49		
Cancelled and forfeited	(7)	78.35		
Outstanding, March 31, 2009	19	39.28	3	33
Granted	2	40.59		
Exercised	(5)	33.34		
Outstanding, March 31, 2010	16	41.26	3	394
Granted	1	67.95		
Exercised	(8)	37.63		
Outstanding, March 31, 2011	9	49.01	4	269
Vested and expected to vest ⁽¹⁾	9	49.01	4	268
Vested and exercisable, March 31, 2011	5	44.19	2	174

- (1) The number of options expected to vest takes into account an estimate of expected forfeitures.
(2) The aggregate intrinsic value is calculated as the difference between the period-end market price of the Company's common stock and the option exercise price, times the number of "in-the-money" option shares.

The following table provides data related to stock option activity:

<i>(In millions, except per share data and years)</i>	Years Ended March 31,		
	2011	2010	2009
Weighted-average grant date fair value per stock option	\$ 18.37	\$ 12.56	\$ 16.16
Aggregate intrinsic value on exercise	\$ 276	\$ 115	\$ 30
Cash received upon exercise	\$ 319	\$ 165	\$ 49
Tax benefits realized related to exercise	\$ 106	\$ 37	\$ 14
Total fair value of shares vested	\$ 21	\$ 16	\$ 13
Total compensation cost, net of estimated forfeitures, related to unvested stock options not yet recognized, pre-tax	\$ 41	\$ 37	\$ 30
Weighted-average period in years over which stock option compensation cost is expected to be recognized	1	1	1

RSUs and PeRSUs

RSUs, which entitle the holder to receive at the end of a vesting term a specified number of shares of the Company's common stock are accounted for at fair value at the date of grant. Total compensation expense for RSUs under our stock plans is determined by the product of the number of shares that are expected to vest and the grant date market price of the Company's common stock. The Compensation Committee determines the vesting terms at the time of grant. These awards generally vest in three to four years. We recognize expense for RSUs with a single vest date on a straight-line basis over the requisite service period. We have elected to expense the grant date fair value of RSUs with only graded vesting and service conditions on a straight-line basis over the requisite service period.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Non-employee directors receive an annual grant of RSUs, which vest immediately and are expensed upon grant. However, issuance of any underlying shares granted prior to the July 2008 Annual Meeting of Stockholders is deferred until the director is no longer performing services for the Company. For those RSUs granted subsequent to July 2008, the director may choose to receive payment immediately or defer receipt of the underlying shares if they meet director stock ownership guidelines. At March 31, 2011, 113,000 RSUs for our directors are vested, but shares have not been issued.

PeRSUs are RSUs for which the number of RSUs awarded may be conditional upon the attainment of one or more performance objectives over a specified period. PeRSUs are accounted for as variable awards until the performance goals are reached and the grant date is established. Total compensation expense for PeRSUs is determined by the product of the number of shares eligible to be awarded and expected to vest, and the market price of the Company's common stock, commencing at the inception of the requisite service period. During the performance period, the compensation expense for PeRSUs is re-computed using the market price and the performance modifier at the end of a reporting period. At the end of the performance period, if the goals are attained, the awards are granted and classified as RSUs and accounted for on that basis. For PeRSUs granted during or prior to 2009, for which the related RSU grant has multiple vesting dates, we recognize the compensation expense of these awards on a graded vesting basis over the requisite aggregate service period of four years. For PeRSUs granted during or after 2009, for which the related RSU has a single vesting date, we recognize compensation expense of these awards on a straight-line basis over the requisite aggregate service period of four years.

The following table summarizes RSU activity during 2011, 2010 and 2009:

<i>(In millions, except per share data)</i>	Shares	Weighted-Average Grant Date Fair Value Per Share
Nonvested, March 31, 2008	3	\$ 54.13
Granted	1	57.38
Vested	(1)	57.61
Nonvested, March 31, 2009	3	\$ 54.70
Granted	2	40.94
Vested	(1)	50.42
Nonvested, March 31, 2010	4	\$ 49.21
Granted	3	67.84
Vested	(1)	61.05
Nonvested, March 31, 2011	6	\$ 57.79

The following table provides data related to RSU activity:

<i>(Dollars in millions)</i>	Years Ended March 31,		
	2011	2010	2009
Total fair value of shares vested	\$ 43	\$ 74	\$ 101
Total compensation cost, net of estimated forfeitures, related to nonvested RSU awards not yet recognized, pre-tax	\$ 131	\$ 61	\$ 52
Weighted-average period in years over which RSU cost is expected to be recognized	2	2	1

In May 2010, the Compensation Committee approved 1 million PeRSU target share units representing the base number of awards that could be granted, if goals are attained, and would be granted in the first quarter of 2012 (the "2011 PeRSU"). These target share units are not included in the table above as they have not been granted in the form of RSUs. As of March 31, 2011, the total compensation cost, net of estimated forfeitures, related to nonvested 2011 PeRSUs not yet recognized was approximately \$93 million, pre-tax (based on the period-end market price of the Company's common stock) and the weighted-average period over which the cost is expected to be recognized is 3 years.

McKESSON CORPORATION
FINANCIAL NOTES (Continued)

Employee Stock Purchase Plan (“ESPP”)

The Company has an ESPP under which 16 million shares have been authorized for issuance. The ESPP allows eligible employees to purchase shares of our common stock through payroll deductions. The deductions occur over three-month purchase periods and the shares are then purchased at 85% of the market price at the end of each purchase period. Employees are allowed to terminate their participation in the ESPP at any time during the purchase period prior to the purchase of the shares. The 15% discount provided to employees on these shares is included in compensation expense. The shares related to funds outstanding at the end of a quarter are included in the calculation of diluted weighted average shares outstanding. These amounts have not been significant. In 2011, 2010 and 2009, 1 million shares were issued under the ESPP and 2 million shares remain available for issuance at March 31, 2011.

4. Other Income, Net

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Interest income	\$ 18	\$ 16	\$ 31
Equity in (loss) earnings, net ⁽¹⁾	(6)	6	7
Reimbursement of post-acquisition interest expense	16	—	—
Gain on sale of investment ⁽¹⁾	—	17	24
Impairment of investments ⁽¹⁾	—	—	(63)
Other, net	8	4	13
Total	\$ 36	\$ 43	\$ 12

(1) Recorded within our Distribution Solutions segment.

In 2011, other income, net included a credit of \$16 million representing the reimbursement of post-acquisition interest expense by the former shareholders of US Oncology, which is recorded in Corporate.

In 2010, we sold our 50% equity interest in McKesson Logistics Solutions LLC (“MLS”), a Canadian logistics company, for a pre-tax gain of \$17 million or \$14 million after-tax.

In 2009, we sold our 42% equity interest in Verispan LLC, a data analytics company, for a pre-tax gain of \$24 million or \$14 million after-tax.

We evaluate our investments for impairment when events or changes in circumstances indicate that the carrying values of such investments may have experienced an other-than-temporary decline in value. In 2009, we determined that the fair value of our interest in Parata Systems, LLC (“Parata”) was lower than its carrying value and that such impairment was other-than-temporary. Fair value was determined using a discounted cash flow analysis based on estimated future results and market capitalization rates. We determined the impairment was other-than-temporary based on our assessment of all relevant factors including deterioration in the investee’s financial condition and weak market conditions. As a result, we recorded a pre-tax impairment of \$58 million (\$55 million after-tax) on this investment, which is recorded within other income, net in the consolidated statements of operations. Our investment in Parata is accounted for under the equity method of accounting

In 2009, we also recorded a pre-tax impairment of \$5 million (\$5 million after-tax) on another equity-held investment.

McKESSON CORPORATION
FINANCIAL NOTES (Continued)

5. Income Taxes

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Income from continuing operations before income taxes			
U.S.	\$ 1,161	\$ 1,340	\$ 623
Foreign	474	524	441
Total income from continuing operations before income taxes	\$ 1,635	\$ 1,864	\$ 1,064

The provision for income taxes related to continuing operations consists of the following:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Current			
Federal	\$ 283	\$ 255	\$ 177
State and local	40	25	(111)
Foreign	54	44	35
Total current	377	324	101
Deferred			
Federal	121	269	69
State and local	1	13	62
Foreign	6	(5)	9
Total deferred	128	277	140
Income tax provision	\$ 505	\$ 601	\$ 241

In 2011, income tax expense included \$34 million of net income tax benefits for discrete items, which primarily relate to the recognition of previously unrecognized tax benefits and accrued interest.

In 2009, income tax expense included \$111 million of net income tax benefits for discrete items of which, \$87 million represents a non-cash benefit. These benefits primarily relate to the recognition of previously unrecognized tax benefits and related accrued interest. The recognition of these discrete items was primarily due to the lapsing of the statutes of limitations.

The U.S. Internal Revenue Service (“IRS”) is currently examining our fiscal years 2003 through 2006 and we anticipate the field work will be completed and they will issue the Revenue Agent Report in our first quarter of fiscal 2012. We have received assessments from the Canada Revenue Agency (“CRA”) for a total of \$169 million related to transfer pricing for 2003 through 2007. Payments of most of the assessments to the CRA have been made to stop the accrual of interest. We have appealed the assessment for 2003 to the Tax Court of Canada and have filed a notice of objection for 2004 through 2007. If we are not successful in resolving these issues with the CRA, a trial date has been set for October 17, 2011 with the Tax Court of Canada. We believe that we have adequately provided for any potential adverse results relating to the IRS and CRA examinations. However, the final resolution of these issues could result in an increase or decrease to income tax expense.

In nearly all jurisdictions, the tax years prior to 2003 are no longer subject to examination.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Significant judgments and estimates are required in determining the consolidated income tax provision. Although our major taxing jurisdictions are the U.S. and Canada, we are subject to income taxes in numerous foreign jurisdictions. Annually, we file a federal consolidated income tax return with the IRS and over 1,200 returns with various state and foreign jurisdictions. Our income tax expense, deferred tax assets and liabilities reflect management's best assessment of estimated current and future taxes to be paid.

The reconciliation between our effective tax rate on income from continuing operations and statutory tax rate is as follows:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Income tax provision at federal statutory rate	\$ 572	\$ 652	\$ 372
State and local income taxes net of federal tax benefit	33	25	18
Foreign income taxed at various rates	(105)	(144)	(120)
Unrecognized tax benefits and settlements	14	53	(21)
Tax credits	(16)	(8)	(20)
Other, net	7	23	12
Income tax provision	\$ 505	\$ 601	\$ 241

At March 31, 2011, undistributed earnings of our foreign operations totaling \$2.7 billion were considered to be permanently reinvested. No deferred tax liability has been recognized on the basis difference created by such earnings since it is our intention to utilize those earnings in the foreign operations as well as to fund certain research and development activities for an indefinite period of time. The determination of the amount of deferred taxes on these earnings is not practicable because the computation would depend on a number of factors that cannot be known until a decision to repatriate the earnings is made.

Deferred tax balances consisted of the following:

<i>(In millions)</i>	March 31,	
	2011	2010
Assets		
Receivable allowances	\$ 48	\$ 56
Deferred revenue	107	107
Compensation and benefit related accruals	409	349
AWP litigation accrual	97	56
Loss and credit carryforwards	494	481
Other	241	235
Subtotal	1,396	1,284
Less: valuation allowance	(99)	(97)
Total assets	<u>\$ 1,297</u>	<u>\$ 1,187</u>
Liabilities		
Basis difference for inventory valuation and other assets	\$ (1,450)	\$ (1,363)
Basis difference for fixed assets and systems development costs	(221)	(210)
Intangibles	(532)	(209)
Other	(58)	(63)
Total liabilities	(2,261)	(1,845)
Net deferred tax liability	<u>\$ (964)</u>	<u>\$ (658)</u>
Current net deferred tax liability	\$ (1,036)	\$ (975)
Long-term net deferred tax asset	72	317
Net deferred tax liability	<u>\$ (964)</u>	<u>\$ (658)</u>

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

We have federal, state and foreign income tax net operating loss carryforwards of \$267 million, \$2.9 billion and \$239 million. The federal and state net operating losses will expire at various dates from 2012 through 2031. Substantially all of our foreign net operating losses have indefinite lives. We believe that it is more likely than not that the benefit from certain federal, state and foreign net operating loss carryforwards may not be realized. In recognition of this risk, we have provided valuation allowances of \$16 million and \$58 million on the deferred tax assets relating to these state and foreign net operating loss carryforwards. We also have state capital loss carryforwards of \$27 million which will expire at various dates from 2012 through 2015.

We also have domestic income tax credit carryforwards of \$191 million which are primarily alternative minimum tax credit carryforwards that have an indefinite life. However, we believe that it is more likely than not that the benefit from certain state tax credits of \$15 million may not be fully realized. In recognition of this risk, we have provided a valuation allowance of \$2 million. In addition, we have Canadian research and development credit carryforwards of \$12 million. The Canadian research and development credits will expire at various dates from 2018 to 2031.

On December 30, 2010, we acquired all of the outstanding shares of US Oncology. As part of acquisition accounting, we recorded net deferred tax liabilities of \$170 million on the opening balance sheet. The \$170 million included deferred tax liabilities of \$339 million for basis differences in intangible assets, offset by deferred tax assets of \$83 million for federal and state net operating losses and \$86 million for other future deductible and taxable differences.

The following table summarizes the activity related to our gross unrecognized tax benefits for the last three years:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Unrecognized tax benefits at beginning of period	\$ 619	\$ 526	\$ 496
Additions based on tax positions related to prior years	32	50	77
Reductions based on tax positions related to prior years	(60)	(12)	—
Additions based on tax positions related to current year	50	72	61
Reductions based on settlements	(6)	(16)	(41)
Reductions based on the lapse of the applicable statutes of limitations	—	(1)	(67)
Unrecognized tax benefits at end of period	\$ 635	\$ 619	\$ 526

Of the total \$635 million in unrecognized tax benefits at March 31, 2011, \$415 million would reduce income tax expense and the effective tax rate if recognized. During the next twelve months, it is reasonably possible that audit resolutions and the expiration of statutes of limitations could potentially reduce our unrecognized tax benefits by up to \$88 million. However, this amount may change because we continue to have ongoing negotiations with various taxing authorities throughout the year.

We report interest and penalties on tax deficiencies as income tax expense. At March 31, 2011, before any tax benefits, our accrued interest on unrecognized tax benefits amounted to \$136 million. We recognized an income tax expense of \$16 million, before any tax effect, related to interest in our consolidated statements of operations during 2011. We have no material amounts accrued for penalties.

6. Discontinued Operation

In July 2010, our Technology Solutions segment sold its wholly-owned subsidiary, McKesson Asia Pacific Pty Limited (“MAP”), a provider of phone and web-based healthcare services in Australia and New Zealand, for net sales proceeds of \$109 million. The divestiture generated a pre-tax and after-tax gain of \$95 million and \$72 million. As a result of the sale, we were able to utilize capital loss carry-forwards for which we previously recorded a valuation allowance of \$15 million. The release of the valuation allowance is included as a tax benefit in our after-tax gain on the divestiture. The after-tax gain on disposition was recorded as a discontinued operation in our statement of operations in 2011. The historical financial operating results and net assets of MAP were not material to our consolidated financial statements for all periods presented.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

7. Earnings Per Common Share

Basic earnings per common share are computed by dividing net income by the weighted average number of common shares outstanding during the reporting period. Diluted earnings per common share are computed similar to basic earnings per common share except that it reflects the potential dilution that could occur if dilutive securities or other obligations to issue common stock were exercised or converted into common stock. Potentially dilutive securities primarily include outstanding stock options, RSUs and PeRSUs.

The computations for basic and diluted earnings per common share from continuing and discontinued operations are as follows:

<i>(In millions, except per share amounts)</i>	Years Ended March 31,		
	2011	2010	2009
Income from continuing operations	\$ 1,130	\$ 1,263	\$ 823
Discontinued operation - gain on sale, net of tax	72	—	—
Net income	\$ 1,202	\$ 1,263	\$ 823
Weighted average common shares outstanding:			
Basic	258	269	275
Effect of dilutive securities:			
Options to purchase common stock	3	3	3
Restricted stock units	2	1	1
Diluted	263	273	279
Earnings per common share: ⁽¹⁾			
Basic			
Continuing operations	\$ 4.37	\$ 4.70	\$ 2.99
Discontinued operation, net	0.28	—	—
Total	\$ 4.65	\$ 4.70	\$ 2.99
Diluted			
Continuing operations	\$ 4.29	\$ 4.62	\$ 2.95
Discontinued operation, net	0.28	—	—
Total	\$ 4.57	\$ 4.62	\$ 2.95

(1) Certain computations may reflect rounding adjustments.

Approximately 6 million, 8 million and 5 million of potentially dilutive securities were excluded from the computations of diluted net earnings per common share in 2011, 2010 and 2009, as they were anti-dilutive.

8. Receivables, Net

<i>(In millions)</i>	March 31,	
	2011	2010
Customer accounts	\$ 7,982	\$ 7,256
Other	1,341	968
Total	9,323	8,224
Allowances	(136)	(149)
Net	\$ 9,187	\$ 8,075

The allowances are primarily for estimated uncollectible accounts and sales returns to vendors.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

9. Property, Plant and Equipment, Net

<i>(In millions)</i>	March 31,	
	2011	2010
Land	\$ 70	\$ 50
Building, machinery, equipment and other	1,973	1,808
Total property, plant and equipment	2,043	1,858
Accumulated depreciation	(1,052)	(1,007)
Property, plant and equipment, net	\$ 991	\$ 851

10. Goodwill and Intangible Assets, Net

Changes in the carrying amount of goodwill were as follows:

<i>(In millions)</i>	Distribution Solutions	Technology Solutions	Total
Balance, March 31, 2009	\$ 1,869	\$ 1,659	\$ 3,528
Goodwill acquired	7	4	11
Acquisition accounting and other adjustments	(26)	—	(26)
Foreign currency translation adjustments	21	34	55
Balance, March 31, 2010	\$ 1,871	\$ 1,697	\$ 3,568
Goodwill acquired	819	8	827
Acquisition accounting and other adjustments	(32)	(13)	(45)
Foreign currency translation adjustments	4	10	14
Balance, March 31, 2011	\$ 2,662	\$ 1,702	\$ 4,364

Information regarding intangible assets is as follows:

<i>(In millions)</i>	March 31, 2011				March 31, 2010		
	Weighted Average Remaining Amortization Period (years)	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Customer lists	7	\$ 1,057	\$ (444)	\$ 613	\$ 832	\$ (347)	\$ 485
Service agreements	17	723	(11)	712	—	—	—
Trademarks and trade names	14	76	(31)	45	45	(20)	25
Technology	3	204	(170)	34	190	(156)	34
Other	9	76	(24)	52	29	(22)	7
Total		\$ 2,136	\$ (680)	\$ 1,456	\$ 1,096	\$ (545)	\$ 551

Amortization expense of intangible assets was \$132 million, \$121 million and \$128 million for 2011, 2010 and 2009. Estimated annual amortization expense of intangible assets is as follows: \$186 million, \$168 million, \$154 million, \$136 million and \$115 million for 2012 through 2016, and \$697 million thereafter. All intangible assets were subject to amortization as of March 31, 2011 and 2010.

McKESSON CORPORATION
FINANCIAL NOTES (Continued)

11. Debt and Financing Activities

<i>(In millions)</i>	March 31,	
	2011	2010
7.75% Notes due February, 2012	\$ 399	\$ 399
5.25% Notes due March, 2013	499	499
6.50% Notes due February, 2014	350	350
3.25% Notes due March, 2016	598	—
5.70% Notes due March, 2017	499	499
7.50% Notes due February, 2019	349	349
4.75% Notes due March, 2021	598	—
7.65% Debentures due March, 2027	175	175
6.00% Notes due March, 2041	493	—
Other	44	25
Total debt	4,004	2,296
Less current portion	(417)	(3)
Total long-term debt	\$ 3,587	\$ 2,293

Senior Bridge Term Loan Facility

In connection with our execution of an agreement to acquire US Oncology, in November 2010 we entered into a \$2.0 billion unsecured Senior Bridge Term Loan Agreement (“Bridge Loan”). In December 2010, we reduced the Bridge Loan commitment to \$1.0 billion. On January 31, 2011, we borrowed \$1.0 billion under the Bridge Loan. On February 28, 2011, we repaid the funds obtained under the Bridge Loan with long-term debt, as further described below, and the Senior Bridge Term Loan Agreement was terminated. During the time it was outstanding, the Bridge Loan bore interest of 1.76%, which was based on the London Interbank Offered Rate plus a margin based on the Company’s credit rating. Bridge Loan fees of \$25 million were included in interest expense.

US Oncology Debt Acquired

Upon our purchase of US Oncology in December 2010, we assumed the outstanding debt of US Oncology Holdings, Inc. and its wholly-owned subsidiary US Oncology, Inc. Immediately prior to our acquisition, US Oncology Holdings, Inc. called for redemption all of its outstanding Senior Unsecured Floating Rate Toggle Notes due 2012 and US Oncology, Inc. called for redemption all of its outstanding 9.125% Senior Secured Notes due 2017 and 10.75% Senior Subordinated Notes due 2014. In the fourth quarter of 2011, we paid interest of \$50 million and redeemed these notes, including the remaining accrued interest for \$1,738 million using cash on hand and borrowings under our Bridge Loan.

Long-Term Debt

On February 28, 2011, we issued 3.25% notes due March 1, 2016 in an aggregate principal amount of \$600 million, 4.75% notes due March 1, 2021 in an aggregate principal amount of \$600 million and 6.00% notes due March 1, 2041 in an aggregate principal amount of \$500 million. Interest is payable on March 1 and September 1 of each year beginning on September 1, 2011. We utilized net proceeds, after discounts and offering expenses, of \$1,673 million from the issuance of these notes (each note constitutes a “Series”) for general corporate purposes, including the repayment of borrowings under the Bridge Loan.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

On February 12, 2009, we issued 6.50% notes due February 15, 2014 in an aggregate principal amount of \$350 million and 7.50% notes due February 15, 2019 in an aggregate principal amount of \$350 million. Interest is payable on February 15 and August 15 of each year. We utilized net proceeds, after discounts and offering expenses, of \$693 million from the issuance of these notes (each note constitutes a “Series”) for general corporate purposes.

Each Series constitutes an unsecured and unsubordinated obligation of the Company and ranks equally with all of the Company’s existing and future unsecured and unsubordinated indebtedness outstanding from time-to-time. Each Series is governed by materially similar indentures and an officers’ certificate specifying certain terms of each Series.

Upon 30 days notice to holders of a Series, we may redeem that Series at any time prior to maturity, in whole or in part, for cash at redemption prices that include accrued and unpaid interest and a make-whole premium, as specified in the indenture and officers’ certificate relating to that Series. In the event of the occurrence of both (1) a change of control of the Company and (2) a downgrade of a Series below an investment grade rating by each of Fitch Ratings, Moody’s Investors Service, Inc. and Standard & Poor’s Ratings Services within a specified period, an offer will be made to purchase that Series from the holders at a price in cash equal to 101% of the then outstanding principal amount of that Series, plus accrued and unpaid interest to, but not including, the date of repurchase. The indenture and the related officers’ certificate for each Series, subject to the exceptions and in compliance with the conditions as applicable, specify that we may not incur liens, enter into sale and leaseback transactions or consolidate, merge or sell all or substantially all of our assets. The indentures also contain customary events and default provisions.

In March 2010, we repaid our \$215 million 9.13% Series C Senior Notes which had matured.

Scheduled future principal payments of long-term debt are \$417 million in 2012, \$509 million in 2013, \$352 million in 2014, \$2 million in 2015, \$604 million in 2016 and \$2.1 billion thereafter.

Accounts Receivable Sales Facility

In May 2010, we renewed our accounts receivable sales facility (the “Facility”) for an additional one year period under terms substantially similar to those previously in place, and in doing so, we increased our committed balance from \$1.1 billion to \$1.35 billion. From time-to-time, the available amount of the Facility may be less than \$1.35 billion based on accounts receivable concentration limits and other eligibility requirements. The renewed Facility will expire in May 2011. We anticipate renewing this facility before its expiration.

Through the Facility, McKesson Corporation, the parent company, transfers certain U.S. pharmaceutical trade accounts receivable on a non-recourse basis to a wholly-owned and consolidated subsidiary, which then sells these receivables to a special purpose entity (“SPE”), which is a wholly-owned, bankruptcy-remote subsidiary of McKesson Corporation that is consolidated in our financial statements. This SPE then sells undivided interests in the pool of accounts receivable to third-party purchaser groups (the “Purchaser Groups”), which include financial institutions and commercial paper conduits.

Interests in the pool of accounts receivable that are sold to the Purchaser Groups and accounts receivable retained by the Company are carried at face value, which, due to the short-term nature of our accounts receivable and terms of the Facility, approximates fair value. McKesson receives cash in the amount of the face value for the undivided interests sold. No gain or loss is recorded upon the utilization of the facility as fee charges from the Purchaser Groups are based upon a floating yield rate and the period the undivided interests remain outstanding.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

The Facility contains requirements relating to the performance of the accounts receivable and covenants relating to the SPE and the Company. If we do not comply with these covenants, our ability to use the Facility may be suspended and repayment of any outstanding balances under the Facility may be required. At March 31, 2011, we were in compliance with all covenants. Should we default under the Facility, the Purchaser Groups are entitled to receive only collections on the accounts receivable owned by the SPE.

Prior to 2011, transactions in the Facility were accounted for as sales because we met the requirements of the existing accounting guidance, including relinquishing control of the accounts receivable. Accordingly, accounts receivable sold would have been excluded from accounts receivable, net in the accompanying March 31, 2010 consolidated balance sheet had any balances been outstanding in the Facility at that date. On April 1, 2010, we adopted amended accounting guidance for transfers of financial assets. Transactions under the Facility no longer meet the requirements for sale as defined in the amended accounting guidance primarily because the Company's retained interest in the pool of accounts receivable is subordinated to the Purchaser Groups to the extent there is any outstanding balance in the Facility. Consequently, the related accounts receivable would continue to be recognized on our consolidated balance sheets and proceeds from the Purchaser Groups would be shown as secured borrowings. Commencing in 2011, fee charges from the Purchaser Groups are recorded in interest expense within the consolidated statements of operations. Prior to 2011, these fee charges were recorded in Corporate administrative expenses. Additionally, any proceeds from these accounts receivable transactions would be reflected in the financing section within the statements of cash flows.

We continue servicing the accounts receivable sold. No servicing asset is recorded at the time of utilization of the facility because we do not receive any servicing fees from third parties or other income related to servicing the receivable. We do not record any servicing liability at the time of the utilization of the facility as the accounts receivable collection period is relatively short and the costs of servicing the accounts receivable over the servicing period are insignificant. Servicing costs are recognized as incurred over the servicing period.

Information regarding receivables subject to borrowings as of March 31, 2011 or our outstanding balances related to our interests in accounts receivable sold or qualifying receivables retained as of March 31, 2010 is as follows:

<i>(In millions)</i>	March 31,	
	2011	2010
Receivables subject to borrowings or sold	\$ —	\$ —
Receivables retained, net of allowance for doubtful accounts	N/A	4,887

The following table summarizes the activity related to our interests in accounts receivable sold:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Proceeds from accounts receivable sales	\$ N/A	\$ —	\$ 5,780
Fees and charges ⁽¹⁾	9	11	10

(1) Recorded in interest expense in 2011 and operating expenses in 2010 and 2009 in the consolidated statements of operations.

The delinquency ratio for the qualifying receivables represented less than 1% of the total qualifying receivables as of March 31, 2011 and 2010.

McKESSON CORPORATION
FINANCIAL NOTES (Continued)

Revolving Credit Facility

We have a syndicated \$1.3 billion five-year senior unsecured revolving credit facility, which expires in June 2012. Borrowings under this credit facility bear interest based upon either a Prime rate or the London Interbank Offered Rate. There were no borrowings under this facility in 2011 or 2010 and \$279 million for 2009. As of March 31, 2011 and 2010, there were no amounts outstanding under this facility.

Commercial Paper

There were no commercial paper issuances during 2011 and 2010 and no amount outstanding at March 31, 2011 and 2010. We issued and repaid \$3.3 billion of commercial paper in 2009.

Debt Covenants

Our various borrowing facilities and long-term debt are subject to certain covenants. Our principal debt covenant is our debt to capital ratio under our unsecured revolving credit facility, which cannot exceed 56.5%. If we exceed this ratio, repayment of debt outstanding under the revolving credit facility could be accelerated. As of March 31, 2011, this ratio was 35.7% and we were in compliance with our other financial covenants.

12. Pension Benefits

We maintain a number of qualified and nonqualified defined pension benefit plans and defined contribution plans for eligible employees.

Defined Pension Benefit Plans

Eligible U.S. employees who were employed by the Company prior to December 31, 1996 are covered under the Company-sponsored defined benefit retirement plan. In 1997, we amended this plan to freeze all plan benefits based on each employee's plan compensation and creditable service accrued to that date. The Company has made no annual contributions since this plan was frozen. The benefits for this defined benefit retirement plan are based primarily on age of employees at date of retirement, years of service and employees' pay during the five years prior to retirement. We also have defined benefit pension plans for eligible Canadian and United Kingdom employees as well as an unfunded nonqualified supplemental defined benefit plan for certain U.S. executives. Defined benefit plan assets and obligations are measured as of the Company's fiscal year-end.

The net periodic expense for our pension plans is as follows:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Service cost—benefits earned during the year	\$ 6	\$ 4	\$ 6
Interest cost on projected benefit obligation	31	35	33
Expected return on assets	(29)	(24)	(39)
Amortization of unrecognized actuarial loss, prior service costs and net transitional obligation	28	25	10
Settlement charges and other	—	—	1
Net periodic pension expense	\$ 36	\$ 40	\$ 11

The projected unit credit method is utilized in measuring net periodic pension expense over the employees' service life for the U.S. pension plans. Unrecognized actuarial losses exceeding 10% of the greater of the projected benefit obligation or the market value of assets are amortized straight-line over the average remaining future service periods.

McKESSON CORPORATION
FINANCIAL NOTES (Continued)

Information regarding the changes in benefit obligations and plan assets for our pension plans is as follows:

<i>(In millions)</i>	Years Ended March 31,	
	2011	2010
Change in benefit obligations		
Benefit obligation at beginning of period	\$ 593	\$ 456
Service cost	6	4
Interest cost	31	35
Actuarial loss	21	132
Benefit payments	(32)	(38)
Foreign exchange impact and other	6	4
Benefit obligation at end of period ⁽¹⁾	\$ 625	\$ 593
Change in plan assets		
Fair value of plan assets at beginning of period	\$ 391	\$ 309
Actual return on plan assets	40	97
Employer and participant contributions	11	18
Benefits paid	(32)	(38)
Foreign exchange impact and other	6	5
Fair value of plan assets at end of period	\$ 416	\$ 391
Funded status at end of period ⁽²⁾	\$ (209)	\$ (202)
Amounts recognized on the balance sheet		
Noncurrent assets	\$ 4	\$ —
Current liabilities	(4)	(4)
Noncurrent liabilities	(209)	(198)
Total	\$ (209)	\$ (202)

(1) The benefit obligation is the projected benefit obligation.

(2) The unfunded status of our plans at March 31, 2011 and 2010 was primarily due to the unfavorable effect from the reduction in discount rates.

The accumulated benefit obligations for our pension plans were \$622 million at March 31, 2011 and \$574 million at March 31, 2010. The following table provides the projected benefit obligation, accumulated benefit obligation and fair value of plan assets for all our pension plans with an accumulated benefit obligation in excess of plan assets.

<i>(In millions)</i>	March 31,	
	2011	2010
Projected benefit obligation	\$ 533	\$ 503
Accumulated benefit obligation	529	499
Fair value of plan assets	319	307

McKESSON CORPORATION
FINANCIAL NOTES (Continued)

Amounts recognized in accumulated other comprehensive loss consist of:

<i>(In millions)</i>	March 31,	
	2011	2010
Net actuarial loss	\$ 239	\$ 253
Prior service cost	2	4
Net transition obligation	1	1
Total	\$ 242	\$ 258

Other changes in plan assets and benefit obligations recognized in other comprehensive loss (income) during the reporting periods were as follows:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Net actuarial loss	\$ 10	\$ 59	\$ 121
Prior service credit	—	(2)	—
Amortization of:			
Net actuarial loss	(26)	(23)	(10)
Prior service cost	(2)	(2)	(2)
Total recognized in net periodic benefit cost and other comprehensive loss (income)	\$ (18)	\$ 32	\$ 109

We expect to amortize \$2 million of prior service cost and \$25 million of actuarial loss for the pension plans from stockholders' equity to pension expense in 2012. Comparable 2011 amounts were \$2 million and \$26 million.

Projected benefit obligations relating to our unfunded U.S. plans were \$154 million and \$137 million at March 31, 2011 and 2010. Pension obligations for our unfunded plans are funded based on the recommendations of independent actuaries.

Expected benefit payments for our pension plans are as follows: \$38 million, \$42 million, \$34 million, \$136 million and \$36 million for 2012 to 2016 and \$194 million for 2017 through 2021. Expected benefit payments are based on the same assumptions used to measure the benefit obligations and include estimated future employee service. Expected contributions to be made for our pension plans are \$16 million for 2012.

Weighted-average assumptions used to estimate the net periodic pension expense and the actuarial present value of benefit obligations were as follows:

	Years Ended March 31,		
	2011	2010	2009
Net periodic pension expense			
Discount rates	5.30%	7.68%	5.34%
Rate of increase in compensation	3.75	3.62	3.93
Expected long-term rate of return on plan assets	7.79	7.90	7.75
Benefit obligation			
Discount rates	4.99%	5.33%	7.74%
Rate of increase in compensation	3.74	3.75	3.93

Our U.S. defined benefit pension plan liabilities are valued using a discount rate based on a yield curve developed from a portfolio of high quality corporate bonds rated AA or better whose maturities are aligned with the expected benefit payments of our plans. For March 31, 2011, we used a weighted average discount rate of 4.88%, which represents a decrease of 41 basis points from our 2010 weighted-average discount rate of 5.29%.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Sensitivity to changes in the weighted-average discount rate for our U.S. pension plans is as follows:

<i>(In millions)</i>	One Percentage Point Increase	One Percentage Point Decrease
Increase (decrease) on projected benefit obligation	\$ (36)	\$ 42
Increase (decrease) on net periodic pension cost	(2)	3

Plan Assets

Investment Strategy: The overall objective for McKesson's pension plan assets is to generate long-term investment returns consistent with capital preservation and prudent investment practices, with a diversification of asset types and investment strategies. Periodic adjustments are made to provide liquidity for benefit payments and to rebalance plan assets to their target allocations.

The target allocations for plan assets at March 31, 2011 are 61% equity securities, 32% fixed income securities and 7% to all other types of investments including cash and cash equivalents. The target allocations for plan assets at March 31, 2010 were 59% equity securities, 33% fixed income securities and 8% to all other types of investments including cash and cash equivalents. Equity securities include primarily exchange-traded common stock and preferred stock of companies from diverse industries. Fixed income securities include corporate bonds of companies from diverse industries, government securities, mortgage-backed securities, asset-backed securities and other. Other investments include real estate funds, hedge funds and cash and cash equivalents. Portions of the equity, fixed income and cash and cash equivalent investments are held in commingled funds.

We develop our expected long-term rate of return assumption based on the historical experience of our portfolio and review of projected performance by asset class of broad, publicly traded equity and fixed-income indices. Our target asset allocation was determined based on the risk tolerance characteristics of the plans and at times may be adjusted to achieve our overall investment objectives.

Fair Value Measurements: The following tables represent our pension plan assets as of March 31, 2011 and 2010, using the fair value hierarchy by asset class. The fair value hierarchy has three levels based on the reliability of the inputs used to determine fair value. Level 1 refers to fair values determined based on unadjusted quoted prices in active markets for identical assets. Level 2 refers to fair values estimated using significant other observable inputs and Level 3 includes fair values estimated using significant unobservable inputs.

<i>(In millions)</i>	March 31, 2011			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	\$ 14	\$ 31	\$ —	\$ 45
Equity securities:				
Common and preferred stock	104	1	—	105
Equity commingled funds	—	144	—	144
Fixed income securities:				
Government securities	—	20	—	20
Corporate bonds	—	26	—	26
Mortgage-backed securities	—	28	—	28
Asset-backed securities and other	—	19	—	19
Fixed income commingled funds	—	34	—	34
Other:				
Real estate funds	—	—	5	5
Hedge funds	—	—	5	5
Total	\$ 118	\$ 303	\$ 10	\$ 431
Receivables ⁽¹⁾				19
Payables ⁽¹⁾				(34)
Total				\$ 416

(1) Represents pending trades at March 31, 2011.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

<i>(In millions)</i>	March 31, 2010			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	\$ 10	\$ 17	\$ —	\$ 27
Equity securities:				
Common and preferred stock	104	1	—	105
Equity commingled funds	—	126	—	126
Fixed income securities:				
Government securities	—	23	—	23
Corporate bonds	—	41	—	41
Mortgage-backed securities	—	17	1	18
Asset-backed securities and other	—	15	1	16
Fixed income commingled funds	—	22	—	22
Other:				
Real estate funds	—	—	19	19
Hedge funds	—	—	5	5
Total	\$ 114	\$ 262	\$ 26	\$ 402
Receivables ⁽¹⁾				6
Payables ⁽¹⁾				(17)
Total				\$ 391

(1) Represents pending trades at March 31, 2010.

Cash and cash equivalents – Cash and cash equivalents consist of short-term investment funds that maintain daily liquidity and have a constant unit value of \$1.00. The funds invest in short-term domestic fixed income securities and other securities with debt-like characteristics emphasizing short-term maturities and quality. Cash and cash equivalents are generally classified as Level 1 investments. Some cash and cash equivalents are held in commingled funds, which have a daily net value derived from quoted prices for the underlying securities in active markets; these are classified as Level 2 investments.

Common and preferred stock – This investment class consists of common and preferred shares issued by U.S. and non-U.S. corporations. Common shares are traded actively on exchanges and price quotes are readily available. Preferred shares are not actively traded. Holdings of common shares are generally classified as Level 1 investments. Preferred shares are classified as Level 2 investments.

Equity commingled funds – Some equity securities consisting of common and preferred stock are held in commingled funds, which have daily net asset values derived from quoted prices for the underlying securities in active markets; these are classified as Level 2 investments.

Government securities – This investment class consists of bonds and debentures issued by central governments or federal agencies. Multiple prices and price types are obtained from pricing vendors whenever possible, which enables cross-provider validations. We have obtained an understanding of how these prices are derived, including the nature and observability of the inputs used in deriving such prices. These securities are classified as Level 2 investments.

Corporate bonds – This investment class consists of bonds and debentures issued by corporations. Multiple prices and price types are obtained from pricing vendors whenever possible, which enables cross-provider validations. We have obtained an understanding of how these prices are derived, including the nature and observability of the inputs used in deriving such prices. When inputs are observable, securities are classified as Level 2 investments; otherwise, securities are classified as Level 3 investments.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Mortgage-backed securities – This investment class consists of debt obligations secured by a mortgage or collection of mortgages. Multiple prices and price types are obtained from pricing vendors whenever possible, which enables cross-provider validations. We have obtained an understanding of how these prices are derived, including the nature and observability of the inputs used in deriving such prices. When inputs are observable, securities are classified as Level 2 investments; otherwise, securities are classified as Level 3 investments.

Asset-backed securities and other – This investment class consists of debt obligations secured by non-mortgage-backed assets or pools of assets. Multiple prices and price types are obtained from pricing vendors whenever possible, which enables cross-provider validations. We have obtained an understanding of how these prices are derived, including the nature and observability of the inputs used in deriving such prices. When inputs are observable, securities are classified as Level 2 investments; otherwise, securities are classified as Level 3 investments.

Fixed income commingled funds – Some of the fixed income securities are held in commingled funds, which have daily net asset values derived from the underlying securities; these are classified as Level 2 investments.

Real estate funds – The value of the real estate funds is reported by the fund manager and is based on a valuation of the underlying properties. Inputs used in the valuation include items such as cost, discounted future cash flows, independent appraisals and market based comparable data. The real estate funds are classified as Level 3 investments.

Hedge funds – The hedge funds are invested in fund-of-fund structures and consist of multiple investments in interest and currency funds designed to hedge the risk of rate fluctuations. Given the complex nature of valuation and the broad spectrums of investments, the hedge funds are classified as Level 3 investments.

The following table represents a reconciliation of Level 3 plan assets held during the years ended March 31, 2010 and 2011:

<i>(In millions)</i>	Real Estate Funds	Hedge Funds	Other	Total
Balance at March 31, 2009	\$ 25	\$ 5	\$ 2	\$ 32
Unrealized (loss) on plan assets still held	(6)	—	—	(6)
Balance at March 31, 2010	\$ 19	\$ 5	\$ 2	\$ 26
Purchases, sales and settlements	(14)	—	—	(14)
Transfer in and/or out of Level 3	—	—	(2)	(2)
Balance at March 31, 2011	\$ 5	\$ 5	\$ —	\$ 10

Concentration of Credit Risk: We evaluated our pension plans' asset portfolios for the existence of significant concentrations of credit risk as of March 31, 2011. Types of concentrations that were evaluated include investment funds that represented 10% or more of the pension plans' net assets. As of March 31, 2011, 11% of our plan assets is comprised of Bartram International Fund, which holds only actively traded stock.

Other Defined Benefit Plans

Under various U.S. bargaining unit labor contracts, we make payments into multi-employer pension plans established for union employees. We are liable for a proportionate part of the plans' unfunded vested benefit upon our withdrawal from the plan; however, information regarding the relative position of each employer with respect to the actuarial present value of accumulated benefits and net assets available for benefits is not available. Contributions to the plans and amounts accrued were not material for the years ended March 31, 2011, 2010 and 2009.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Defined Contribution Plans

We have a contributory profit sharing investment plan (“PSIP”) for U.S. employees not covered by collective bargaining arrangements. Effective January 1, 2011, eligible employees may contribute to the PSIP up to 75% of their monthly eligible compensation for pre-tax contributions and up to 75% of compensation for catch-up contributions not to exceed IRS limits. The Company makes matching contributions in an amount equal to 100% of the employee’s first 3% of pay contributed and 50% for the next 2% of pay contributed. The Company also may make an additional annual matching contribution for each plan year to enable participants to receive a full match based on their annual contribution.

The Company’s leveraged employee stock ownership plan (“ESOP”) had purchased an aggregate of 24 million shares of the Company’s common stock since its inception. These purchases were financed by 10 to 20 year loans from or guaranteed by us. At March 31, 2011 and 2010, there were no outstanding ESOP loans nor the related receivables from the ESOP as the ESOP fully repaid the loans during 2010. The loans were repaid by the ESOP from interest earnings on cash balances and common dividends on unallocated shares and Company cash contributions. The ESOP loan maturities and rates were identical to the terms of related Company borrowings. Stock was made available from the ESOP based on debt service payments on ESOP borrowings. In 2011 and 2009, the Company made contributions primarily in cash or with the issuance of treasury shares. In the first quarter of 2011, all of the 24 million common shares had been allocated to plan participants. As a result, future PSIP contributions will be funded with cash or treasury shares.

The McKesson Corporation PSIP was a member of the settlement class in the Consolidated Securities Litigation Action. On April 27, 2009, the court issued an order approving the distribution of the settlement funds. On October 9, 2009, the PSIP received approximately \$119 million of the Consolidated Securities Litigation Action proceeds. Approximately \$42 million of the proceeds were attributable to the allocated shares of McKesson common stock owned by the PSIP participants during the Consolidated Securities Litigation Action class-holding period and were allocated to the respective participants on that basis in the third quarter of 2010. Approximately \$77 million of the proceeds were attributable to the unallocated shares (the “Unallocated Proceeds”) of McKesson common stock owned by the PSIP in an ESOP suspense account. In accordance with the plan terms, the PSIP distributed all of the Unallocated Proceeds to current PSIP participants after the close of the plan year in April 2010. The receipt of the Unallocated Proceeds by the PSIP was reimbursement for the loss in value of the Company’s common stock held by the PSIP in its ESOP suspense account during the Consolidated Securities Litigation Action class-holding period and was not a contribution made by the Company to the PSIP or ESOP. Accordingly, there were no accounting consequences to the Company’s financial statements relating to the receipt of the Unallocated Proceeds by the PSIP.

As a result of the PSIP’s receipt of the Unallocated Proceeds, in 2010 the Company contributed \$1 million to the PSIP. Accordingly, the PSIP expense for 2010 was nominal. In 2011, the Company resumed its contributions to the PSIP.

PSIP expense by segment for the last three years was as follows:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Distribution Solutions	\$ 23	\$ —	\$ 23
Technology Solutions	32	1	28
Corporate	4	—	2
PSIP expense	<u>\$ 59</u>	<u>\$ 1</u>	<u>\$ 53</u>
Cost of sales ⁽¹⁾	\$ 17	\$ —	\$ 12
Operating expenses	42	1	41
PSIP expense	<u>\$ 59</u>	<u>\$ 1</u>	<u>\$ 53</u>

(1) Amounts recorded to cost of sales pertain solely to our McKesson Technology Solutions segment.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

13. Postretirement Benefits

We maintain a number of postretirement benefits, primarily consisting of healthcare and life insurance (“welfare”) benefits, for certain eligible U.S. employees. Eligible employees consist of those who retired before March 31, 1999 and those who retired after March 31, 1999, but were an active employee as of that date, after meeting other age-related criteria. We also provide postretirement benefits for certain U.S. executives. Defined benefit plan obligations are measured as of the Company’s fiscal year-end.

The net periodic expense (income) for our postretirement welfare benefits is as follows:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Service cost—benefits earned during the year	\$ 1	\$ 1	\$ 1
Interest cost on projected benefit obligation	8	9	10
Amortization of unrecognized actuarial loss (gain) and prior service costs	(4)	(25)	(14)
Net periodic postretirement expense (income)	\$ 5	\$ (15)	\$ (3)

Information regarding the changes in benefit obligations for our postretirement welfare plans is as follows:

<i>(In millions)</i>	Years Ended March 31,	
	2011	2010
Change in benefit obligations		
Benefit obligation at beginning of period	\$ 154	\$ 133
Service cost	1	1
Interest cost	8	9
Actuarial loss	2	26
Benefit payments	(13)	(15)
Benefit obligation at end of period	\$ 152	\$ 154

The components of the amount recognized in accumulated other comprehensive income for the Company’s other postretirement benefits at March 31, 2011 and 2010 were net actuarial loss of \$5 million and net actuarial gain of \$1 million and net prior service credits of \$2 million and \$2 million. Other changes in benefit obligations recognized in other comprehensive income were net actuarial losses of \$6 million for 2011 and \$51 million for 2010 and net actuarial gain of \$12 million for 2009.

We estimate that the amortization of the actuarial loss from stockholders’ equity to other postretirement expense in 2012 will be \$1 million (\$4 million of actuarial gain in 2011).

Other postretirement benefits are funded as claims are paid. Expected benefit payments for our postretirement welfare benefit plans, net of expected Medicare subsidy receipts of \$1 million annually, are as follows: \$12 million annually for 2012 to 2016 and \$56 million cumulatively for 2017 through 2021. Expected benefit payments are based on the same assumptions used to measure the benefit obligations and include estimated future employee service. Expected contributions to be made for our postretirement welfare benefit plans are \$14 million for 2012.

Weighted-average discount rates used to estimate postretirement welfare benefit expenses were 5.33%, 7.86% and 6.19% for 2011, 2010 and 2009. Weighted-average discount rates for the actuarial present value of benefit obligations were 5.09%, 5.33% and 7.86% for 2011, 2010 and 2009.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Actuarial gain or loss for the postretirement welfare benefit plan is amortized to income or expense over a three-year period. The assumed healthcare cost trends used in measuring the accumulated postretirement benefit obligation were 8.5% and 8.5% for prescription drugs, 7.5% and 7.5% for medical and 5.8% and 6% for dental in 2011 and 2010. For 2011, 2010 and 2009, a one-percentage-point increase or decrease in the assumed healthcare cost trend rate would not have a material impact on the postretirement benefit obligations.

14. Financial Instruments and Hedging Activities

At March 31, 2011 and 2010, the carrying amounts of cash and cash equivalents, restricted cash, marketable securities, receivables, drafts and accounts payable and other current liabilities approximated their estimated fair values because of the short maturity of these financial instruments. All highly liquid debt instruments purchased with original maturity of three months or less at the date of acquisition are included in cash and cash equivalents. Included in cash and cash equivalents at March 31, 2011 and 2010, are money market fund investments of \$1.7 billion and \$2.3 billion, which are reported at fair value. The fair value of these investments was determined by using quoted prices for identical investments in active markets, which are considered to be Level 1 inputs under the fair value measurements and disclosures guidance. The carrying value of all other cash equivalents approximates fair value due to their relatively short-term nature.

The carrying amount and estimated fair value of our long-term debt and other financing was \$4.0 billion and \$4.3 billion at March 31, 2011 and \$2.3 billion and \$2.5 billion at March 31, 2010. The estimated fair value of our long-term debt and other financing was determined using quoted market prices and other inputs that were derived from available market information and may not be representative of actual values that could have been realized or that will be realized in the future.

In the normal course of business, we are exposed to interest rate changes and foreign currency fluctuations. We limit these risks through the use of derivatives such as interest rate swaps and forward foreign exchange contracts. In accordance with our policy, derivatives are only used for hedging purposes. We do not use derivatives for trading or speculative purposes. The volume of activity related to derivative financial instruments was not material for 2011, 2010 and 2009.

15. Lease Obligations

We lease facilities and equipment almost solely under operating leases. In connection with our acquisition of US Oncology, we assumed noncancellable operating lease obligations of office space and equipment. At March 31, 2011, future minimum lease payments required under operating leases that have initial or remaining noncancellable lease terms in excess of one year for years ending March 31 are:

<i>(In millions)</i>	Noncancellable Operating Leases
2012	\$ 178
2013	143
2014	115
2015	94
2016	73
Thereafter	241
Total minimum lease payments	<u>\$ 844</u>

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Rental expense under operating leases was \$157 million, \$154 million and \$146 million in 2011, 2010 and 2009. We recognize rent expense on a straight-line basis over the term of the lease, taking into account, when applicable, lessor incentives for tenant improvements, periods where no rent payment is required and escalations in rent payments over the term of the lease. Deferred rent is recognized for the difference between the rent expense recognized on a straight-line basis and the payments made per the terms of the lease. Remaining terms for facilities leases generally range from one to seven years, while remaining terms for equipment leases range from one to three years. Most real property leases contain renewal options (generally for five-year increments) and provisions requiring us to pay property taxes and operating expenses in excess of base period amounts. Sublease rental income was not material for any period presented.

16. Financial Guarantees and Warranties

Financial Guarantees

We have agreements with certain of our Canadian customers' financial institutions under which we have guaranteed the repurchase of our customers' inventory or our customers' debt in the event these customers are unable to meet their obligations to those financial institutions. For our inventory repurchase agreement, among other requirements, inventories must be in resalable condition and any repurchase would be at a discount. The inventory repurchase agreements mostly range from one to two years. Customers' debt guarantees range from one to five years and were primarily provided to facilitate financing for certain customers. The majority of our customers' debt guarantees are secured by certain assets of the customer. We also have an agreement with one software customer that, under limited circumstances, may require us to secure standby financing. Because the amount of the standby financing is not explicitly stated, the overall amount of this guarantee cannot reasonably be estimated. At March 31, 2011, the maximum amounts of inventory repurchase guarantees and customers' debt guarantees were \$138 million and \$38 million, none of which had been accrued.

The expirations of the above noted financial guarantees are as follows: \$119 million, \$21 million, \$3 million, \$4 and \$1 million from 2012 through 2016 and \$28 million thereafter.

In addition, at March 31, 2011, our banks and insurance companies have issued \$128 million of standby letters of credit and surety bonds, which were issued on our behalf mostly related to our customer contracts and in order to meet the security requirements for statutory licenses and permits, court and fiduciary obligations and our workers' compensation and automotive liability programs.

Our software license agreements generally include certain provisions for indemnifying customers against liabilities if our software products infringe a third party's intellectual property rights. To date, we have not incurred any material costs as a result of such indemnification agreements and have not accrued any liabilities related to such obligations.

In conjunction with certain transactions, primarily divestitures, we may provide routine indemnification agreements (such as retention of previously existing environmental, tax and employee liabilities) whose terms vary in duration and often are not explicitly defined. Where appropriate, obligations for such indemnifications are recorded as liabilities. Because the amounts of these indemnification obligations often are not explicitly stated, the overall maximum amount of these commitments cannot be reasonably estimated. Other than obligations recorded as liabilities at the time of divestiture, we have historically not made significant payments as a result of these indemnification provisions.

McKESSON CORPORATION
FINANCIAL NOTES (Continued)

Warranties

In the normal course of business, we provide certain warranties and indemnification protection for our products and services. For example, we provide warranties that the pharmaceutical and medical-surgical products we distribute are in compliance with the Food, Drug and Cosmetic Act and other applicable laws and regulations. We have received the same warranties from our suppliers, which customarily are the manufacturers of the products. In addition, we have indemnity obligations to our customers for these products, which have also been provided to us from our suppliers, either through express agreement or by operation of law.

We also provide warranties regarding the performance of software and automation products we sell. Our liability under these warranties is to bring the product into compliance with previously agreed upon specifications. For software products, this may result in additional project costs, which are reflected in our estimates used for the percentage-of-completion method of accounting for software installation services within these contracts. In addition, most of our customers who purchase our software and automation products also purchase annual maintenance agreements. Revenues from these maintenance agreements are recognized on a straight-line basis over the contract period and the cost of servicing product warranties is charged to expense when claims become estimable. Accrued warranty costs were not material to the consolidated balance sheets.

17. Other Commitments and Contingent Liabilities

In addition to commitments and obligations in the ordinary course of business, we are subject to various claims, other pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of our business. As described below, many of these proceedings are at preliminary stages and many seek an indeterminate amount of damages.

When a loss is considered probable and reasonably estimable, we record a liability in the amount of our best estimate for the ultimate loss. However, the likelihood of a loss with respect to a particular contingency is often difficult to predict and determining a meaningful estimate of the loss or a range of loss may not be practicable based on the information available and the potential effect of future events and decisions by third parties that will determine the ultimate resolution of the contingency. Moreover, it is not uncommon for such matters to be resolved over many years, during which time relevant developments and new information must be reevaluated at least quarterly to determine both the likelihood of potential loss and whether it is possible to reasonably estimate a range of possible loss. When a loss is probable but a reasonable estimate cannot be made, disclosure of the proceeding is provided.

Disclosure also is provided when it is reasonably possible that a loss will be incurred or when it is reasonably possible that the amount of a loss will exceed the recorded provision. We review all contingencies at least quarterly to determine whether the likelihood of loss has changed and to assess whether a reasonable estimate of the loss or range of loss can be made. As discussed above, development of a meaningful estimate of loss or a range of potential loss is complex when the outcome is directly dependent on negotiations with or decisions by third parties, such as regulatory agencies, the court system and other interested parties. Such factors bear directly on whether it is possible to reasonably estimate a range of potential loss and boundaries of high and low estimates.

We are party to the legal proceedings described below. Unless otherwise stated, we are currently unable to estimate a range of reasonably possible losses for the unresolved proceedings described below. Should any one or a combination of more than one of these proceedings be successful, or should we determine to settle any or a combination of these matters, we may be required to pay substantial sums, become subject to the entry of an injunction or be forced to change the manner in which we operate our business, which could have a material adverse impact on our financial position or results of operations.

McKESSON CORPORATION
FINANCIAL NOTES (Continued)

I. Average Wholesale Price Litigation

The following matters involve a drug reimbursement benchmark referred to as the “AWP” utilized by some public and private payers to calculate at least some portion of the amount a pharmacy will be reimbursed for dispensing a covered prescription drug.

A. In re McKesson Governmental Entities Average Wholesale Price Litigation

Commencing in May of 2008, a series of complaints were filed in the United States District Court for the District of Massachusetts by various public payers — governmental entities that paid any portion of the price of certain prescription drugs — alleging that in late 2001 the Company and First DataBank, Inc. (“FDB”), a publisher of pharmaceutical pricing information, conspired to improperly raise the published AWP for certain prescription drugs, and that this alleged conduct resulted in higher drug reimbursement payments by plaintiffs and others similarly situated. These actions were all consolidated under the caption *In re McKesson Governmental Entities Average Wholesale Price Litigation*. A description of these actions is as follows:

The San Francisco Action

On May 20, 2008, an action was filed by the San Francisco Health Plan on behalf of itself and a purported class of political subdivisions in the State of California and by the San Francisco City Attorney on behalf of the “People of the State of California” in the United States District Court for the District of Massachusetts against the Company as the sole defendant, alleging violations of the federal Racketeer Influenced and Corrupt Organizations Act (“RICO,”) 18 U.S.C. § 1962(c), the California Cartwright Act, California's False Claims Act, California Business and Professions Code §§ 17200 and 17500 and seeking damages, treble damages, civil penalties, restitution, interest and attorneys' fees, all in unspecified amounts, *San Francisco Health Plan, et al. v. McKesson Corporation*, (Civil Action No. 1:08-CV-10843-PBS) (“San Francisco Action”). On July 3, 2008, an amended complaint was filed in the San Francisco Action adding a claim for tortious interference. On January 13, 2009, a second amended complaint was filed in the San Francisco Action that abandoned all previously alleged antitrust claims.

The Connecticut Action

On May 28, 2008, an action was filed by the State of Connecticut in the United States District Court for the District of Massachusetts against the Company, again as the sole defendant, alleging violations of civil RICO, the Sherman Act and the Connecticut Unfair Trade Practices Act and seeking damages, treble damages, restitution, interest and attorneys' fees, all in unspecified amounts, *State of Connecticut v. McKesson Corporation*, (Civil Action No. 1:08-CV-10900-PBS) (“Connecticut Action”). On January 13, 2009, an amended complaint was filed in the Connecticut Action abandoning all previously alleged antitrust claims.

On October 15, 2010, the Company executed an agreement to settle the Connecticut Action for \$26 million. The settlement, which was not subject to court approval, includes an express denial of liability and a release by the State of Connecticut of the Company as to all matters alleged or which could have been alleged in the action. As a result, during the second quarter of 2011, the Company recorded a \$24 million pre-tax charge. On November 8, 2010, the Court entered a Notice of Dismissal with prejudice in the Connecticut Action pursuant to the October 15 settlement agreement. The Connecticut Action has thus concluded.

The Douglas County, Kansas Nationwide Class Action

On August 7, 2008, an action was filed in the United States District Court for the District of Massachusetts by the Board of County Commissioners of Douglas County, Kansas on behalf of itself and a purported national class of state, local and territorial governmental entities against the Company and FDB alleging violations of civil RICO and federal antitrust laws and seeking damages and treble damages, as well as injunctive relief, interest, attorneys' fees and costs of suit, all in unspecified amounts, *Board of County Commissioners of Douglas County, Kansas v. McKesson Corporation, et al.*, (Civil Action No. 1:08-CV-11349-PBS) (“Douglas County, Kansas Action”).

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Separate class actions based on essentially the same factual allegations were subsequently filed against the Company and FDB in the United States District Court for the District of Massachusetts by the City of Panama City, Florida on August 18, 2008 (“Florida Action”), the State of Oklahoma on October 15, 2008 (“Oklahoma Action”), the County of Anoka, Minnesota on November 3, 2008 (“Minnesota Action”), Baltimore, Maryland on November 7, 2008 (“Maryland Action”), Columbia, South Carolina on December 12, 2008 (“South Carolina Action”) and Goldsboro, North Carolina on December 15, 2008 (“North Carolina Action”) in each case on behalf of the filing entity and a class of state and local governmental entities within the same state, alleging violations of civil RICO, federal and state antitrust laws and various state consumer protection and deceptive and unfair trade practices statutes and seeking damages and treble damages, civil penalties, as well as injunctive relief, interest, attorneys' fees and costs of suit, all in unspecified amounts.

On December 24, 2008, an amended and consolidated class action complaint was filed in the Douglas County, Kansas Action. The amended complaint added the named plaintiffs from the Florida, Oklahoma, Minnesota, Maryland, South Carolina and North Carolina Actions and abandoned the previously alleged antitrust claims. On January 9, 2009, the Florida, Oklahoma, Minnesota, Maryland, South Carolina and North Carolina Actions were voluntarily dismissed without prejudice. On March 3, 2009, a second amended and consolidated class action complaint was filed in the Douglas County, Kansas Action, adding the state of Montana as a plaintiff, adding Montana state law claims and adding a claim for tortious interference.

On February 10, 2009, plaintiffs in the Douglas County, Kansas Action filed a notice of dismissal without prejudice of defendant FDB. On April 2, 2009, the Company filed answers to each of the pending complaints in the San Francisco Action, the Connecticut Action and the County of Douglas, Kansas Action, denying the core factual allegations and asserting numerous affirmative defenses. On April 9, 2009, the Company filed a demand for a jury in each of these actions.

On May 20, 2009, an action was filed in the United States District Court for the District of Massachusetts by Oakland County, Michigan and the City of Sterling Heights, Michigan against the Company as the sole defendant, alleging violations of RICO, the Michigan Antitrust Reform Act, the Michigan Consumer Protection Act, the California Cartwright Act and common law fraud and seeking damages, treble damages, interest and attorneys' fees, all in unspecified amounts, *Oakland County, Michigan et al. v. McKesson Corporation*, (Civil Action No. 1:09-CV-10843-PBS) (“Michigan Action”). On August 4, 2009, the court granted the Company's motion to stay the Michigan Action.

On February 19, 2010, discovery closed in the consolidated public payer actions. On April 12, 2010, plaintiffs in the Douglas County, Kansas Action withdrew their motion to certify an opt-in state Medicaid class. A hearing on the remaining classes in the Douglas County, Kansas and San Francisco Actions was held on August 31, 2010.

On August 5, 2010, the court set a trial date of January 24, 2011, for the claims asserted by the State of Oklahoma on behalf of its Medicaid program in the Douglas County, Kansas Action, or, in the alternative, the claims asserted by the State of Montana on behalf of its Medicaid program in the Douglas County, Kansas Action if the Oklahoma Medicaid claims were resolved before the final pretrial conference, which the court scheduled for January 19, 2011. On December 2, 2010, the Company executed a Memorandum of Understanding documenting an agreement in principle with the States of Oklahoma and Montana to settle and release those States' share of their Medicaid claims in the Douglas County, Kansas Action subject to consent from the federal government not to seek any portion of the settlement recovery. In light of the Memorandum of Understanding, on December 7, 2010, the Court vacated the previously reported trial date of January 24, 2011. On January 11, 2011, the court entered a settlement order of dismissal with respect to the Medicaid claims of Oklahoma and Montana, subject to reopening of those actions if the settlement was not consummated by April 11, 2011. On March 23, 2011, the court granted an unopposed motion filed by the States of Oklahoma and Montana to extend the date on which their Medicaid claims would be dismissed.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

On March 4, 2011, the court entered an order granting in part, and denying in part, plaintiffs' motions for class certification in the Douglas County, Kansas Action and denying plaintiff's motion for class certification in the San Francisco Action. Specifically, the court denied the San Francisco Health Plan's motion to certify a class of governmental entities within the State of California including the state of California itself. In the Douglas County, Kansas Action, the court certified a nationwide class comprised of all non-federal and non-state governmental entities for liability and equitable relief for the period from August 1, 2001, to June 2, 2005, and for damages for the period August 1, 2001, to December 31, 2003.

On March 14, 2011, plaintiffs filed a motion for reconsideration to extend the liability-only class period from June 2, 2005, to September 26, 2009. On March 30, 2011, the court granted, in part, plaintiffs' motion for reconsideration by extending the liability-only class period from June 2, 2005, to October 6, 2006.

On March 18, 2011, the Company filed a petition with the Court of Appeals for the First Circuit seeking permission to appeal the district court's March 4, 2011 class certification order on the grounds that it improperly certified a damages class based on an aggregate damages model that improperly included workers' compensation programs. On March 31, 2011, plaintiffs filed an answer in opposition to the Company's petition as well as a cross-petition for review of the district court's decision to exclude all state entities from the certified class. The First Circuit has not yet ruled on the parties' petitions. No trial date is set in the San Francisco or Douglas County, Kansas Actions.

B. State Medicaid AWP Cases

Beginning in September 2010, a series of suits were filed by individual states in jurisdictions other than the United States District Court for the District of Massachusetts based on essentially the same factual allegations as alleged in *In re McKesson Governmental Entities Average Wholesale Price Litigation*. A description of these actions is as follows:

The Kansas Action

On September 13, 2010, an action was filed in the Kansas state court of Wyandotte County by the State of Kansas against the Company and FDB asserting claims under the Kansas Restraint of Trade Act, the Kansas Consumer Protection Act, and the Kansas False Claims Act, and for civil conspiracy, fraud, unjust enrichment, and breach of contract, and seeking damages and treble damages, civil penalties, as well as injunctive relief, interest, disgorgement of profits, attorneys' fees and costs of suit, all in unspecified amounts, *State of Kansas ex rel. Steve Six v. McKesson Corporation, et al.*, (Case No. 10CV1491). On November 22, 2010, the Company filed a motion to dismiss the Kansas Action. On February 24, 2011, the court denied the Company's motion to dismiss. The case is set for trial in August 2012.

The Mississippi Action

On October 8, 2010, an action was filed in the Mississippi state court of Hinds County by the State of Mississippi against the Company asserting claims under RICO, the Mississippi Medicaid Fraud Control Act, the Mississippi Consumer Protection Act, and for civil conspiracy, tortious interference with contract, unjust enrichment, and fraud, and seeking damages and treble damages, civil penalties, restitution, as well as injunctive relief, interest, attorneys' fees and costs of suit, all in unspecified amounts, *State of Mississippi v. McKesson Corporation, et al.*, (Case No. 251-10-862CIV). On November 9, 2010, the Company filed a Notice of Removal to the United States District Court, Southern District of Mississippi. On January 27, 2011, the case was remanded back to Mississippi state court after the state dismissed its RICO claim. On February 15, 2011, the Company filed a motion to transfer the Mississippi Action from the Circuit Court of Hinds County to the Chancery Court of Hinds County, or in the alternative, to dismiss the State's claim under the Mississippi Consumer Protection Act for lack of subject matter jurisdiction. The trial court has not yet ruled on the Company's motion.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

The Alaska Action

On October 12, 2010, an action was filed in Alaska state court by the State of Alaska against the Company and FDB asserting claims under state unfair and deceptive trade practices statutes, and for fraud and civil conspiracy, and seeking damages, treble damages, punitive damages, civil penalties, disgorgement of profits, as well as declaratory relief, interest, attorneys' fees and costs of suit, all in unspecified amounts, *State of Alaska v. McKesson Corporation, et al.*, (Case No. 3AN-10-11348-CI). The Company filed a motion to dismiss the complaint on January 10, 2011. A hearing on the Company's motion to dismiss has not yet been scheduled.

The Wisconsin Qui Tam Action

On October 18, 2010, the Company was informed that a qui tam action was previously filed by four law firms in Wisconsin state court of Dane County, purportedly on behalf of the State of Wisconsin against the Company based on essentially the same factual allegations as alleged in *In re McKesson Governmental Entities Average Wholesale Price Litigation*, asserting claims under the Wisconsin False Claims for Medical Assistance statute, and seeking damages, treble damages, civil penalties, as well as attorneys' fees and costs of suit, all in unspecified amounts, *State of Wisconsin ex rel. Hagens Berman Sobol Shapiro LLP, et al. v. McKesson Corporation*, (Case No. 10CV3411). On August 26, 2010, the Wisconsin Department of Justice filed a motion to dismiss this qui tam action, and on December 14, 2010, the court granted the State's motion. No appeal has been filed.

The Utah Action

On October 20, 2010, an action was filed against the Company in the United States District Court, Northern District of California, by the State of Utah asserting claims under RICO and for civil conspiracy, tortious interference with contract, and unjust enrichment, and seeking damages and treble damages, restitution, as well as injunctive relief, interest, attorneys' fees and costs of suit, all in unspecified amounts, *State of Utah v. McKesson Corporation, et al.*, (Case No. CV 10-4743-SC). On December 22, 2010, the Company filed a motion to dismiss the Utah Action, which has not yet been ruled upon.

The Arizona Administrative Proceeding

On November 5, 2010, the Company received a Notice of Proposed Civil Monetary Penalty from the Office of Inspector General ("OIG") for the Arizona Health Care Cost Containment System ("AHCCCS") purporting to initiate an administrative claim process against the Company, and seeking civil penalties in the amount of \$101 million and an assessment in the amount of \$112 million for false claims allegedly presented to the Arizona Medicaid program, (Case No. 2010-1218).

On February 28, 2011, the Company filed a complaint in Arizona Superior Court, County of Maricopa, against AHCCCS and its Director, alleging that the administrative proceeding commenced by OIG violates the Arizona Administrative Procedure Act and the Due Process Clauses of the Arizona Constitution and the United States Constitution, and seeking to enjoin OIG's administrative proceeding, a declaratory judgment that AHCCCS lacks jurisdiction and legal authority to impose penalties or assessments against the Company, as well as costs of suit, *McKesson Corporation v. AHCCCS*, (Case No. CV-2011-004446). Also on February 28, 2011, the Company filed an application for an interlocutory order staying, or alternatively dismissing, OIG's administrative proceeding. On April 28, 2011, the trial court ruled that AHCCCS has no jurisdiction to impose penalties or assessments against the Company and enjoined AHCCCS from prosecuting or reinitiating any penalty proceeding against the Company.

The Hawaii Action

On November 10, 2010, an action was filed in Hawaii state court by the State of Hawaii against the Company and FDB asserting claims under the Hawaii False Claims Act, state unfair and deceptive trade practices statutes, fraud, and civil conspiracy, and seeking damages, treble damages, punitive damages, civil penalties, disgorgement of profits, as well as interest, attorneys' fees and costs of suit, all in unspecified amounts, *State of Hawaii v. McKesson Corporation, et al.*, (Civil No. 10-1-2411-11-GWBC). The Company filed a motion to dismiss the complaint on January 14, 2011, which was denied by the trial court on April 12, 2011.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

The Louisiana Action

On December 20, 2010, an action was filed in Louisiana state court by the State of Louisiana against the Company asserting claims under state unfair and deceptive trade practices statutes, the Louisiana Medical Assistance Programs Integrity Law, state antitrust statutes, and for fraud, negligent misrepresentation, civil conspiracy, and unjust enrichment, seeking damages, statutory fines, civil penalties, disgorgement of profits, as well as interest, attorneys' fees and costs of suit, all in unspecified amounts, *State of Louisiana v. McKesson Corporation*, (Case No. C597634 Sec. 23). The Company filed a motion to dismiss the complaint on March 7, 2011. A hearing on the Company's motion to dismiss is scheduled for May 9, 2011.

C. The New Jersey United States' Attorney's Office AWP Investigation

In June of 2007, the Company was informed that a qui tam action by an unknown relator was previously filed in the United States District Court in the District of New Jersey, purportedly on behalf of the United States, twelve states (California, Delaware, Florida, Hawaii, Illinois, Louisiana, Massachusetts, Nevada, New Mexico, Tennessee, Texas and Virginia) and the District of Columbia against the Company and seven other defendants. The Company has not been provided with the original complaint, which was filed in 2005, and does not know the identity of the original parties to the action. The Company was advised that the United States and the various states are considering whether to intervene in the suit, but none has done so to date. The suit thus remains under seal and has not been served on the Company.

In January 2009, the Company was provided with a courtesy copy of a third amended complaint filed in the qui tam action. This complaint has also not been served on the Company. The third amended complaint alleges multiple claims against the Company under the federal False Claims Act and the various states' and District of Columbia's false claims statutes. These and additional claims are also alleged against other parties. The claims arise out of alleged manipulation of AWP by defendants which plaintiffs claim caused them to pay more than they should have in reimbursement for prescription drugs covered by various government programs that base reimbursement payments on AWP. The complaint is brought on behalf of the United States, the twelve states named above, ten additional states (Georgia, Indiana, Michigan, Montana, New Hampshire, New Jersey, New York, Oklahoma, Rhode Island and Wisconsin) and the District of Columbia and seeks damages including treble damages and civil penalties (which the relator claims would be several billion dollars) as provided under the various false claims act statutes, as well as attorneys' fees and costs.

As has also been previously reported regarding the New Jersey qui tam action, the United States and various states have been considering whether to intervene in the suit, but none has done so to date. The Company has at all times cooperated with these investigations, and has engaged in settlement discussions with the purpose of resolving all Medicaid related AWP claims by the states and federal government. The pace and progress of settlement discussions accelerated during and after the third quarter of 2011. Except as previously reported with respect to the States of Connecticut, Oklahoma and Montana, the Company has not reached agreement relating to those claims.

As previously reported, during the third quarter of 2009, the Company recorded a pre-tax charge of \$143 million to establish a reserve for estimated probable losses related to pending and expected AWP claims by public payer entities. As of March 31, 2009 and 2010, the reserve relating to AWP public entity claims was \$143 million. The Company recorded an additional pre-tax charge of \$24 million for the settlement with the State of Connecticut during the second quarter of 2011. In November 2010, a cash payment of \$26 million was made for this settlement. Following the Company's most recent review of the reserve for estimated probable losses from current and possible future public entity AWP claims, which review included consideration of the pace and progress of the above described settlement discussions during and after the third quarter relating to state and federal Medicaid claims, the Company recorded a pre-tax charge of \$189 million within its Distribution Solutions segment's operating expenses during the third quarter of 2011. As of March 31, 2011, the reserve relating to AWP public entity claims was \$330 million and was included in other current liabilities in the consolidated balance sheet. However, in view of the number of outstanding cases and expected future claims, and the uncertainties of the timing and outcome of this type of litigation, it is possible that the ultimate costs of these matters may exceed or be less than the reserve.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

II. Other Litigation and Claims

On April 7, 2010, an action was filed in the Superior Court of the State of California for the County of Los Angeles against, among others, the Company, its indirect subsidiary, NDCHealth Corporation (“NDC”) and “Relay Health,” a trade name under which NDC conducts business, *Rodriguez et al. v. Etreby Computer Company et al.*, (Civ. No. BC435303) (“Rodriguez”). The plaintiffs in Rodriguez purport to represent a class of California residents whose individual confidential medical information was allegedly illegally released and used by defendants. Plaintiffs also purport to bring their claims as a private Attorney General action. The claims asserted in the complaint against the Company defendants include negligence, statutory violations and violation of California Business and Professions Code, Sections 17200 *et seq.*, covering unfair, unlawful and fraudulent business acts and practices. The statutory violations alleged by plaintiffs purport to arise out of California Civil Code, Sections 56 through 56.37, also known as the Confidentiality of Medical Information Act (“CMIA”). The complaint seeks compensatory and statutory damages under the CMIA, equitable and injunctive relief, as well as interest and attorneys’ fees and costs, all in unspecified amounts. On May 10, 2010, defendants removed the action to United States District Court for the Central District of California, *Rodriguez et al. v. Etreby Computer Company et al.*, (Civil Action No. CV 10-3522-VBF). On June 10, 2010, the Company and NDC moved to dismiss the complaint on grounds that it fails to allege the required element of knowledge by defendants, fails to allege actual harm to any plaintiff and improperly names certain defendants, including the Company and RelayHealth. On July 23, 2010, the court granted defendants’ motion to dismiss on grounds that plaintiffs had failed to sufficiently plead any of their causes of action and gave plaintiffs until August 9, 2010 to file an amended pleading. On December 9, 2010, the parties executed a settlement agreement which, in consideration of payment by the Company of a non-material sum, resolves the claims of all class members who do not affirmatively opt out of the class. On January 12, 2011, the trial court issued an order granting preliminary approval of the settlement, directing notice to the class and setting a hearing for final approval of the settlement. The final approval hearing is presently set to occur on June 27, 2011.

On October 3, 2008, the United States filed a complaint in intervention in a pending qui tam action in the United States District Court for the Northern District of Mississippi, naming as defendants, among others, the Company and its former indirect subsidiary, McKesson Medical-Surgical MediNet Inc. (“MediNet”), now merged into and doing business as McKesson Medical-Surgical MediMart Inc., *United States ex rel. Jamison v. McKesson Corporation, et al.*, (Civil Action No. 2:08-CV-00214-SA). The United States (“USA”) alleges violations of the federal False Claims Act, 31 U.S.C. Sections 3729-33, in connection with billing and supply services rendered by MediNet to the long-term care facility operator co-defendants. The action seeks monetary damages in an unstated amount. On July 7, 2009, defendants filed motions to dismiss the action filed by the relator, arguing that the relator was not the original source of the claims which he attempts to pursue in his qui tam action. On March 25, 2010, the trial court granted defendants’ motions to dismiss the relator and his complaint, which ruling has been appealed by the relator to the United States Court of Appeals for the Fifth Circuit. On June 2, 2010, the USA filed a motion for partial summary judgment, seeking a finding that the Company’s co-defendant, a Medicare Part B supplier, failed to comply with certain of the 21 Supplier Standards (“Standards”) established by federal regulations covering such Medicare suppliers, and that the relevant claims for which MediNet provided contract billing and/or supply services were rendered “false” by reason of such non-compliance. On July 2, 2010 the Company and MediNet filed their opposition to the USA’s motion and themselves moved for summary judgment as to certain counts based on numerous arguments, including that the USA cannot, as a matter of law, establish that the co-defendant Medicare Part B supplier failed to meet the Standards. On March 28, 2011, the trial court issued its order denying the motion of the USA and granting the partial summary judgment motions of the Company and its co-defendants on grounds that, as a matter of law, the Standards had not been violated. All causes of action based on the alleged failure to comply with the Standards were dismissed. Discovery regarding the balance of the USA’s allegations continues. Trial is presently set to commence on February 6, 2012.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

On July 14, 2006, an action was filed in the United States District Court for the Eastern District of New York against McKesson, two McKesson employees, several other drug wholesalers and numerous drug manufacturers, *RxUSA v. Alcon Laboratories et al.*, (Case No. 06-CV-3447-DRH). Plaintiff alleges that the Company, along with various other defendants, unlawfully engaged in monopolization and attempted monopolization of the sale and distribution of pharmaceutical products in violation of the federal antitrust laws, as well as in violation of New York State's Donnelly Act. There are also alleged violations of the Sarbanes-Oxley Act of 2002, the Donnelly Act and Sections 1962 (c) and (d) of the federal civil RICO statute. Plaintiff alleges generally that defendants have individually, and in concert with one another, taken actions to create and maintain a monopoly and to exclude secondary wholesalers, such as the plaintiff, from the wholesale pharmaceutical industry. The complaint seeks monetary damages of approximately \$1.6 billion and also seeks treble damages, attorneys' fees and injunctive relief. All defendants filed motions to dismiss all claims. The motions were briefed and submitted to the trial court on March 13, 2007. On September 24, 2009, the trial court issued its order granting "with prejudice" defendants' motions to dismiss and on September 28, 2009, the trial court entered judgment dismissing all of plaintiff's claims. On October 23, 2009, plaintiff filed a Notice of Appeal in the United States Court of Appeals for the Second Circuit seeking reversal of the trial court's orders of dismissal and judgment. On August 30, 2010 the Court of Appeals affirmed the rulings of the trial court, including the dismissal of plaintiff's entire case with prejudice. The period for seeking an appeal to the United States Supreme Court having expired, this matter has been concluded.

The Company is a defendant in approximately 305 cases alleging that the plaintiffs were injured by Vioxx, an anti-inflammatory drug manufactured by Merck & Company ("Merck"). The cases typically assert causes of action for strict liability, negligence, breach of warranty and false advertising for improper design, testing, manufacturing and warnings relating to the manufacture and distribution of Vioxx. None of the cases involving the Company is scheduled for trial. The Company has tendered each of these cases to Merck and has reached an agreement with Merck to defend and indemnify the Company.

Our subsidiary, Northstar Rx LLC, is one of multiple defendants in approximately 350 cases alleging that plaintiffs were injured after ingesting Reglan and/or its generic equivalent, metoclopramide. The cases usually include claims for strict liability, failure to warn, negligence, and breach of warranty. Most of these cases are pending in state courts in Pennsylvania, California and New Jersey, with other cases pending in Alabama, Louisiana, Missouri, Mississippi, Oklahoma, Oregon and Tennessee. The first case involving Northstar Rx is set for trial in September 2011 in Pennsylvania. Northstar Rx's insurers are providing coverage for these cases. The Company is also named in approximately 550 cases as a distributor of these products.

On September 15, 2010, an action was filed in the United States District Court for the Western District of Wisconsin against the Company by Independent Pharmacy Cooperative, a Wisconsin based cooperative purchasing organization for independent pharmacies, alleging that the Company has breached, and continues to breach, a February 21, 2003, supply agreement between the parties, *Independent Pharmacy Cooperative, v. McKesson Corporation*, (Case No. 10-CV-00527 (BC)). In addition to alleging breach of contract, plaintiff alleges breach of the implied covenant of good faith and fair dealing in connection with the supply agreement and intentional interference with contractual relations between plaintiff and its members. In its complaint, plaintiff claims that the Company has caused certain pharmacies to terminate their memberships in plaintiff's cooperative and has entered into separate agreements intended to cause members to terminate in the future. Plaintiff seeks declaratory and injunctive relief, monetary damages in an unspecified amount, punitive damages, attorneys' fees and costs of suit. On October 28, 2010 the Company filed a motion to dismiss plaintiff's intentional interference with contractual relations cause of action on grounds, among others, that Wisconsin's "economic loss" doctrine, which requires parties seeking economic loss to pursue contract, not tort, claims, required dismissal of plaintiff's interference claim as a matter of law. On March 23, 2011 the court granted the Company's motion and dismissed the plaintiff's interference cause of action based on the economic loss doctrine. On March 24, 2011 this action was dismissed "with prejudice" by stipulation of the parties and without any payment by the Company.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

On January 4, 2011, the Company was served with a qui tam complaint that was originally filed in November 2005 in the United States District Court for the Eastern District of Pennsylvania by a relator, a former employee of a Johnson & Johnson affiliate, against the Company, Johnson & Johnson and its affiliate companies, and Omnicare, Inc., alleging that the Company engaged in conduct that violated the federal Anti-Kickback Statute, causing subsequent claims for certain drugs manufactured by Johnson & Johnson to be submitted in violation of the federal False Claims Act and the false claims act statutes of various states, *United States ex rel. Scott Bartz v. Ortho McNeil Pharmaceuticals, Inc., et al.*, (Case No. 2:05-cv-06010). The United States declined to intervene in the suit, which alleges that the Company received illegal “kickbacks” from Johnson & Johnson that were disguised as discounts and rebates. On February 23, 2011, the case was transferred to the District of Massachusetts. The Company has not yet responded to the complaint.

In August of 2010, the Company was notified by the United States Attorneys’ Office in Kansas City that a qui tam action had been filed on an unidentified date by two relators, a former pharmacy customer of the Company and the customer’s advisor, in which the relators allege that in or about January of 2006, the Company and a competitor drug wholesaler engaged in conduct that violated the federal Anti-Kickback Statute, causing subsequent claims by the customer relator to be submitted in violation of the federal False Claims Act, United States ex rel. *Saleaumua et al. v. McKesson Corporation et al.*, (Case No. 4:08-CV-0848 (ODS)). The complaint alleges that the defendants’ conduct prior to the Company’s losing the account to the competitor in January of 2006, caused the customer relator to file subsequent claims in violation of the False Claims Act. The complaint seeks monetary damages in an unspecified amount, as well as attorneys’ fees and costs. The complaint has not been served on the Company. On April 22, 2011, the Company was informed by the United States Attorney’s Office that the Department of Justice had determined not to intervene against McKesson and that the qui tam action would be dismissed.

III. Government Investigations and Subpoenas

From time-to-time, the Company receives subpoenas or requests for information from various government agencies. The Company generally responds to such subpoenas and requests in a cooperative, thorough and timely manner. These responses sometimes require considerable time and effort and can result in considerable costs being incurred by the Company. Such subpoenas and requests also can lead to the assertion of claims or the commencement of civil or criminal legal proceedings against the Company and other members of the health care industry, as well as to settlements. In addition to the government investigations associated with the matters reported on in *Other Litigation and Claims* above, examples of such requests and subpoenas include the following: (1) the Company has responded to a request from the Federal Trade Commission for certain documents as part of a non-public investigation to determine whether the Company may have engaged in anti-competitive practices with other wholesale pharmaceutical distributors in order to limit competition for provider customers seeking distribution services; (2) the Company has received and responded to a Civil Investigative Demand from the Attorney General’s Office of the State of Tennessee related to an investigation into possible violations of the Tennessee Medicaid False Claims Act in connection with repackaged pharmaceuticals; (3) the Company has responded to a subpoena from the office of the Attorney General of the State of New York requesting documents and other information concerning its participation in the secondary or “alternative source” market for pharmaceutical products; (4) the Company has responded to subpoenas and requests for information from a number of Offices of state Attorney Generals or other state agencies, relating to the pricing for branded and generic drugs; and (5) the Company has completed its response to a subpoena, issued by the United States Attorney’s Office in Houston, which seeks documents relating to billing and collection services performed by a Company subsidiary for certain healthcare operations associated with the University of Texas from 2004 through the dates of the subpoenas, which investigation the Company has been informed has been closed.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

As previously reported, on January 26, 2007, the Company acquired Per-Se Technologies, Inc. ("Per-Se"), which became a wholly-owned subsidiary. Prior to its acquisition, Per-Se had publicly disclosed that in December 2004, the SEC issued a formal order of investigation relating to accounting matters at NDC, a then public company, which was acquired by Per-Se in January 2006, prior to the Company's acquisition of Per-Se. In March 2005, NDC restated its financial statements for the fiscal years ended May 28, 2004, May 30, 2003 and May 31, 2002, and for the fiscal quarters ended August 22, 2004, and August 29, 2005, to correct errors relating to certain accounting matters. NDC produced documents to the SEC and fully cooperated with the SEC in its investigation. The SEC has taken testimony from a number of current and former NDC employees. There has been no activity in this matter for some time and the SEC has taken no action against NDC or its successor to date.

Prior to its recent acquisition by the Company, US Oncology was informed that the United States Federal Trade Commission ("FTC") and the Attorney General for the State of Texas had opened investigations to determine whether a transaction in which certain Austin, Texas based oncology physicians became employees of an existing Texas US Oncology affiliated oncology practice group violated relevant state or federal antitrust laws. US Oncology has responded to requests for information from the government agencies and the Company has continued to cooperate with the FTC and the Texas Attorney General regarding these investigations.

IV. Environmental Matters

Primarily as a result of the operation of the Company's former chemical businesses, which were fully divested by 1987, the Company is involved in various matters pursuant to environmental laws and regulations. The Company has received claims and demands from governmental agencies relating to investigative and remedial actions purportedly required to address environmental conditions alleged to exist at eight sites where it, or entities acquired by it, formerly conducted operations and the Company, by administrative order or otherwise, has agreed to take certain actions at those sites, including soil and groundwater remediation. In addition, the Company is one of multiple recipients of a New Jersey Department of Environmental Protection Agency directive and a separate United States Environmental Protection Agency directive relating to potential natural resources damages ("NRD") associated with one of these eight sites. Although the Company's potential allocation under either directive cannot be determined at this time, it has agreed to participate with a potentially responsible party ("PRP") group in the funding of an NRD assessment, the costs of which are reflected in the aggregate estimates set forth below.

Based on a determination by the Company's environmental staff, in consultation with outside environmental specialists and counsel, the current estimate of the Company's probable loss associated with the remediation costs for these eight sites is \$7.5 million, net of approximately \$1.9 million that third parties have agreed to pay in settlement or is expected, based either on agreements or nonrefundable contributions which are ongoing, to be contributed by third parties. The \$7.5 million is expected to be paid out between April 2011 and March 2031. The Company's estimated probable loss for these environmental matters has been entirely accrued for in the accompanying consolidated balance sheets.

In addition, the Company has been designated as a PRP under the Superfund law for environmental assessment and cleanup costs as the result of its alleged disposal of hazardous substances at 19 sites. With respect to these sites, numerous other PRPs have similarly been designated and while the current state of the law potentially imposes joint and several liability upon PRPs, as a practical matter, costs of these sites are typically shared with other PRPs. The Company's estimated probable loss at those 19 sites is approximately \$0.9 million, which has been entirely accrued for in the accompanying consolidated balance sheets. The aggregate settlements and costs paid by the Company in Superfund matters to date have not been significant.

V. Other Matters

The Company is involved in various other litigation and governmental proceedings, not described above, that arise in the normal course of business. While it is not possible to determine with certainty the ultimate outcome or the duration of any such litigation or governmental proceedings, the Company believes, based on current knowledge and the advice of counsel, that such litigation and proceedings will not have a material impact on the Company's financial position or results of operations.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

18. Stockholders' Equity

Each share of the Company's outstanding common stock is permitted one vote on proposals presented to stockholders and is entitled to share equally in any dividends declared by the Company's Board of Directors (the "Board"). In May 2010, the quarterly dividend was raised from \$0.12 to \$0.18 per common share. Dividends were \$0.72 per share in 2011 and \$0.48 per share in 2010 and 2009. In April 2011, the Board approved an increase in the quarterly dividend from \$0.18 to \$0.20 per share, applicable to ensuing quarterly dividend declarations. The Company anticipates that it will continue to pay quarterly cash dividends in the future. However, the payment and amount of future dividends remain within the discretion of the Board and will depend upon the Company's future earnings, financial condition, capital requirements and other factors.

Share Repurchase Plans

In April 2010, the Board authorized the repurchase of up to an additional \$1.0 billion of the Company's common stock and in October 2010, authorized the repurchase of up to an additional \$1.0 billion of the Company's common stock. The Board previously authorized the repurchase of up to \$1.0 billion in April 2008. As of March 31, 2011, \$500 million remained available for future repurchases under the October 2010 authorization. In April 2011, the Board authorized the repurchase of up to an additional \$1.0 billion of the Company's common stock. Stock repurchases may be made from time-to-time in open market transactions, privately negotiated transactions, through accelerated share repurchase ("ASR") programs, or by any combination of such methods. The timing of any repurchases and the actual number of shares repurchased will depend on a variety of factors, including our stock price, corporate and regulatory requirements, restrictions under our debt obligations and other market and economic conditions.

In May 2010, we entered into an ASR program with a third party financial institution to repurchase \$1.0 billion of the Company's common stock. As a result of the ASR program, we repurchased 12.7 million shares for \$1.0 billion during the first quarter of 2011, which was funded with cash on hand. The May 2010 ASR program was completed on July 26, 2010 and we received 1.9 million additional shares on July 29, 2010. The total number of shares repurchased under this program was 14.6 million shares at an average price per share of \$68.66.

In March 2011, we entered into another ASR program with a third party financial institution to repurchase \$275 million of the Company's common stock. The program was funded with cash on hand. As of March 31, 2011, we had received 3.1 million shares representing the minimum number of shares due under the program. The ASR program was completed on May 2, 2011 and we received 0.4 million additional shares on May 5, 2011. The total number of shares repurchased under this ASR program was 3.5 million shares at an average price per share of \$79.65.

Total shares repurchased over the last three years were:

<i>(in millions, except per share data)</i>	Years Ended March 31,		
	2011	2010	2009
Number of shares repurchased ⁽¹⁾	29	8	10
Average price paid per share	\$ 69.62	\$ 41.47	\$ 50.52
Total value of shares repurchased	\$ 2,032	\$ 299	\$ 484

(1) All of the shares repurchased were part of publically announced programs. The number of shares purchased reflects rounding adjustments.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

In July 2008, the Board authorized the retirement of shares of the Company's common stock that may be repurchased from time-to-time pursuant to its stock repurchase program. In 2009, 4 million repurchased shares for a total of \$204 million, were formally retired by the Company. The retired shares constitute authorized but unissued shares. We elected to allocate any excess of share repurchase price over par value between additional paid-in capital and retained earnings. As such, \$165 million was recorded as a decrease to retained earnings.

Accumulated Other Comprehensive Income (Loss)

Information regarding our accumulated other comprehensive income (loss) is as follows:

<i>(In millions)</i>	March 31,	
	2011	2010
Unrealized net loss and other components of benefit plans, net of tax	\$ (157)	\$ (162)
Translation adjustments	244	168
Total	\$ 87	\$ 6

19. Related Party Balances and Transactions

Notes receivable outstanding from certain of our current and former officers and senior managers totaled \$15 million and \$16 million at March 31, 2011 and 2010. These notes related to purchases of common stock under our various employee stock purchase plans. The notes bear interest at rates ranging from 4.7% to 7.1% and were due at various dates through February 2004. Interest income on these notes is recognized only to the extent that cash is received. These notes, which are included in other capital in the consolidated balance sheets, were issued for amounts equal to the market value of the stock on the date of the purchase and are at full recourse to the borrower. At March 31, 2011, the value of the underlying stock collateral was \$14 million. The collectability of these notes is evaluated on an ongoing basis. At March 31, 2011 and 2010, we provided a reserve of approximately \$1 million and \$4 million for the outstanding notes.

We incurred \$11 million in 2011 and 2010 and \$10 million in 2009 of annual rental expense paid to an equity-held investment.

20. Segments of Business

We report our operations in two operating segments: McKesson Distribution Solutions and McKesson Technology Solutions. The factors for determining the reportable segments included the manner in which management evaluates the performance of the Company combined with the nature of the individual business activities. We evaluate the performance of our operating segments based on operating profit before interest expense, income taxes and results from discontinued operations.

The Distribution Solutions segment distributes ethical and proprietary drugs, medical-surgical supplies and equipment and health and beauty care products throughout North America. This segment also provides specialty pharmaceutical solutions for biotech and pharmaceutical manufacturers, sells financial, operational and clinical solutions for pharmacies (retail, hospital, alternate site) and provides consulting, outsourcing and other services. This segment includes a 49% interest in Nadro, S.A. de C.V. ("Nadro"), one of the leading pharmaceutical distributors in Mexico, and a 39% interest in Parata, which sells automated pharmacy and supply management systems and services to retail and institutional outpatient pharmacies.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

The Technology Solutions segment delivers enterprise-wide clinical, patient care, financial, supply chain, strategic management software solutions, pharmacy automation for hospitals, as well as connectivity, outsourcing and other services, including remote hosting and managed services, to healthcare organizations. This segment also includes our Payer group of businesses, which includes our InterQual® clinical criteria solution, medical management tools, claims payment solutions and care management programs. The segment's customers include hospitals, physicians, homecare providers, retail pharmacies and payers from North America, the United Kingdom, Ireland, other European countries and Israel.

Revenues for our Technology Solutions segment are classified in one of three categories: services, software and software systems and hardware. Services revenues primarily include fees associated with installing our software and software systems, as well as revenues associated with software maintenance and support, remote processing, disease and medical management, and other outsourcing and professional services. Software and software systems revenues primarily include revenues from licensing our software and software systems, including the segment's clinical auditing and compliance and InterQual® businesses.

Corporate includes expenses associated with Corporate functions and projects, certain employee benefits and the results of certain equity-held investments. Corporate expenses are allocated to the operating segments to the extent that these items can be directly attributable to the segment.

McKESSON CORPORATION

FINANCIAL NOTES (Continued)

Financial information relating to the reportable operating segments is presented below:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Revenues			
Distribution Solutions ⁽¹⁾			
Direct distribution & services	\$ 77,554	\$ 72,210	\$ 66,876
Sales to customers' warehouses	18,631	21,435	25,809
Total U.S. pharmaceutical distribution & services	96,185	93,645	92,685
Canada pharmaceutical distribution & services	9,784	9,072	8,225
Medical-Surgical distribution & services	2,920	2,861	2,658
Total Distribution Solutions	108,889	105,578	103,568
Technology Solutions			
Services	2,483	2,439	2,337
Software & software systems	590	571	572
Hardware	122	114	155
Total Technology Solutions	3,195	3,124	3,064
Total	\$ 112,084	\$ 108,702	\$ 106,632
Operating profit			
Distribution Solutions ⁽²⁾	\$ 1,897	\$ 1,988	\$ 1,158
Technology Solutions ⁽³⁾	301	385	334
Total	2,198	2,373	1,492
Corporate	(341)	(342)	(284)
Litigation credit, net	—	20	—
Interest expense	(222)	(187)	(144)
Income from continuing operations before income taxes	\$ 1,635	\$ 1,864	\$ 1,064
Amortization of acquisition-related intangibles ⁽⁴⁾			
Distribution Solutions	\$ 70	\$ 54	\$ 51
Technology Solutions	62	67	77
Corporate	—	—	—
Total	\$ 132	\$ 121	\$ 128
Depreciation and other amortization ⁽⁵⁾			
Distribution Solutions	\$ 155	\$ 148	\$ 126
Technology Solutions	147	145	128
Corporate	62	63	59
Total	\$ 364	\$ 356	\$ 313
Expenditures for long-lived assets ⁽⁶⁾			
Distribution Solutions	\$ 162	\$ 95	\$ 83
Technology Solutions	26	31	43
Corporate	45	73	69
Total	\$ 233	\$ 199	\$ 195
Segment assets, at year end			
Distribution Solutions	\$ 22,983	\$ 19,803	\$ 18,674
Technology Solutions	3,504	3,635	3,606
Total	26,487	23,438	22,280
Corporate			
Cash and cash equivalents	3,612	3,731	2,109
Other	787	1,020	878
Total	\$ 30,886	\$ 28,189	\$ 25,267

(1) Revenues derived from services represent less than 1% of this segment's total revenues for 2011, 2010 and 2009.

(2) Operating profit for 2011 includes a \$213 million charge associated with the AWP litigation and also includes a \$51 million credit representing our share of a settlement of an antitrust class action lawsuit brought against a drug manufacturer, which was recorded as a reduction to cost of sales. Operating profit for 2009 includes a \$63 million charge to write-down two equity-held investments and a \$493 million charge associated with the AWP litigation.

(3) Operating profit in 2011 includes a \$72 million asset impairment charge for capitalized software held for sale.

(4) Amounts include amortization of acquired intangible assets purchased in connection with acquisitions by the Company.

(5) Other amortization includes amortization of capitalized software held for sale and capitalized software for internal use.

(6) Long-lived assets consist of property, plant and equipment.

McKESSON CORPORATION

FINANCIAL NOTES (Concluded)

Revenues and property, plant and equipment by geographic areas were as follows:

<i>(In millions)</i>	Years Ended March 31,		
	2011	2010	2009
Revenues			
United States	\$ 102,089	\$ 99,387	\$ 98,194
International	9,995	9,315	8,438
Total	\$ 112,084	\$ 108,702	\$ 106,632
Property, plant and equipment, net, at year end			
United States	\$ 901	\$ 764	\$ 719
International	90	87	77
Total	\$ 991	\$ 851	\$ 796

International operations primarily consist of our operations in Canada, the United Kingdom, Ireland, other European countries and Israel. We also have an equity-held investment (Nadro) in Mexico. Net revenues were attributed to geographic areas based on the customers' shipment locations.

21. Quarterly Financial Information (Unaudited)

<i>(In millions, except per share amounts)</i>	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
Fiscal 2011					
Revenues	\$ 27,450	\$ 27,534	\$ 28,247	\$ 28,853	\$ 112,084
Gross profit ⁽¹⁾	1,392	1,366	1,461	1,751	5,970
Net income ⁽¹⁾⁽²⁾	298	327	155	422	1,202
Earnings per common share ⁽¹⁾⁽²⁾					
Diluted					
Continuing operations	\$ 1.10	\$ 0.97	\$ 0.60	\$ 1.62	\$ 4.29
Discontinued operation ⁽³⁾	—	0.28	—	—	0.28
Total	\$ 1.10	\$ 1.25	\$ 0.60	\$ 1.62	\$ 4.57
Earnings per common share ⁽¹⁾⁽²⁾					
Basic					
Continuing operations	\$ 1.12	\$ 0.99	\$ 0.61	\$ 1.65	\$ 4.37
Discontinued operation ⁽³⁾	—	0.28	—	—	0.28
Total	\$ 1.12	\$ 1.27	\$ 0.61	\$ 1.65	\$ 4.65
Fiscal 2010					
Revenues	\$ 26,657	\$ 27,130	\$ 28,272	\$ 26,643	\$ 108,702
Gross profit	1,303	1,335	1,455	1,583	5,676
Net income ⁽⁴⁾	288	301	326	348	1,263
Earnings per common share ⁽⁴⁾					
Diluted	\$ 1.06	\$ 1.11	\$ 1.19	\$ 1.26	\$ 4.62
Basic	1.07	1.13	1.21	1.29	4.70

- (1) Financial results for the first quarter and full year of 2011 include a credit of \$51 million representing our share of a settlement of an antitrust class action lawsuit. Financial results for the second quarter and full year 2011 include a \$72 million asset impairment charge for capitalized software held for sale. Financial results of US Oncology are included in our consolidated financial statements beginning in the fourth quarter of 2011.
- (2) Financial results for the second and third quarters and full year 2011 include charges of \$24 million pre-tax (\$16 million after-tax), \$189 million pre-tax (\$133 million after-tax) and \$213 million pre-tax (\$149 million after-tax) associated with the AWP litigation.
- (3) Financial results for the second quarter and full year of 2011 include a \$95 million pre-tax (\$72 million after-tax) gain from the sale of MAP.
- (4) Financial results for the third quarter and full year 2010 include a \$17 million pre-tax gain (\$14 million after-tax) on sale of our 50% interest in MLS.

McKESSON CORPORATION

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

Not applicable.

Item 9A. Controls and Procedures

Disclosure Controls and Procedures

Our Chief Executive Officer and our Chief Financial Officer, with the participation of other members of the Company's management, have evaluated the effectiveness of the Company's "disclosure controls and procedures" (as such term is defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) as of the end of the period covered by this report, and have concluded that our disclosure controls and procedures are effective based on their evaluation of these controls and procedures as required by paragraph (b) of Exchange Act Rules 13a-15 or 15d-15.

Internal Control over Financial Reporting

Management's report on the Company's internal control over financial reporting (as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) and the related report of our independent registered public accounting firm are included on page 52 and page 53 of this Annual Report on Form 10-K, under the headings, "Management's Annual Report on Internal Control Over Financial Reporting" and "Report of Independent Registered Public Accounting Firm" and are incorporated herein by reference.

Changes in Internal Controls

There were no changes in our internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Exchange Act Rules 13a-15 or 15d-15 that occurred during the most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information

Not applicable.

McKESSON CORPORATION

PART III

Item 10. Directors, Executive Officers and Corporate Governance

Information about our Directors is incorporated by reference from the discussion under Item 1 of our Proxy Statement for the 2011 Annual Meeting of Stockholders (the “Proxy Statement”) under the heading “Election of Directors.” Information about compliance with Section 16(a) of the Exchange Act is incorporated by reference from the discussion under the heading “Section 16(a) Beneficial Ownership Reporting Compliance” in our Proxy Statement. Information about our Audit Committee, including the members of the committee and our Audit Committee Financial Expert, is incorporated by reference from the discussion under the headings “Audit Committee Report” and “Audit Committee Financial Expert” in our Proxy Statement.

Information about the Code of Ethics governing our Chief Executive Officer, Chief Financial Officer, Controller and Financial Managers can be found on our Web site, www.mckesson.com, under the Investors – Corporate Governance tab. The Company’s Corporate Governance Guidelines and Charters for the Audit and Compensation Committees and the Committee on Directors and Corporate Governance can also be found on our Web site under the Investors – Corporate Governance tab.

The Company intends to disclose required information regarding any amendment to or waiver under the Code of Ethics referred to above by posting such information on our Web site within four business days after any such amendment or waiver.

Item 11. Executive Compensation

Information with respect to this item is incorporated by reference from the discussion under the heading “Executive Compensation” in our Proxy Statement.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

Information about security ownership of certain beneficial owners and management is incorporated by reference from the discussion under the heading “Principal Stockholders” in our Proxy Statement.

McKESSON CORPORATION

The following table sets forth information as of March 31, 2011 with respect to the plans under which the Company's common stock is authorized for issuance:

<i>Plan Category</i> <i>(In millions, except per share amounts)</i>	Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights ⁽¹⁾	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in the first column)
Equity compensation plans approved by security holders	13.0 ⁽²⁾	\$ 52.46	15.8 ⁽³⁾
Equity compensation plans not approved by security holders	1.7 ⁽⁴⁾	\$ 34.30	—

- (1) The weighted-average exercise price set forth in this column is calculated excluding outstanding restricted stock unit ("RSU") awards, since recipients are not required to pay an exercise price to receive the shares subject to these awards.
- (2) Represents options and RSUs awarded under the following plans: (i) 1994 Stock Option and Restricted Stock Plan; (ii) 1997 Non-Employee Directors' Equity Compensation and Deferral Plan; and (iii) the 2005 Stock Plan
- (3) Represents 2,378,455 shares that remained available for purchase under the 2000 Employee Stock Purchase Plan and 13,431,887 shares available for grant under the 2005 Stock Plan.
- (4) Represents options and RSUs awarded under the following plans: (i) 1999 Stock Option and Restricted Stock Plan; and (ii) the 1998 Canadian Stock Incentive Plan. No further awards will be made under any of these plans.

The following are descriptions of equity plans that have been approved by the Company's stockholders. The plans are administered by the Compensation Committee of the Board of Directors, except for the portion of the 2005 Stock Plan related to Non-Employee Directors, which is administered by the Committee on Directors and Corporate Governance.

2005 Stock Plan: The 2005 Stock Plan was adopted by the Board of Directors on May 25, 2005 and approved by the Company's stockholders on July 27, 2005. The 2005 Stock Plan permits the granting of up to 42.5 million shares in the form of stock options, restricted stock ("RS"), RSUs, performance-based restricted stock units ("PeRSUs") and other share-based awards. For any one share of common stock issued in connection with a RS, RSU, PeRSU or other share-based award, two shares shall be deducted from the shares available for future grants. Shares of common stock not issued or delivered as a result of the net exercise of a stock option, shares used to pay the withholding taxes related to a stock award or shares repurchased on the open market with proceeds from the exercise of options shall not be returned to the reserve of shares available for issuance under the 2005 Stock Plan.

Stock options are granted at no less than fair market value and those options granted under the 2005 Stock Plan generally have a contractual term of seven years. Prior to 2005, stock options typically had a contractual term of ten years. Options generally become exercisable in four equal annual installments beginning one year after the grant date or after four years from the date of grant. The vesting of RS or RSUs is determined by the Compensation Committee at the time of grant. RS and RSUs generally vest over four years. Vesting of PeRSUs ranges from one to three-year periods following the end of the performance period and may follow the graded or cliff method of vesting.

Non-employee directors may be granted an award on the date of each annual meeting of the stockholders for up to 5,000 RSUs, as determined by the Board. Such non-employee director award is fully vested on the date of the grant.

1997 Non-Employee Directors' Equity Compensation and Deferral Plan. The 1997 Non-Employee Directors' Equity Compensation and Deferral Plan was approved by the Company's stockholders on July 30, 1997; however, stockholder approval of the 2005 Stock Plan on July 27, 2005 had the effect of terminating the 1997 Non-Employee Directors' Equity Compensation and Deferral Plan such that no new awards would be granted under the 1997 Non-Employee Directors' Equity Compensation and Deferral Plan.

1994 Stock Option and Restricted Stock Plan. The 1994 Stock Option and Restricted Stock Plan expired by its terms on October 18, 2004, ten years after approval by the Board of Directors on October 19, 1994.

McKESSON CORPORATION

2000 Employee Stock Purchase Plan (the "ESPP"): The ESPP is intended to qualify as an "employee stock purchase plan" within the meaning of Section 423 of the Internal Revenue Code. In March 2002, the Board amended the ESPP to allow for participation in the plan by employees of certain of the Company's international and certain other subsidiaries. As to those employees, the ESPP does not qualify under Section 423 of the Internal Revenue Code. Currently, 16 million shares have been approved by stockholders for issuance under the ESPP.

The ESPP is implemented through a continuous series of three-month purchase periods ("Purchase Periods") during which contributions can be made toward the purchase of common stock under the plan.

Each eligible employee may elect to authorize regular payroll deductions during the next succeeding Purchase Period, the amount of which may not exceed 15% of a participant's compensation. At the end of each Purchase Period, the funds withheld by each participant will be used to purchase shares of the Company's common stock. The purchase price of each share of the Company's common stock is based on 85% of the fair market value of each share on the last day of the applicable Purchase Period. In general, the maximum number of shares of common stock that may be purchased by a participant for each calendar year is determined by dividing \$25,000 by the fair market value of one share of common stock on the offering date.

The following are descriptions of equity plans that have not been submitted for approval by the Company's stockholders:

On July 27, 2005, the Company's stockholders approved the 2005 Stock Plan which had the effect of terminating the 1999 Stock Option and Restricted Stock Plan, the 1998 Canadian Stock Incentive Plan and certain 1999 one-time stock option plan awards, which plans had not been submitted for approval by the Company's stockholders, and, as noted above, the 1997 Non-Employee Directors' Equity Compensation and Deferral Plan, which had previously been approved by the Company's stockholders. Prior grants under these plans include stock options, RS and RSUs. Stock options under the terminated plans generally have a ten-year life and vest over four years. RS contains certain restrictions on transferability and may not be transferred until such restrictions lapse. Each of these plans has outstanding equity grants, which are subject to the terms and conditions of their respective plans, but no new grants will be made under these terminated plans.

Item 13. Certain Relationships and Related Transactions and Director Independence

Information with respect to certain transactions with management is incorporated by reference from the Proxy Statement under the heading "Certain Relationships and Related Transactions." Additional information regarding certain related party balances and transactions is included in the Financial Review section of this Annual Report on Form 10-K and Financial Note 19, "Related Party Balances and Transactions," to the consolidated financial statements appearing in this Annual Report on Form 10-K.

Item 14. Principal Accounting Fees and Services

Information regarding principal accounting fees and services is set forth under the heading "Ratification of Appointment of Deloitte & Touche LLP as the Company's Independent Registered Public Accounting Firm for Fiscal 2012" in our Proxy Statement and all such information is incorporated herein by reference.

McKESSON CORPORATION

PART IV

Item 15. Exhibits and Financial Statement Schedule

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Consolidated Balance Sheets as of March 31, 2011 and 2010	55
Consolidated Statements of Stockholders' Equity for the years ended March 31, 2011, 2010 and 2009	56
Consolidated Statements of Cash Flows for the years ended March 31, 2011, 2010 and 2009	57
Financial Notes	58
(a)(2) Financial Statement Schedule	
Schedule II—Valuation and Qualifying Accounts	112
All other schedules not included have been omitted because of the absence of conditions under which they are required or because the required information, where material, is shown in the financial statements, financial notes or supplementary financial information.	
(a)(3) Exhibits submitted with this Annual Report on Form 10-K as filed with the SEC and those incorporated by reference to other filings are listed on the Exhibit Index.....	113

McKESSON CORPORATION

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

McKESSON CORPORATION

Dated: May 5, 2011

/s/ Jeffrey C. Campbell
Jeffrey C. Campbell
Executive Vice President and Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the date indicated:

*
John H. Hammergren
Chairman, President and Chief Executive Officer
(Principal Executive Officer)

*
M. Christine Jacobs, Director

*
Jeffrey C. Campbell
Executive Vice President and Chief Financial Officer
(Principal Financial Officer)

*
Marie L. Knowles, Director

*
Nigel A. Rees
Vice President and Controller
(Principal Accounting Officer)

*
David M. Lawrence, M.D., Director

*
Andy D. Bryant, Director

*
Edward A. Mueller, Director

*
Wayne A. Budd, Director

*
Jane E. Shaw, Director

*
Alton F. Irby III, Director

/s/ Lauren E. Seeger
Lauren E. Seeger
*Attorney-in-Fact

Dated: May 5, 2011

McKESSON CORPORATION

SCHEDULE II

SUPPLEMENTARY CONSOLIDATED FINANCIAL STATEMENT SCHEDULE
 VALUATION AND QUALIFYING ACCOUNTS
 For the Years Ended March 31, 2011, 2010 and 2009
 (In millions)

Description	Balance at Beginning of Year	Additions		Deductions From Allowance Accounts ⁽¹⁾	Balance at End of Year ⁽²⁾
		Charged to Costs and Expenses	Charged to Other Accounts ⁽³⁾		
Year Ended March 31, 2011					
Allowances for doubtful accounts	\$ 131	\$ 18	\$ 5	\$ (30)	\$ 124
Other allowances	24	—	(2)	(6)	16
	<u>\$ 155</u>	<u>\$ 18</u>	<u>\$ 3</u>	<u>\$ (36)</u>	<u>\$ 140</u>
Year Ended March 31, 2010					
Allowances for doubtful accounts	\$ 152	\$ 17	\$ 7	\$ (45)	\$ 131
Other allowances	12	6	10	(4)	24
	<u>\$ 164</u>	<u>\$ 23</u>	<u>\$ 17</u>	<u>\$ (49)</u>	<u>\$ 155</u>
Year Ended March 31, 2009					
Allowances for doubtful accounts	\$ 163	\$ 27	\$ 3	\$ (41)	\$ 152
Other allowances	9	6	1	(4)	12
	<u>\$ 172</u>	<u>\$ 33</u>	<u>\$ 4</u>	<u>\$ (45)</u>	<u>\$ 164</u>

	2011	2010	2009
(1) Deductions:			
Written off	\$ 36	\$ 49	\$ 27
Operation sold	—	—	6
Credited to other accounts	—	—	12
Total	<u>\$ 36</u>	<u>\$ 49</u>	<u>\$ 45</u>

(2) Amounts shown as deductions from current and non-current receivables	<u>\$ 140</u>	<u>\$ 155</u>	<u>\$ 164</u>
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(3) Primarily represents reclassifications from other balance sheet accounts.

McKESSON CORPORATION

EXHIBIT INDEX

The agreements included as exhibits to this report are included to provide information regarding their terms and not intended to provide any other factual or disclosure information about the Company or the other parties to the agreements. The agreements may contain representations and warranties by each of the parties to the applicable agreement that were made solely for the benefit of the other parties to the applicable agreement, and;

- should not in all instances be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate;
- may apply standards of materiality in a way that is different from what may be viewed as material to you or other investors; and
- were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement and are subject to more recent developments.

Accordingly, these representations and warranties may not describe the actual state of affairs as of the date they were made or at any other time.

Exhibits identified under “Incorporated by Reference” in the table below are on file with the Commission and are incorporated by reference as exhibits hereto.

Exhibit Number	Description	Incorporated by Reference			
		Form	File Number	Exhibit	Filing Date
3.1	Amended and Restated Certificate of Incorporation of the Company as filed with the Delaware Secretary of State on July 25, 2007.	10-Q	1-13252	3.1	October 31, 2007
3.2	Amended and Restated By-Laws of the Company, as amended through April 22, 2009.	8-K	1-13252	3.2	April 28, 2009
4.1	Indenture, dated as of March 11, 1997, by and between the Company, as Issuer, and The First National Bank of Chicago, as Trustee.	10-K	1-13252	4.4	June 19, 1997
4.2	Indenture, dated as of January 29, 2002, between the Company, as Issuer, and The Bank of New York, as Trustee.	10-K	1-13252	4.6	June 12, 2002
4.3	Indenture, dated as of March 5, 2007, by and between the Company, as Issuer, and The Bank of New York Trust Company, N.A., as Trustee.	8-K	1-13252	4.1	March 5, 2007
4.4	First Supplemental Indenture, dated as of February 28, 2011, to the Indenture, dated as of March 5, 2007, among the Company, as Issuer, The Bank of New York Mellon Trust Company, N.A. (formerly known as The Bank of New York Trust Company, N.A.), and Wells Fargo Bank, National Association, as Trustee.	8-K	1-13252	4.2	February 28, 2011
10.1*	McKesson Corporation 1994 Stock Option and Restricted Stock Plan as amended through July 31, 2001.	10-K	1-13252	10.4	June 12, 2002

McKESSON CORPORATION

Exhibit Number	Description	Incorporated by Reference			
		Form	File Number	Exhibit	Filing Date
10.2*	McKesson Corporation 1999 Stock Option and Restricted Stock Plan, as amended through May 26, 2004.	10-K	1-13252	10.2	May 7, 2008
10.3*	McKesson Corporation 1997 Non-Employee Directors' Equity Compensation and Deferral Plan, as amended through January 29, 2003.	10-K	1-13252	10.4	June 10, 2004
10.4*	McKesson Corporation Supplemental Profit Sharing Investment Plan, as amended and restated on January 29, 2003.	10-K	1-13252	10.6	June 6, 2003
10.5*	McKesson Corporation Supplemental Profit Sharing Investment Plan II, as amended and restated on October 24, 2008.	10-Q	1-13252	10.1	October 29, 2008
10.6*	McKesson Corporation Deferred Compensation Administration Plan, as amended and restated as of October 28, 2004.	10-K	1-13252	10.6	May 13, 2005
10.7*	McKesson Corporation Deferred Compensation Administration Plan II, as amended and restated as of October 28, 2004, and Amendment No. 1 thereto effective July 25, 2007.	10-K	1-13252	10.7	May 7, 2008
10.8*	McKesson Corporation Deferred Compensation Administration Plan III, as amended and restated October 24, 2008.	10-Q	1-13252	10.2	October 29, 2008
10.9*	McKesson Corporation Option Gain Deferral Plan, as amended and restated as of October 28, 2004.	10-K	1-13252	10.8	May 13, 2005
10.10*	McKesson Corporation Executive Benefit Retirement Plan, as amended and restated on October 24, 2008.	10-Q	1-13252	10.3	October 29, 2008
10.11*	McKesson Corporation Executive Survivor Benefits Plan, as amended and restated as of January 20, 2010.	8-K	1-13252	10.1	January 25, 2010
10.12*	McKesson Corporation Severance Policy for Executive Employees, as amended and restated December 29, 2008.	10-K	1-13252	10.12	May 5, 2009
10.13*	McKesson Corporation Change in Control Policy for Selected Executive Employees, as amended and restated on October 26, 2010.	10-Q	1-13252	10.2	February 1, 2011
10.14*	McKesson Corporation 2005 Management Incentive Plan, as amended and restated on April 21, 2010, effective July 28, 2010.	10-Q	1-13252	10.3	July 30, 2010

McKESSON CORPORATION

Exhibit Number	Description	Incorporated by Reference			
		Form	File Number	Exhibit	Filing Date
10.15*	Form of Statement of Terms and Conditions Applicable to Awards Pursuant to the McKesson Corporation 2005 Management Incentive Plan, effective April 20, 2010.	10-K	1-13252	10.15	May 4, 2010
10.16*	McKesson Corporation Long-Term Incentive Plan, as amended and restated effective May 26, 2010.	10-Q	1-13252	10.1	July 30, 2010
10.17*	Form of Statement and Terms and conditions Applicable to Awards Pursuant to the McKesson Corporation Long-Term Incentive Plan, made on or after May 26, 2009.	10-Q	1-13252	10.2	July 30, 2010
10.18*	McKesson Corporation 2005 Stock Plan, as amended and restated on July 28, 2010.	10-Q	1-13252	10.4	July 30, 2010
10.19*	Forms of (i) Statement of Standard Terms and Conditions applicable to Options, Restricted Stock, Restricted Stock Units and Performance Shares, (ii) Stock Option Grant Notice and (iii) Restricted Stock Unit Agreement, under the McKesson Corporation 2005 Stock Plan, as amended and restated on October 26, 2010.	10-Q	1-13252	10.1	February 1, 2011
10.20	Third Amended and Restated Receivables Purchase Agreement, dated as of May 19, 2010, among the Company, as servicer, CGSF Funding Corporation, as seller, the several conduit purchasers from time to time party to the Agreement, the several committed purchasers from time to time party to the Agreement, the several managing agents from time to time party to the Agreement, and JPMorgan Chase Bank, N.A., as collateral agent.	10-Q	1-13252	10.6	July 30, 2010

McKESSON CORPORATION

Exhibit Number	Description	Incorporated by Reference			
		Form	File Number	Exhibit	Filing Date
10.21	Amended and Restated Credit Agreement, dated as of June 8, 2007 among the Company and McKesson Canada Corporation, collectively, the Borrowers, Bank of America, N.A., as Administrative Agent, Bank of America, N.A. (acting through its Canada branch), as Canadian Administrative Agent, JPMorgan Chase Bank and Wachovia Bank, National Association, as Co-Syndication Agents, Wachovia Bank, National Association, as L/C Issuer, The Bank of Nova Scotia and The Bank of Tokyo-Mitsubishi UFJ, LTD., Seattle branch, as Co-Documentation Agents, and The Other Lenders Party Hereto Banc of America Securities LLC, as sole lead arranger and sole book manager.	8-K	1-13252	10.1	June 14, 2007
10.22†††	Purchase Agreement, dated as of December 31, 2002, between McKesson Capital Corp. and General Electric Capital Corporation.	10-Q	1-13252	10.7	July 30, 2010
10.23†††	Services Agreement, dated as of December 31, 2002, between McKesson Capital Corp. and General Electric Capital Corporation.	10-Q	1-13252	10.8	July 30, 2010
10.24	Senior Bridge Term Loan Agreement, dated as of November 23, 2010, among The Company, Bank of America N.A., as Administrative Agent, and the Lenders party thereto.	8-K	1-13252	10.1	November 29, 2010
10.25*	Amended and Restated Employment Agreement, effective as of November 1, 2008, by and between the Company and its Chairman, President and Chief Executive Officer.	10-Q	1-13252	10.10	October 29, 2008
10.26*	Amended and Restated Employment Agreement, effective as of November 1, 2008, by and between the Company and its Executive Vice President and Group President.	10-Q	1-13252	10.12	October 29, 2008
10.27*	Form of Director and Officer Indemnification Agreement.	10-K	1-13252	10.27	May 4, 2010
12†	Computation of Ratio of Earnings to Fixed Charges.	—	—	—	—
21†	List of Subsidiaries of the Registrant.	—	—	—	—
23†	Consent of Independent Registered Public Accounting Firm, Deloitte & Touche LLP.	—	—	—	—

McKESSON CORPORATION

Exhibit Number	Description	Incorporated by Reference			
		Form	File Number	Exhibit	Filing Date
24†	Power of Attorney.	—	—	—	—
31.1†	Certification of Chief Executive Officer Pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act of 1934, as amended, and adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.	—	—	—	—
31.2†	Certification of Chief Financial Officer Pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act of 1934 as amended, and adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.	—	—	—	—
32††	Certification Pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	—	—	—	—
101††	The following materials from the McKesson Corporation Annual Report on Form 10-K for the fiscal year ended March 31, 2011, formatted in Extensible Business Reporting Language (XBRL): (i) the Consolidated Statements of Operations, (ii) Consolidated Balance Sheets, (iii) Consolidated Statements of Stockholders' Equity, (iv) Consolidated Statements of Cash Flows, and (v) related notes.	—	—	—	—

* Management contract or compensation plan or arrangement in which directors and/or executive officers are eligible to participate.

† Filed herewith.

†† Furnished herewith.

††† Confidential treatment has been granted for certain portions of this exhibit and such confidential portions have been filed with the Commission.

Registrant agrees to furnish to the Commission upon request a copy of each instrument defining the rights of security holders with respect to issues of long-term debt of the registrant, the authorized principal amount of which does not exceed 10% of the total assets of the registrant.

McKESSON CORPORATION

DIRECTORS AND OFFICERS

BOARD OF DIRECTORS

John H. Hammergren
Chairman, President and Chief Executive Officer,
McKesson Corporation

Andy D. Bryant
Executive Vice President and
Chief Administrative Officer,
Intel Corporation

Wayne A. Budd
Senior Counsel,
Goodwin Procter LLP

Alton F. Irby III
Chairman and Founding Partner,
London Bay Capital

M. Christine Jacobs
Chairman of the Board, President and
Chief Executive Officer,
Theragenics Corporation

Marie L. Knowles
Executive Vice President and
Chief Financial Officer, Retired,
Atlantic Richfield Company

David M. Lawrence, M.D.
Chairman of the Board and
Chief Executive Officer, Retired,
Kaiser Foundation Health Plan, Inc. and
Kaiser Foundation Hospitals

Edward A. Mueller
Chairman of the Board and
Chief Executive Officer, Retired,
Qwest Communications International Inc.

Jane E. Shaw, Ph.D.
Chairman of the Board, Intel Corporation;
Chairman of the Board and
Chief Executive Officer, Retired,
Aerogen, Inc.

CORPORATE OFFICERS

John H. Hammergren
Chairman, President and Chief Executive Officer

Patrick J. Blake
Executive Vice President and Group President

Jeffrey C. Campbell
Executive Vice President and Chief Financial Officer

Jorge L. Figueredo
Executive Vice President, Human Resources

Paul C. Julian
Executive Vice President and Group President

Marc E. Owen
Executive Vice President, Corporate Strategy and
Business Development

Laureen E. Seeger
Executive Vice President, General Counsel and
Chief Compliance Officer

Randall N. Spratt
Executive Vice President, Chief Technology Officer
and Chief Information Officer

Nicholas A. Loiacono
Vice President and Treasurer

Nigel A. Rees
Vice President and Controller

Willie C. Bogan
Secretary

McKESSON CORPORATION
CORPORATE INFORMATION

Common Stock

McKesson Corporation common stock is listed on the New York Stock Exchange (ticker symbol MCK) and is quoted in the daily stock tables carried by most newspapers.

Stockholder Information

Wells Fargo Shareowner Services, 161 Concord Exchange North, South St. Paul, MN 55075 acts as transfer agent, registrar, dividend-paying agent and dividend reinvestment plan agent for McKesson Corporation stock and maintains all registered stockholder records for the Company. For information about McKesson Corporation stock or to request replacement of lost dividend checks, stock certificates, 1099-DIVs, or to have your dividend check deposited directly into your checking or savings account, stockholders may call Wells Fargo Shareowner Services' telephone response center at (866) 614-9635. For the hearing impaired call (651) 450-4144. Wells Fargo Shareowner Services also has a Web site: <http://www.wellsfargo.com/shareownerservices> – that stockholders may use 24 hours a day to request account information.

Dividends and Dividend Reinvestment Plan

Dividends are generally paid on the first business day of January, April, July and October. McKesson Corporation's Dividend Reinvestment Plan offers stockholders the opportunity to reinvest dividends in common stock and to purchase additional shares of common stock. Stock in an individual's Dividend Reinvestment Plan is held in book entry at the Company's transfer agent, Wells Fargo Shareowner Services. For more information, or to request an enrollment form, call Wells Fargo Shareowner Services' telephone response center at (866) 614-9635. From outside the United States, call +1-651-450-4064.

Annual Meeting

McKesson Corporation's Annual Meeting of Stockholders will be held at 8:30 a.m. PDT, on Wednesday, July 27, 2011 at the Palace Hotel, Sea Cliff Room, 2 New Montgomery Street, San Francisco, California.

**CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE SECURITIES EXCHANGE ACT, AS ADOPTED
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, John H. Hammergren, certify that:

1. I have reviewed this annual report on Form 10-K of McKesson Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
 - a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 5, 2011

/s/ John H. Hammergren
John H. Hammergren
Chairman, President and Chief Executive Officer

**CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE SECURITIES EXCHANGE ACT, AS ADOPTED
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Jeffrey C. Campbell, certify that:

1. I have reviewed this annual report on Form 10-K of McKesson Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
 - a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 5, 2011

/s/ Jeffrey C. Campbell

Jeffrey C. Campbell

Executive Vice President and Chief Financial Officer

**CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the annual report of McKesson Corporation (the “Company”) on Form 10-K for the year ended March 31, 2011 as filed with the Securities and Exchange Commission on the date hereof (the “Report”), the undersigned, in the capacities and on the dates indicated below, each hereby certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that to the best of their knowledge:

1. The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ John H. Hammergren
John H. Hammergren
Chairman, President and Chief Executive Officer
May 5, 2011

/s/ Jeffrey C. Campbell
Jeffrey C. Campbell
Executive Vice President and Chief Financial Officer
May 5, 2011

This certification accompanies the Report pursuant to § 906 of the Sarbanes-Oxley Act of 2002, and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for the purposes of Section 18 of the Securities Exchange Act of 1934, as amended.

A signed original of this written statement required by Section 906 has been provided to McKesson Corporation and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.

MARY JO MARX
Senior Strategic Account Manager

Ms. Marx has been in the healthcare industry over 18 years.

McKesson Health Solutions, Broomfield, CO **1995 – Present**

Senior Strategic Account Manager, McKesson Health Solutions, Broomfield, CO **2002 – Present**

- Responsible for overall relationship with strategic clients encompassing all products and services. This includes Managed Care Organizations providing services to the Medicaid FFS, TANF and ABD/SPD population.
- Interaction at all levels within the organization – CEO, CFO, CIO, CNO, CMO, Directors, and end-users.
- Educate customers on value-add opportunities available via peer networking, product education, add-on modules, and new offerings.

Sales Executive **2000 – 2002**

- Responsible for sale of Decision Support and Contract Management suite of products to new and existing client base.
- Interact with all client levels – CEO, CFO, CIO, CNO, CMO, Directors, and end-users.

Account Manager **1995 – 2000**

- Responsible for establishing / maintaining day-to-day relationship with new and existing clients.
- Educate customers on value-add opportunities available via peer networking, product education, add-on modules, and new product offerings.
- Coordinate Annual Regional User Conferences – identify location, develop agenda, and secure speakers.
- Develop / facilitate state level User Groups to provide low cost peer networking opportunities.

Decision Support Coordinator, Northside Hospital, Atlanta, GA **1993 – 1995**

- Identified, analyzed and implemented Decision Support issues for financial system conversion.
- Designed, developed, and distributed ad hoc clinical and financial reports.
- Maintained Decision Support database.
- Developed department policies relating to system maintenance, data sources and information reporting / distribution.

Operations Supervisor, Madera Enterprises, San Antonio, TX **1992 – 1993**

- Supervised daily operations of multi-million dollar construction firm.
- Developed and maintained job-costing and accounts payable/receivable database.

EDUCATION

Texas A&M University, B.S. Computer Information Systems, Magna Cum Laude 1992

REFERENCES UPON REQUEST

CORIANNE C. BATZ

Client Service Manager

Ms. Batz has twenty years of experience in the healthcare industry with more than 15 years of working with Medicaid managed care populations. She has demonstrated success in developing and implementing strategic service architecture and a customer service operations plan required to exceed customer and business expectations. She has the ability to effectively manage multiple project responsibilities simultaneously while motivating and guiding teams. Ms. Batz's experience is concentrated in the areas of client services, contractual compliance, operations and technical support.

Client Service Manager, McKesson Health Solutions, Broomfield, CO **1999 – Present**

- Currently maintain two of Health Solutions' largest commercial clients with a 90+% customer service rating
- Responsible for providing implementation and ongoing operational support to assigned clients. Includes implementing new accounts, conversion of existing accounts to current platforms, and ongoing management of the accounts.
- Accountable for interpreting and executing the terms of a client's contract, conducting meetings, and managing an entire implementation process. Post-implementation duties include acting as an expert to the assigned accounts and serving as a liaison to all internal departments for support of coordination and problem resolution.
- Responsible for independently managing accounts of key strategic value, ensuring client satisfaction with McKesson products and services while service as the central point of contact for operational issues between clients and McKesson.
- Provide continued support to the assigned client throughout the continuum of the relationship to help the client achieve their business objectives.

Account Marketing Representative, Health Script division Dura Pharmaceuticals, Inc Englewood, Colorado **1996-1999**

- Served in an account marketing and sales capacity aiding a specific region. Involved in maintenance, growth, and proactive marketing of Health Script services and products to all marketing channels.
- Played an integral part in the development and implementation of the home health strategy for Home Rx. Interacted with Specialty Sales representatives to develop new accounts into productive long term customers.
- Awards include February 1996 and October 1997 Employee of the Month in addition to a reward recognition for training other Account Marketing Representatives in the Direct to consumer program.

Admissions/Marketing Representative, Mediplex Rehab Hospital, Thornton, CO. **1994-1995**

- Coordinated with nurses and doctors on patient status, verified patient insurance, and assigned rooms for patient placement.
- Acted as liaison with referring facilities to promote efficient intakes of patients and smooth transition of patient transfers.
- Performed marketing functions such as direct mail lead referrals and providing hospital tours of its services and programs to patients and their families.

Pharmacy Technician, Wal-Mart Pharmacy, Fort Collins, CO. **1991-1994**

- Responsible for filling prescriptions, cashiering, and managing product inventory.
- **Aided customers with questions regarding availability and pricing.**

EDUCATION

Bachelor of Arts, Speech Communications

Colorado State University, Fort Collins, Colorado, 1995

REFERENCES UPON REQUEST

**Instructions for completing the
McKesson Job Description**

McKesson
Job Description

Job Title: Triage Level II Registered Nurse
Job Code:
Dept./Group:
FLSA Status:
Grade:
Position reports to: Operations Supervisor

(Attach the current organizational chart associated with this position)

Position Summary (Purpose of job):

Triage RN provides care to individuals or defined patient populations through the use of telecommunications in accordance with computer-based algorithms, protocols, or guidelines. The Triage nurse uses critical thinking and communication skills to assess, plan, implement, educate and evaluate patient outcomes. Services are performed telephonically and interventions are recorded in the Personal Health Advisor (PHA) application.

Key Responsibilities (List the top five to seven essential responsibilities in priority order):

		%
1.	Using the Nursing Process, provides nursing care within the standards of the state Nurse Practice Act.	
2.	Provides care to individuals or defined patient populations through the use of telecommunications in accordance with computer-based algorithms, protocols, or guidelines.	
3.	Using the defined process, adheres to nursing standards, company policies and shared principles when providing clinical assessments and health education.	
4.	Uses the nursing process to identify patient care needs, risk and safety issues, educational opportunities, and appropriate health care referrals.	
5.	Processes calls based on Quality Management guidelines.	
6.	Demonstrates compliance with all product specific performance metrics.	
7.	Should be competent in multiple products.	
8.	May participate as a preceptor and/or resource nurse	
		100%

Minimum Job Qualifications:

- Current, valid RN license in good standing
- A minimum of one year of clinical call center experience delivering product services, or experience resulting in full proficiency in proprietary systems
- Registered nurse responsible and accountable for advanced clinical practice and ability to serve as a professional role model.
- Excellent communication, telephone and customer relation skills
- Good critical thinking, decision-making, and problem-solving skills.
- Computer skills

Knowledge and Skills:

- Ability to apply clinical knowledge to effectively meet business standards
- Fully competent in product delivery and business requirements
- Identifies opportunities for improvement and recommends workable solutions
- Volunteers to participate in special projects

- Seeks out learning opportunities for professional development
- Facilitates change
- Proactive
- Exercises judgment within defined practices and procedures to determine appropriate action
- Ability to determine when to escalate issues appropriately and in a timely manner
- Builds rapport with members and effectively influences member behavior
- Comprehensive communication (listening, reflection, and clarification) skills
- Communicates with co-workers in a professional manner
- Manages time effectively

Working Conditions:

Environment – Office or work-at-home environment. For staff located outside of McKesson’s office environment, must have access to high speed internet connection (e.g. DSL, Cable) and be able to comply with work-at-home agent requirements.

Physical Requirements:

General office demands. Occasional overnight travel.

(This description is general in nature and is not intended to be an exhaustive list of all responsibilities. Other duties may be assigned as needed to meet company goals.)



Job Description

Job Title: Health Resource Coordinator

Job Code: 201119

Dept/Group: Care Center Operations

FLSA Status: Non exempt

Grade: CS Rep 2

Position reports to: Care Center Supervisor/Manager

Position Summary (Purpose of job):

This position is non-clinical. The Health Resource Coordinator (HRC) provides physician referrals and class registration/enrollment services for the consumer/member. The HRC may conduct outbound follow-up calls, satisfaction surveys, and other types of outbound services as well. The HRC does not provide any medical advice.

Key Responsibilities (List five to seven essential responsibilities in priority order):

- Effectively performs physician referrals and class registration/enrollment services for the consumer/member on an inbound and outbound basis.
- Maintains a constructive working relationship with callers, physician offices, clients, team members, and supervisors.
- Accurately records, tracks, and reports on all activities on an as needed basis.
- Maintains and updates physician information and database information in a timely and accurate manner.
- Adheres to McKesson Policies and Procedures.

Minimum Job Qualifications

Education/Training:

- High school degree or equivalent experience.

Business Experience:

- One year previous experience working in an office setting as a receptionist, telephone customer service representative, telemarketing representative, or health care representative required.

Specialized Knowledge/Skills:

- Types 40 words per minute and has computer experience in a “Windows” environment.
- Knowledge of basic medical terminology.
- Strong verbal and written communication skills. Demonstrated active listening skills.
- Good problem-solving skills.
- Demonstrated ability to handle multiple tasks at the same time.
- Demonstrated team work skills.
- Ability to work with little supervision.

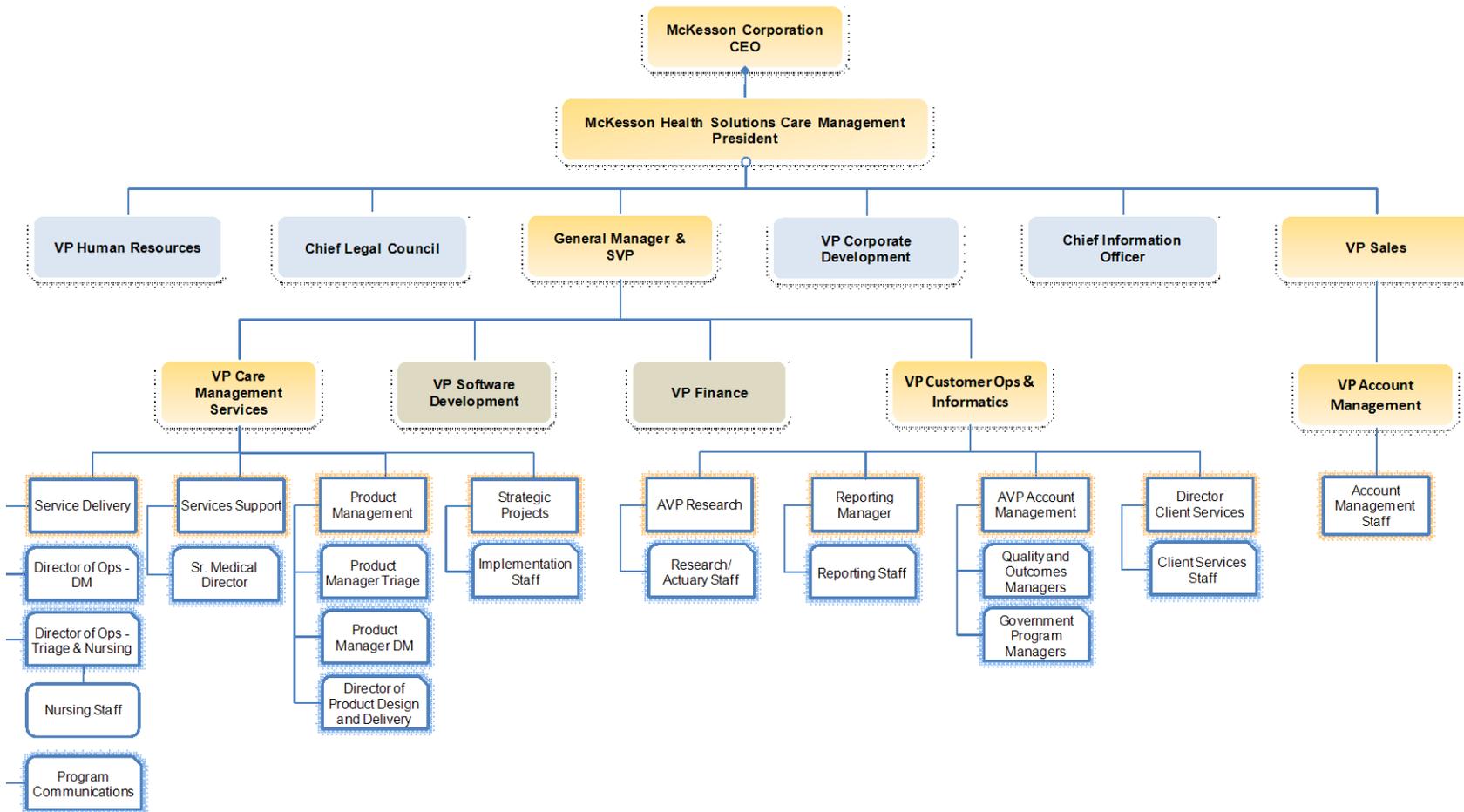
Working Conditions

Environment (Office, warehouse, etc.): **Office environment.**

Physical Requirements (Lifting, standing, etc.): **Ability to use a computer keyboard, mouse, telephone, and telephone head set.**

(This description is general in nature and is not intended to be an exhaustive list of all responsibilities. Other duties may be assigned as needed to meet company goals.)

McKesson Organizational Structure



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Publicly Funded Managed Care Clients

POPULATION	Trade Name	Scope of Work	Contract Duration	Contact Name	Contact Phone	Population Types (TANF, ABD, Dual, etc)	Annual Contract Payments	Capitated (Y/N)	Role of Subcontractors
1,392,908	Coventry Health Care Inc.	24/7 Nurse Advice Line Services	3 years	Mary Jo Marx	678-441-0015	ABD/TANF	Proprietary and Confidential	No	N/A
1,197,638	WellCare HMO	24/7 Nurse Advice Line Services	Evergreen	Matt Roan	717-233-0987	ABD/TANF	Proprietary and Confidential	No	N/A
951,392	Health Net California	24/7 Nurse Advice Line Services	3 years	Mary Jo Marx	678-441-0015	ABD/TANF	Proprietary and Confidential	No	N/A
260,389	Care1st Health Plan	24/7 Nurse Advice Line Services	4 years	Melanie Earwood	678-714-4837	ABD/TANF	Proprietary and Confidential	No	N/A
205,937	Community Health Plan	24/7 Nurse Advice Line Services	4 years	LeeAnne Clayberger	770-649-7865	ABD/TANF	Proprietary and Confidential	No	N/A
252,478	Boston Medical Center HealthNet Plan	24/7 Nurse Advice Line Services	2 years	Mary Jo Marx	678-441-0015	ABD/TANF	Proprietary and Confidential	No	N/A
149,131	Virginia Premier Health Plan	24/7 Nurse Advice Line Services	Evergreen	Melanie Earwood	678-714-4837	ABD/TANF	Proprietary and Confidential	No	N/A
142,724	LA Care Health Plan	24/7 Nurse Advice Line Services	3 years	Melanie Earwood	678-714-4837	ABD/TANF	Proprietary and Confidential	No	N/A
125,969	Regence	24/7 Nurse Advice Line Services	3 years	Mary Jo Marx	678-441-0015	ABD/TANF	Proprietary and Confidential	No	N/A
76,685	Healthy Way LA	24/7 Nurse Advice Line Services	4 years	LeeAnne Clayberger	770-649-7865	ABD/TANF	Proprietary and Confidential	No	N/A
44,760	Family Health Partners	24/7 Nurse Advice Line Services	Evergreen	Melanie Earwood	678-714-4837	ABD/TANF	Proprietary and Confidential	No	N/A
17,964	Metropolitan Health Plan	24/7 Nurse Advice Line Services	7 years	Melanie Earwood	678-714-4837	ABD/TANF	Proprietary and Confidential	No	N/A

Managed Care Non-Medicaid Clients

POPULATION	Trade Name	Scope of Work	Contract Duration	Contact Name	Contact Phone	Population Types (TANF, ABD, Dual, etc)	Annual Contract Payments	Capitated (Y/N)	Role of Subcontractors
8,391,464	Health Care Service Corporation	24/7 Nurse Advice Line Services	6 years	Matt Roan	717-233-0987	Dual	Proprietary and Confidential	No	N/A
5,246,919	Federal Employees Program	24/7 Nurse Advice Line Services	2 years	Bruce Reinhold	302-292-1565	Dual	Proprietary and Confidential	No	N/A
2,870,855	BCBS MA	24/7 Nurse Advice Line Services	Evergreen	Brian Cherubini	413-458-8406	Dual	Proprietary and Confidential	No	N/A
1,549,641	CareFirst BCBS	24/7 Nurse Advice Line Services	Evergreen	Brian Cherubini	413-458-8406	Dual	Proprietary and Confidential	No	N/A
562,396	Capital BlueCross	24/7 Nurse Advice Line Services	5 years	Matt Roan	717-233-0987	Dual	Proprietary and Confidential	No	N/A
527,414	BlueCross BlueShield South Carolina	24/7 Nurse Advice Line Services	Evergreen	Brian Cherubini	413-458-8406	Dual	Proprietary and Confidential	No	N/A
255,992	BlueCross BlueShield Mississippi	24/7 Nurse Advice Line Services	Evergreen	Mary Jo Marx	678-441-0015	Dual	Proprietary and Confidential	No	N/A
205,828	Coventry Health Care Inc.	24/7 Nurse Advice Line Services	3 years	Mary Jo Marx	678-441-0015	Dual	Proprietary and Confidential	No	N/A

McKesson Health Solutions Quality Improvement Program Description

July 2010



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Introduction

Each year, McKesson Health Solutions produces a Quality Improvement Program Description summarizing the global quality and performance improvement activities occurring throughout our organization every day.

As leaders at McKesson Health Solutions, we embrace several performance improvement methodologies as a mechanism for continuous operational improvement. We are confident that the Quality Improvement Program Description is evidence of the quality and performance improvement activities that shape our business culture.

The Quality Improvement Program Description contains information regarding:

- Quality Improvement Program mission, goals, methodologies and culture
- Quality Improvement Committees
- Operations Program and strategies for measuring performance
- Technical Quality Assurance and Technical Recovery Plan
- Risk and Regulatory Compliance Program
- Analysis of the FY 2010 Performance Improvement Program

Sincerely,



Peter Csapo
CFO/Vice President, Informatics of McKesson
Health Solutions



Fredric Leary
Senior Medical Director/Chief Medical Officer,
Quality and Clinical Outcomes of McKesson
Health Solutions

McKesson Health Solutions Quality Improvement Program

Quality Improvement Mission Statement

McKesson Health Solutions' mission is to become the best care management service company that engages members and their physicians to improve the health of the population and create positive outcomes for our clients.

Quality improvement functions facilitate the realization of the McKesson Health Solutions (MHS) mission by promoting member safety and monitoring quality performance standards, product performance standards, client performance standards, and client satisfaction. The MHS Quality Improvement Program is administered by quality and performance improvement experts that consult with internal and external clients in the development of:

- Clinical competencies
- Program compliance standards
- Tools and processes to monitor administrative and clinical performance
- Management training (monitoring, auditing, and process improvement)
- Process improvement recommendations

The Quality Improvement Program is responsible for facilitating improvement efforts as identified by the General Manager, Services Executive Team (SET) and key stakeholders within the organization.

Quality Improvement (QI) is a proven, structured process for change, and a systematic and measurable way to examine business practices. Relying on the creativity of all members of the organization, the MHS QI Program leads empowered teams through a logical sequence of steps that encourage thorough analysis of problems, identification of potential causes, and possible solutions. The purpose of the QI Program is to continually improve our products, processes, and systems to support the highest quality of care and services delivery to our members, clients, and providers.

The QI process within an organization ensures quality, which guarantees that the clients' changing business needs and program goals are continuously met. QI allows us to stay abreast of these changes and proactively review program outcomes to ensure positive results for our customers.

Quality Improvement Models

We are committed to providing the highest quality in delivery of the MHS suite of products and services. We have developed a comprehensive integrated QI process to achieve our quality outcomes and fulfill our corporate mission. The QI program for MHS is based on four primary models:

1. Quality Control
2. Continuous Performance Improvement (CPI)
3. Six Sigma™
4. The Capability Maturity Model Integration® (CMMI)

Quality Control Model

Quality Control is defined as a system for maintaining desired standards in a product or process. This is accomplished through the inspection of samples of the product.

MHS uses Quality Control, primarily as a methodology in Operations, which relies on consistent evaluation of performance metrics to control our service delivery. Some of the metrics used to monitor the care management services such as Personal Health Advisor® Nurse Advice Line, Care Management/Disease Management and care coordination services are listed in Table 1:

Personal Health Advisor® Nurse Advice Line	Care Management/Disease Management
Service Level Standards	Call Delivery
Call Length	Call Timeliness
Algorithm Utilization	Nurse Performance
Sorting Metrics	Clinical Outcomes
Safety	Safety

Table 1: Examples of Quality Control Indicators

The data collection for quality control is obtained through routine monitoring, audits, special projects, and other monitoring methodologies. The data is reviewed by operations, program outcomes managers, quality committees, the SET and the General Manager on a regular basis. Quality control provides one of the many avenues used to identify improvement opportunities.

Continuous Performance Improvement Model

Continuous Performance Improvement (CPI), adopted from the principles of Total Quality Management (TQM), is a concept that is integral to the QI efforts of MHS. CPI provides a set of management processes, practices and tools throughout the organization, geared to ensure the organization consistently meets or exceeds client requirements and places a strong focus on process measurement as means of continuous improvement.

MHS uses CPI as the QI foundation with years of documented successes. MHS, being a matrix organization, provides many opportunities for multi-departmental integration of improvement efforts and collaboration with clients and providers.

Six Sigma™ Model

Six Sigma™, a federally registered trademark of Motorola, is defined as a way of measuring processes. Six Sigma™ is; a goal of near perfection represented by 3.4 defects per million opportunities (DPMO); an approach to changing the culture of an organization; a broad and comprehensive system for building and sustaining business performance successes and leadership. The objectives of Six Sigma™ are to use rigorous collection and analysis of data in order to identify defects in existing processes and products, and to correct problems that prevent optimal performance.

McKesson is proud to lead the way as the first healthcare services enterprise to adopt Six Sigma™, the leading edge quality process improvement methodology. The Six Sigma™ strategy is a commitment to client quality and a key tool for defining and implementing operational excellence. Six Sigma™ is a key corporate wide culture shift to process redesign and optimization.

As a division of McKesson, MHS began using Six Sigma™ for process improvement in 2005. MHS' leadership is committed to the incorporation of Six Sigma™ into our business practices. The commitment allows for allocation of significant resources to put new quality tools in place throughout the organization. This process improvement approach provides training to associates who use the methodology and its analytical tools to solve problems, eliminate variation and improve quality and client satisfaction. MHS has adopted the Six Sigma™ approach to operational excellence, enhancing our commitment to quality and maintaining our leading market position among healthcare service businesses. Focusing on total client satisfaction together with increasing efficiency in our operations is an important part of fulfilling our corporate mission.

Capability Maturity Model Integration® Model

CMMI® is an innovative approach to quality and process improvement for product development that was introduced by Carnegie Mellon Software Engineering Institute (SEI). It consists of best practices that cover the life-cycle of product production from conception through delivery and maintenance. SEI developed a model that integrates the usual and customary dimensions of focus: people, procedures, methods, tools and equipment integrated through process development. The focus of a capability maturity model is to improve the processes within an organization related, in this application, to software development.

The MHS product/software development team is committed to the pursuit of CMMI® levels of maturity. In a rigorous assessment process, completed by an independent assessor, the development organization assessed at CMM Maturity Level 2.

MHS Quality Improvement Program Goals

MHS has a longstanding commitment to delivering programs with high levels of clinical quality that are scrutinized both internally and externally with oversight by multiple organizations including the National Committee on Quality Assurance (NCQA) and the American Accreditation HealthCare Commission, Inc. (URAC).

The MHS QI Program has specific goals used to establish priorities and facilitate program evaluation. For each goal, corresponding objectives are used to accomplish specific program goals. Objectives associated with service or product lines have measurement strategies to assist in evaluating the service or product. Table 2 below lists the QI program goals and objectives:

<i>Quality Improvement Program Goals</i>	<i>Objectives</i>	<i>Evaluation Methodology</i>
<p>1. Execute and maintain the operational functions of the QI Program in a timely and effective manner and in accordance with plan and regulatory requirements.</p>	<p>Systematic and Ongoing Evaluation of the Quality Improvement Plan: Review and revise the Quality Improvement Plan, as needed, to maintain an effective QI plan and QI program in compliance with recognized legal, and regulatory standards, patient safety standards, industry standards and the business commitment to healthcare quality. Multidisciplinary review is completed at a minimum of annually, with approval by the corresponding quality committees and business executive.</p> <p>Coordinate Standing QI Committees: Facilitate and maintain an effective liaison with other MHS committees to ensure coordination of performance improvement activities and to appropriately route any identified improvement opportunities.</p> <p>Maintain Physician and Nurse Credentialing: Oversee maintenance of Physician and Nursing credentialing functions as delineated by the American Nursing Credentialing Center (ANCC), American Medical Association (AMA) standards, and other legal and accreditation standards.</p>	<ul style="list-style-type: none"> • <i>Annual Plan Review Process</i> • <i>Services Quality Steering Committee (SQSC) minutes</i> • <i>Minutes of corresponding committees</i> • <i>Signatures of Executives</i> • <i>Disease Management Quality Committee (CM/DM QC) – meets not less than quarterly with minutes</i> • <i>Personal Health Advisor® Nurse Advice Line Quality Committee (PHA NAL QC) – meets not less than quarterly with minutes</i> • <i>Compliance Committee meets not less than quarterly with minutes</i> • <i>Other MHS QI Committees</i>

<i>Quality Improvement Program Goals</i>	<i>Objectives</i>	<i>Evaluation Methodology</i>
	<p>Oversee Policies and Operational Guidelines: Develop and maintain policies and operational guidelines. Create or consult on policy development.</p> <p>Monitor Regulatory Requirements: Provide quality and performance improvement support to maintain URAC and NCQA accreditation and HIPAA compliance.</p>	<ul style="list-style-type: none"> • <i>Policy and Operational Guideline Committee – meets not less than monthly with minutes</i> • <i>Minutes of DM QC, NAL QC and Compliance Committee</i>
<p>2. Identify, conduct and establish multi-disciplinary teams to achieve process improvement activities that support performance improvement projects and organizational goals.</p>	<p>Evaluate QI Project Results: Analyze the results of QI activities, evaluate data generated, and make recommendation for changes in MHS policies, procedures, practices, and product delivery.</p> <p>Report QI Project Findings: Report relevant information and recommendations to the Services Quality Steering Committee and Services Executive Team, Disease Management Quality Meeting, Triage Quality Meeting and other committees as appropriate.</p> <p>Coordinate QI Project Committees: Facilitate and maintain an effective liaison with other MHS groups to ensure coordination and implementation of QI activities.</p> <p>Track QI Activities: Provide expertise and QI tools to facilitate and track improvement activities undertaken by other MHS groups to meet quality deliverables.</p>	<ul style="list-style-type: none"> • <i>SQSC – meets not less than quarterly with minutes</i> • <i>DMQC – meets not less than quarterly with minutes</i> • <i>PHA NAL QC – meets not less than quarterly</i> • <i>Compliance Committee – meets not less than quarterly</i> • <i>Clinical Improvement Committee (CIC) – meets not less than quarterly</i>
<p>3. Utilize performance improvement expertise and tools to support quality and performance improvement efforts.</p>	<p>Data Driven Improvement Efforts: Utilize data to improve the health status of the populations we serve through provider intervention, self-management education and motivational nursing interventions. Monitor and intervene as possible to maintain appropriate utilization rates.</p> <p>Service Level Improvement Efforts: Participate in establishing internal target goals for clinical indicators. Monitor and intervene as necessary to meet or exceed client and business financial goals related to service.</p> <p>Provider Level Improvement Efforts: Utilize data and evaluate provider feedback to assist local medical advisors in creating effective provider outreach strategies to</p>	<ul style="list-style-type: none"> • <i>DMQC minutes</i> • <i>PHA NAL QC minutes</i> • <i>CIC minutes</i> • <i>Disease Management Clinical Outcomes Reports</i> • <i>Annual Disease Management Clinical Outcomes Review</i> • <i>Provider satisfaction surveys</i> • <i>Member satisfaction surveys</i> • <i>Client satisfaction surveys</i> • <i>Provider Advisory Board meetings with minutes</i>

	meet program goals.	
Quality Improvement Program Goals	<i>Objectives</i>	<i>Evaluation Methodology</i>
	<p>Customer Level Improvement Efforts: Evaluate the performance of each program against the set targets and intervene as necessary to meet or exceed customer targets.</p> <p>Professional Development: Develop internal quality improvement resources and knowledge to support process improvement efforts through development and ongoing education of Six Sigma practitioners.</p> <p>Communication: Performance measures are communicated to the staff to promote understanding, consistency of purpose and idea generation. Projects are communicated to the organization through meetings, newsletters and a central project display board.</p> <p>Internal Consultation: Provide internal consultation across the organization to assist in process improvement projects, measurement and outcomes.</p>	<ul style="list-style-type: none"> • <i>ITRAQ updates and self studies</i> • <i>Compliance Committee minutes</i> • <i>McKesson Intranet Quality site</i>
4. Monitor quality and operational metrics to ensure safety, program integrity and compliance with client and business goals.	<p>Monitor Operational Metrics: Monitor metrics for both Personal Health Advisor® Nurse Advice Line and Care Management/Disease Management product lines to ensure compliance with client and business goals. Evaluate in a systematic and ongoing basis, operational metrics critical to the delivery of service, with revision or interventions as needed.</p> <p>Monitor Self-Reported Indicators: Monitor HEDIS-like indicators related to clinical performance in order to improve patient safety, outcomes and service quality. Indicators are reviewed and revised as needed to ensure they are supporting outcomes as defined by evidence-based practice (Clinical Practice Guidelines). PCM and PHA application and reporting methodologies are reviewed and evaluated on an ongoing basis for measurement systems validation.</p> <p>Monitor Claims Based Metrics: Monitor claims based metrics for Care Management/Disease Management product line to ensure compliance with client and business goals. Evaluate and intervene as needed.</p>	<ul style="list-style-type: none"> • <i>DMQC minutes</i> • <i>PHA NAL QC minutes</i> • <i>Operations – meets not less than quarterly with minutes</i> • <i>Disease Management Clinical Outcomes Reports</i> • <i>Annual Disease Management Clinical Outcomes Review</i> • <i>Claims based metrics reports</i>

<i>Quality Improvement Program Goals</i>	<i>Objectives</i>	<i>Evaluation Methodology</i>
	<p><i>Monitor Satisfaction Results:</i> Monitor satisfaction results of members, providers and clients to ensure that satisfaction goals are met and intervene when concerns are identified. This includes formal and informal avenues of obtaining satisfaction information.</p> <p><i>Refine Performance Indicators:</i> Identify performance indicators for specific product lines as a mechanism for measuring user, application, process, and system performance. All performance indicators reviewed as part of the performance improvement program are based on the nationally recognized clinical guidelines, professional, legal and regulatory organizations and clinical evaluation.</p>	<ul style="list-style-type: none"> • <i>Provider satisfaction surveys</i> • <i>Member satisfaction surveys</i> • <i>Client satisfaction surveys</i> • <i>Provider Advisory Board meetings with minutes</i>

Table 2: QI Program Goals and Objectives

Delegation of Authority Statement

The authority for providing oversight for improvement activities and credentialing of clinical personnel has been delegated to the Services Quality Steering Committee from the McKesson Governing Board. The MHS Quality Improvement Program Description and related work plans require annual review and approval by a manager of McKesson Health Solutions LLC (hereinafter "McKesson Health Solutions or MHS) -- ("Corporate Delegation of Authority for Quality Improvement" on file).

MHS Quality Improvement Culture

Various departments within MHS conduct and participate in QI activities. The section below highlights departments with functions critical in accomplishing the QI goals listed above.

Quality and Product Structure

Services Quality Steering Committee

The SQSC is the overall quality governing body, which provides oversight and direction to the specific quality groups within our organization, including: Personal Health Advisor® Nurse Advice Line Quality Committee (NAL QC), Care Management/Disease Management Quality Committee, and the Compliance Committee.

The SQSC is responsible for the following quality functions:

- Ensures the development, implementation, and evaluation of the quality improvement program using a systematic process to monitor, measure, trend, evaluate and improve the quality of the services delivered
- Develops corrective action plans for global quality issues, and ensure the corrective action plans effectively address quality issues
- Provides oversight to the individual quality teams and committees
- Administers the Quality Improvement Initiative project review, prioritization and approval of resource allocation
- Serves as a forum for escalating issues
- Prepares and report to the SET and General Manager

The SQSC is facilitated by the Director of Quality and members to include:

- VP of Customer Operations
- VP of Operations
- VP of Product Management
- VP of Technology
- Chief Legal Counsel
- Chief Medical Officer

The SQSC will meet at a minimum on a quarterly basis. A report on our organizational quality activities and status is submitted to the SET quarterly and the MHS quality work plan will be updated based on material reviewed in this meeting.

Care Management/Disease Management Quality Committee

The Care Management/Disease Management Quality Committee (CM/DM QC) is a forum for discussion of quality initiatives and outcomes as they relate to the Care Management/Disease Management (CM/DM) product, review of quality assurance measures, identification of performance improvement opportunities; and guidance of quality improvement activities. Meeting topics include, but are not limited to: program outcomes, complaints, service level standards, regulatory discussions, client satisfaction, operational delivery; information technology metrics; Client Management Team metrics and quality improvement project reporting, as well as HIPAA compliance.

The CM/DM QC is responsible for the following quality functions:

- Measurement and reporting of key aspects of program effectiveness and quality
- Review performance indicator data and processes, and ensure measurement of key aspects of program and service quality
- Review clinical, operational and satisfaction data, provide analysis and propose improvement plans to the SQSC as quality improvement initiative projects
- Prepare and report to the SQSC quarterly

The CM/DM QC is chaired by one of our DM Medical Directors, and the members of this committee include:

- Director of Product Management
- AVP of Government Programs
- Director, Quality
- Director of Nursing, and Personal Health Advisor® Nurse Advice Line Services
- Medical Director
- Director of Clinical Content (as needed)
- Representation from Risk Management and Regulatory Compliance
- Representation from Service Design
- Senior Manager, Training and Education
- Operations Director
- Representation from Marketing (as needed)
- Sr. Manager, Operational Reporting
- Sr. Manager, Quality Assurance Automation
- Program Outcomes Managers (as needed)
- Account Managers (as needed)
- Any member of the MHS staff as required

CM/DM QC meetings occur no less than quarterly, with minutes documented and kept on file.

Personal Health Advisor® Nurse Advice Line Quality Committee

The Personal Health Advisor® Nurse Advice line Quality Committee (NAL QC) is a forum for discussion of quality initiatives and outcomes as they relate to the Personal Health Advisor® (PHA NAL) product, review of quality assurance measures, identification of performance improvement opportunities, and guidance of quality improvement activities. Meeting topics include, but are not limited to: call metrics, complaints, service level standards, regulatory discussions, client satisfaction, as well as HIPAA compliance, Information Technology metrics, Client Management Team metrics and quality improvement project reporting.

The NAL QC is responsible for the following quality functions:

- Ensures measurement of key aspects of program effectiveness and quality
- Reviews of performance indicator data and processes, and ensures measurement of key aspects of program and service effectiveness and quality
- Reviews clinical, operational and satisfaction data, provide analysis and implement improvement plans as needed
- Prepares and report to the SQSC quarterly

The NAL QC is chaired by the Senior Manager, Training and Education and the members of this committee include:

- Director, Product Management
- Director, Quality
- Director of Nursing, and Personal Health Advisor® Nurse Advice Line Services
- Physician VP, Chief Clinical Architect
- Director of Clinical Content (as needed)
- Director, National Accounts
- Senior Manager, Operational Reporting
- Senior Manager, Quality Assurance Automation
- Triage Manager, Puerto Rico
- Representation from Risk Management and Regulatory Compliance
- Representation from Member Communications
- Representation from Marketing (as needed)
- Account Managers (as needed)
- Any member of the MHS staff as required.

NAL QC meetings occur no less than quarterly, with minutes documented and kept on file.

Compliance Committee

The Compliance Committee oversees many of the quality assurance tasks necessary to monitor member safety. It also provides oversight for the requirements for regulatory compliance and accreditation purposes. The Compliance Committee monitors the results of all client and accreditation audits to ensure we meet the timelines and comply with the recommendations, reviews legal concerns raised and complaints received in order to make recommendations on program improvement, and monitors and reports on the proper maintenance of professional credentials for staff and Nurse Practice issues. Meeting topics include, but are not limited to: regulatory discussions, Policy and Operational Guideline Committee reports; vendor/partner annual audit results, and staff credentialing.

In addition, the Compliance Committee authorizes two subcommittees to aid them. They appoint a Policy and Operational Guideline Committee, which meets monthly, who along with the CMO act as the approver of these policies and guidelines. The confidential Peer Review Committee serves as an internal quality improvement/risk management tool. The Compliance Committee governs the peer review process and is responsible for reporting the findings to the SQSC.

The Compliance Committee is responsible for the following quality functions:

- Ensures Policies and Guidelines are current and effective
- Reviews of program performance with an overview of regulatory changes and complaints
- Reviews clinical, operational and satisfaction data, provides analysis, and implements improvement plans based on peer review, accreditation requirements, and audit results
- Oversees staff credentialing
- Prepares and reports to the SQSC quarterly

The Compliance Committee is chaired by the Regulatory Compliance Manager, and the members of this committee include:

- Chief Legal Counsel
- Risk Manager
- Director of Nursing, and Personal Health Advisor® Nurse Advice Line Services
- Director, Quality
- Chief Medical Officer
- Any member of the MHS staff as required

The Compliance Committee meetings occur no less than quarterly, with minutes documented and kept on file.

Peer Review Committee

The Peer Review Committee provides a confidential internal Quality Improvement process to conduct nursing peer review for all product lines. Peer review is strictly confidential, and results will not be shared externally outside of the committee. Cases for review are identified through the risk assessment process and support an open reporting process if issues are identified internally by McKesson employees or externally by client employees such as plan physicians, risk management representatives, members, or designees. Members of the committee provide peer review of the nurse performance, algorithm performance, systems and product performance in order to mitigate high-risk areas. The committee recommends appropriate interventions based on the findings, which may include teaching and learning opportunities, algorithm changes, and practice changes.

The Peer Review Committee is chaired by the Risk and Regulatory Compliance Department and the members include:

- Director of Risk and Regulatory Compliance
- Director of Nursing, and Personal Health Advisor® Nurse Advice Line Service
- Chief Legal Counsel
- Physician Vice President, Chief Clinical Architect

- Senior Manager of Clinical Content
- Director, Quality
- Representation from Director of Operations
- Peer Member from Registered Nurse Staff
- Representation from Training and Education
- Any member of the MHS staff that requests to be placed on the agenda

Peer Review Council meetings occur no less than quarterly and minutes documented and kept on file.

Policy and Operational Guideline Committee

The Policy and Operational Guideline Committee (P&G) provides a forum to facilitate the development, review, revision, and approval of policies affecting the clinical operations. The committee also has oversight of the operational guideline process. Policies and guidelines are reviewed or revised on an annual basis.

The P&G is chaired by the Quality Department and the members include:

- Chief Medical Officer
- Director, Quality
- Quality Manager
- Director of Nursing, and Personal Health Advisor® Nurse Advice Line Services
- Representation from Risk and Regulatory Compliance
- Representation from Training and Education
- Representation from Operations
- Representation from Clinical Content
- Account Managers and Program Outcomes Managers (as needed)
- Any member of the MHS staff that requests to be placed on the agenda

P&G meetings occur no less than quarterly and minutes documented and kept on file.

Operations Department Structure

The section below highlights the Operations Department Structure with functions critical in accomplishing the QI goals.

Vice President, Operations

The Vice President monitors and evaluates the delivery and operational metrics related to the delivery of services of the MHS programs. The Operations Oversight team is led by the VP of Operations. The Vice President is a member of the SQSC and the SET.

Director of Operations

MHS Directors of Operations monitor and evaluate operational metrics related to field and/or telephonic staff performance. Consistent call handling is critical to the quality of all MHS programs. Periodic evaluation of operational metrics assists the Director of Operations in identifying inconsistencies and designing improvement initiatives as needed. Operations Managers and Supervisors report to the Director of Operations. This group is responsible for:

- Ensuring performance targets are met by staff
- Ensuring quality delivery of services
- Ensuring program targets are met

Quality Department

The MHS Quality Department is focused on process improvement and outcomes metrics directly related to operational functions. Major functions of this group are:

- Quality Improvement

- Ensures the quality assurance process is being completed to include IRR, chart audits, case studies and general interaction compliance
- Facilitates the implementation of quality monitoring tools and initiatives as needed
- Develops interaction tools and monitor performance
- Develops policies and operational guidelines from Service design and Program Outcomes Management workflows
- Policies and Operational Guidelines
 - Develops and write policies and operational guidelines to support interventions designed and developed by product management and service design
 - Ensures processes are in place to maintain policies and operational guidelines documents

Director of Nursing (DON)

- Professional Nursing Practice
 - Provides leadership and organizational focus on the practice of professional nursing across our geographic and delivery model settings
 - Provide leadership of our regional self-governance Nurse Practice Councils

Training and Education

- Corporate Training
 - Develops training and education materials to support program design and improvements
 - Trains staff to deliver services as designed and developed by product management and service design
 - Evaluates post training effectiveness and develop plans to improve education

Support Services

- Workforce Support
 - Manage staff schedules to ensure appropriate coverage is provided to deliver services per service level standards
 - Develop staff plans and budgets to support delivery of services

Medical Directors

- Provider Outreach
 - Creates strategic relationships to ensure overall success of the program
 - Engages in clinical opportunities or barriers that impact the success of the program.

Other Entities Involved with Quality Improvement

The QI process is a part of the business operations at MHS. QI within MHS is budgeted in many departments throughout the organization. Based on annual business and QI plans, the following additional departments carry out various QI efforts:

- Clinical Content
- Service Design
- Informatics
- Development
- Account Management
- Marketing Strategy

The departments listed above support the QI process by reviewing member satisfaction surveys, analyzing outcome indicators, monitoring performance, and updating software applications.

External Feedback

To improve the quality of its clinical tools, MHS works with the following external entities:

- American Accreditation HealthCare Commission (URAC) accreditation
- National Committee for Quality Assurance (NCQA) accreditation

Learn more about MHS accreditations in the Regulatory Compliance section of the Quality Improvement Program Description.

MHS also solicits feedback from clients and the provider community regarding program and clinical improvements. This is done through a variety of mechanisms; some of the more formal channels are listed below.

Client Advisory Board (CAB): This board is comprised of client professionals and executive leadership members who oversee or implement our programs, meets regularly to review process and monitor progress towards reaching our mutual goals, and provide feedback on product innovations and new products before they are implemented.

Provider Advisory Boards (PAB): This board is comprised of clinical professionals located in selected states where the PAB has oversight. The PAB was established to strengthen ties to the provider community and give providers a forum to suggest program improvements. Some clients include consumers/beneficiaries in this committee along with providers.

Independent New Client Review: To ensure that the clinical tools reflect an acceptable local standard of care, MHS provides clients with all clinical tools and supporting documentation for review. To date, more than 100 clients' medical staffs have reviewed and approved the clinical content of the Personal Health Advisor® Nurse Advice Line Program.

External Physicians: MHS Algorithms, Clinical Reference Systems (CRS) member education content, and DM guidelines may be reviewed and validated by external physician consultants with current expertise in Triage, member education, and the diseases included in our Care Management/Disease Management programs.

Quality Improvement Activities

Below is a list of other activities that may take place, usually at a client level, where specific contract performance indicators are discussed.

- Annual Clinical Indicators Review
- Medical Director Advisory Board
- Regional Advisory Committees
- Cross-functional QI Teams

MHS Program Operations

MHS adheres to a precise credentialing process as that has been reviewed and approved by all applicable credentialing and accreditation agencies. Hiring, orientation, and training processes are consistent with these standards for all programs.

Hiring and Selection

Staff hiring and selection procedures include the following steps:

- Potential Candidate Selection

Staff Credentialing begins with the selection process. The MHS management team screens resumes of potential candidates for a broad base of experience, including adult and pediatric practice. A primary care experience is preferred. In addition, the candidates' licenses are verified and must be in good standing with the appropriate state professional boards.

- Interview and Screening Process

Once a candidate passes the above selection criteria, the management team schedules interviews and the screening process begins. The screening consists of an interpersonal communication interview with a management representative(s) who presents an overview of the MHS products and services and a brief orientation to the applications. The candidate is asked a series of questions based on job function or applicable role and encouraged to share their experiences and goals. This interview allows managers and supervisors to evaluate the candidate's interaction, listening, and information synthesizing skills. The management representative(s) uses a tool to assess the candidate's knowledge, prioritization, and problem-solving abilities. In addition, the interview assesses the candidate's job fit, and the candidate's knowledge of computer basics and typing. The management team screens for Windows-based software knowledge, ability to use a mouse, and typing ability. A debriefing of the candidates by the management team occurs. This process is a collaboration of all the information gathered about each candidate. The team rank orders the candidates and decides on those who will best suit the organization's needs. Finally, the team selects the candidates and, contingent on references and drug screen compliance, initiates verbal offers.

Ideal Staff Profile (all products):

- Ability to communicate via telephone or in person with members/customers/providers and provide good customer service
- Good listening skills
- Demonstrates professional oral and written communication
- Applies ICARE principles to all aspects of the job
- Demonstrates sound judgment in accordance with the Professional Practice Acts
- Makes decisions that adhere to policy using basic critical thinking skills
- Self-motivated
- Able to ask for assistance and guidance
- Adapts to change
- Possesses ability to effectively manage time

Orientation Process

Orientation at MHS is a comprehensive, on-going education activity. A web-based learning management system supports the Training and Education Department in delivering the core curriculum via distance learning. With distance learning, staff can be hired into a home office environment and learn from home.

- Core Training

New employees receive a combination of didactic and experiential learning activities that include; building rapport with callers, active listening skills, interviewing techniques, review of pathophysiology, critical thinking techniques, structure and components of the product specific tools (i.e. algorithms, Care Management/Disease Management Q&A and care plan), software application navigation, and client-specific call handling.

- Preceptor Program

New employees in all programs receive precepting following core and cross training. Employees are assigned a preceptor who provides support and feedback to them as they take live calls. During this time, the preceptor monitors calls, reviews call records, reinforces policies and guidelines, and provides more detailed client-specific training. Employees must meet expectations as defined by the Call Coaching Tool for each program prior to transition to their supervisors.

- Transition to Operations

As the new employee becomes competent in communication, clinical application, and call handling, the employee transitions to an Operations supervisor who is in the role of mentor and coach.

- Mentoring Program

The purpose of the mentoring program is to provide guidance to new employees and employees cross-training into new products or areas with respect to MHS' corporate culture. The goal is to establish a bond with new employees, to provide the new employee with a sounding board for work-related issues or questions, and to foster engagement between the new employee and MHS. This program is closely linked with the organizational initiatives to help staff accept and adapt to MHS' culture in a manner consistent with their own personal values. Existing staff volunteer as mentors and there is a selection process in place to ensure the mentors meet the qualifications as set forth.

- Continuing Education

Post-core continuing education is an integral component of the MHS programs. MHS has partnered with Nurseweek to provide continuing education for the clinical staff. MHS' advanced technology abilities allow distance learning opportunities for staff unable to commute to a primary site. In addition to clinical continuing education, MHS has an extensive library of online and classroom-based learning opportunities spanning topics such as general and proprietary application use and leadership. Two proprietary, internally developed web-based tools are used to deliver and track continuing education:

The Insider is the intranet site used throughout the MHS Health Solution organization and is maintained by the MHS Webmaster. Program-specific links contain policies and guidelines, news updates, client specifics, quick references, clinical reference systems, and quality management reporting forms.

ITRAQ is a proprietary application created to track information for Care Center staff related to Credentialing, Training, Risk Management, and Clinical Quality. It allows users to access information pertinent to them through Insider including: licensure status in multiple states, training updates, self-studies, web-based training, competencies, evaluations, and self-printed continuing education certificates.

Work at Home Program

MHS has implemented a Work at Home (WAH) program and 99% of the staff from our Personal Health Advisor® Nurse Advice Line and CM/DM programs have transitioned from the Care Center setting to perform their job duties at home. A centralized resourcing process is in place so that all clinical resource procedures including crisis call handling, which is managed the same way regardless if you are working from home or in a Care Center. All policies and operational guidelines are applicable to all staff. All employees employed to work at home receive additional training to learn the technology needed to work from an environment outside of the office. The Work at Home staff is held accountable to the same performance expectations, quality processes, and training requirements as our Care Center staff.

All work-at-home Telehealth employees use a THIN client. A THIN client is a computer that is "locked down" (no ability to load software) and has limited capabilities. The THIN client will allow you to access the MHS network applications required to work from home. Every time it is powered off, the memory is cleared, which helps support confidentiality and HIPAA requirements.

Survey results that were obtained in March 2004 from those staff in the original pilot indicate an increased job satisfaction by each employee. Supervisors are reporting an increased productivity level to the employees working from home. With the current cost of gasoline, the work at home environment is a tremendous satisfier. Overall, it has been a very successful program. Many other initiatives and projects are underway to help support distant training and learning.

Cultural Competency

MHS recognizes the importance of intensive outreach strategies to engage members of all cultures. Although cultural competency is a value held across all products, community health workers (i.e. Promotoras) serve as a cultural bridge between the client, Care Management/Disease Management program nurses, providers, Provider Outreach Coordinators, and the community. Their primary role is to identify and encourage client participation in the program, to minimize barriers to care, and to facilitate opportunities for care coordination through program nurses, the Care Center, and providers. Cultural competence within MHS is addressed in multiple ways. A cultural competency self-study, which covers these four areas, is required for all employees:

- Cultural Awareness: Self-awareness, cultural identity, heritage adherence, and ethnocentricity
- Cultural Knowledge: Health beliefs and behaviors, barriers to cultural sensitivity, stereotyping, ethno-history, sociological understanding, similarities and variations
- Cultural Sensitivity: Empathy, interpersonal communication, trust, acceptance, appropriateness, and respect
- Cultural Competence: Assessment skills, diagnostic skills, clinical skills, challenging and addressing prejudice, discrimination and inequalities

MHS recognizes the importance of social organization and its role in an individual's health. Social norms and mores vary with race, ethnicity, and environment. Where we grow up, what we learn from our parents and what we learn from our community all contribute to our perceptions and beliefs. Religion, familial roles and responsibilities, food practices, and health practices are all influenced by social experiences. Cultures reviewed in the self-study:

- Hispanic Population
- Mexico and the Rio Grande Valley
- Puerto Rico
- Native American Population
- Asian Population
- Armenian Population
- Russian Population
- African-American Population

Cultural Competence is a life-long process of self-assessment, seeking knowledge and being sensitive to the needs of the member. While not realistic for any one healthcare provider to know and understand all of the healing practices used by all the members they serve, thorough assessment and asking questions in a non-pejorative manner is an effective way to find out what health practices are used by a member.

Providing culturally competent care is not optional - it is essential. Achieving a level of competence is not something that will happen immediately or after reading the cultural competency self-study.

Call Monitoring and Coaching

Calls are monitored across all products by different methods including shadowing and audio (with or without a video component). Call monitoring is completed on a regular schedule, dependent upon the level of performance. Each product line outlines the minimum amount of call monitoring that must be performed on a monthly basis. The staff member and supervisor/coach collaborate to determine the type of call monitoring that provides the best opportunity for feedback beyond this requirement. The supervisor/ coach will have the final decision dependent upon the staff member's performance. When a staff member performs calls for more than one product line on a routine basis, they will be monitored based on the percentage of time spent performing each product line's calls per month. If performance does not meet expectations either overall or within a specific category, an appropriate level of increased monitoring should be performed above the minimum expectations based upon the action plan developed between the supervisor/coach and staff member. Staff performance studies, completed regularly and at frequent intervals, are accumulated and are the basis for employee review. On a monthly basis, the team supervisor reviews the staff member for competency as delineated in the job description.

Call Monitoring System

A call monitoring system (Witness), randomly records audio and video samples for Quality Improvement purposes across all product lines. Members are notified that their calls may be recorded. A random recording schedule is established for each staff member. Staff can also initiate recording of their own calls. Live monitoring and precepting can also be accomplished with the call monitoring system. The Witness system continues to provide an excellent method for monitoring calls and providing feedback to each staff member for improvement of delivery of the programs.

Inter-Rater Reliability

In order to decrease variability between users of the call monitoring/coaching tool, IRR sessions are performed for all coaching tools. These sessions look at the degree of "reliability" or agreement reached by a specific group of individuals using the same call monitoring tools. It measures how closely all users of the tool interpret and apply its accompanying interpretation standards. The objective of this activity is not to measure the performance of the individuals who performed the IRR test calls, rather to measure the users of the tools. Testing determines individual users' skill and expertise level. We can audit how accurately individual users and groups apply the tool interpretation standards. It allows us to determine when re-training or re-education is necessary by individual user, groups of users, or an entire user group. We can evaluate the efficiency and accuracy of users who have had formal training against users who have had no formal training on the monitoring tools and interpretation standards.

Member File Audit

Member file audits are performed using the PCM application biannually. Each audit covers a date range from the previous six months and includes review of completed enrollment, assessment and coaching (monitoring) calls. Audits include a random sample of records weighted by the population of disease management nurses. Additional records may be included in the audit to review specific conditions. Audit findings are reported to the CM/DM QC and operations, to assist them in identifying opportunities for improvement and opportunities to complement the nurses for a job well done. The member file audit is another example of MHS' commitment to maintaining regulatory compliance with NCQA.

Performance Evaluation

The Operations Directors and Senior Manager of Education and Training review QI findings to ensure that MHS staff is evaluated in the following performance areas:

- Program competence
- Interpersonal competence
- Professionalism
- Quality indicators

The staff is required to be at a “meets expectations” level for each performance criterion at six months, and monthly from then on. Operations supervisors complete performance studies, which are the accumulation of call coaching reports, call record review, productivity statistics, and aggregate performance reports. MHS evaluates the following aspects of care, which have been identified as high volume and high risk to clinical quality:

Care Management/Disease Management

- Initial and ongoing assessments
- Ongoing coaching
- Program content delivered (clinical indicators)
- Education delivery
- Program Alerts and Case Manager Updates
- Program outcomes and goals

Personal Health Advisor® Nurse Advice Line

- Assessment of chief complaint
- Endpoint selection and implementation
- Overrides of the algorithm recommendation
- Individual nurse sorting as it relates to urgent care and self-care recommendations
- Self-care measures and education delivered
- Quality initiatives
- Navigation survey delivery

Informed Decision Support

- Initial and ongoing assessments
- Care plan development and implementation
- Clinical content delivered
- Education delivered

Quality Improvement

Each aspect of care has a process for continuous and ongoing improvement. The MHS Quality Improvement Program uses performance reports to identify variation in staff performance across our services. A comprehensive study of staff performance has been designed to reduce variation among the staff. Any exceptions (those performing outside the group average) are identified and undergo additional coaching and training.

MHS Technical Quality Assurance

MHS' Technical Quality Assurance department (TOA) adheres to precise testing procedures prior to launching new software releases. In cooperation with Product and Project Managers, QA ensures that all software application specifications are met, allowing the end user to receive full benefit of the products' capabilities.

Test Set Creation

To validate any software release requirements, TOA has created a complete set of manual and automated tests. These tests allow for the validation of all current and future software application requirements. In addition, they reduce project risk and identify software deficiencies and discrepancies early enough in the process to minimize schedule and budgeting conflicts.

Test Approaches

TOA carries out the following verification activities during the software application developmental steps:

- Envisioning and Planning:
 - Determination of verification approach
 - Determination of requirements adequacy
 - Determination of consistency with design requirements
 - Generation of functional test data
- Developing:
 - Determination of design adequacy
 - Determination of consistency with design
 - Determination of implementation adequacy
 - Generation of structural and functional test data
 - Generation of structural and functional test data for programs
 - Testing of application system
- Stabilizing:
 - Modification and regression test
 - Placement of tested system into production.

Testing Tools

TOA uses a variety of testing tools to verify application requirements, including:

- Walk-through
- Requirements matrix
- Desk checking
- Data flow analysis
- Design reviews
- Inspections
- Checklists
- Fact-finding
- Peer review
- Automated test tools
- Test Factor Risks

TOA tests the following factors during software application development. Factors are arranged in order of risk contribution to the product:

Accuracy: Assurance that the data entered, processed, and outputted is accurate and complete

File Integrity: Assurance that the data entered will be returned unaltered

Authorization: Assurance that the data is processed in accordance with Management's intent

Audit Trail: The capability to validate processing if problems occur

Processing Continuity: The ability to sustain processing if problems occur

Service Level: Assurance that the user's desired results occur within acceptable timeframes

Access Control: Assurance that application resources will be protected against accidental or intentional modifications, destruction, misuse, and disclosure

Compliance: Assurance that the application is designed in accordance with organizational strategy, policies, procedures, and standards

Reliability: Assurance that the application will perform its intended function with the required precision, over time

Ease of Use: The extent of effort required for learning, operating, preparing input for, and interpreting output from the application

Maintainability: The effort required locating and correcting a system error

Portability: The effort required transferring a program from one hardware configuration and/or software system to another

Coupling: The effort required in interconnecting components within and across applications

Performance: The amount of computing resources and code a system requires to perform its stated functions

Ease of Operation: The amount of effort required to integrate the system into the operating environment and to operate it

Reporting of Test Results: TQA generates summary testing reports following each testing phase, and prior to final application release.

Testing Phases: At the conclusion of each testing phase, TQA delivers the test results to the Project Management team. These reports include recommendations for proceeding to the next development phase. Once the application has passed TQA's tests, it proceeds into User Acceptance testing. User Acceptance testing is a process, managed by the Quality Management department, whereby the actual users of the software are able to identify problematic issues and report back to Product Management for immediate attention. While TQA's tests validate specific functionality, User Acceptance testing validates that the application is valid from the user's perspective. Software releases will not occur until the User Acceptance process occurs.

Release Stage: Following the final TQA and User Acceptance testing process, TQA delivers a set of summary reports to the Project Management team. At this time, TQA also recommends that the application be released to production. The final report set consists of:

- Test Procedure Results: include test procedures executed, number of steps passed or failed, percentage of steps passed or failed, specifications that were not testable and those not yet tested.
- Monthly Accomplishment Reports: include internal testing activities and accomplishments of the TQA group.

Technical Issue Tracking

All issues related to software requirements are entered and tracked through a tracking system. Each of these issues is assigned a priority level based on the following severity types:

- Critical: Involves data integrity failure, data loss; functional processing reliability failure; software unusable, may be no available work-around.
- High: Involves high potential for data or functional processing reliability loss, software useable but unable to perform critical tasks, may be an available work-around.
- Medium: Involves possible data loss, lack of functional processing accuracy, bothersome defect, and feasible work-around available.
- Low: Involves no data loss, some loss of functional processing reliability, rare occurrence, and easy work-around available.
- Very Low: Involves no data loss, processing lacks efficiency, a refinement to have corrected.

Multiple Stage Construction Methodology

Software application test procedures are developed to support a multiple staged construction methodology. Requirements from the Software Requirement Specifications (SRS) are deconstructed and applied to each construction phase as appropriate. Each phase of application development builds upon existing test procedures from the previous construction phase. Finally, TQA implements a comprehensive suite of test procedures, which is traced to all existing requirements to verify complete test coverage.

Requirements Traceability Matrix (RTM)

Each TQA team generates and maintains a Requirements Traceability Matrix (RTM). The RTM eventually becomes a part of the SRS, and provides a link from defined software requirements, to the implemented design, to the verification test cases and their results. This matrix, along with test results, serves as the basis for final product acceptance by the product line Project Management team.

MHS Technical Recovery Plan

McKesson requires incident recovery plans for all business units. McKesson has a formal escalation policy in place at all sites, to facilitate an expedited recovery of equipment and data. MHS has deployed a comprehensive database and system backup plan to ensure that in the event of a catastrophic Care Center system failure, the system can be restored quickly and efficiently. Below is a brief overview of the MHS incident response and recovery plan.

Care Center Telecommunications Recovery

McKesson provides Disease Management and Personal Health Advisor® Nurse Advice Line services from two Care Centers located in Sacramento, California and a back-up location in Wheeling, Illinois. Our toll free number telephony service is handled through AT&T Network Services, which routes inbound and outbound traffic via dedicated voice circuits. Currently we have seven voice T-1 spans in each of our locations, with the ability to add more as call capacity increases and additional trunking is required. Each site has an AT&T AccuRing to deliver the call and data traffic to and from the outside world. AT&T AccuRing is a dual SONET fiber ring with an OC12 capacity for bandwidth, which offers significant protection and quick expansion to handle future growth. These spans have alternate and backup routing plans in place in the AT&T network to handle unplanned outages and planned maintenance and/or incident disaster recovery to ensure that call flow will continue without interruption. Our Data Center utilizes a 300kW generator to power our Care Centers during commercial power outages.

McKesson employs the Aspect release 9.3 ACD in each of our call centers to support inbound and outbound calls. This is a fully redundant call processing and voice system ACD. In the event of a call center outage or closure, we have full network access using AT&T's Route IT tool to re-route voice calls to an alternate Care Center. The Aspect ACD is capable of supporting unlimited DNIS numbers across 1000 applications. It provides complete activity reporting and is currently configured with over 1000 voice channels and is expandable to support 4800 voice channels simultaneously. The Aspect system can support 4800 telesets and over 156 hours of digital voice storage. Each location also incorporates dual system processing to maximize call efficiency and ensure redundant call processing capability. We also utilize Aspect Enterprise Contact Center (ECS) to provide advanced queuing and routing intelligence such as caller specific information, license and skill based routing as screen pop functionality. We currently have a single instance of the Aspect ECS CTI 6.2 solution in our California site and we are in the process of deploying a highly redundant ECS solution in our Broomfield Colorado site. We currently do not have CTI functionality in our Illinois backup ACD site.

To ensure that technical needs are anticipated and addressed, we monitor voice systems 24 hours a day, seven days a week using automated monitoring and reporting processes. When a system limitation or failure occurs, appropriate support personnel are notified, and depending on the severity, trouble escalation processes are activated thereby ensuring that system issues are handled in a timely manner.

Care Center Recovery

McKesson Health Solutions has deployed a robust environment to support Care Center activities. This environment includes redundant database servers, redundant (clustered) application servers, redundant power systems, redundant data center air conditioning, redundant networking, and highly available interconnection.

Disaster Preparedness

McKesson Health Solutions has deployed a comprehensive database and system backup plan to ensure that in the event of a catastrophic failure of a Care Center system, that system can be restored to function as quickly and efficiently as achievable. Backups are performed while the database is active and do not negatively impact performance. These backups are restored to a test server on a rotating basis to validate their integrity. Two copies of all backups are kept, one on site and one off site. Off site, copies are created and sent within 24 hours, to a secure off site facility in a fireproof container.

Priority Level Definitions

- Priority 1 High: response time of less than 15 minutes, resolution time of less than six hours
- Priority 2 Medium: response time of less than one hour, resolution time of less than one business day
- Priority 3 Low: response time of less than two hours, resolution time of less than two business days

In the Event of Disaster

In the event of the failure of a Care Center system, operations would continue on the redundant system. The cause of the failure will be immediately investigated and corrected as soon as possible based on service contract specifications. Once the cause of the failure is corrected, the system will be restored to operation.

In a worst case scenario in which a failure is of such a magnitude as to require a complete rebuild of a system, the system will be restored to service within one day after repairs are complete.

Service contracts are maintained on the Care Center database servers and supporting peripherals that require the vendor to respond to problems within four hours of notification. MHS has a self-service agreement with the vendor of the application server hardware. Replacement parts are available within one day of order.

Building Equipment Recovery

Computer rooms are design to withstand heat, moisture and fire damage. All computer room systems are set on raised floors and have early fire warning detection systems installed. All computer rooms are equipped with fire sprinklers. Heating ventilation and air conditioning systems (HVAC) controls are installed to provide humidity and temperature control.

McKesson uses a two-fold approach to utility power outages. First, all systems are equipped with UPS battery back-up power, which will keep systems running for up to one hour. Second, generators are installed to automatically sense power failures. If utility power is lost, UPS power will switch on long enough for the generator to power up. Computer, Care Center and HVAC systems will run on generators in the event of a utility power outage. Generators can power systems for up to six hours.

All McKesson offices have secure entrances and are monitored by video and security staff seven days a week. Information security precautions have been designed to prevent or limit immediate impact of adverse events such as malicious code attack, unauthorized access to McKesson systems, unauthorized utilization of McKesson services, denial of service attacks and general misuse of systems or hoaxes.

MHS Risk and Regulatory Compliance

Risk Management

Risk Management has developed and implemented an online process using the ITRAO (Training, Risk and Quality) system for managing risk issues. Through the Issue Input Form, all staff across all products submit clinical, member, system and product issues. Risk Incidents include any situation in which there has been an adverse outcome for a member within one week of an interaction with a MHS employee, or if potential legal action has been mentioned. Coaching Opportunities identify situations in which a staff member's performance or behavior is outside standard practice or deviates from established policies. This system provides real-time electronic notification of risk management issues, assuring full and timely accountability for all issues. Risk Management analyzes rate-based data for trends in overall performance and individual nurse performance, and reports these trends no less than quarterly to the appropriate quality committee.

Risk Management Activities

Risk Management adheres to the practice of thorough analysis of each risk incident, its potential causes and possible solutions. The operations management staff, under the oversight of the Risk Manager, investigates risk incidents. Risk incidents are reviewed by the Peer Review Council, comprised of RNs, quality staff Legal Counsel and the VP, Chief Clinical Architect who is a physician. Investigation of risk incidents may result in recommendations for coaching, disciplinary action, referral to the appropriate insurance carrier, or clinical content changes. These recommendations are then implemented by the appropriate departments.

The supervisor of the nurse involved reviews coaching opportunities and provides appropriate coaching. Risk Management's priority is maintaining the integrity of its process. Thus, Risk Management activities include, but are not limited to, the following:

- MHS nurses, across all products, are instructed on the Risk Management philosophy and processes.
- MHS nurses, across all products, are required to participate in a number of continuing education programs to enhance specific product understanding. Examples of these programs are the Nurse Calibration process, client-specific instruction, instruction based on recommendations from the Peer Review Council, and new product training.
- Complaints and compliments are forwarded to the Risk Manager, Risk Management Specialist and Account Managers who then work in conjunction with other appropriate personnel for resolution.
- MHS has established a communication network with Account Managers to ensure immediate notification of risk issues identified by clients.
- Risk Management maintains close communications with Legal Counsel. This ensures an accurate understanding of issues, and allows for informed decisions to be made quickly.
- All risk incidents, coaching opportunities, and complaints are tracked and trended.
- Crisis calls are monitored to ensure appropriate reporting to appropriate agencies, i.e., suspected child/elder abuse.

Confidentiality

Healthcare deals with a personal side of life in which we discuss intimate physical, emotional, and psychological information. Possession of this knowledge gives healthcare personnel access to information, which if used inappropriately, could be damaging to members who use our services. It is our professional duty to protect the private Protected Health Information (PHI) of our members and only release information on a need to know basis and in accordance with the law.

MHS collects both demographic and clinical information from its clients and their members. This is confidential information and should be treated as such. As a company, MHS will not allow the clinical database to be exploited for purposes of marketing to specific groups without expressed individual consent. For example, MHS will not identify diabetic members in the database for use by third parties in marketing diabetes-related products unless member consent has been obtained and documented.

The first kind of confidentiality by which all McKesson employees must abide is intellectual property obligations, which is the knowledge that a company holds as to how it functions. Intellectual property information is protected by the McKesson Employee Agreement and McKesson Code of Business Conduct, which all new employees sign.

The second kind of confidentiality is privileged and confidential communication. Conversations between a member and a nurse or Health Resource Coordinator, a member and a physician, or a lawyer and a client, should be considered confidential and privileged information. Federal and state laws as well as professional ethical standards protect the communication we have with members.

Access to evaluation data is limited to appropriate MHS personnel and clients as deemed necessary. MHS maintains the following standards for member confidentiality:

Release of/Access to Information

A number of rules govern release of and access to MHS member information:

- Medical record requests: All requests for medical records from members or their authorized representative must be routed via a Request for Medical Records form.
- Written authorization: Written authorization must be provided to MHS or the health plan prior to the release of medical records to those not directly involved in the member's care.
- Client requests: All clients requesting member medical records must be routed through the Client Service Manager.
- Social Service, Law Enforcement, Employer or Legal requests: All Social Service, Law Enforcement, Employer, and Legal parties requesting member medical records must be routed through MHS' Legal Counsel and/or Risk Management department.
- Parental/Guardian Consent: In cases where a minor is involved with the treatment for alcohol/drug abuse, abortion, venereal disease, or birth control, generally both member and parent/guardian must give consent.
- Faxing of Medical Records: All automatic or manual fax reports must have the MHS confidentiality disclaimer on the cover sheet

Definitions:

- "Authorized Representative" or "Designated Representative": Refers to an individual authorized in writing by the member, by court order, or designated as a proxy medical decision maker, to act on behalf of the member.
- "Minor Member": Refers to any individual under 18 years of age, except one who is 15 years or older, lives apart from the parents or legal guardian and manages one's own financial affairs, or is legally married.
- "Emancipated Minor": Refers to one who has been formally recognized by the court as an adult.

Protected Health Information

Information that is:

- Created or received by MHS.
- Related to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for provision of health care to an individual.
- Identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- Emailing of Protected Health Information: Protected health information may be emailed internally or externally only following the protocols listed in the HIPAA Email Operational Guideline. Other methods will be used to share this information when necessary, and will only be shared with parties that need to know the information to perform their job.
- Confidentiality of Medical Records: All member medical records are confidential. Viewing of these records may occur for auditing, QI or Risk Management purposes, or other service-related functions as defined by MHS.

- Review during Triage episode: During a symptomatic Triage call, a McKesson Health Solutions nurse may review the member's medical record to assist in providing the most appropriate recommendation.
- Confidentiality Statement for Visitors: Potential employees and prospective clients will not be allowed to listen in to live calls and may listen to mock recorded calls only. Current clients may do listen-ins for calls for their members only, with the exception of employer groups. Employers may not listen-in to calls from their employees since employers should not have access to the employees' protected health information. Legal Counsel and Senior Management must approve any requests for exceptions to this policy.

Security of Member Medical Records:

Member medical records are secured in the following ways:

- Restricted servers: All database servers are restricted in access from end users, and available only to support staff. The MHS system is operated in a secure and encrypted model. System access is controlled via secure facilities and authenticated systems access. MHS systems are comprised of multiple data systems that are integrated to provide a complete Care Management/Disease Management platform. The system is based upon a Web Services core infrastructure that consists of Database Systems, Data Warehouses, Transaction Management Systems, Application Servers, Reporting Servers and Client workstations. This framework provides an n-Tier system, connected via Transaction Services that is scalable to meet the business needs. These systems are housed in MHS' world class data centers located in Drohan, CA, and Broomfield, CO. MHS maintains fully redundant systems that provide high availability and fault tolerance over a geographically dispersed operational footprint with 24x7 availability and greater than 99% uptime.
- Denied access to Local Area Network (LAN): Access to the Internet from the company's internal LAN is available through two separate locations, both protected by UNIX firewalls. Access to the internal LAN is not allowed from the Internet.
- User security measures: All end users have individual logins and passwords to enter and retrieve member information.
- Full database back-ups: MHS performs nightly database back-ups on all production database servers.
- Audit trails: The Personal Health Advisor® Nurse Advice Line (PHA NAL) platform and Population Care Management (PCM) has retrievable audit trails that log all accesses to clinical information. The log includes date, time of access, records accessed and user ID.
- Medical record hard copies: All medical records in hard copy form must be stored in a secured, locked area.

Complaints

The Complaint process is used to identify and communicate concerns and complaints from members, providers, clients, or agents acting on their behalf. Complaints and grievances may come from many different sources, both internal and external. The Complaint and Grievances Policy outlines the step-by-step process for employee/client/member interaction. The policy addresses:

- Concerns and complaints received
- Investigation of member complaints
- Complaints not pertinent to the organization
- Responding to complaints
- Notification and updating on investigation
- Resolving of complaints
- Timeliness

MHS follows the complaint process for both member and practitioner concerns. In addition, MHS tracks issues in the ITRAQ system to ensure the systematic and timely resolution of oral and written complaints. Oversight committees evaluate this process quarterly. The Member Bill of Rights and Responsibilities is included in the initial member communication information, informing the member how to initiate a complaint, and similar information is sent to providers in our Care Management/Disease Management program.

Regulatory

Accreditation and External Regulation

MHS generally operates under the same rules and regulations that govern our clients. Governmental laws may drive the care that is delivered. Regulations are also set by various oversight agencies including:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- National Committee for Quality Assurance (NCQA)
- Utilization Review Accreditation Commission (URAC)
- Federal and State Government

Healthcare delivery systems are striving to improve their ability to provide cost-effective, quality healthcare in a highly competitive environment. Learn more about MHS accreditations and external regulations in the Regulatory Compliance section below.

Credentialing

MHS conducts verification of credentials for licensed employees at the time of hire and minimally every two years, depending upon state, province, or country of license. Primary site license verification is performed online and is then entered into our computerized ITRAQ system.

Nurse Credentialing

The nurse credentialing process includes the following activities:

- **Credentialing Review:** MHS reviews, manages, and approves the credentialing and re-credentialing of advice nurses, specialty nurses, nurse supervisors, educators, and managers. The Managing Member of MHS and Senior Management delegate oversight of this function to the Chief Medical Officer/designee.
- **Credentialing Cycle:** The credentialing and re-credentialing cycle ranges from yearly in some states, to every three years in others. Each nurse license is screened with the state, province, or country Board of Nursing, with any suspended licenses identified and action plans developed. The operations nursing managers are responsible to the Director of Risk and Regulatory Compliance for the ongoing evaluation of nurse performance.
- **License Renewal:** If the health professional does not renew his or her license in the appropriate time period, and/or the license is not in good standing, the health professional will be prohibited from working until he or she produces a license in good standing.
- **Application Review:** The credentialing application includes an attention to the veracity of the application. None of the following can have occurred: impairment to clinical practice, history of loss of license, felony conviction, or a history of loss or limitation to practice.
- **Adherence to Practice Standards:** All nurses must follow the applicable state, province, or country Nurse Practice Act or advanced practice act statutes and stipulations. If any nurse is in violation of the practice act while performing his or her role at MHS, he or she will be referred to the state, province, or country Board of Nursing, and/or the state Attorney General for review. All nurses must adhere to the MHS Credentialing Policy.

Eligibility Requirements for Health Professional Employment is that the nurse be a Registered Nurse, which is a protected title under each state's nurse practice act. A registered nurse may be an AD educated nurse, Diploma nurse, Bachelor of Science nurse, etc. These protected titles are defined in each state's statutes. At MHS, being a RN means that a nurse may hold the position with "any" RN degree.

A nurse is eligible for hire pending license verification, the review of work history completed and found to be in good standing, and a negative drug-screening test is received. During the hiring process, depending upon the job description, the nurse is tested for clinical knowledge and competency in interpersonal communication and computer literacy. Test results are used as a benchmark for subsequent educational activities and a competency-based orientation program.

RN Licensure policy requires MHS RNs possess licensure in his or her home state and other states as required by state laws and regulations and client needs, and must be in good standing and eligible for licensure in those states mandated by specific job descriptions. In addition, the job description identifies qualifications and education requirements that the potential candidate must have prior to the interview process. Qualifications include previous work-related experience, critical thinking skills, and verbal communication skills. The job description includes key responsibilities to perform the functions of a nurse.

Physician Credentialing

Every physician employed by or under contract to MHS for professional medical services to make clinical decisions, to give final approval to clinical content of programs or applications, or to act in a consulting role is credentialed using appropriate accreditation standards. Utilizing the American Medical Association's (AMA) Credentialing Service, primary source verification and board certification of such credentials is completed. MHS adheres to credentialing standards for its physicians and consultants, as appropriate. These credentialing activities are in compliance with NCQA, URAC, and AMA standards.

Other healthcare professionals' credentialing is validated by requiring at a minimum, that all employees and potential candidates submit an application for credential review prior to hire and upon request. All applications and credentialing are processed according to current policy and procedure. MHS conducts verification to ensure that credentialing and re-credentialing activities are in accordance with nationally recognized standards, such as NCQA and URAC.

Insurance for health professionals employed by MHS is covered under MHS' Errors and Omissions (professional liability) coverage.

Regulatory Compliance

Risk & Regulatory Compliance is responsible for the ongoing monitoring of federal proposed rules regulating the delivery of care to Medicare and Medicaid beneficiaries. Federal regulations affecting health plans as CMS approved Medicare Advantage fall to MHS as a delegated entity. MHS has established processes and resource tools for ongoing communication to staff regarding federal and state laws and requirements that affect designated program functions and processes. Adapting to changing governmental regulations is accomplished through guidance from McKesson corporate Regulatory Affairs Council (RAC) and the corporate Office of Public Affairs.

The company-wide RAC was established to enhance dialogue among regulatory managers at our various operating business units and to ensure a coordinated corporate strategy on regulatory issues of importance to the company.

Since regulatory affairs managers from different operating business units often work with the same federal and state agencies (i.e. FDA, Centers for Medicare and Medicaid Services, Department of Health and Human Services, State Boards of Pharmacy, State Health Departments) to ensure operating company compliance with existing regulations, the Council increases intra-company awareness of issues and government contacts that might conflict with or potentially benefit another MHS operation.

National Committee for Quality Assurance

The National Committee for Quality Assurance is a private, 501(c) (3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

NCQA has helped to build consensus around important health care quality issues by working with large employers, policymakers, doctors, patients and health plans to decide what is important, how to measure and promote improvement. That consensus is invaluable — transforming our health care system requires the collected will and resources of all these constituencies and more.

NCQA's programs and services reflect a straightforward formula for improvement: Measure. Analyze. Improve. Repeat. NCQA makes this process possible in health care by developing quality standards and performance measures for a broad range of health care entities. These measures and standards are the tools that organizations and individuals can use to identify opportunities for improvement. The annual reporting of performance against such measures has become a focal point for the media, consumers, and health plans, which use these results to set their improvement agendas for the following year

NCQA Disease Management (DM) Accreditation

NCQA offers a flexible evaluation program, including Accreditation for organizations that offer comprehensive DM programs with services to patients, practitioners or both. These standards build on NCQA's years of Accreditation and Certification experience, detailed market research and input from industry experts and other stakeholders.

NCQA Accreditation will allow organizations that offer quality DM programs and services to receive the market advantage, high standards of quality and recognition from key contractors the industry demands. The NCQA Accreditation seal of approval may help organizations relieve delegation oversight from health plans and meet many request-for-proposal (RFP) requirements. Organizations eligible for DM accreditation take responsibility for developing content and systems and for operating DM programs. Organizations may bring as many programs or conditions forward for accreditation as they wish. There are three accreditation/evaluation options: Patient and Practitioner oriented; Patient oriented and Practitioner oriented.

NCQA Health Information Product (HIP) #4/Health Information Line (HIL) Certification

NCQA released the *2007 Standards and Guidelines for Certification in Health Information Product (HIP)*, which became effective November 1, 2007. NCQA designed the certification program to highlight organizations that provide services to Health Plans related to recently released NCQA standards addressing member connections, the care management and health improvement standards addressing wellness and provider directories. Prior to the release of these standards, delegates and vendors of Health Plans for these functions did not have a program that directly reviewed their performance. This certification program focuses on an organization's role as a delegate to provide services for NCQA accredited Health Plans that meet the standards and is specifically designed to help streamline the survey process for both the delegates/vendors and the health plans.

An organization may seek certification in any or all of the following seven certification options: Health Risk Appraisals; Interactive Consumer Health Tools; Pharmacy Benefits; Health Information Line; Encouraging Wellness and Prevention; Hospital Performance and Physician and Hospital Directories.

For elements where the activities are performed by another entity, Health Plans that use the services of organizations that hold NCQA certification are relieved from the responsibility of performing formal oversight reviews of the standards for which the HIP program has been certified. Therefore, HIP certification reduces oversight by organizations seeking NCQA accreditation or distinction and takes the place of the annual organization review of performance on NCQA requirements that are delegated to an organization certified in HIP. In addition, those Health Plans receive automatic credit for these standards when undergoing an NCQA Accreditation survey.

NCQA Accreditation/Certification at McKesson Health Solutions

McKesson's Disease Management Program received NCQA Patient and Practitioner Oriented Accreditation in 2002, 2005 and 2008. The 2008 accreditation will be in effect until October 30, 2011. Conditions accredited include Asthma, CAD, COPD, Diabetes and Heart Failure.

McKesson's Personal Health Advisor® Nurse Advice Line received NCQA Health Information Product (HIP) #4/Health Information Line (HIL) Certification May 6, 2009. This certification will be in effect until May 6, 2011.

NCQA continually reevaluates and revises its standards in order to reflect industry changes and to maintain appropriate benchmarks. As a result, on an ongoing basis, all of the McKesson Health Solutions program policies and procedures are reviewed and revised to maintain compliance with NCQA standards. A tracking tool was developed to guide continued compliance of the Disease Management Program and

the PHA NAL Program to the applicable NCQA Standards. This tool is reviewed and updated on a quarterly basis by the MHS Regulatory Compliance Manager.

URAC

URAC, an independent, nonprofit organization, is well known as a leader in promoting health care quality through its accreditation and certification programs. URAC offers a wide range of quality benchmarking programs and services that keep pace with the rapid changes in the health care system, and provide a symbol of excellence for organizations to validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire health care industry.

Originally, URAC was incorporated under the name "Utilization Review Accreditation Commission." However, that name was shortened to just the acronym "URAC" in 1996 when URAC began accrediting other types of organizations such as health plans and preferred provider organizations. In addition, URAC sometimes uses a second corporate name or "DBA" which is the "American Accreditation HealthCare Commission, Inc." This corporate name is sometimes used on URAC certificates and other written communications to help explain what URAC does.

Accreditation is a symbol of quality in the health care industry that identifies best practices and promotes performance measurement by evaluating operations and services against national standards developed by experts and stakeholders in the health care marketplace. Accreditation also advances the goal of value-based health care purchasing: obtaining the highest quality care at the most reasonable cost. By engaging in a hands-on process of evaluating quality and efficiency, URAC accreditation goes far beyond the assurances provided by an RFP, and is a critical measure used for purchaser decision making. Organizations earn accreditation by voluntarily undergoing a rigorous and comprehensive review that ensures ongoing compliance.

URAC Core and Health Call Center (HCC) Accreditation at McKesson Health Solutions

McKesson has been accredited for HCC Standards since 1997 and for Core Standards since 2000. Accreditation was good for two years until 2006 when the accreditation cycle was extended to three years, depending on the results of the review. An Intracycle monitoring visit is part of the three-year cycle. McKesson's present Core and HCC Accreditation extends from September 1, 2009 to September 1, 2012.

URAC Core and Disease Management Accreditation at McKesson Health Solutions

For the first time, McKesson applied for URAC Core and Disease Management Accreditation in 2009. After submission of evidence and an onsite survey, McKesson was granted full accreditation from October 1, 2009 to October 1, 2012.

URAC Health Web Site Accreditation at McKesson Health Solutions

McKesson is applying for initial URAC health Web Site Accreditation. The Core Standards are not a part of this accreditation. In December, 2009, McKesson completed the URAC Accreditation Application Agreement and submitted it to URAC. Submission of evidence is due October 1, 2010. There will be no onsite visit. This accreditation will be good for two years.

URAC continually re-evaluates and revises its standards in order to reflect industry changes and to maintain appropriate benchmarks. As a result, on an ongoing basis, all of the McKesson Health Solutions program policies and procedures are reviewed and revised to maintain compliance with applicable URAC Standards. A tracking tool was developed to guide continued compliance of the Disease Management, Health Call Center and Health Web Site Programs to the URAC Standards. This tool is reviewed and updated on a quarterly basis by the MHS Regulatory Compliance Manager.

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans.

MHS' Care Management/Disease Management program closely follows the standards set by NCQA by supporting the selected HEDIS® measurements. The clinical indicators are taken both from the national guidelines for each disease state and selected HEDIS® requirements. As we support change through educating and supporting the member to meet clinical indicators, we are also supporting our business needs. When positive outcomes are impacting the member's lifestyle, they are also positively supporting our clients to whom the programs are sold.

Since self-reported information is not accepted by HEDIS®, the nurse role in Care Management/Disease Management at MHS is to act as a support for empowering the members to obtain lab work, check blood sugars, do daily weights, comply with medication, and receive education on other measures. By providing the results of this measurable information through Client Outcomes Reports, MHS' Care Management/Disease Management programs are supporting both the health plans and our business viability.

Centers for Medicare and Medicaid (CMS)

The MHS Risk and Regulatory Compliance department is responsible for the ongoing monitoring of federally proposed rules regulating the delivery of care to Medicare and Medicaid beneficiaries. Federal regulations affecting CMS-approved health plan Managed Care Organizations (MCOs) fall to MHS as a delegated entity. MHS has established processes and resource tools for ongoing communication to staff regarding federal and state laws and requirements that affect designated program functions and processes.

Health Information Technology for Economic and Clinical Health (HITECH) Act

The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as Subtitle D of Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act (ARRA), which was signed into law on February 17, 2009.

Subtitle D: Improved Privacy & Security Provisions

- Substantive changes to HIPAA statutory provisions and privacy and security regulations.
- Enhanced enforcement of HIPAA
- Provisions to address health information held by some entities not covered by HIPAA.

Although the HIPAA Rule has many different parts, the sections that demand the most attention from MHS are:

- The Privacy Rule
- The Security Rule

The Security Rule defines the safeguards necessary to protect the confidentiality, integrity, and availability of sensitive patient information. By contrast, the Privacy Rule sets standards for how that sensitive information should be controlled by establishing appropriate uses and disclosures and creating patient rights with respect to their health information.

Whenever MHS contracts with a Covered Entity, we are required to sign a Business Associate Agreement ("BAA"). Under HIPAA, all BAA's signed by MHS must:

- Describe the permitted and required uses of PHI by MHS
- Provide that MHS will not use or further disclose PHI other than as permitted or required by the contract or as required by law
- Require that MHS use appropriate safeguards to prevent a use or disclosure of PHI other than as provided for by the contract

Under the HITECH legislation a new category of business associate was defined as: an organization that transmits PHI to a covered entity and routinely requires access to such PHI, for example:

- E-prescribing gateways
- Health Information Organizations

- Vendors that contract with a covered entity in order to offer a Personal Health Record to its patients

State Regulatory Compliance

MHS has established processes and resource tools for ongoing communication to Care Management/Disease Management and Personal Health Advisor® Nurse Advice Line reviewers regarding state laws and requirements that affect the program functions and assessment processes. This ongoing support for state regulatory compliance is supported through the Risk and Regulatory Compliance Department.

Healthcare Standards

In addition to the governmental laws that drive care delivered, healthcare standards are set by various agencies. For several of these agencies, MHS has been asked to play a proactive advisory role as it implemented accreditation/certification standards for Disease Management (DM) services and Personal Health Advisor® Nurse Advice Line services. Notably, NCQA and URAC implemented these standards. MHS was an “Early Adopter” with NCQA DM accreditation and participates on the Healthcare Standards Board that finalized the URAC Standards.

Delegated Entities

As a tool for the annual partner/vendor audit process, MHS utilizes the NCQA Disease Management standards that are pertinent to contracts, as applicable. If a partner/vendor is accredited by a MHS recognized Disease Management organization, MHS may waive a portion or all of the pre-delegation and oversight activities. This statement also pertains to accreditations/certifications covering other subcontracted services.

An audit is performed no less than annually or as determined by the Director of Risk and Regulatory Compliance in collaboration with the Vice President of Corporate Development. The subcontractor will submit a written action plan within thirty days for any standards or elements not conforming to the NCQA Disease Management standards. MHS has the right to conduct a second audit to validate completion of the action plan.

For those delegated entities that have nationally recognized accreditations/certifications, the following items, at minimum, will be discussed/examined prior to launch of a contract and on an annual basis or as determined by the Director of Risk and Regulatory Compliance in collaboration with the Vice President of Corporate Development, during an onsite audit: evidence of accreditation/certification; organizational chart; job descriptions of pertinent employees; pertinent policies and procedures; complaint log/process; risk management process; list of states in which doing business; credentialing/licensure; confidentiality; relevant HIPAA documents; certificate of insurance; references of current/former clients; conflict of interest determination; professional memberships; outcomes documents including member and provider satisfaction; regulatory audits/reviews; training and education; clinical content if indicated; technical interfaces; skill sets of pertinent employees; QA processes including measurements/outcomes; documentation; reports; description of services and/or program descriptions; case files (protected health information redacted or dummy files) and financial information.

MHS conducts medical management activities on behalf of health plan clients as a delegated entity. Health plan clients are responsible for monitoring the MHS performance through approval of our programs, routine reporting, and annual evaluation to determine our compliance with NCQA standards.

Service Level Standards (SLS)

Service Level Standards (SLS) are performance metrics derived from MHS Service Level Agreements (SLAs) with clients to ensure the standard of services performed. These performance standards are

specific to Personal Health Advisor® Nurse Advice Line and Care Management/Disease Management and are measured on an aggregate level. Individual clients are also monitored and tracked for compliance to the standards. The intent of the standards is for internal departments to monitor performance, identify issues, and report monthly compliance rates for their assigned standards/metrics. The product specific reports detail monthly and yearly compliance statistics of the specified standards/metrics which allows MHS to track, trend, and analyze the results.

MHS' performance standards are related to the following areas of service:

Personal Health Advisor® Nurse Advice Line:

- Accounting
- Account Management of Client Inquiries
- Data Transfer
- Client Reporting
- Training and Education
- Complaint Policy
- Member Complaint Management
- Confidentiality
- Member Satisfaction
- Quality Management
- Client On-site Review
- Personal Health Advisor® Nurse Advice Line Metrics
- Personal Health Advisor® Nurse Advice Line Action Plans

Care Management/Disease Management:

- Accounting
- Account Management of Client Inquiries
- Data Transfer
- Client Reporting
- Training and Education
- Complaint Policy
- Member Complaint Management
- Confidentiality
- Member Satisfaction
- Quality Management
- Client On-site Review
- Clinical Metrics
- Provider Policy
- Provider Complaint Management
- Provider Satisfaction
- Referral Processing

SLS Reporting

The SLS Reports review all SLS activities on a monthly basis or as needed. In order to ensure compliance with the SLS, the NAL QC and CM/DM QC proactively reviews key reports from the delegated service departments responsible for the standards/metrics listed above. If potential issues are identified, the Committees work with the respective department or develop an action plan for improvement. These statistics are then reported to the SQSC through the CM/DM QC, NAL QC and the Compliance Committee. The statistics are used extensively by the pertinent departments within MHS for process improvement and for our corporate scorecard. The goal is to identify problems or performance trends before they affect our external client service.

Criteria that do not meet the established SLS in accordance with client service level agreements require action plans written by the pertinent department to explain the deviation from the SLS. The Action Plan template is used to document the initial investigation and action plan follow-up for the appropriate QC or

CMT (Customer Management Team). Action plans are shared with the appropriate Account Management representative(s) so that the deficiency can be corrected to meet the SLS per the client contract.

If the service levels remain unmet in accordance with the client service level agreement and/or client contract, the action plans are distributed to the clients per the contract at the discretion of the Account Manager with senior management approval as appropriate and follow-up as necessary.

MHS Standard Services and Performance Strategies

The following section includes information on MHS' primary service products and how the QI Program is involved in ensuring product quality and operational success. For complete information regarding the products mentioned in this section, please refer to the product program description.

Care Management/Disease Management Program

Description of Product and Services

MHS provides an integrated Care Management/Disease Management (CM/DM) service, including: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Coronary Artery Disease (CAD), Heart Failure (HF), Depression, Schizophrenia, Hypertension, Dyslipidemia, Stroke, Transient Ischemic Attack (TIA), Lupus (Systemic Lupus Erythematosus (SLE)), Multiple Sclerosis (MS), Back Pain (Chronic), Headache (Chronic), Hepatitis B or C, GERD or Barrett's esophagus, Inflammatory Bowel Disease (Ulcerative Colitis or Crohn's Disease), Seizure Disorder, Rheumatoid Arthritis, Cystic Fibrosis, Peptic Ulcer Disease, and Atherosclerosis (to address Peripheral Vascular/Arterial Disease). All DM programs are managed through one delivery platform. MHS' programs are aimed toward providing preventive care and behavior modification designed to improve the member's quality of life while providing cost savings to Clients. MHS' Care Management/Disease Management programs are based on nationally recognized clinical guidelines such as those published by: the National Heart, Lung, and Blood Institute (NHLBI); American Diabetes Association (ADA); American Heart Association (AHA); Global Initiative for Chronic Obstructive Lung Disease (GOLD); American Thoracic Society; the American College of Cardiology (ACC); and the American Psychiatric Association (APA). The integrated Care Management/Disease Management (CM/DM) service helps the members understand his/her condition by developing and reviewing the plan of care, monitoring the member's adherence to the plan, and provides an individualized approach to assessing a member's needs and barriers. The goal of MHS' Care Management/Disease Management programs is to measurably reduce the complications associated with chronic diseases and improve the member's overall quality of life.

The Program is designed to be in accordance with standards of the following external agencies:

- Centers for Medicare and Medicaid Services (CMS)
- National Committee for Quality Assurance (NCQA)
- URAC
- Any contracted or regulatory entity in the geographic regions covered by MHS and its DM program.

The Program is based on the Disease Management Association of America (DMAA) definition of disease management. It also provides for additional coordination of services via referral to Targeted Care Coordination and/or Case Management. In particular, the Program includes population and risk identification, and the use of evidence-based guidelines to promote self-management and adherence to the prescribed treatment plan, thereby measurably improving outcomes. The Program is consistently delivered and supported by proprietary software and information systems. Program results are reported, as applicable, to the purchasing client, members, their practitioners, and relevant consented parties in terms of the clinical, satisfaction, quality of life, and financial outcomes.

The purpose of the Care Management/Disease Management Program Description is to define the goals, scope, structure, and function of MHS' Care Management/Disease Management Program and the activities associated with providing these services. The program description is evaluated and approved annually by the CM/DM Quality Committee.

Precise Documentation

MHS has standards that define documentation guidelines and expectations for each call type. Every effort must be made to ensure that all data collected, maintained, and acted upon is accurate, comprehensive, and timely.

To meet professional and legal demands for accountability, documentation is maintained on all member records. Documentation is to be clear and concise with times, dates, names of person(s) involved and/or contacted, and action(s) taken. Chart documentation does not include personal or pejorative comments or opinions regarding the member, family, Client, or Client departments. The nurse is responsible for documenting, by means of free text and application-guided fields and prompts, baseline assessment of member severity, member coaching and counseling activities, and member compliance and understanding.

Multi-disciplinary Staffing Approach

Accessibility of Telephonic Staff

MHS provides access to CM/DM staff for members, practitioners, and clients through a toll free telephone number generally between the hours of 8 AM and 8 PM (member time) Monday through Friday, and limited hours on Saturdays, excluding corporate holidays. The member has access during these hours to non-clinicians, registered nurses, and other allied healthcare professionals. After-hours, the member may access a voice messaging option where the member may leave a message for all non-urgent requests. The messages are retrieved and acted upon the next business day. Emergency and urgent care access is available 24 hours a day, seven days a week via the Personal Health Advisor® Nurse Advice Line program. Members are encouraged to contact their physician when appropriate. Personal Health Advisor® Nurse Advice Line nurses have access to a physician advisor 24 hours a day, seven days a week.

Care Coordination

For health plan clients that do not already have a care coordination service, a CM/DM program offering may include care coordination services. Care coordination includes:

- Facilitating the connection between CM/DM members and needed services
- Providing resources to staff to manage client issues that are beyond the standard scope of delivery
- Aggregating issues related to special needs/resources concerns, elevating and participating in problem solving as appropriate
- Acting as subject matter expert on the delivery of our CM/DM Program and specific programs and/or resources
- Facilitating the transfer of members between telephonic staff and Community Based staff as applicable and appropriate
- Increasing Member Involvement

Member Communication

MHS has processes in place to provide all eligible members with written program information at the time of member identification.

After data is received from the client and eligible members are identified, introductory materials are sent to eligible members explaining the program. The members' health plan, employer group or Medicaid agency determines the member eligibility.

In the member introductory letter, members are informed that they are eligible to participate in the program because their health plan or employer group is offering the program as a benefit to help them better understand and manage their chronic condition. For Medicaid programs or other clients choosing the option out model, members are informed they have been enrolled in the CM/DM program, but can choose not to participate. The program explanation informs eligible members that the program is available to them as an added benefit from their health plan or employer group, describes what the program does, details what they can expect from the program, addresses how to file a complaint or concern, and how to contact a CM/DM nurse to initiate enrollment into the program. The focus of the member materials is to encourage program participation and to promote and support self-management of the member's condition.

After a CM/DM nurse completes the member assessment, further communication from MHS on behalf of the client encourages the member to call with any questions or concerns. If, at any time (24 hours a day, seven days a week), the member has questions or an urgent medical need, the member can speak to one of the nurses from the Personal Health Advisor® Nurse Advice Line. This nurse screens for and addresses any symptoms present, but especially rules out an emergent/urgent situation. If no new or changed symptoms are present and the member desires to speak with CM/DM Program staff, the Personal Health Advisor® Nurse Advice Line nurse will transfer the call to the CM/DM Program. During hours of CM/DM Program operation, member calls are handled by CM/DM staff. After hours, members wishing to speak with the CM/DM Program nurses may leave a message for the CM/DM staff to return the call on the next business day. The goal is to handle all symptomatic calls when received, and to channel non-emergent calls to the CM/DM program as soon as possible.

In addition to addressing questions and concerns, the post-enrollment mailing also includes the Member Bill of Rights and Responsibilities with further information on how to communicate complaints or other feedback, and how to contact MHS in an urgent situation. MHS has defined a complaint as a concern or grievance per the Complaints and Grievances Policy. A CM/DM nurse refers to condition-specific scripted language at the end of the call to give the member information on how to contact MHS using a toll free number to communicate a concern, if the member is experiencing symptoms or has medical questions. An example is in the condition-specific assessment scripts, in which the member is given the number of the Personal Health Advisor® Nurse Advice Line for symptom management. These scripts are reflective of the language used to close calls for all conditions.

Health Resource Coordinators

The CM/DM department uses non-clinical staff titled Health Resource Coordinators (HRC) to handle inbound and outbound calls dealing with non-clinical issues. The HRCs make up a support department for the members. Their service includes:

- Understanding the distinction between the clinical and non-clinical role
- Introducing and promoting the program to selected Client members
- Facilitating enrollment for a member into the condition-specific program
- Handling fulfillment requests for self-care guides
- Rescheduling of CM/DM appointments
- Supporting members in accessing and navigating web pages
- Assisting with surveys and administrative duties

At MHS, auxiliary staff provides information that is non-clinical. As outlined in job descriptions, the Call Coaching Tool, policies and operational guidelines, non-clinical staff members indicate their role for supporting the program during conversations with members and practitioners.

Provider Outreach Coordinators

The Provider and Community Outreach model has been developed based on MHS' experience in the Medicaid and Medicare markets. Delivery of the Care Management/Disease Management services to our clients, providers, and beneficiaries is enhanced through the activities outlined in the Outreach Strategy. In an effort to launch the Care Management/Disease Management program in a collegial and collaborative manner, a series of outreach toolkits has been developed. From the first contacts with state officials and interested stakeholders to the full implementation of a state-wide outreach plan, these toolkits offer successful solutions in building and implementing the Outreach Plan. The toolkit is built on best practice experiences and is used as a guide when creating a state specific tailored program. Samples and templates are provided for all elements of the program and are meant to be adapted to the special and unique characteristics of each state outreach effort. The role of provider outreach coordinator may or may not be combined with the Community Based Registered Nurse.

Community Based Registered Nurses

Implementation of Community Based Registered Nurse (CBRN) staff in the state Medicaid Care Management/Disease Management (CM/DM) program delivery model provides a resource that enables MHS Internal Quality Improvement Program Description July 2010 Proprietary and Confidential

the high risk or high cost client to be engaged and managed more effectively. The work of the CBRN is primarily focused on high risk/high cost members who cannot be appropriately or effectively managed telephonically. The CBRN delivers a portion of the DM services face-to-face, reducing or eliminating barriers to care and facilitating care coordination.

Priorities of CBRN activities for clients follow the principles of Maslow's hierarchy of needs. The meeting of basic physiological (food, water, sleep) and safety needs (security, a shelter or home, and family, caregiver, or social support) increases the chances that the client will actively engage in the DM interventions and adopt beneficial self-management practices. The CBRN identifies client vulnerability, needs, and goals related to improving outcomes and reducing cost. Through creative problem solving and advocacy, the CBRN provide DM services and care coordination.

The primary CBRN activities include, but are not limited to, the following:

- Assessment and management of high risk/high cost members as needed per criteria
- Identification and removal of significant barriers to self care management
- Care coordination activities to improve financial and clinical quality indicator outcomes
- Facilitating referrals to other services
- Post hospitalization/utilization interventions

The secondary CBRN activities include but are not limited to:

- Identifying the need for community based resources and working with HRCs and/or other allied healthcare staff to coordinate them
- Strengthening community network ties through coordination of services with the Provider Outreach Coordinators
- Building partnerships with formal healthcare delivery systems to connect the client with the services needed

Practitioner Program Information

MHS designs program content for practitioners consistent with current evidence-based clinical practice guidelines. Promoting adherence and practice of evidence-based clinical guidelines into professional practice is a primary objective to achieve positive outcomes for all CM/DM programs. Evidenced based guidelines form the basis for practitioner communications and outreach.

Our practitioner decision support or outreach includes a variety of communications that may be written, verbal or both, depending on the nature of the situation. This information is designed for all practitioners rather than specialists. The purpose of the communication is to engage the practitioner in the program and coordinate the delivery of the member's care. Program content is designed to benefit both the member and the practitioner; practitioners are not required to adhere to the recommendations or material presented.

Communications to practitioners includes program introductory letters, post-assessment letters, clinical alerts, and phone calls. As part of the program design, practitioners are informed of how to access information and obtain additional information about their members. Feedback is encouraged at all times and practitioners are provided a toll-free number to enable contact with either a CM/DM Nurse or a Medical Director. Fax inquiries are also accepted.

The member is also encouraged to collaboratively develop a written action plan with his or her practitioner. Both the care plan and risk stratification ensure the intervention is appropriate and reasonable to meet member needs.

Prior to enrollment, identified practitioners are sent a letter notifying them of the CM/DM program and providing them with a list of their members that may be eligible for the program. Practitioners will receive monthly reports. The report summarizes self-reported information supplied by the member, caregiver (i.e. Parent or caretaker) reported, provider reported or claims-based data and provides this data in the context of national clinical guideline recommendations. Physicians are encouraged to call with questions

or provide instructions on specific areas of their treatment plan for reinforcement. Alerts to the physicians occur in a tiered manner (phone or fax) if a member has signs or symptoms of possible decompensation or reports circumstances adversely impacting his/her condition. Regardless of the risk level, communication with the practitioner and/or case manager may be generated at any time during the assessment and monitoring process. Practitioners are engaged and integrated throughout the CM/DM intervention.

Communications to practitioners about their individual members comes from the CM/DM nurses and may be verbal, written, or both depending on the specific situation. The purpose of the communication is to engage the practitioner in the program and coordinate the delivery of the member's care. In addition to program information and clinical guidelines, member-specific communication is system generated and sent via the Fulfillment Department upon completion of the initial assessment. Communicated information specific to the member includes but is not limited to self-reported:

- Medication usage and status of adherence
- Member-specific action plan
- Perception of health status
- Preventive health practices
- Positive lifestyle management
- Co-morbidities

Member Satisfaction for the Care Management/Disease Management Program

MHS conducts a member satisfaction survey of Care Management/Disease Management participants after their biannual assessment, generally within two to four weeks of their encounter with the nurse.

Survey Purpose

The primary purpose of the survey is to obtain information concerning member satisfaction with the Care Management/Disease Management program.

Survey Assessment Criteria

To measure participant satisfaction, MHS uses a modified version of DMAA's DM participant satisfaction survey instrument. Specifically, McKesson uses DMAA's 18 "core" questions, along with 39 of DMAA's optional questions. The survey assesses:

- General satisfaction with the Care Management/Disease Management program
- Satisfaction with the nurse's advice, education, and understanding of specific disease
- Satisfaction with the program's written and educational materials
- Value of the program with regard to management of disease
- Usefulness of the program in members' communications with their doctors

Survey Procedures

An independent outside contractor administers the member satisfaction outcome surveys telephonically using a client-specific sample of all participants.

Client-specific survey results are provided annually, or as stated in the client contract. Aggregate results are reviewed internally on a quarterly basis, to identify potential areas of improvement.

Practitioner Feedback for the Care Management/Disease Management Program

MHS elicits provider feedback about CM/DM services. The primary purpose of this feedback is to obtain provider opinions about the Care Management/Disease Management program.

The feedback assesses:

- Usefulness of the Care Management/Disease Management program to providers and their patients
- Usefulness of the program materials (clinical alerts, national guidelines, patient rosters, assessment reports, etc.) to providers
- Knowledge and helpfulness of the MHS' Care Management/Disease Management program staff
- Ability of the CM/DM program to improve patient compliance with provider recommendations
- Provider willingness to refer eligible patients to the MHS' CM/DM program.

Feedback Procedures

A variety of different means may be used to obtain feedback, which may include focus groups and surveys. All feedback is captured and reported to categorize and seek trends in the above referenced assessment criteria through an annual analysis of the results.

An aggregate report of all practitioner feedback is reviewed annually to determine satisfaction across specific clients and identify potential areas of improvement.

Clinical Decision Architecture

A team of board certified specialists and physicians, nurses, and other healthcare experts with extensive experience in managing chronic and co-morbid conditions develop MHS' CM/DM Programs. MHS uses a standardized process originating in nationally accepted guidelines as the basis for all CM/DM programs, condition-specific technical documents, and position statements used to deliver or facilitate the delivery of clinical care.

Examples of the guidelines used for each condition are as follows:

Asthma:

National Heart, Lung, and Blood Institute. Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, Full Report 2007. Bethesda, MD: US Department of Health and Human Services, National Institutes of Health, National Heart Lung and Blood Institute: 2007. NIH publication 07-4051. Available at <http://www.nhlbi.nih.gov/guidelines/asthma/index.htm>

Chronic Obstructive Pulmonary Disease (COPD):

Global Initiative for Chronic Obstructive Lung Disease (GOLD). Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease: 2009. Available at: <http://www.goldcopd.org>

Diabetes:

American Diabetes Association. Standards of medical care in diabetes-2009. Diabetes Care. 2009;32(Suppl 1):S1-S61. http://care.diabetesjournals.org/content/vol31/suppl_1/

Coronary Artery Disease (CAD):

Smith SC Jr, Allen J, Blair SN, et al. AHA/ACC guidelines for secondary prevention for patients with coronary and other atherosclerotic vascular disease: 2006 update: endorsed by the National Heart, Lung, and Blood Institute. J Am Coll Cardiol. 2006;47:2130-2139. Available at: <http://content.onlinejacc.org/cgi/reprint/47/10/2130>

Gibbons RJ, Abrams J, Chatterjee K, et al. ACC/AHA 2002 Guideline Update for the Management of Patients with Chronic Stable Angina: a Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. 2002. Available at: http://www.acc.org/qualityandscience/clinical/guidelines/stable/stable_clean.pdf

Furster V, Rydén LE, Cannom DS, et al. ACC/AHA/ESC 2006 guidelines for the management of patients with atrial fibrillation: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the European Society of Cardiology Committee for Practice Guidelines. J Am Coll Cardiol. 2006;48:e149 –246.

Available at http://www.acc.org/qualityandscience/clinical/guidelines/atrial_fib/pdfs/AF_Full_Text.pdf

Fraker TD Jr., Fihn SD, et al. 2007 chronic angina focused update of the ACC/AHA 2002 guidelines for the management of patients with chronic stable angina. *J Am Coll Cardiol* 2007;50:2264 –74. Available at <http://content.onlinejacc.org/cgi/content/full/j.jacc.2007.08.002>

Heart Failure:

Hunt SA, Abraham WT, Chin MH, et al. 2009 focused update incorporated into the ACC/AHA 2005 guidelines for the diagnosis and management of heart failure in adults. *J Am Coll Cardiol*. 2009;53:e1-90. Available at: <http://www.acc.org>

Guidelines

Use of disease-specific standardized clinical guidelines ensures consistency of the assessment and monitoring processes delivered to the member by the CM/DM nurse. Tools are used to evaluate staff performance and knowledge of the clinical guidelines during all aspects of the program intervention, such as the enrollment, assessment, and monitoring/coaching processes.

The Clinical Content staff receives ongoing updates from a variety of recognized sources. The Clinical Content staff is on the email distribution list for new information from the National Guideline Clearinghouse at www.Guideline.gov, as well as publications such as the *New England Journal of Medicine*, *Diabetes Care*, *Asthma Web*, *NHLBI News*, and www.Medscape.com. Additionally, the Clinical Content staff has web site listings of relevant professional associations and government sites such as the NHLBI, Center for Disease Control (CDC), HHS, AHRQ, ADA, ACC, APA, and others.

The Vice President, Chief Clinical Architect approves the resource list annually. The Clinical Content Department approves use of national clinical guidelines and recommended resources throughout the year. Approved resources are posted on MHS' intranet.

Each condition-specific program is reviewed, updated, and modified as national guidelines are updated and other relevant information is made available from the recognized resources. Updates occur as frequently as the national guidelines are updated, but reviewed no less than annually. The Clinical Content Department will always reference the source for any new information added to a program so that MHS can easily research and update program content in subsequent reviews.

As available, MHS uses only nationally recognized and accepted clinical practice guidelines (CPGs) for condition standard deliverables. These are formulated from evidenced based medicine and peer reviewed clinical outcomes studies. The clinical practice guidelines used for our standard deliverables are based on professional knowledge that has been evaluated and deemed current by the clinical leaders at MHS. MHS uses actively practicing practitioners to review the new or revised guidelines.

In the event that a client would have their own Care Management/Disease Management materials to use, MHS has a process in place to review and evaluate those materials.

Members receive educational materials based on clinical guidelines. As guidelines are subsequently updated, further practitioner communications (i.e. alerts, post assessment letters) are modified as needed to be congruent with those updates.

Care Management/Disease Management Program Performance Strategies

There are four primary QI strategies, which are intended to measure CM/DM program performance. Each QI strategy has specific quality and operational indicators that are used to gauge the level of impact of QI activities. QI activities are adjusted during the year based on evaluation of these indicators. All indicators are regularly monitored.

Performance improvement strategies used to monitor the Care Management/Disease Management program are listed in Table 3 below.

CM/DM Measurement Strategy	Definition/Purpose	Quality or Operational Indicators
1. Clinical Integrity	<p>Care Management/Disease Management programs are developed using condition specific evidence based guidelines along with consultation from physician clinical specialists. The focus is on the identification of member self-care barriers, and the use of validated behavior change techniques that are utilized to address member specific needs, goals and risk.</p> <p>The delivery of programs uses an application that is designed to deliver consistent Care Management/Disease Management content that includes patient safety. Key condition specific clinical goals and targets are initially assessed and periodically monitored for each member.</p> <p>Program outcomes are continuously monitored in aggregate and for each purchasing client. Any areas not showing favorable trend are addressed utilizing well established regulatory and industry standards of care.</p>	<p>Quality Indicators</p> <ul style="list-style-type: none"> • Clinical outcome reports • Clinical value metric reports • Claim based reports • Patient Safety <p>Operational Indicators</p> <ul style="list-style-type: none"> • Miscellaneous quality initiatives • Product delivery consistency (RN, HRC, allied health professionals) • Accurate data collection (RN, HRC, allied health professionals)
2. Consistent Call Handling	<p>Collaboratively develop, implement, and maintain an efficient call process that supports business and clinical objectives. The call handling methodology is intended to ensure the quality and consistency in the delivery of the call, including call logic, application efficiency and documentation of the member interaction. Member interaction methods are designed to use strategies to engage members to participate in the Care Management/Disease Management programs and to assist the member in</p>	<p>Quality Indicators</p> <ul style="list-style-type: none"> • Member file audit • Inter-rater reliability • Coaching opportunities and risk incidents trends • Compliments, complaints, risk incident trends <p>Operational Indicators</p> <ul style="list-style-type: none"> • Training report/Calibration/Competencies • Call coaching tool/ Call interaction tool • DM weekly operations report

CM/DM Measurement Strategy	Definition/Purpose	Quality or Operational Indicators
	<p>behavior change to adhere to established clinical objectives. Strategies used for member engagement include Solution Selling and Motivational Interviewing techniques.</p>	<ul style="list-style-type: none"> • DM metrics report (closing rate/MR) • Call metrics • Enrollment rate • Additional call metrics • Product delivery consistency (HRC)
<p>3. Program Satisfaction</p>	<p>Assess member satisfaction to determine experience with: overall program, nurse advice, education, and understanding of program materials, assessed value of managing disease and enhancing communication with practitioner.</p> <p>Assess provider satisfaction to determine experience with: overall program, staff helpfulness, program material usefulness, Assessed value of decision support and usefulness to increase member communication with practitioner.</p> <p>Assess client satisfaction to determine experience with: overall program, staff administrators, value of service and impact on population.</p>	<p>Quality Indicators</p> <ul style="list-style-type: none"> • Member satisfaction survey results • Provider satisfaction survey results • Provider advisory committee feedback • Client satisfaction survey results • Compliments, complaints, coaching opportunities, risk incidents and trends. • Client retention • Delivery of quality product in accordance with our promises to clients, and ethical and regulatory standards
<p>4. Quality Call Delivery</p>	<p>The call handling methodology is intended to ensure the quality in the delivery of the call, and documentation of the member interaction. The focus is on the identification of member self-care barriers, and the use of validated behavior change techniques that are utilized to address member specific needs, goals and risk. Strategies used for member engagement include Solution Selling and Motivational Interviewing techniques.</p> <p>The delivery of programs uses an application that is designed to deliver consistent Care Management/Disease Management content that includes patient safety. Key condition specific clinical goals and targets are initially assessed and periodically monitored for each member.</p>	<p>Quality Indicators</p> <ul style="list-style-type: none"> • Member file audit • Inter-rater reliability • Coaching opportunities • Compliments, complaints, risk incident trends <p>Operational Indicators</p> <ul style="list-style-type: none"> • Miscellaneous quality initiatives • Call coaching tools and interpretation standards • Product delivery consistency (RN, HRC, allied health professionals)

Table 3: Performance Improvement Strategies for CM/DM

Personal Health Advisor® Nurse Advice Line Program

Description of Product and Services

The Personal Health Advisor® Nurse Advice Line (PHA NAL) program is a 24 hours a day, seven days a week operation that provides immediate triage assessment, referral services, and member education to client members and/or employees. The program encompasses complete nurse triage, accurate symptom assessment, precise call documentation, and relevant member education, Health Resource Coordinators to handle non-clinical issues, immediate risk incident resolution, and efficient problem tracking. NAL nurses have access to a physician advisor 24 hours a day, seven days a week.

Symptomatic callers will be triaged per client instructions in order to provide a recommendation to the appropriate level of care by the appropriate provider. The Personal Health Advisor® Nurse Advice Line Program is designed to be in accordance with standards of the American Accreditation HealthCare Commission/Utilization Review Accreditation Commission (URAC).

Accurate Symptom Assessment

Using MHS-developed Clinical Decision Algorithms and the Personal Health Advisor® (PHA) application, advice nurses listen to each member's chief complaint, identify member symptoms, and select the most appropriate algorithm to perform a thorough assessment. Using the correct algorithm, the nurses assess member symptoms and document pertinent information that will enhance evaluation. A combination of member input and clinical judgment allows nurses to answer clinical questions for determining the level and timeliness of care. The nurse implements the appropriate endpoint across the following levels of acuity:

- Activate Emergency Procedures: Call 911 or local emergency service for en-route care
- Urgent Care: Member must be seen between now and 48 hours from now
- Speak to Provider: Member must speak to a provider within 30 minutes to 72 hours
- Early Illness Appointment: Member must visit a provider within 72 hours
- Routine Illness Appointment: Member must visit a provider within the next two weeks
- Access Self Care Instructions: Member receives a series of self-care instructions to complete at home as well as instructions detailing the circumstances under which to seek additional evaluation or care

Precise Call Documentation

The nurse precisely documents the algorithm transversal, assessment data, and any pertinent information for all calls. Whenever nursing judgment is used to override any endpoint, the nurse also documents the reason(s) for the override.

Relevant Member Education

The nurse reviews recommendations with the caller and explains the reason(s) for these recommendations. When applicable, the nurse:

- Provides clinically relevant member teaching
- Empowers the caller to make appropriate decisions
- Delivers self-care instructions, including references to changed or new symptoms that would require re-evaluation

Health Resource Coordinators

(HRCs) are non-clinical staff members who assist with calls that do not require a licensed clinician to handle. These include calls related to benefits, provider referrals, and other program referrals (such as Informed Decision Support and Literature). Per policy, HRCs ask if members are experiencing symptoms, and strongly encourage referrals to Registered Nurses for assessment, before proceeding with non-clinical call handling. HRCs also assist with client-defined outbound call campaigns.

When a risk incident or clinical complaint is identified, staff follow the MHS risk incident policy and process. (See Risk Management section).

Efficient Problem Tracking

When a non-clinical complaint is identified, such as a system or clinical content issue or problem, it is logged into a tracking system, assigned a severity code, and forwarded to the appropriate department for resolution. Each department is responsible for tracking and trending these issues or problems and providing resolution as needed.

Member Satisfaction Survey Assessment Criteria

The survey assesses:

- General satisfaction with the Personal Health Advisor® Nurse Advice Line service
- Satisfaction with the nurse/caller interaction
- Caller agreement and compliance with the nurse recommendation
- Health outcomes
- Impact of the Personal Health Advisor® Nurse Advice Line service on caller satisfaction with the health plan
- Performance of the triage algorithms

Survey Procedures

An independent outside contractor administers the caller satisfaction outcome survey telephonically by randomly sampling a baseline percentage of MHS symptomatic callers each month. For clients with smaller enrollments, where the baseline percentage may be an insufficient sample from which to draw conclusions, a minimum number of callers are contacted each month. Client-specific survey results are provided annually, or as stated in the client contract. Aggregate results are reviewed internally on a quarterly basis, to identify potential areas of improvement.

Clinical Decision Architecture

MHS has developed 435 Personal Health Advisor® Nurse Advice Line algorithms used to assess members to the appropriate level of care within an appropriate time frame, based on presenting symptoms. The algorithms' performance was originally designed to meet expert panel standards. However, these standards have shifted to evidence-based research, due to a sample size of more than 15 million triage encounters.

Algorithm Performance Studies

To help identify sources of variance and increase algorithm quality, the MHS Quality Improvement Program regularly measures algorithm performance and compares these data to the performance level predicted by our algorithm authors.

Clinical Review and Updates

In addition to prospective algorithm review, updates are published quarterly that incorporate ongoing algorithm improvements. These updates, which are based on annual clinical review by physician consultants as well as Clinical Content staff, triage nurse feedback regarding clinical issues and direct client feedback, resolve problems that affect algorithm traversal or sorting. In addition, clinical enhancements and additions, as determined by the VP, Chief Clinical Architect, may be introduced, as needed, throughout the year.

Personal Health Advisor® Nurse Advice Line Program Performance Strategies

The same four primary QI strategies are intended to measure Personal Health Advisor® Nurse Advice Line (PHA NAL) and CM/DM program performance. Each QI strategy has specific quality and operational indicators that are used to gauge the level of impact of QI activities. QI activities are adjusted during the year based on evaluation of these indicators. All indicators are regularly monitored.

Performance improvement strategies used to monitor the Personal Health Advisor® Nurse Advice Line program are listed in Table 4 below.

PHA NAL Measurement Strategy	Definition/Purpose	Quality or Operational Indicators
1. Clinical Integrity	Clinical recommendations during calls provide safe and appropriate delivery of triage service, with industry-leading quality. Clinical recommendations and call handling maintain adherence to regulatory standards, consistent and safe delivery of Personal Health Advisor® Nurse Advice Line services, and adherence to established industry and/or MHS standards for member care.	<p>Quality Indicators</p> <ul style="list-style-type: none"> • Coaching opportunities and risk incidents trends • Product delivery • Patient Safety <p>Operational Indicators</p> <ul style="list-style-type: none"> • Urgent Care sorting • Self-Care sorting • Algorithm Endpoint Overrides • Call type percentages • Pre-intent percentage • Miscellaneous quality initiatives (i.e. anonymous caller, reverse outliers, algorithm not on list) • Product delivery consistency (HRC) • Accurate data collection (HRC)
2. Consistent Call Handling	Call handling methods deliver a quality service, independent of where or when the call is handled, providing the highest quality of service to the maximum number of members. Call handling methods are intended to address member inquiries as effectively as possible, in order to satisfy member expectations that the Personal Health Advisor® Nurse Advice Line service can help with respectful use of the member's time.	<p>Quality Indicators</p> <ul style="list-style-type: none"> • Training report • Inter-rater reliability • Compliments, complaints, coaching opportunities, risk incident trends <p>Operational Indicators</p> <ul style="list-style-type: none"> • Call coaching tool • Service level • Abandonment Rate • Call length (handle time) • Signed on to Paid • Call metrics • Product delivery consistency • Completed calls • Appropriate use of "Other" call type
3. Program Satisfaction	Clinical integrity and consistent call handling assist to maintain the members' perception of their Personal Health Advisor® Nurse Advice Line call experience, with the objective of encouraging members to trust and observe	<p>Quality Indicators</p> <ul style="list-style-type: none"> • Member satisfaction survey results • Client retention • Delivery of quality product in accordance with our promises to clients, and ethical and regulatory standards

PHA NAL Measurement Strategy	Definition/Purpose	Quality or Operational Indicators
	recommendations or advice given. Clinical integrity and consistent call handling support a positive relationship between clients and MHS, specifically to preserve the clients' perception that the quality that was sold has been delivered.	<ul style="list-style-type: none"> • Compliments, complaints, coaching opportunities, risk incidents and trends
4. Quality Call Delivery	The call handling methodology is intended to ensure the quality in the delivery of the call, and documentation of the member interaction while providing the highest quality of service to the maximum number of members.	<p>Quality Indicators</p> <ul style="list-style-type: none"> • Training report • Inter-rater reliability • Compliments, complaints, coaching opportunities, risk incident trends <p>Operational Indicators</p> <ul style="list-style-type: none"> • Call coaching tool • Delivery of quality product in accordance with our promises to clients, and ethical and regulatory standards • Compliments, complaints, coaching opportunities, risk incidents and trends

Table 4: Performance Improvement Strategies, PHA NAL Program

Navigation Program

Description of Product and Services

Navigation is a 24 hours a day, seven days a week health service that extends beyond the Personal Health Advisor® Nurse Advice Line Program to serve as a central point of decision support, early identification, and referrals. It acts as the hub from which:

- A 360° view of each caller's health status is compiled (from acute symptoms and lifestyle issues to newly diagnosed and chronic conditions)
- Callers with chronic, catastrophic, behavioral, and other health concerns are identified and linked to appropriate programs (often long before claims are filed)
- Members are transitioned from episodic encounters to longitudinal care
- Members seeking symptom assessment, general health information, or shared decision making access Navigation via an inbound phone call. In non-urgent situations, once the primary service is complete, a short assessment is conducted to evaluate the overall health status of the individual and/or family. The nurse, using a highly configurable supported system, provides education and appropriate referrals to MHS and/or plan-sponsored programs such as: CM/DM, Case Management, behavioral health, health counseling, and other programs creating a source for data exchange.

Clinical Decision Architecture

MHS has developed a survey tool that allows the nurse to conduct a short assessment with program referrals, as configured by the client. Appropriate departments participate in the development and review of the survey process and content to assure member safety and appropriate program identification and member referral mechanisms.

PHA Online Services

Description of Product and Services

Since 1995, McKesson Health Solutions has offered CareEnhance Online as an extension of its Care Center services. These online services provide healthcare information and interactive tools to members through a Web interface that can be customized for the client.

In 2010, McKesson Health Solutions launched a new offering, internally referred to as "Health Hub". "Health Hub" is McKesson Health Solutions Care Management Services' offering to provide health plans with a central, integrated set of tools that directly support their members' self management.

The "Health Hub" solution is designed to give health plans the tools they need to engage and support members in their journey to better care for themselves and effectively navigate the healthcare system. Health plans can pick and choose which online components they want to supplement the Nurse Advice line with; the "Health Hub" optional components are listed below.

- **Online Symptom Advisor**
Symptom assessments and point-of-care recommendations using consumer versions of McKesson's Nurse Advice Line algorithms. Live hospital field-testing, nurse concordance studies, and consumer review panels have been conducted to ensure ease of use, accuracy of recommendations, and program safety.
- **Live Chat**
Provides members the ability to interact with nurses via an instant messaging application. Members can "chat" with a nurse 24x7 regarding any health issue and receive an instant response. Live chat, as are our other online programs, is fully backed by our 24x7 Nurse Line Service to ensure consistency in the content and delivery of our clinical algorithms.

- **Ask Our Nurses**
Secure messaging connection to an Informed Decision Support counselor with a secured response within 24 hours.
- **Health Risk Assessment**
Interactive guided evaluation tool that provides a picture of a members overall health, based on information provided by the member. It includes a customized action plan and several online programs and tools to support a healthier lifestyle.
- **Personal Health Record (PHR)**
Provides members with a secure, pre-populated online view of their important healthcare activities that can easily be shared with healthcare providers. The PHR is a central place for members to view, retrieve and store healthcare information.
- **Benefit Summary**
Provides members with a summary view of their benefits, healthcare services and out of pocket costs. It is designed to help members plan for future healthcare expenses. Individual statements are provided on a monthly or quarterly basis for each covered family member and include a list of finalized medical and pharmacy claims.
- **Clinical Reference System**
Provides health information, illustrations and video pertaining to thousands of medical conditions, surgical procedures, and medications. The comprehensive articles are written and reviewed by McKesson clinical professionals.
- **Condition Centers**
The Chronic Condition Center contains comprehensive informational services designed to help members understand their condition and related risks, and how to take action now to control them.
- **Health Trackers**
An easy way for members to create a personalized record that tracks key health metrics, such as blood pressure, cholesterol, peak flow meter, blood sugar, and A1c, over time. The Health Tracker also graphs metrics over time so members and their provider can determine if numbers are improving, staying level, or getting worse.
- **Health Calendar**
Provides a place for members to log upcoming medical appointments and procedures, enter personal reminders to schedule annual exams or get flu shots, and record regular health activities, such as weight or lab values.
- **Health Videos**
Informative videos that help members understand different treatment options before having a surgical procedure. Provides information that will help members understand the risks and benefits, and also what to expect before, during and after each procedure.
- **News Feeds**
Daily health news covering topics of specific interest to members or general stories that are of significant importance to the members.
- **Audio Health Library**
Choose from over 1000 health-related topics in the Audio Health Library for a concise overview of any subject of interest. All articles are available in text and MP3 audio formats.
- **Secure Message Center**
Secure email message box to promote key clinical or program messages to help drive utilization of health resources.

- **Disease Management Services**

McKesson provides an integrated Disease Management and Condition Management service including: Asthma, Diabetes, Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease, Chronic Pain, Depression, Schizophrenia, Hypertension, and Dyslipidemia programs. All services are managed through one delivery platform to effectively coordinate the care for members with chronic diseases and risk factors. McKesson's programs are aimed toward providing preventive care and behavior modification designed to improve the member's quality of life while providing cost savings to clients. McKesson's Disease Management and Condition Management programs utilize nationally recognized clinical guidelines.

Program Metrics

Application Response Time

For all applications within the McKesson environment and within the environment of any entity with which McKesson has contracted to provide Services under the Agreement (collectively the "McKesson entity" or "McKesson entities").

Uptime/System Availability

McKesson entities hardware and network must be available 24 x 7 x 52 except for scheduled downtime. Scheduled downtime is for maintenance of hardware, applying operating system patches and system tuning. Unscheduled downtime is defined as time that member facing web-based applications are not available to users exclusive of scheduled downtime.

Informed Decision Support

Description of Product and Services

IDS is a case-oriented program that provides in-depth health information to help members work through areas of potential health risk. IDS operates Monday through Friday from 8:00 am to 8:00 pm (member time), with limited Saturday hours. This is a value added service and is offered on a client-by-client basis.

There are two ways to refer a caller to IDS: 1) Set up an IDS callback in a member's chart in PHA; or 2) Submit a Care Management/Disease Management Informed Decision Support Referral form.

IDS is an education and empowerment program for members who have in-depth questions, are facing major health issues, or need to make health decisions. Fully integrated with MHS' other programs, IDS offers the latest medical information to empower members to make educated health decisions for themselves and their families. The IDS program includes the following types of interactions:

- In-Depth Health Information and Counseling (Interpretive Library) and
- Healthcare professionals provide customized education that goes beyond the depth of information provided in a typical Personal Health Advisor® Nurse Advice Line or CM/DM call. Information regarding procedures, diet, and activity issues, as well as medications and disease issues, are available through this service. Staff may conduct customized research to supplement health information provided through MHS-approved online resources.

Shared Decision Making

For members facing treatment decisions, (i.e., deciding between a mastectomy versus a lumpectomy for treatment of breast cancer) staff will help define various options, and support the member throughout the decision making process.

Education Literature

Members receive specialized literature appropriate for their needs and questions. This literature may include pamphlets and brochures regarding the medical issue the member is facing, and/or copies of the

results of customized research conducted for the member. Members will also receive references to any MHS approved Internet resources pertaining to their specific condition.

Clinical Decision Architecture

MHS has developed a care plan clinical content tool that allows the healthcare professional to use a traditional process that includes assessment, planning, implementation, and evaluation to meet the members' needs. The Clinical Content, Product, and Operations teams collaborate as needed regarding potential enhancements to this process to better support our ability to meet member and user needs. Additional clinical reference tools including online resources, web sites, and hard copy text resources are available to support information research and delivery.

Audio Health Library

Description of Product and Services

The Audio Health Library® provides information and education about health-related topics to educate and empower the member. The Interactive Voice Response (IVR) platform delivers information 24 hours a day, seven days a week, allowing callers to listen to educational information on over 1,177 healthcare topics. More than 500 of the topics are available in Spanish. An Internet version of the library allows members to access text and audio content with industry-standard MP3 format.

MHS FY10 Performance Improvement Program Analysis

As part of the MHS QI Program, the QI plan, including goals and objectives, are reviewed and revised as needed. Based on the findings and new goals, a work plan is developed to guide the program for the coming year. The MHS QI work plan is an internal, administrative document and is not included in the Performance Improvement Program Description that is distributed externally. However, in our endeavor to partner with our clients, we have provided the annual program analysis that follows.

Performance Improvement Program SWOT Analysis

Strengths

The MHS QI Program involves all departments and is strong, stable and effective. Outcomes of the products and services continue to show excellence in clinical performance and member satisfaction. Six Sigma has become an imbedded component of the business and the Quality Department team is Six Sigma trained.

Client Management teams provide individual client QI efforts during the year. These teams are interdisciplinary and monitor progress and goals for each client through individual client scorecards. Clinical Improvement Committees (CIC) support the CMTs for the analysis of the clinical measures within the scorecard, and recommend and implement clinical QI projects for individual clients.

The MHS QI program has multiple methods in place to gather data and metrics to monitor program progress. A database of QI projects, for our MHS staff, is implemented and functioning well. A robust QI project funnel with objective scoring matrices and project approval through the SQSC ensures the appropriate utilization of business resources.

Weaknesses

Feedback from our internal quality groups, departments, and clients, pointed to the complexity of our quality model, and the difficulty in describing committee responsibilities and relationships between the committees. In response, the Quality Structure is reorganized to support a less complicated and more descriptive model.

Opportunities

There continue to be opportunities in the enhancement of client and provider performance. The QI team identifies improvement opportunities and evaluates feedback gathered during client and provider advisory board meetings.

MHS collects, utilizes and reports on a vast amount of health information. With the evolution of health information technology and the regulation surrounding it, appropriate data stewardship, integrity of the data platforms, data analysis and consistent reporting standards are increasingly important for success and safety in our business. The Quality structure will incorporate Informatics and Reporting quality metrics into the CM/DM QC and the NAL QC.

The new Disease Management product launch, which occurred in FY10, will improve the ability to evaluate performance and improve overall outcomes. The QI team has a tremendous opportunity to help facilitate improvement projects and create educational resources to assist staff in their endeavors. The current healthcare environment has increased focus on healthcare organizations. The ability to develop robust programs and demonstrate outcomes offers MHS multiple opportunities. The goal to collaborate across the healthcare continuum and share communications is vital to improved member outcomes.

As the PHA/NAL product is changing, there exists the opportunity to utilize more technology to engage the member population and support them in the management of their health.

Threats

The rapidly fluctuating national healthcare environment, including the Healthcare Reform Bill provides the greatest threat to any health care organization (HCO). In addition, the constant shift in populations provides a challenge in CM/DM because of possible loss in continuity. Maintaining an effective QI program will require vigilance as it relates to the changes.

Current financial pressures are currently impacting the business internally and externally. This can make it difficult to track business needs due to shifting priorities. Oversight & management of old and new applications concurrently can impact program outcomes.

Care Management/Disease Management Program Analysis Executive Summary

The Care Management/Disease Management program for Fiscal Year 2010 has demonstrated stability and improvements. The achievements' driving strategies behind all quality initiatives were three-fold:

- Clinical Integrity
- Consistent Call Handling
- Program Satisfaction
- Quality Call Delivery

The following indicators were monitored as part of the CM/DM measurement strategy:

Clinical Outcomes

Overall, aggregate clinical outcomes are stable or improving with many aggregate scores far exceeding the targets. The summary of finding for fiscal year 2010 shows the top three indicators for Diabetes, HF, and CAD disease programs have either met actual performance goals or met targeted percent change goals. The Asthma indicator for, "Not a Current Smoker," did not meet the target or percent change goal. Additionally, the COPD indicator, "Flu Vaccine in last 12 Months," did not meet the target goals or percent change goal.

Indicators are reported on a rolling 24-month cohort report. All the indicators tracked for NCQA and URAC are meeting goals except the indicator tracking Diabetes HgbA1c in the past six months. This metric had an issue identified with an overlapping metric regarding HgbA1c requiring a date of test completion plus a value for HgbA1c, and was retired in FY 2010. The updated reporting on this metric is still pending. The Asthma indicator "Limits Passive Smoke", is just meeting the target goal @ 70%, and is below the percent change goal by 4%. Historically this target has not been met and continues to be monitored closely. Nursing staff has had continued training on Motivational Interviewing to support member behavior change to address this metric. The clinical indicator "Flu Vaccine in the last 12 months" for COPD has shown a significant drop in the percent change goal from 25% to 7% with the target goal showing a decrease of 1% for FY 2010. This may be due in part to the prioritization of the H1N1 vaccine and lack of follow-through and documentation of the annual flu shot. With the plan for those vaccines to be combined for flu season FY 2011, and renewed focus on the annual vaccine, the metric should again meet the Target Change % and will be monitored during that time frame. A sample of the DM Clinical Outcomes report structure can be seen below in Table 3. The report is designed as a stoplight to visually demonstrate indicator performance. All indicators are colored green, yellow or red. Green indicators are meeting or exceeding goals, yellow colored indicators are trending downward and red colored indicators are missing targets.

Figure 1: DM Stoplight Report Sample

URAC	NCQA	CIR #	DIA Clinical Indicator	TG%	Target Goal Q4 FY 10 - 3 Month Avg %	TGC %	Change Goal Q4 FY 10- 3 Month Avg %	Analysis	Status
		3	Member is on Daily ASA or Anti-platelet	50%	71%	15%	48%	<p>Quantitative: We continue to exceed both the target goal and change percent goal.</p> <p>Qualitative: Persons with diabetes have a two-four times higher risk of complications from CVD. Daily aspirin therapy has been shown to reduce cardiovascular events in diabetics age >30 years with CV risk factors. This is a low cost intervention that presents few barriers to compliance yet has great potential for improvement to health status. It appears that the members are gaining understanding into the necessity of ASA use and are in compliance. Nurses should continue to stress the importance of compliance to an ASA or anti-platelet regime.</p>	

LEGEND:

Green = on track

Yellow = at risk

Red = critical

DEFINITIONS:

URAC and NCQA columns reflect clinical indicator is also monitored for these organizations.

TG% - Target Goal Percent: aggregate goal for compliance

TGC%-Target Goal Change Percent: % change between initial assessment (IA) and annual assessment (AA)

CIR= Clinical Indicator

Ranking

Call Processing Efficiency

MHS is very pleased with the call handling performance. The metrics support the positive outcomes. Staffing is continually adjusted to meet the volume of calls. Maintaining our call process efficiency remains an important objective for the DM program. Opportunity for improvement will be determined by routine review of data found on the Operations Report, Inter-rater Reliability process and other metrics. Initiatives were implemented throughout the year and were effective in reaching projected targets.

Member Satisfaction

We are pleased with our fiscal year 2010 results and believe they reflect the high quality of care we deliver to our members. Our target is to have 90% of survey question responses at six or higher, on a scale of one to ten. Below are sample graphs of two main survey questions:

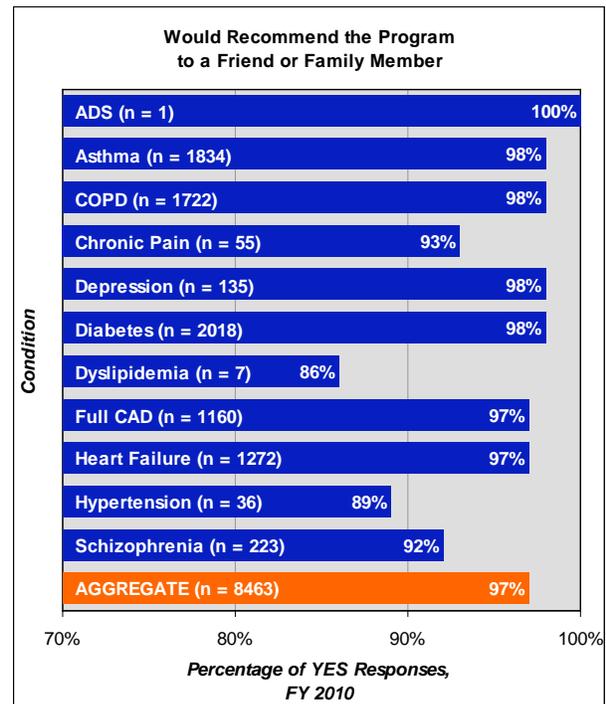
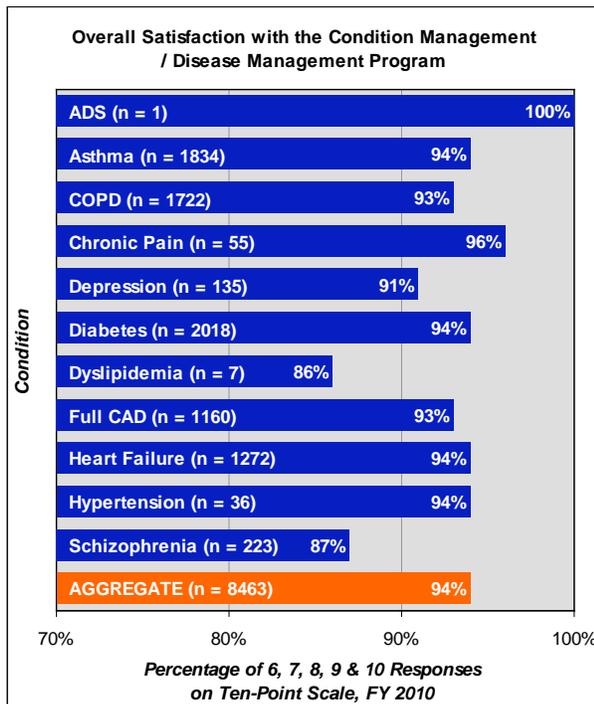
(1) Your overall satisfaction with the care management/disease management program?

(2) Would you recommend the program to a friend or family member with X condition?

These graphs show we continue to exceed the 90% target for all programs in aggregate, and for most individual programs.

Figure 2: DM Survey Question 1

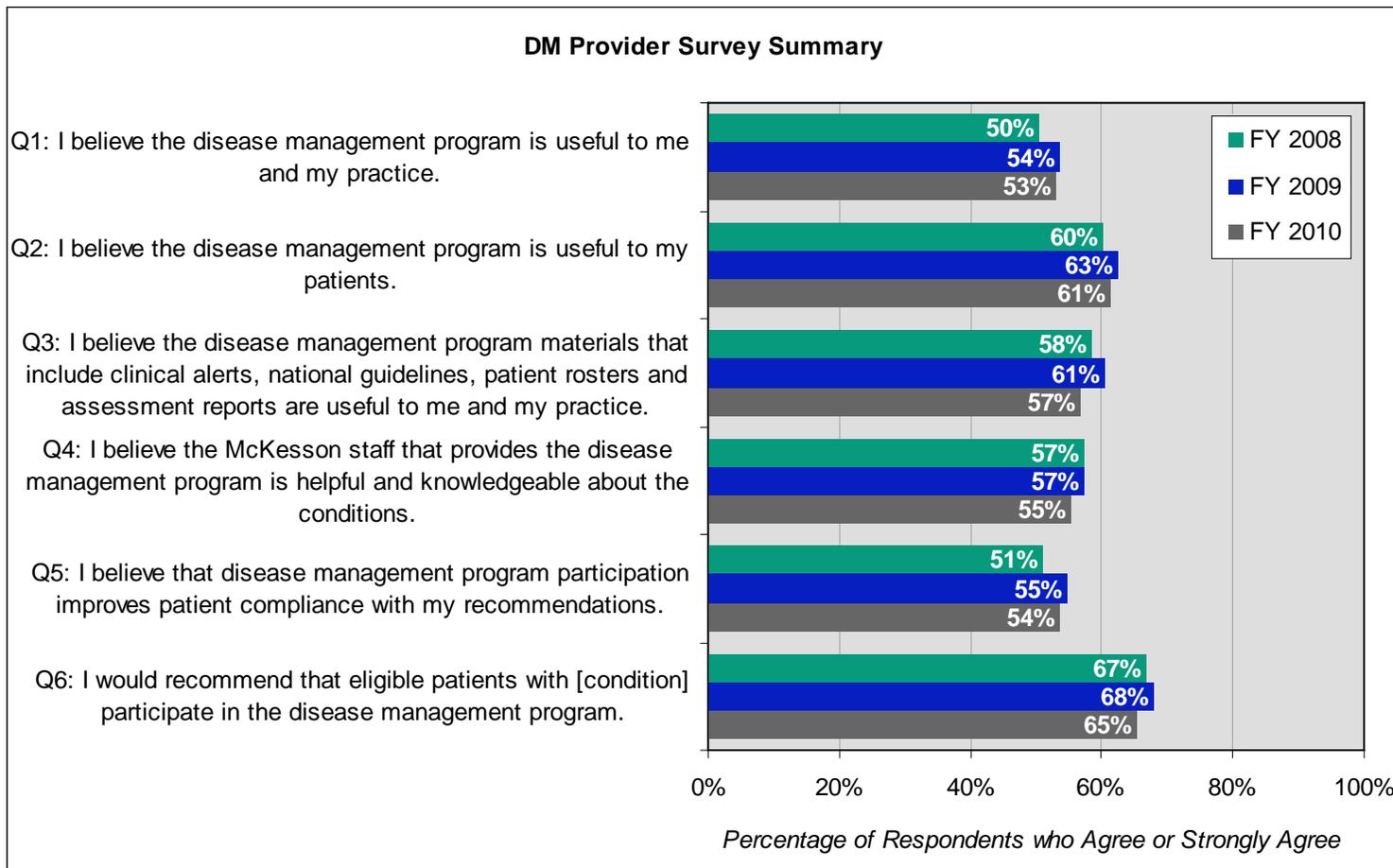
DM Survey Question 2



Provider Feedback

Provider survey results and provider response rates have been consistent from FY 2009 (1,702 total responses, 23% response rate) to FY 2010 (1,483 total responses, 22% response rate). We continue to work with the Local Medical Advisors (LMAs) and the local Physician Advisory Board (PAB) to evaluate how the community-based staff, Community based RNs (CBRNs) and Provider Outreach Coordinators (POCs) may provide us with more information from their interaction with the providers as we move into the new year.

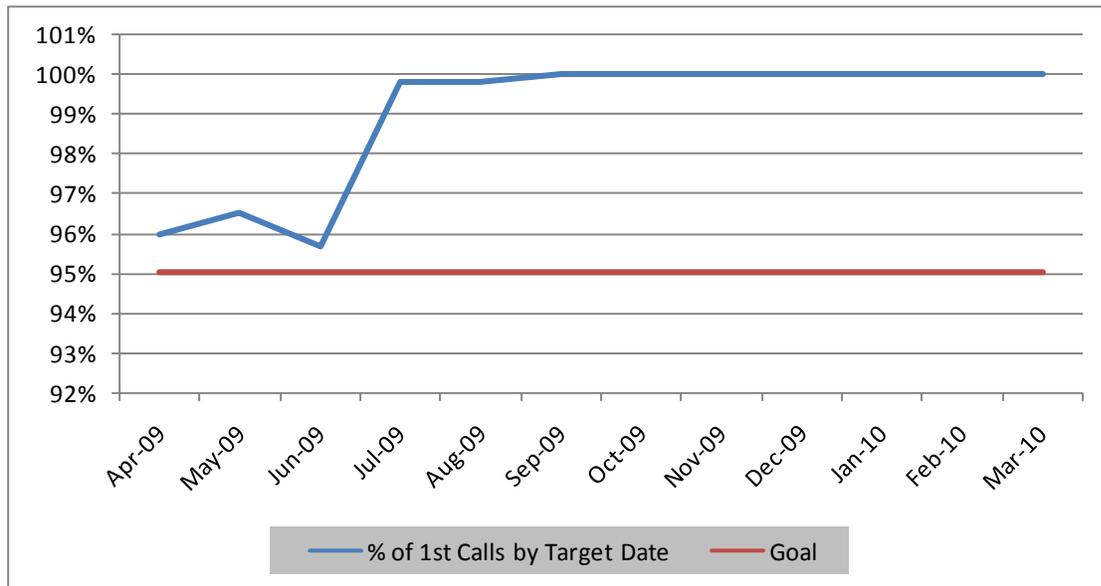
Figure 3: DM Provider Survey Summary



DM Operations Service Level Standards

We establish internal Service Level Standards that we monitor on a monthly basis. Each SLS is addressed on an individual basis to identify opportunities for improvement. These metrics give us an overall picture of the performance of our product. The following example of an operations service level standard is percent of 1st call attempts for the enrollment calls completed by target date. In Figure 5 below, the monthly data is year-to-date with a target of 95%. Quantitative: As evidenced by the graph, the SLS standard was met from April 2009 through March 2010. Qualitative: For all of FY10, we met the Service Level Standard for enrollment calls, and for the majority of FY10 made the first attempt by the target date over 99% of the time.

Figure 4: DM SLS



The Training and Education Department Service Level Standard definition is: All appropriate McKesson clinical and administrative staff will be provided with education and training regarding Client items within 14 business days of request. Quantitative: Of the total 277 requested Client item updates requested from April 2009 through March 2010, 99% of all requests monthly met the 14-business day goal and the SLS.

FY 2010 DM Performance Improvements

Some of the Quality and PI achievements for the FY 2010 DM program include the following:

- Introduction of DM Interaction and DM Record Audit tools with scoring as of January 2010
- H1N1 was introduced as a priority clinical indicator after the Spring 2009 H1N1 outbreak
- Continued Inter-rater reliability (IRR) Process improvement to better support Call Coaching Process
- Enrollment to Assessment process improvement to support a seamless entry into the program to improve member participation
- Policy and Guideline Process improved to ensure annual review and testing of the staff to improve knowledge, and application of critical policies and guidelines
- Flu Shot Reminder IVR Program completed to facilitate education for members on where to obtain their flu shots
- Renewed URAQ accreditation in Oct 2009
- New Chronic Care Management software launched
- Improved prioritization of Quality Initiatives through SQSC
- Throughout FY 2010 multiple quality projects were implemented for individual clients on targeted initiatives

Personal Health Advisor ® Nurse Advice Line Program Analysis Executive Summary

The Personal Health Advisor® Nurse Advice Line (PHA NAL) program successfully met all the quality initiatives set forth in the PHA NAL Performance Measurement Strategies, which includes the following:

- Clinical Integrity
- Consistent Call Handling
- Program Satisfaction
- Quality Call Performance

FY 2010 Personal Health Advisor ® Nurse Advice Line Performance Improvements

Some of the Quality and Performance Improvement (PI) achievements for the Fiscal Year (FY) 2010 Personal Health Advisor® Nurse Advice Line program include the following:

- Personal Health Advisor® Nurse Advice Line Call Length Efficiency and Effectiveness project.
- Personal Health Advisor® Nurse Advice Line NCOA Health Information Product (HIP) #4/Health Information Line (HIL) Certification May 6, 2009, valid through May 6th, 2011.
- Rigorous, ongoing clinical content review for improving the PHA NAL platform, utilizing the Vice President and Chief Clinical Architect for algorithm development and interpretation.
- Personal Health Advisor® Nurse Advice Line Quality Committee (PHA NAL QC) continued to be an interdepartmental collaborative committee providing oversight to the program. The Committee structure and processes was evaluated on an ongoing basis during FY 2010, which better served the quality goals and initiatives.
- An Annual review of the Personal Health Advisor® Program Description was done at the committee level.
- The Peer Review Council met on a quarterly basis to review potentially high-risk incidents and coaching opportunities.
- Continuous review of clinical and operations trend data was done to identify and manage exceptions. Metrics show acceptable performance for the Personal Health Advisor® Nurse Advice Line product.
- The Call Coaching Tool was maintained to measure and improve nurse performance by utilization of the Witness tool to monitor calls on a monthly basis.
- An Inter Rater Reliability (IRR) process, evaluating the use of the Call Coaching Tool (by a variety of users) in order to decrease variation, is ongoing on a monthly basis. Aggregate level reporting is presented at the PHA NAL Quality Committee.
- Satisfaction of members, clients and providers was reviewed and monitored by the PHA NAL QC. Overall member satisfaction goals were met.
- Process improvement efforts are continuous and client specific issues are investigated with interventions as needed.

Personal Health Advisor ® Nurse Advice Line Operational Training

- The Interpretation Standards were evaluated and improved to assist in standardization of the call monitoring process.
- Real time support of staff is accomplished through training updates, pre and post calibration training, self studies, precepting, mentoring and supervisor coaching.
- One new core training class occurred for HRC staff and three PHA NAL cross training classes occurred for 36 Disease Management nurses.

Personal Health Advisor ® Nurse Advice Line Operations Service Level Standards

Internal Operational Service Level Standards have been established (SLS) and are monitored on a monthly basis. These metrics provide an overall picture of the performance of our product. Quantitative: For FY 2010, the average speed to answer (ASA) exceeded the goal (≤ 30 seconds) at 25 seconds. In addition, our abandonment rate met the goal ($< 5\%$) at 3.6% Each SLS is addressed on an individual basis to identify opportunities for improvement. Qualitative analysis was completed by the Operations Oversight Team and the findings identified all metrics are within target on an aggregate basis.

Conclusion and Recommendation

We are pleased with our continued accomplishments in the Personal Health Advisor® Nurse Advice Line program. Overall, the Personal Health Advisor® Nurse Advice Line program is stable and performing at a high level. We continue to focus on maintaining our client and member satisfaction with our service delivery. Our efforts in meeting our quality initiatives and to better support the call process delivery have translated into no loss of clients due to concerns over program safety or operations quality. In addition, it translated into an overall member satisfaction rate of 95%. We look forward to continuing our partnerships with our clients to maintain and improve our high level of service to meet our member satisfaction objectives during FY 2011.

Quality Improvement Work Plan

The work plan is an administrative (internal) document and is not included in the external version of the program description; however, we are including a sample document to illustrate the process. The work plan document is dynamic, meaning elements may be changed in accordance with the needs of the organization, clients or members. The work plan includes performance improvement projects, deliverables, clinical and service level initiatives. It is supported with detailed reporting by those performing the improvement initiatives.

The work plan serves multiple purposes, some include:

- Communication to the Senior Leadership Team
- Project oversight as discussed during quality and PI meetings
- Annual Quality Improvement Program evaluation: to monitor the effectiveness and success of items listed within work plan

Sample Work Plan

Goal 1. Execute and maintain the operational functions of the QI Program in a timely and effective manner and in accordance with plan and regulatory requirements.

Item #	QI Goal (1-4)	Project Title/Description	Start Date	Target Finish Date	Status	Lead	Team	Sponsor or Champion
1	1	Personal Health Advisor Program Description	Jan-10	Feb-10	COMPLETED-May 2010	M. Gaffney-Nelson		B. Dwyer
2	1	Care Management Disease Management Program Description	Feb-10	Feb-10	COMPLETED – Mar. 2010	M. Gaffney-Nelson		M. Whalen
3	1	External Plan Quality Improvement Program Description	Mar-10	Jul-10	COMPLETED - Jul. 2010	D. Johnson	A. Bashline E. Heatherly S. McBride	F. Leary
4	1	Internal Plan Quality Improvement Program Description	Mar-10	Jul-10	COMPLETED - Jul. 2010	D. Johnson	A. Bashline E. Heatherly S. McBride	F. Leary
5	1	Quality Improvement Program Evaluation (annual)	Mar-10	Jul-10	COMPLETED – Jul. 2010	D. Johnson	A. Bashline E. Heatherly S. McBride	F. Leary

Table 5: Sample Work Plan

Addendum

Effective July 1, 2010, the Services Executive Team (or "SET") was changed to the Services Operating Team. All oversight and responsibility referenced in this document as assigned to the Services Executive Team (or "SET") have been transferred to the Services Operating Team.

Insert Color Slip Sheet



From Appendix KK

B.1 Indicate your organization’s legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization’s ultimate parent (e.g. publicly traded corporation).

Describe your organization’s form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

Legal Name/Acronym: Medical Transportation Management, Inc. (MTM)

Physical/Mailing Address of Headquarters: 16 Hawk Ridge Drive, Lake St. Louis, MO 63367

Telephone Number of Headquarters: (636) 695-5686

Form of Business: Privately held “S” corporation

MTM is not owned or operated by a publicly traded parent company.

The names, mailing addresses, and telephone numbers of our officers and directors are as follows:

Board of Directors	
Peggy A. Griswold, Chairperson of the Board 2608 Arrowhead Estates Rd. Lake Ozark, MO 65049 888-561-8747, Ext. 5578	Lynn C. Griswold, Executive Vice President 2608 Arrowhead Estates Rd. Lake Ozark, MO 65049 888-561-8747, Ext.5568
Alaina Macia, President and CEO 6 Windsor Lane Kirkwood, MO 63122 888-561-8747, Ext.5503	J B Bowers, Board Member 10222 East Southwind Lane #1006 Scottsdale, AZ 85262 480-585-9552



Other Officers

Gary Richardson, CFO, Treasurer 642 Woodchuck Lane Lake St. Louis, MO 63367 888-561-8747, Ext.5549	Elaine Sneed, Vice President 10 Forest Knoll Circle Lake St. Louis, MO 63367 888-561-8747, Ext. 5017
Donald C. Tiemeyer, Executive Vice President and General Counsel, Secretary 2012 Willow Trail St. Charles, MO 63303 888-561-8747, Ext. 5550	Kimberly Matreci, Vice President 319 Crystal Brook Ct. Lake St. Louis, MO 63367 888-561-8747, Ext. 5563
Thomas L. Sweeney, Vice President 3638 Flora Place St. Louis, MO 63110 888-561-8747, Ext. 5524	Patrick McNiff, Vice President 19 Ravens Pointe Lake St. Louis, MO 63367 888-561-8747, Ext. 5038
Aaron Crowell, Vice President 4011 Austin Drive Saint Charles, MO 63304 888-561-8747, Ext. 5123	Alison Whitelaw, Vice President 116 Antoinette Terrace Lake St. Louis, MO 63367 888-561-8747, Ext. 5529

No health professionals have a financial interest in our organization.

Federal Taxpayer Identification Number: 43-1719762

MTM Corporate Identification Number in Louisiana: 36564296F

Louisiana Tax Account Identification Number: 1516723001200

MTM was incorporated in Missouri and is domiciled in Missouri.

MTM's local representative is CT Corporation System, 8550 United Plaza Blvd., Baton Rouge, LA 70809.

MTM has not been engaged by DHH within the past 24 months.

B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. Include your organization's parent organization, affiliates, and subsidiaries.

Neither MTM nor its affiliates have had any mergers, acquisitions, or sales of the organization within the last 10 years, nor do we anticipate any change in ownership during the 12 months following the Proposal Due Date.





B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have **ever** been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. **Include your organization's parent organization, affiliates, and subsidiaries.**

Neither MTM nor its affiliates, employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense, or have ever been debarred or suspended by any federal or state governmental body.

B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. **Include your organization's parent organization, affiliates, and subsidiaries.**

As is typical for any large transportation management firm, and its affiliates, with numerous ongoing contracts, MTM occasionally has accident damage and workers compensation claims in process. All of these matters are of a size or scope that would not impact this contract, and we work diligently to resolve all legal matters quickly and in a fair manner. MTM has, at all times, sufficient liability insurance to cover all vehicle accident claims and workers compensation claims. MTM is not under investigation by any government or agency.

MTM is, from time to time, involved in litigation with transportation providers. Examples of what this might pertain to include a provider not meeting MTM contract requirements, such as not providing verification of trips, via passenger signatures, assessment of liquidated damages for contract noncompliance, etc. The financial stability of MTM or the ability of MTM to perform any of its contractual obligations is not threatened, in anyway, by any current litigation should an adverse judgment be entered against MTM.

The providing by MTM, and the subsequent reviewing of all details of litigation for a large company such as MTM, with a national scope and numerous large contracts, is impractical since much of this information is subject to attorney-client privilege or privacy/confidentiality considerations. MTM is hopeful that the submittal of the summary statement above will suffice. Should you require, for the purposes of evaluating MTM, information on any specific litigation or claim, MTM will supply that information which can be released without jeopardizing attorney-client privilege or privacy/confidentiality considerations incident to litigation.



B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. **Include your organization's parent organization, affiliates, and subsidiaries.**

Neither MTM nor its affiliates has ever filed any bankruptcy or insolvency proceedings or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.

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

MTM is not a publicly traded corporation.

B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

MTM is neither substantially nor wholly owned by another organization.



B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.

If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.

If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.

For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.

The following MTM key personnel will perform duties and services pertaining to this contract:

Key Personnel Title	Name	Reports To	Full Time
Account Manager	Duane Williams	V.P. Client Services	No
Call Center Manager	Kevin Cales	Director, Customer Service Center	Yes
Care Manager Coordinator	Jeanie Butler	Manager, Care Management	Yes
Quality Service Coordinator	TBD	Quality Management Team Lead	Yes
Network Representative	Damion Frederick	Manager, Network Operations	No
Area Liaison	Eric Kuntz	Manager, Network Recruiting	No

Duane Williams, as Account Manager, has dotted line authority over all other listed key personnel for this contract. Resumes for all key personnel are located in **Attachment A**. A job description for the Quality Service Coordinator is also included in **Attachment A**.

None of the staff listed are current or former Louisiana state employees.

Duane Williams manages other managed care clients throughout the nation. He will dedicate approximately 25% of his time to this account, but can increase that amount dependent on client requirements. His other time is spent overseeing the NEMT programs for other managed care clients.





Similarly, Damion Frederick and Eric Kuntz have network responsibilities in states other than Louisiana. They will each dedicate 50% of their time to building and strengthening our network of transportation providers in Louisiana. The other portion of their time will be spent performing similar duties in other states.

B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. **Include your organization's parent organization, affiliates, and subsidiaries.**

Information about our Medicaid and Medicare managed care clients that fit the criteria listed above are included in **Attachment B**.

B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. **Include your organization's parent organization, affiliates, and subsidiaries.**

The requested information for MTM contracts no longer held is contained in **Attachment C**.

B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries.

In each of the contracts no longer held identified in **Attachment C**, the termination/non-renewal was not based on performance issues from our company.

B. 19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:

- AM Best Company (financial strengths ratings);
- TheStreet.com, Inc. (safety ratings); and
- Standard & Poor's (long-term insurer financial strength).

MTM is not rated by Standard & Poor or The Street because we are not publicly traded, and we do not operate in a regulated industry that would require an AM Best rating.



B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization's parent organization, affiliates, and subsidiaries.

MTM does not provide physical health services.

B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.

MTM sought and received URAC Core accreditation in March 2010. This accreditation is effective April 1, 2010 through April 1, 2013.

B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include your organization's parent organization, affiliates, and subsidiaries.

Neither MTM nor our affiliates have ever had an accreditation status in any state for any product line adjusted down, suspended, or revoked.

B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. Include your organization's parent organization, affiliates, and subsidiaries.

We are not NCQA accredited, but we have established and hold our Customer Service Center operations to high performance standards. Across our book of business, we strive to maintain and meet NCQA standards for Customer Service Center operations.

B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization's parent organization, affiliates, and subsidiaries) in response to the report.

We do not receive copies of the external quality review reports that our managed care clients are required to participate in. From time to time, we are asked to provide information on our processes and copies of our policies that our clients use for the quality review. We participate on behalf of our clients, but do not have access to the reports.



B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries.

MTM has had no regulatory action or sanction imposed by any federal or state regulatory entity against our organization within the last five (5) years.

B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. Include your organization's parent company, affiliates and subsidiaries.

In 2009, the Federal government conducted an audit of the Minnesota Department of Human Services Medicaid NET services program and had questions concerning MTM's billing processes. MTM conducted its claims billings processes in accordance with a contract amendment executed by the Department of Human Services. When a copy of the contract amendment was provided to the Federal agency, the matter was closed and no action was taken.



B.27 Submit client references (minimum of three, maximum of five) for your organization from major subcontractors; with at least one reference from a major subcontractor who have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

- a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:
 - Your/Subcontractor's name;
 - Geographic Service Area(s) for which the reference is being submitted;
 - Reference organization's name; and
 - Reference contact's name, title, telephone number, and email address.
- b. Send the form to each reference contact along with a new, sealable standard #10 envelope;
- c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;
- d. Instruct the reference contact to:
 - Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);
 - Sign and date it;
 - Seal it in the provided envelope;
 - Sign the back of the envelope across the seal; and
 - Return it directly to you.
- e. Enclose the unopened envelopes in easily identifiable and labeled larger

MTM will submit the requested references under separate cover.

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Career Summary

Medical Transportation Management, Inc., St. Louis, MO, 2009 to Present *Account Manager, Client Services*

As Account Manager of Client Services, Duane works with multiple Managed Care Organizations to ensure client satisfaction and contract compliance. He prepares and analyzes reports to provide clients the most useful information to help guide their Non-Emergency Medical Transportation programs. The interpretations he provides allows for adjustments in processes and protocols leading to the most cost efficient program available, customized to each client. Duane monitors utilization data to provide clients with additional opportunities to improve member compliance and increase HEDIS scores.

Duane provides Education, Training, and Outreach to stakeholders on the benefits we provide. His work in the communities served includes presentations and partnering at our client's health education events. Duane is responsible for the day-to-day support provided to clients, including finding creative solutions to any issues or complaints as they arise. Duane stays in constant contact by conducting monthly and/or quarterly meetings with clients reviewing all aspects of contract compliance to maximize cost efficiency and member satisfaction.

Centene Corporation, St. Louis MO, 2001 to 2007 *Corporate Director, Provider Relations*

At Centene, Duane provided oversight to the Provider Relations, Provider Services (Call Center), Member Services and Credentialing Departments of eight (8) managed care health plans while developing and implementing new business ventures for the company. Here, he created RFP responses that generated four new business ventures and increased revenue for the company. He reviewed results of annual provider satisfaction surveys and implemented performance improvement plans increasing overall provider satisfaction. Duane developed a new business model that included performance standards to meet contract requirements, policy creation, and hiring and training of personnel. He negotiated contracts for all provider types ensuring adequate access for all members and developed EPSDT educational materials resulting in increased EPSDT rates meeting State contract requirements.

Manager, Provider Relations

In this position, Duane managed eight (8) external Provider Relations Specialists focused on establishing and maintaining relationships with in-network providers within Centene's Indiana Medicaid Managed Care Health Plan. He successfully analyzed provider contract performance on a quarterly basis to ensure profitability for the health plan as well as providers contracted in the network. He performed an audit of claims activities for providers identified for aberrant billing activities resulting in recoupments. Duane created servicing standards to ensure provider needs were met and increased health plan visibility within the provider community. He also created, implemented, and conducted educational in-services for in-network providers.

Manager, Provider Services

Duane managed Provider Services Call Center for Centene's Indiana Medicaid Managed Care Health Plan. Here, he researched both simple and complex claims issues for providers. During this time, he developed training materials for providers which increased proper claims submission. He also created policies to ensure state and corporate requirements were met.



Career Highlights:

Brings over 10 years of experience working with MCOs and the healthcare industry and understanding of participant utilization

Acts as a liaison between the client and MTM

Reviews monthly financial, complaint, and call center statistics to ensure contract compliance

Works with clients to enhance the transportation benefit through community outreach and education

Career Summary

(2)

Health Care Excel, Indianapolis, IN, 1998 to 2001

Prepayment Review Specialist

As a Prepayment Review Specialist, Duane adjudicated health care claims for Hoosier Healthwise (Indiana Medicaid) providers placed on prepayment review for aberrant billing activities resulting in a savings to the State of Indiana. He conducted on-site medical record reviews for all specialty types including hospitals and presented reports monthly to the Indiana Office of Medicaid Policy and Planning.

Recoupment Specialist

Duane monitored refunds made by providers identified as having been overpaid by the Hoosier Healthwise (Indiana Medicaid) program as a Recoupment Specialist at Health Care Excel. He kept detailed records of payments from providers and notified providers of refunds due to the State. Duane also presented monthly reports to the Indiana Office of Medicaid Policy and Planning.

EDUCATION

Indiana State University, Terre Haute, IN

Bachelors of Arts, Business Administration

Career Summary

Medical Transportation Management, Inc., Anderson, SC, 2008 to Present *CSC Supervisor*

Kevin is responsible for daily operations and supervision of Customer Service Representatives, Bilingual Customer Service Representatives, and CSC Assistants. His primary function is to assure compliance to protocols and procedures and to ensure customer satisfaction. For staffing, he recruits, interviews, tests, and hires new applicants. He then completes new hire orientation and trains new hires on MTM policies and practices. Kevin also creates and maintains training manuals and user guides, and provides ongoing training to existing employees at local and remote centers.

Outside of Customer Service Centers, Kevin attends unemployment hearings as a representative of MTM. He also creates and reviews ad hoc reports as requested by client and program management.

Verizon Wireless, Greenville, SC, 2007 to 2008 *Customer Service Representative*

As a Customer Service Representative, Kevin researched and responded to customer inquiries and billing issues in a fast-paced inbound environment. He tracked changes and remained educated on Verizon Wireless products and services to inform callers of their options in choosing the best solution for their needs and to ensure that they received the best customer service experience possible.

TeleTech, Inc. Uniontown, Pennsylvania, 1998 to 2005 *Operations Supervisor*

Kevin supervised and provided both positive and constructive feedback to employees as an Operations Supervisor. He provided assistance to employees on complex inquiries on phone calls, conducted and reviewed quality assurance monitors with employees, and attended weekly calibration meetings with the quality assurance department to ensure client expectations were being met. He also interviewed and hired new employees while providing up to date training as needed.

Customer Service Representative – NICS Project (National Instant Criminal Background Check System)

Kevin was responsible for performing background checks for clients through inbound calls. He maintained 99% QA score average and handled approximately 75-150 calls per day.

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Career Summary

Medical Transportation Management, Inc., Lake St. Louis, MO, 2001 to Present
Care Management Coordinator (Non-Clinical)

As a Care Management Coordinator, Jeanie receives calls to set non-emergent medical transportation for Medicaid recipients. She works one-on-one with mental health, dialysis, and substance abuse facilities, as well as social workers to ensure that their clients were transported to their daily programs for treatments. She is also responsible for making sure the client's schedules are set up properly and for responding to social workers requests for new enrollments.

Amerihost Inn, 1998 to 2001
Front Desk Supervisor

Jeanie was responsible for the overall administrative duties and personnel as the Front Desk Supervisor. She ensured that exceptional guest service was delivered by leading the front desk team smoothly while creating a pleasant, welcoming atmosphere for guests. Jeanie had oversight of hiring, training, evaluating, and firing housekeepers and front end clerks as needed.

Education

St. Charles Community College, St. Charles, MO
Currently enrolled



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Career Summary

Medical Transportation Management Inc., Lake St. Louis, MO, 2010 to Present
Network Management Representative

As a Network Management Representative, Damion improves relationships with vendors in New York. He also works closely with other departments to improve operations. Damion works to not only respond to vendor issues, but to proactively create processes that improve the function of the network.

Turnback Specialist

As a Turnback Specialist, Damion Re-shops high price RTPs, sets trips that have been returned by original transportation provider, and sets trips that were escalated from the call center.

GAIN Enterprises, Warrenton, MO, 2005 to Present
President

Damion hires and trains new employees, delivers marketing and advertising, and oversees and implements organizational goals. Damion is responsible for the administrative tasks for a tanning salon, wireless phone retail store, and small accounting office.



Education

St. Louis Community College, St. Louis, MO
Associates of Business Administration

Liberty University, Lynchburg, VA
Bachelors of Business Administration (in progress)

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Career Summary

Medical Transportation Management, Inc., Lake St. Louis, MO, 2005 to Present *Area Liaison*

As an Area Liaison, Eric serves as a main point of contact between Medical Transportation Management (MTM) and transportation providers. His primary functions include conducting on-site visits and on-street observations, assuring compliance with MTM Provider Guidelines, and assuring that MTM is providing customer service that meets or exceeds all MTM and client standards. Eric works closely with transportation providers, training and assisting them with maintaining assigned standards by making sure all providers understand set guidelines. For new plans, he assists with implementation and recruitment of providers. Eric also works closely with network managers and other departments throughout the company.

Network Management Representative

As a Network Management Representative, Eric researched and recruited new providers to expand and maintain the MTM provider network. He did this in part by creating high-quality relationships with providers to assure the highest possible quality of transportation was provided. Eric worked with transportation providers to educate them on MTM and its policies and requirements, completed yearly audits on provider files, and ensured that all providers in the assigned territory had information that was current and accurate in the network database, AS400, public contacts and hard files. Eric was diligent to resolve transportation provider questions and problems, coordinating with other departments when needed. He also assisted internal departments with transportation provider issues.

Care Manager

Eric was responsible for prompt response to all queue calls and fax requests for discharges from Social Workers, Nurse Case Managers, Transportation Coordinators and members. He distributed incoming faxes, reconciled facility token/swiper usage, set RTP requests from the Call Center, and entered trips from mileage reimbursement trip logs. Eric also prioritized transportation requests to ensure the most urgent requests were met first, and closely monitored use of most appropriate transportation and provider, as well as most appropriate mode of transportation. Eric ensured member satisfaction by assuring compliance with the contract source and by using MTM policies and procedures.

Customer Service Representative

As a Customer Service Representative, Eric answered incoming automated call distribution (ACD) calls for passengers, vendors, and clients. He handled daily scheduling of trips by documenting trip requests and selecting the most appropriate vendor, utilized correct coding and documentation procedures, and provided prompt response to all trip requests. When necessary, he reported issues, unusual trip circumstances, and efficiency of vendor operations to CSC Team Lead for prompt resolution. Eric also acquired and maintained in-depth knowledge of, and adhered to, established CSC Protocols and Procedures.

321 Studios, St. Louis, MO, 2004 to 2005

Customer Service Representative

Eric answered incoming automated call distribution (ACD) calls for customers in the customer service and tech support departments. He explained and answered questions about the products produced, processed sales, and helped software owners install, operate, and resolve issues with the package they purchased.

Education

University of Phoenix

*Bachelor of Science Business Management
In progress*

University of Phoenix

Associates of Business Administration

Broadcast Center

Certificate of Audio and Video Production



		Exempt	X		
		Non-exempt			
		Full-time	X		
		Part-time			
		Location	MO		
		Origination Date	6/11/04		
Job Title	Quality Service Coordinator	Last Revision Date	2/19/10		
Department	Quality Management				
Reports to	Team Lead, Quality Management	Page	1	OF	2

POSITION SUMMARY: The **Quality Service Coordinator** is responsible for managing complaints for designated clients, in accordance with client requirements and MTM Policies and Procedures for Quality Management.

PERFORMANCE MEASURES – MAJOR JOB OBJECTIVES

Major Job Objective	What's Expected	Measurement Criteria	%
Manage Complaints for Designated Clients	<ul style="list-style-type: none"> • A working knowledge of all health plan protocols • Document, review, investigate and provide follow up for all complaints and complaint issues reported for assigned clients. • Enter complaints submitted via fax or voice mail. • Provide follow up contact to member/beneficiary/recipients per their request in regards to complaint resolution • Enter data for the application of Liquidated Damages. • Obtain timely responses from the transportation providers to complaints and complaint issues. (24 to 48 hour timeframe) • Provide immediate follow up for complaint responses that are not submitted within the specified timeframe and enforce disciplinary measures as needed • Provide and document all vendor education given in response to complaints. • Respond to client, Program Manager, or Account Manager Inquiries sent via email, or fax, within the specified timeframe. • Send complaint resolution letters to member/beneficiary/recipients per health plan contract. 	Call Stats Daily, weekly, monthly complaint reports QM Inter-Rater Daily Task List	50%
Risk Management	<ul style="list-style-type: none"> • Compile monthly incident/accident summary reports for assigned clients. • Obtain timely responses to all incident/accident issues from the transportation providers. (24 hour response time required) • Provide follow up to the member/recipient/beneficiary in regards to accident/incident issues. • Forward notification of accidents/incidents as they occur to the QM Team Lead and Manager • Manage all risk issues for designated clients 	Email notification	15%
Complaint Reports	<ul style="list-style-type: none"> • Compile daily complaint reports to be submitted to designated health plans per contract • Compile weekly/monthly complaint reports for designated clients • Proof read all complaint reports before submission to Team Lead • Track and tend complaint ratios for transportation providers • Provide monthly/year to date data for Complaint Summary 	Daily, weekly, monthly complaint reports	15%

	reflected on monthly quality reports.		
Interdepartmental Communication	<ul style="list-style-type: none"> Assist Care Management/Account Managers/Program Managers with complaint/facility issues Update Network Management in regards to non-compliance issues with transportation providers and advise of incident/accident issues 	Complaint Reports Email notification	10%
Independently manage trips with issues, complaints, or special needs	<ul style="list-style-type: none"> Triage issues, complaints & unusual trip circumstances and determine appropriate action by reviewing complaint history, trip history, etc. Determine changes needed and implement them accordingly 	Complaint Reports	10%

OTHER JOB FUNCTIONS:

- Enter complaints submitted via fax or voice mail, as assigned
- Enter data for the application of Liquidated Damages
- Update client statistics as needed
- Other duties as assigned
- Regular attendance required
- Job share with other QSCs to ensure adequate coverage during inclement weather and sick days
- Attend client/implementation meetings upon request

KNOWLEDGE, SKILLS, AND ABILITIES:

- Proficiency with Microsoft applications, including Word, Excel, and Access required.
- Excellent written communication skills, with an emphasis on grammar and spelling required.
- Ability to tactfully question and obtain information required.
- Excellent organizational and interpersonal skills required.
- Demonstrated ability to manage multiple priorities required.
- Typing skills 30 wpm
- Ability to handle confidential information in a professional manner
- Superior problem solving skills

EDUCATION:

- High School Diploma or G.E.D. required
- Associates degree required

EXPERIENCE:

- Previous Customer Service experience required
- Previous Quality Management experience preferred
- A minimum of six months in the MTM Customer Service Center preferred
- Working knowledge of MTM Customer Service protocols and procedures preferred

POSITIONS SUPERVISED:

None

TOOLS/EQUIPMENT/MACHINES USED:

Computer, copy machine, fax machine, slide projector, Cisco phone system

PHYSICAL REQUIREMENTS AND WORKING CONDITIONS:

Normal office conditions apply. Employee must have clear, close vision for reading and computer work. Must be able to sit, stand, walk, balance, stoop, grasp, talk, hear, and operate computer keyboard. Job requires sitting at a desk, talking on the phone, a high level of data entry, and viewing a computer screen for the majority of the day. Job may require reaching at shoulder level and below waist. Will occasionally lift/push/pull up to 20 pounds and carry objects 50 feet.

MTM MCO Clients

Organization Name	Medicaid/ Medicare	Geographic Specs	Effective Date	Scope of Service	Members	Annual Value of Contract	Capitated	Contact, Title	Address	Contact Phone #	Role of Subcontractor
Healthplan of Michigan/Meridian	Medicaid	<u>MI</u> : All MI will be serviced	11/1/2010	Non-emergency Transportation services	283,562	Proprietary and Confidential	Yes	Kelly Kramer, Director, Member Services	777 Woodward Avenue Suite 600 Detroit, MI 48226	313-324-3726	Vehicles and transportation
MDWise	Medicaid	<u>IN</u> : Statewide MCO	12/1/2010	Non-emergency Transportation services	246,183	Proprietary and Confidential	Yes	Julie Ulrich, Operations	1200 S. Madison Ave Indianapolis, IN (don't know the zip)	317-822-7109	Vehicles and transportation
HealthCare USA	Medicaid	<u>East</u> : Franklin, Jefferson, Lincoln, Pike, St. Charles, St. Francois, Ste. Genevieve, St. Louis City, St. Louis County, Warren, Washington <u>Central</u> : Audrain, Benton, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Laclede, Linn, Macon, Maries, Marion, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Phelps, Pulaski, Ralls, Randolph, Saline, Shelby <u>West</u> : Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Polk, Platte, Ray, St. Clair, Vernon	9/1/1995	Non-emergency Transportation services	190,198	Proprietary and Confidential	Yes	Kathy Whaley, Vice President of Operations	10 South Broadway, Ste. 1200 St. Louis, MO 63102	314-444-7914	Vehicles and transportation
Unison Health Plan of Ohio	Medicaid	Ashland, Athens, Belmont, Carroll, Columbiana, Coshocton, Gallia, Guernsey, Harrison, Holmes, Jackson, Jefferson, Lawrence, Mahoning, Meigs, Monroe, Morgan, Muskingum, Noble, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas, Vinton, Washington & Wayne	11/1/2005	Non-emergency Transportation services	119,087	Proprietary and Confidential	Yes	Tim Binkley, CFO	9200 Worthington Rd. 3rd Floor Westerville, OH 43082	614-410-7927	Vehicles and transportation
Molina Healthcare of Missouri (formerly Mercy Care Plus)	Medicaid	<u>Eastern</u> : Franklin, Jefferson, Lincoln, Madison, Perry, Pike, St. Charles, St. Francois, Ste. Genevieve, St. Louis, Warren, Washington, St. Louis City <u>Central</u> : Audrain, Benton, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Laclede, Linn, Macon, Maries, Marion, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Phelps, Pulaski, Ralls, Randolph, Saline, Shelby <u>Western</u> : Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair, Vernon	2/9/1997	Non-emergency Transportation services	56,332	Proprietary and Confidential	Yes	Christine Cybulski, Manager Delegation Oversight	12400 Olive Blvd, Ste. 100 St. Louis, MO 63141	314-819-5162	Vehicles and transportation

MTM MCO Clients

Organization Name	Medicaid/ Medicare	Geographic Specs	Effective Date	Scope of Service	Members	Annual Value of Contract	Capitated	Contact, Title	Address	Contact Phone #	Role of Subcontractor
Children's Mercy Family Health Partners	Medicaid	<u>MO:</u> Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair, Vernon <u>KS:</u> Allen, Anderson, Atchison, Barber, Barton, Bourbon, Brown, Butler, Chase, Chautauqua, Cherokee, Clay, Cloud, Coffey, Comanche, Cowley, Crawford, Dickinson, Doniphan, Douglas, Edwards, Elk, Ellis, Ellsworth, Franklin, Geary, Greenwood, Harper, Harvey, Jackson, Jefferson, Jewell, Johnson, Kingman, Kiowa, Labette, Leavenworth, Lincoln, Linn, Lyon, Marion, Marshall, McPherson, Miami, Mitchell, Montgomery, Morris, Nemaha, Neosho, Osage, Osborne, Ottawa, Pawnee, Phillips, Pottawatomie, Pratt, Reno, Republic, Rice, Riley, Rooks, Rush, Russell, Saline, Sedgwick, Shawnee, Smith, Stafford, Sumner, Wabaunsee, Washington, Wilson, Woodson, Wyandotte	1/1/1996	Non-emergency Transportation services	56,091	Proprietary and Confidential	Yes	Cindy Mense, Customer Service Director	2420 Pershing Rd. Suite G-10 Kansas City, MO 64116	816-559-9472	Vehicles and transportation
OmniCare Health Plan	Medicaid	Wayne, Oakland and Macomb counties in MI	10/1/2004	Non-emergency Transportation services	50,258	Proprietary and Confidential	Yes	Sandra McGriff, Vice President Operations	1333 Gratiot, Suite 400 Detroit, Michigan 48207	313-465-1552	Vehicles and transportation
Missouri Care Health Plan	Medicaid	<u>Central Region:</u> Audrain, Benton, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Laclede, Linn, Macon, Maries, Marion, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Phelps, Pulaski, Ralls, Randolph, Saline, Shelby <u>Eastern Region:</u> Franklin, Jefferson, Lincoln, Madison, Perry, Pike, St.Charles, St.Francois, Ste. Genevieve, St.Louis, Warren, Washington, and St.Louis City <u>Western Region:</u> Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St.Clair, Vernon	9/1/1998	Non-emergency Transportation services	49,928	Proprietary and Confidential	Yes	Ed Williams, Member Advocacy and Customer Service Manager	2404 Forum Blvd. Columbia, MO 65203	573-355-4168	Vehicles and transportation
Coventry Nebraska	Medicaid	<u>Nebraska:</u> Counties of Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Seward, Sarpy, Saunders, and Washington may travel in the bordering <u>Iowa</u> <u>Counties:</u> of Fremont, Harrison, Mills and Pottawattamie were services may be provided as long as the distance does not exceed 50 miles.	8/1/2010	Non-emergency Transportation services	47,119	Proprietary and Confidential	Yes	Cassandra Price, Manager of Medicaid Program	15950 W. Dodge Road Omaha, NE 68118	402-995-7177	Vehicles and transportation
Blue Advantage Plus	Medicaid	MO counties of Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Ray, St. Clair Trips going to Wyandotte or Johnson County KS do not need prior auth	1/1/1996	Non-emergency Transportation services	30,899	Proprietary and Confidential	Yes	Judy Brennan, Director of State Programs	2301 Main Street PO Box 419169 Kansas City, MO 64141	816-395-2421	Vehicles and transportation

MTM MCO Clients

Organization Name	Medicaid/ Medicare	Geographic Specs	Effective Date	Scope of Service	Members	Annual Value of Contract	Capitated	Contact, Title	Address	Contact Phone #	Role of Subcontractor
Molina Healthcare of Florida	Medicaid	Broward, Dade and Palm Beach counties	5/1/2009	Non-emergency Transportation services	24,237	Proprietary and Confidential	Yes	Steve Bennet, Manager Provider	8300 NW 33rd Street, Ste. 400 Doral, FL 33122	407-637-1579	Vehicles and transportation
Harmony Health Plan of Missouri	Medicaid	<u>IL</u> : Jackson, Madison, Perry, Randolph, St. Clair, Washington, Williamson <u>MO</u> : St. Louis City, St. Louis County, St. Charles, Franklin, Jefferson, Lincoln, St. Francois, Ste. Genevieve, Warren, Washington, Crawford, Iron, Madison, Perry, Pike	7/1/2006	Non-emergency Transportation services	16,936	Proprietary and Confidential	Yes	Gretchen Stephenson, Sr. Provider Relations Representative	13 Wolf Creek Drive, Ste. 4 Swansea, IL 6226	618-236-8055	Vehicles and transportation
Harmony Health Plan of Illinois	Medicaid	<u>IL</u> : Jackson, Madison, Perry, Randolph, St. Clair, Washington, Williamson <u>MO</u> : St. Louis City, St. Louis County, St. Charles, Franklin, Jefferson, Lincoln, St. Francois, Ste. Genevieve, Warren, Washington, Crawford, Iron, Madison, Perry, Pike	2/1/2002	Non-emergency Transportation services	12,879	Proprietary and Confidential	Yes	Gretchen Stephenson, Sr. Provider Relations Representative	13 Wolf Creek Drive, Ste. 4 Swansea, IL 6226	618-236-8055	Vehicles and transportation
Wellpoint Wisconsin (Community Connect Healthplan)	Medicaid	<u>WI</u> : Milwaukee, Washington, Ozaukee, Waukesha, Racine, and Kenosha <u>IL</u> : Lake and McHenry	09/01/2010	Non-emergency Transportation services	7,307	Proprietary and Confidential	Yes	Terri Maccani, Manager, Vendor Compliance	5151-A Camina Ruiz, CACC01-043C Camarilla, CA 93012	805-910-6238	Vehicles and transportation
Children's Special Health Care Services	Medicaid	State of Michigan, including Upper Peninsula	10/4/2004	Non-emergency Transportation services	828	Proprietary and Confidential	No - per trip	Karla McCandless, Manager, Policy and Program Development	4707 St. Antoine, Suite 620 Detroit, Michigan 48201	313-966-7038	Vehicles and transportation
Advantage Care Select (Schaller Anderson Medical Admin - Advantage Health Solutions)	Medicaid	<u>OH</u> : Hamilton, Butler, Dearborn <u>IL</u> : Cook, Vermillion, Iroquois <u>KY</u> : Jefferson, Davies <u>MI</u> : St Joseph	3/12/2008	Non-emergency Transportation services	133	Proprietary and Confidential	No - per trip	Karen Grays, Member Services Supervisor	9045 River Road Suite 150 Indianapolis, IN 46240	317-810-4468	Vehicles and transportation
Essence Healthcare	Medicare	<u>Missouri</u> : Boone, Jefferson, St. Charles, St. Louis City & County <u>Illinois</u> : Madison, Monroe, St. Clair <u>Washington</u> : King Whatcom, Skagit, Spokane <u>New York</u> : Monroe, Wayne	1/1/11	Non-emergency Transportation services	30,540	Proprietary and Confidential	Yes	Susan Wilson, Manager of Implementation	13900 Riverport Drive Maryland Heights, MO 63043	314-209-2845	Vehicles and transportation
Care Improvement Plus	Medicare	Entire states of AR, GA, MO, SC, TX and the MD counties of Anne Arundel, Baltimore, Baltimore City, Carroll, Harford, Howard, Montgomery, Prince George's, Calvert, St. Mary's, Charles	1/1/2007	Non-emergency Transportation services	93,377	Proprietary and Confidential	Yes	Karl J. Broussard, V.P. of Contracting and Provider Relations	351 West Camden St., Ste. 100 Baltimore, MD 21201	954-778-0224	Vehicles and transportation
Molina National	Medicare	Select counties in CA, FL, MI, NM, OH, TX, UT, WA	01/1/2009	Non-emergency Transportation services	20,725	Proprietary and Confidential	Yes	John Stites, Director of Strategic Contracting	200 Oceangate, Suite 100 Long Beach, CA 90802	562-901-1082	Vehicles and transportation

MTM MCO Clients

Organization Name	Medicaid/ Medicare	Geographic Specs	Effective Date	Scope of Service	Members	Annual Value of Contract	Capitated	Contact, Title	Address	Contact Phone #	Role of Subcontractor
Gateway Health Plan	Medicare	<u>PA:</u> Adams, Allegheny, Armstrong, Beaver, Berks, Blair, Butler, Cambria, Cumberland, Dauphin, Erie, Fayette, Indiana, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Mercer, Northampton, Northumberland, Perry, Schuylkill, Somerset, Washington, Westmoreland, and York	1/1/2009	Non-emergency Transportation services	26,858	Proprietary and Confidential	Yes	Angela Jackson, Director Medicare Administration	600 Grant Street, Floor 41 Pittsburgh, PA 15219	412-255-4296	Vehicles and transportation
Arcadian Health Plan	Medicare	Select counties in AR, CA, GA, LA, ME, MO, NH, NC, OK, SC, TX, VA, NY and WA	1/1/2009	Non-emergency Transportation services	27,229	Proprietary and Confidential	Yes	Chase Milbrandt, V.P. of Marketing and National Contracting	3767 Karicio Lane Suite D Prescott, AZ 86303	928-777-9226	Vehicles and transportation
Colorado Access	Medicare	<u>Colorado:</u> Denver and San Luis Areas	1/1/2010	Non-emergency Transportation services	3,176	Proprietary and Confidential	Yes	Bettina Kline, Director of Operations	10065 E. Harvard Avenue, Ste 600 Denver, CO 80231	800-511-5010	Vehicles and transportation
Humana Health Plan of Louisiana	Medicare	<u>New Orleans:</u> Jefferson, Lafourche, Orleans, Plaquemines, St. Bernard, St. Charles, St. Tammany, St. John the Baptist, Tangipahoa, Terrebonne and Washington Counties; <u>Baton Rouge:</u> Parishes of Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, West Baton Rouge and West Feliciana	1/1/2008	Non-emergency Transportation services	3,043	Proprietary and Confidential	Yes	Cherly Haas, Director, Finance	1 Galleria Blvd, Suite 1122 Metairie, LA 70001	504-219-6635	Vehicles and transportation
Humana Health Plan of Texas	Medicare	Bexar, Dallas and Nueces counties - not covered beyond 10 miles of bordering counties or zip codes. Per Ammendment 7 Effective 01/01/2010 the service area in the corpus christy and San Antonio area shall be expanded by adding the following counties Aransas, Atascosa, Bandera, Bee, Comal, Guadalupe, Jim Wells, Kendall, Kleberg, Medina, San Patricio, and Wilson. Also, El Paso County	1/1/2007	Non-emergency Transportation services	1,591	Proprietary and Confidential	Yes	Charles Majdalani, Finance Director	8431 Fredericksburg Rd, Ste. 580 San Antonio, TX 78229	210-617-1748	Vehicles and transportation
Kaiser Foundation Health Plan of Colorado, Inc.	Medicare	Senior Advantage Gold Plan service area: Adams, Arapahoe, Clear Creek, Douglas, Elbert, Jefferson, Larimer, Park, Weld, Boulder, Broomfield, Denver, Gilpin. The service area for Senior Advantage Silver Plan is Teller, Fremont, Pueblo and El Paso.	1/1/2009	Non-emergency Transportation services	5,040	Proprietary and Confidential	Yes	Deborah Gordon, Medicare Project Manager	2500 South Havanna St. Aurora, CO 80014	303-358-3520	Vehicles and transportation
Premier Plus by Mercy Health Plan	Medicare	IL: Madison, Monroe, Randolph, St. Clair MO: Franklin, Jefferson, Lincoln, St. Charles, St. Louis, St. Louis City, Warren	1/1/1999	Non-emergency Transportation services	6,623	Proprietary and Confidential	Yes	Debbie Todd, Manager Member Services	14528 South Outer 40, Ste. 300 Chesterfield, MO 63017	314-214-8245	Vehicles and transportation
*Estimated											

Contracts No Longer Held

Plan	Contact	Address	Contact Phone #	Reason	Termination Date
Arkansas Department of Human Services	Floyd Sparks	P.O. Box 1439, Slot 414 Little Rock, AR 72203	501-375-1200	Contract award to other broker	1/31/2007
CAPE Health Plan	Rodger Prong	26711 Northwestern Highway, Suite 300 Southfield, Michigan 48034	888-354-2273	Contract award to other broker	12/31/2006
CareSource Indiana	Steve Smitherman	8001 Broadway, Suite 400 Merrville, IN 46410	937-531-3804	Health plan lost contract with the state	12/31/2006
Colorado Access	Christine Pazell	10065 E. Harvard Ave., Ste. 600 Denver, CO 80231	800-511-5010	Contract award to other broker, have regained the business, they are current client	2/29/2008
Community Choice Michigan	Lorna Hoilette	2369 Woodlake Drive, STE 200 Okemos, MI 48864	937-531-3700	Contract award to other broker	12/31/2006
Evercare Choice of Texas	Carl Kidd	9700 Bissonnet, Ste 2225 Houston, TX 77036	713-778-8664	Contract award to other broker	9/1/2007
Great Lakes Health Plan	Meredith Taylor	171117 West Nine Mile Rd. Ste. 1600 Southfield, MI 48075	800-903-5253	Contract award to other broker	6/30/2006
Group Health Plan	Kay Lombardo	111 Corpotate Office Dr., Ste. 400 Earth City, MO 63045	314-506-1592	Contract award to other broker	12/31/2007
Harmony Health Plan of Indiana	Donica Brown	504 Broadway, Suite 200 Gary, IN 46402	219-880-4402	Contract award to other broker	12/31/2006
Health Plan of Michigan	Ray Pitera	777 Woodward Ave., Ste. 600 Detroit, MI 48226	248-204-6006	Contract award to other broker, have regained the business, they are current client	2/1/2007
Managed Health Services	Yolanda Moton	1099 Meridian Street, Ste. 400 Indianapolis, IN 46204	314-684-9478	MTM not certified to operate as WBE in state of Indiana. Health plan required to use MBE or WBE broker	1/31/2008
Molina Healthcare of Indiana	Francine Woodson-Porter	8001 Broadway, Suite 400 Merrville, IN 46410	219-739-9140	Health plan lost contract with the state	12/31/2006
Molina Healthcare of Michigan	Camille Adams	100 W Big Beaver Road, Ste 600 Troy, Michigan 48084	248-925-1813	Contract award to other broker	5/31/2008
Molina Healthcare of Nevada	John Stites, Director of Strategic Contracting	200 Oceangate, Suite 100 Long Beach, CA 90802	562-901-1082	Terminated without cause	1/1/2010
Optima Health Management	Jennifer Varbero	4417 Corporation Lane, Ste 200 Virginia Beach, VA 23462	757-687-6439	Terminated without cause	1/16/2007
Philadelphia County MATP	Patricia Jacobs	P.O. Box 2675 Harrisburg, PA 17105-2675	717-783-3767	Contract award to other broker	11/30/2006
Physicians United Plan (PUP)	Dawn Kinkead	84 NE Loop 410, Ste 200 San Antonio, TX, 78216	727-459-8435	Contract award to other broker	5/10/2010
South Carolina TANF	Goya Spry	1535 Confederate Avenue Extension Columbia, South Carolina 29202	803-898-7802	State deleted the program	1/31/2010
St. Catherine's Hospital	Sarah Woelfl	4321 Fir Street East Chicago, IN 46312	219-392-7039	Health plan lost contract with the state	12/31/2006
Star Plus Medicaid Managed Care Plan	Darla McGahee	9702 Bissonnet, Suite 2225 Houston, TX 77036	713-596-2682	Terminated without cause	3/31/2007

Contracts No Longer Held

Plan	Contact	Address	Contact Phone #	Reason	Termination Date
Bravo Health	Joe Farver	3601 O'Donnell St. Baltimore, MD 21224	410-864-4431	Terminated without cause	5/10/2010
United HealthCare Insurance Company	Joe Hafermann, CFO	990 Bren Road East, Minnetonka, MN 55343	952-936-4943	Both parties could not agree on price	12/31/2007

Insert Color Slip Sheet

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

B.1 Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

*CypraCare, LLC.
c/o SeKayi Holdings, LLC
8777 Purdue Road
Suite 300
Indianapolis, Indiana 46268*

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Limited Liability Company

Refer to Attachment B.11 (g)_1: Roster of Officers and Directors

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

*Federal Identification Number: 27-4700140
Louisiana Taxpayer Identification Number: Pending*

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

Louisiana

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

We have not been engaged by DHH in the past.

B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. **Include your organization's parent organization, affiliates, and subsidiaries.**

No mergers, acquisitions or sales of any kind have ever occurred. No change of ownership is expected in the next 12 months.

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have **ever** been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. **Include your organization's parent organization, affiliates, and subsidiaries.**

No employee within the organization has been pled or been convicted of a felony.

B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. **Include your organization's parent organization, affiliates, and subsidiaries.**

There are no pending or recent litigation against the organization.

B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. **Include your organization's parent organization, affiliates, and subsidiaries.**

No bankruptcy or insolvency proceeding has ever occurred.

B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.

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

We are a private organization

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

No other organization is involved.

Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.

If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.

If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.

For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.

We intend to employ and use Full-Time Employees.

Refer to Attachment B.11 (g)_2: Job Descriptions

B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. **Include your organization's parent organization, affiliates, and subsidiaries.**

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

No other contracts.

B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. **Include your organization's parent organization, affiliates, and subsidiaries.**

No contract has been terminated or not renewed.

B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. **Include your organization's parent organization, affiliates, and subsidiaries.**

No action was necessary.

B.19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:

- AM Best Company (financial strengths ratings); *No Rating*
- TheStreet.com, Inc. (safety ratings); and *No Rating*
- Standard & Poor's (long-term insurer financial strength. *No Rating*)

B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? **Include your organization's parent organization, affiliates, and subsidiaries.**

No contracting party has ever deemed the organization in breach of contract

B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.

NCQA Patient Practitioner Oriented Disease Management Accreditation for High Risk Pregnancy Program. Effective February 10, 2010

B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. **Include your organization's parent organization, affiliates, and subsidiaries.**

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)***No*

B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. **Include your organization's parent organization, affiliates, and subsidiaries.**

CypraCare is not accredited as a health plan.

B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (**including your organization's parent organization, affiliates, and subsidiaries**) in response to the report.

No external quality review report has been needed.

B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. **Include your organization's parent organization, affiliates, and subsidiaries.**

No regulatory action of any kind has been imposed on the organization.

B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. **Include your organization's parent company, affiliates and subsidiaries.**

No previous or current investigations have occurred.

B.27 Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

- a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

- Your/Subcontractor's name;
 - Geographic Service Area(s) for which the reference is being submitted;
 - Reference organization's name; and
 - Reference contact's name, title, telephone number, and email address.
- b. Send the form to each reference contact along with a new, sealable standard #10 envelope;
- c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;
- d. Instruct the reference contact to:
- Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);
 - Sign and date it;
 - Seal it in the provided envelope;
 - Sign the back of the envelope across the seal; and
 - Return it directly to you.
- e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.

Refer to Attachment B.11 (g)_3: Sealed References for CypraCare.

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

Each completed questionnaire should include:

- Proposing Organization/Subcontractor's name;
- GSA (s) for which the reference is being submitted;
- Reference Organization's name;
- Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;
- Date reference form was completed; and
- Responses to numbered items in RFP Attachment # (as applicable).

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

Officers and Directors

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Board Chair and Chief Executive Officer
8717 Gordonshire Drive
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Home Phone: 317-329-8178

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Home Phone: 317-955-0889

Steve Nelson
Director
8520 Allison Pointe Blvd, Suite 220
Indianapolis, IN 46250
Phone: 317-713-2938

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CYPRACARE, LLC

Job Description Form

Division/Department	Compliance
Location	Louisiana
Job Title	Contract Compliance Officer
Reports to	<i>Title</i>

Level/Grade	Type of position: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Contractor <input type="checkbox"/> Intern	Hours ___40+ ___ / week <input type="checkbox"/> Exempt <input type="checkbox"/> Nonexempt
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GENERAL DESCRIPTION

The primary role of this position is to ensure that those entities doing business with the City are in compliance with applicable federal, state and city regulations and ordinances pertaining to affirmative action, equal employment opportunity act, and targeted business utilization. Under the general supervision of the Affirmative Action Director, this position is characterized by independent judgment and discretion. This position provides program direction and supervision to compliance technicians.

WORK EXPERIENCE REQUIREMENTS

- Working knowledge of the principles and practices of affirmative action and equal opportunity laws
- Working knowledge of business administration and business practices
- Ability to provide technical assistance to contractors and vendors in the establishment of affirmative action plans, the recruitment of protected group employees, and targeted business utilization
- Ability to provide technical assistance
- Ability to perform complex analyses relating to the certification of qualified businesses
- Ability to communicate effectively both orally and in writing
- Ability to establish and implement effective monitoring systems
- Ability to prepare and present written and oral reports
- Ability to develop effective working relationships
- Ability to supervise a small staff of technicians

EDUCATION REQUIREMENTS

Bachelor's Degree in Business Administration, Public Administration, Social Science or related area

Combination of training and/or demonstrated experience

Three years of varied professional experience in developing and monitoring affirmative action plans or equal opportunity programs involving significant interaction with the business community either in a technical assistance or compliance capacity.

General knowledge of procurement techniques and strategies; working knowledge of federal and state affirmative action equal opportunity and/or contract compliance laws, rules regulations, procedures, and guidelines; problem solving and analytical skills; thorough and working knowledge of current and historic problems and issues affecting DBE-owned businesses; effective writing and oral communication skills; effective human relation skills, working knowledge of investigative techniques and methods; ability to analyze complex problems involving varying viewpoints; ability to develop workable solutions and communicate with persons possessing diverse attitudes and opinions; effective organizational, planning and program development skills; demonstrated ability to work with top

Division/Department	Compliance
Location	Louisiana
Job Title	Contract Compliance Officer
Reports to	<i>Title</i>
<p>business management and public officials; general knowledge of training strategies and techniques; working knowledge of small business practices and contract administration; and ability to prepare and present detailed and complex written and oral reports.</p> <p>RESPONSIBILITIES:</p> <ul style="list-style-type: none"> ➤ Develop and administer the City's Contract Compliance Program, ensuring that outside vendors, suppliers and contractors are in compliance with executive orders as they relate to affirmative action and equal employment opportunity. ➤ Develop and implement formal procedures in order to review affirmative action plans for compliance. ➤ Oversee and participate in the evaluation of workforce analysis and goals, identification and referral of candidates, and monitoring progress towards achieving goals. ➤ Oversee and provide technical assistance to businesses in completing affirmative action plans, compliance reviews, and conciliatory measures. ➤ Develop and administer monitoring systems ➤ Prepare narrative and statistical reports. ➤ Conduct complaint investigations and review the procedural elements of this function. ➤ Review and evaluate procurement practices to identify barriers to targeted business participation. ➤ Work with design procurement processes to maximize targeted business utilization and identify goods and services utilized. Recruit targeted businesses to provide these goods and services. Develop a monitoring system that measures targeted business rate of contact, availability, utilization and reasons for not being utilized. Develop program enhancement and policy initiatives to meet programmatic goals and objectives. Provide narrative and statistical reports. Implement complaint investigations and resolution processes. ➤ Provide technical assistance to targeted businesses, in order to maximize their participation in City procurements, identify areas of need and develop their business and management skills. Provide referrals to private and public financing sources and small business assistance providers. Develop and coordinate workshops designed to develop business and management skills of targeted businesses. ➤ Develop and administer various grants. Provide liaison with various City committees and commissions, community based organizations, private and public sector small business resources and economic development agencies and federal agencies. Maintain an awareness of relevant legislation and other program considerations. Initiate programmatic changes to respond to changes as necessary. Hire, train, supervise and monitor a technical staff in the performance of the more procedural elements of the work. 	

Special Skills or Qualities:

REVIEWED BY	<i>Title</i>
APPROVED BY	<i>Title</i>
DATE POSTED	
DATE HIRED	



CYPRACARE, LLC

Job Description Form

Division/Department	Compliance & Quality
Location	Louisiana
Job Title	Vice President Compliance & Quality
Reports to	<i>Title</i> President

Level/Grade	Type of position:	Hours <u>40+</u> / week
	<input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Contractor <input type="checkbox"/> Intern	<input checked="" type="checkbox"/> Exempt <input type="checkbox"/> Nonexempt

GENERAL DESCRIPTION

In collaboration with the Senior Team and other appropriate administrators, provides leadership and direction on long-range planning and leadership of Quality, Performance Improvement, Program Management and accrediting body regulations. Recommends and implements an integrated performance and quality improvement system that will improve effectiveness, enhance efficiency, increase cost effectiveness, and ensure high customer satisfaction with optimal outcomes. Incorporate a quality culture through functional policies, goals, and resources and the promotion of performance excellence. Ensures realization of established quality objectives of the organization in fulfillment of the organization's mission, vision and values. Directs and coordinates the organization's efforts to ensure compliance with laws, regulations, and policies that govern business operations.

WORK EXPERIENCE REQUIREMENTS

- Five years (5) minimum of applicable operations experience in a disease management/case management environment
- Five to Seven (5-7) years strategic leadership experience required, with managerial, leadership, and communication skills.
- Experience in health care organizations required, including: healthcare business management, performance improvement, strategic and business planning skills, clinical outcome data analysis, statistical skills, team-based cultures and excellence criterion.
- Experience with setting objectives, goals, and process indicators for programs and organizations.
- Experience executing work plans and evaluations of programs and corporate-wide
- Knowledge of local, state, federal, and accrediting body regulations, as well as accrediting bodies such as URAC and NCQA.
- Experience with organizational and analytical skills; the ability to work both independently and with others in a matrix environment.
- Experience reading, analyzing, and interpreting general business periodicals, professional journals, technical procedures, government regulations, and legal documents.
- Experience with effectively presenting and representing the organization's interests externally with regulators and regulatory agencies.
- Initiation of administrative activities, including adjustments in company policies, procedures, and priorities.
- Advanced understanding of care coordination, case management, and disease management is preferred.
- Track record of additional desirable characteristics: high integrity, excellent judgment, and perseverance.

Division/Department	Compliance & Quality
Location	Louisiana
Job Title	Vice President Compliance & Quality
Reports to	<i>Title</i> President

EDUCATION REQUIREMENTS

Minimum of:

- Minimum of Bachelor's Degree, Master's Degree preferred

RESPONSIBILITIES:

- Develop an integrated, streamlined, coordinated system-wide plan for quality and performance improvement, program management, performance excellence, compliance, provider satisfaction, and member satisfaction. Evaluate effectiveness and revise annually.
- Ensure the provision of education concerning the system-wide plan and report plan activities to the appropriate individuals, departments and committees of CypraCare.
- Direct a performance improvement strategy using the concepts and philosophy of define, measure, analyze, improve, and control operational quality interdepartmentally.
- Ensure safe, evidence-based, timely, efficient, effective, and equitable program management and business processes across all assigned areas of responsibility.
- Provide and maintain an open-door policy, with effective communications at all levels of leadership and staff
- Provide consultative services to appropriate staff, operations, and committees.
- Work with regional, state, federal, and accrediting body stakeholders to improve quality and strategically position the organization for success.
- Support systems integration through commitment.
- Implement, document, and maintain a coordinated compliance program that meets state federal, and accrediting body regulations.
- Coordinate resources to ensure the ongoing effectiveness of the compliance program.
- Present periodic reports and an annual evaluation of the compliance program to the senior staff.
- Manage the compliance unit's administrative duties, including: reporting, supervision of support staff, maintenance of files, etc...
- Stop the submission of data believed to contain material errors.
- Communicate the importance of compliance and the compliance program to staff, management, and committees.
- Develop and maintain productive relationships with internal levels of management and external relationships.
- Work with operational leadership to provide adequate information and ensure their employees have the requisite information and knowledge of regulatory issues and requirements to carry out their responsibilities in a lawful and ethical manner.
- Identify and assess areas of compliance risk, develop and ensure internal controls are capable of preventing and detecting significant instances of patterns of illegal, unethical, or improper conduct.
- Develop and implement policies and procedures designed to promote compliance with the requirements set forth in state, federal, and accrediting body regulations.
- Monitor day-to-day activities to further compliance objectives
- Oversee and follow-up, as applicable, implemented corrective actions to investigations or other issues.
- Coordinate investigations with legal counsel for major violations of law or policy, conduct and oversee as appropriate.
- Performs other duties as assigned/required.

REVIEWED BY	<i>Title</i>
APPROVED BY	<i>Title</i>
DATE POSTED	
DATE HIRED	



POSITION DESCRIPTION

Job Title: Quality Improvement Director
Reports To: Chief Operating Officer
FLSA Status: Exempt
Department: Quality Control Department

SUMMARY

The Quality Improvement Director is responsible for administering and managing the facility's quality improvement program.

ESSENTIAL DUTIES AND RESPONSIBILITIES

- Develops and implements the organization's quality improvement plan in accordance with the mission and strategic goals of the organization, federal and state laws and regulations, and accreditation standards.
- Develops and implements systems, policies, and procedures for the identification, collection, and analysis of performance measurement data.
- Educates and trains the leadership, staff and business associates as to the quality improvement plan, and their respective responsibilities in carrying out the quality improvement program.
- Leads facilitate and advise internal quality improvement teams.
- Collects and summarizes performance data, identifies opportunities for improvement, and presents findings quarterly to the Performance Improvement Committee and Board of Directors.
- Analyzes customer survey data to identify opportunities for improvement and presents findings to appropriate departments.
- Actively participates on, or facilitates committees such as: Quality Improvement, Utilization Management, Patient Safety, and Risk Management.
- Performs any other duties as assigned.

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CYPRACARE, LLC

Job Description Form

Division/Department	Medical Management
Location	Louisiana
Job Title	Director of Care Management Center
Reports to	V.P. Medical Management <i>Title</i>

Level/Grade	Type of position: <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Contractor <input type="checkbox"/> Intern	Hours _____ / week <input checked="" type="checkbox"/> Exempt <input type="checkbox"/> Nonexempt
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GENERAL DESCRIPTION

The person in this position initiates the management of OB patients in the Prenatal Care Coordination Program as designated and outlined by the Department of Medical Management and included in the departmental policies and procedures.

WORK EXPERIENCE REQUIREMENTS

- Ability to manage multiple persons
- Ability to Deliver targeted condition-specific health education
- Ability to assist with strengthening the patient and PNCC staff relationships
- Ability to provide effective customer service through team management concept
- Ability to demonstrate excellent verbal and interpersonal communication skills
- Ability to apply knowledge and understanding of community resources and service networks
- Ability to understand and implement program protocols
- Ability to write clearly and informatively, understand and present numerical data
-

RESPONSIBILITIES:

- Conduct intake calls, initial telephonic assessments
- Initiate management of patients enrolled in Prenatal program
- Assist with management and on-going telephonic support
- Complete appropriate assessments, ensure dissemination of appropriate health education material, conduct telephonic coaching

Division/Department	Medical Management
Location	Louisiana
Job Title	Director of Care Management Center
Reports to	V.P. Medical Management <i>Title</i>
<p>and follow-up services</p> <ul style="list-style-type: none"> ➤ Assist clients and staff with problem-identification and solving, goal setting, decision-making ➤ Provide on-going reinforcement and support, health education ➤ Assist clients with navigating healthcare delivery system ➤ Provide appropriate referrals ➤ Maintain current client records in data management system ➤ Effectively communicate with members, team, and immediate supervisor 	
EDUCATION REQUIREMENTS	
<p>-Bachelor's degree or above in related field</p> <p>-Above average computer skills, with knowledge of Window processing software and spreadsheet software</p> <p>-Valid Louisiana driver's license</p>	

REVIEWED BY	<i>Title</i>
APPROVED BY	<i>Title</i>
DATE POSTED	
DATE HIRED	



CYPRACARE, LLC

Job Description Form

Division/Department	Medical Management	
Location	Louisiana	
Job Title	Director of Training/Director of Nursing	
Reports to	<i>Title</i> Home Health Administrator	
Level/Grade	Type of position: <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Contractor <input type="checkbox"/> Intern	Hours 40 / week <input checked="" type="checkbox"/> Exempt <input type="checkbox"/> Nonexempt

GENERAL DESCRIPTION

Manages, supervises, coordinates, evaluates, and develops client care teams to ensure quality care delivery and appropriate case management within CypraCare, LLC scope of services and policies; state, federal, and local laws; and Nurse Practice Act.

WORK EXPERIENCE REQUIREMENTS

- Graduate of an accredited school of professional nursing. BSN and PHN certification preferred.
- Current license as a Registered Nurse in the state(s) of practice.
- Minimum of two (2) years nursing experience in an acute hospital setting or equivalent experience with one (1) year of supervisory experience.
 - Complies with accepted professional standards and practice.
 - Excellent verbal and written communication skills and strong interpersonal skills.
 - Knowledge of home care federal and state regulations.
 - Knowledge of reimbursement sources and documentation requirements within home health care.
 - Must be a licensed driver with automobile insured in accordance with CypraCare, LLC and state requirements.

EDUCATION REQUIREMENTS

- Graduate of an accredited school of professional nursing. BSN and PHN certification preferred.
- Current license as a Registered Nurse in the state of Louisiana.
- Knowledge of home care federal and state regulations.
- Knowledge of reimbursement sources and documentation requirements within home health care.
- Excellent verbal and written communication skills
- Strong computer skills
- Knowledge of home care, federal and state requirements
- Knowledge of nurse practice act for the state of Louisiana

Requirements:

1. Manages and directs a team of Nurse Case Managers ensuring safe, effective, and appropriate services.
2. Is available at all times during regular business hours and as needed to provide support and assure quality care delivery to home care clients.
3. Receives referrals, determines services required, and CypraCare, LLC's ability to meet needs. Assigns appropriate clinicians to cases.
4. Meets with Case Managers/clinical staff on a regular basis to provide guidance and information related to specific issues. Provides direction to teams to assure that client needs are met and services re provided according to the plan. Assists clinical staff in establishing priorities, setting goals, and evaluating progress toward goals.
5. Attends case conferences and other clinical meetings to facilitate coordination of care.
6. Collaborates with CypraCare, LLC Director in establishing operating budget needs and priorities for the department.

Division/Department	Medical Management
Location	Louisiana
Job Title	Director of Training/Director of Nursing
Reports to	<i>Title</i> Home Health Administrator

7. Regularly reviews team members' productivity information.
8. Coordinates 24-hour CypraCare, LLC coverage by Registered Nurses. Evaluates quality of on-call services.
9. Develops working relationships with other health care professionals in the community and families to identify resources available and to ensure access of information to clients.
10. Provides support and direction to CypraCare, LLC staff, other health care professionals, clients, and families related to appropriate and available health care resources.
11. Educates CypraCare, LLC staff on clinical services, policies, and procedures as needed.
12. Facilitates problem-solving sessions to enable Case Managers and other staff to resolve client and/or reimbursement source issues.
13. Stays current on available community resources, health care costs, and industry trends through self-education and access to outside educational opportunities.
14. Provides guidance to staff, answers questions and assists in resolving issues.
15. Ensures accuracy, completeness, and timeliness of clinical documentation in accordance with CypraCare, LLC policies and procedures, regulatory requirements, and industry standards.
16. Monitors open and closed charts regularly, and participates in the quarterly clinical record reviews.
17. Reviews CypraCare, LLC policies and procedures and recommends changes or revisions as needed.
18. Provides educational programs and information regarding appropriate documentation practices.
19. Provides leadership to team and support staff in identifying CypraCare, LLC/client needs and opportunities for quality improvement.
20. Assists with marketing, public relations, and discharge planning by participating in departmental meetings.
21. Assists quality improvement teams with data collection for the Quality Improvement Plan established by CypraCare.
22. Identifies and implements changes in clinical and/or operational practice based on the findings of the Quality Improvement Program.
23. Interprets and enforces human resource policies and procedures in a fair and consistent manner.
24. Assists in the screening and interviewing of new CypraCare, LLC personnel and makes recommendations to Director. Assists in the orientation of new personnel.
25. Conducts timely performance evaluations in accordance with CypraCare, LLC policy.
26. Provides on-site supervision and training per CypraCare, LLC policy and as needed to determine staff competency and respond to educational and developmental needs.
27. Follows CypraCare, LLC guidelines for disciplinary actions. Documents all disciplinary actions in accordance with Human Resource policies and legal guidelines.
28. Monitors employee turnover, overtime, and absenteeism. Takes appropriate actions to address problems/issues.
29. Collaborates with CypraCare, LLC Director and other clinical management staff to ensure proper staffing of qualified, competent personnel.
30. Promotes personal safety and a safe environment for clients and co-workers.
31. Demonstrates knowledge of safety/infection control practices by compliance with policies and procedures and regulatory requirements.
32. Provides on-call backup for Case Managers, as needed.

REVIEWED BY	<i>Title</i>
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DATE POSTED	
DATE HIRED	



CYPRACARE, LLC

Job Description Form

Division/Department	Medical Management	
Location	Louisiana	
Job Title	OB Program Coordinator	
Reports to	V. P. Medical Management	<i>Title</i>

Level/Grade	Type of position:	Hours_____ / week
	<input type="checkbox"/> Full-time	<input type="checkbox"/> Exempt
	<input type="checkbox"/> Part-time	<input type="checkbox"/> Nonexempt
	<input type="checkbox"/> Contractor	
	<input type="checkbox"/> Intern	

GENERAL DESCRIPTION

Manages, supervises and coordinates the operations of a specific call center or member care duties by performing duties assigned personally, or through subordinate supervisors.

WORK EXPERIENCE REQUIREMENTS

- Ability to solve practical problems, and deal with a variety of concrete variables
- Ability to interpret instructions furnished in written, oral, diagram, or schedule form
- Ability to supervise according to SynCare's policies, procedures and applicable laws

EDUCATION REQUIREMENTS

- Bachelor's degree from a four-year college or university;
 - One-two years related experience and/or training
 - Equivalency combination of education and experience
- Clear Registered Nurse License for the State of LA

RESPONSIBILITIES:

- Assist Director of Medical Management in coordination of Prenatal Care Program
- Complete initial patient assessment, including risk stratification, predictive modeling, environmental/social assessment, community resource utilization and functional status/quality of life measures
- Notify physicians of client's potential participation, obtaining physician's plan of care

Division/Department	Medical Management
Location	Louisiana
Job Title	OB Program Coordinator
Reports to	V. P. Medical Management <i>Title</i>
	<ul style="list-style-type: none"> ➤ Confirms client's acceptance to participate in program ➤ Assumes team leader role for clients requiring intensive level of care ➤ Conducts effective and efficient home visitations for clients, providing real-time updates to member physicians and payors ➤ Coordinates the mailings of materials to physicians, patients and clients as appropriate ➤ Selects, schedules, assigns, and evaluates staff, adjusting hours and shifts as necessary ➤ Conducts orientation of new staff, assuring training and educational needs are met ➤ Coordinates call center activities, work assignments ➤ Evaluates activities of department ensuring members' care, staff relations, and efficiency of service ➤ Directs nursing assessments ➤ Occasionally observes prenatal care coordinators on home visits, ensuring nursing assessments are carried out as directed in accordance with company policies and procedures ➤ Develops, implements, and evaluates policies, goals, and objectives ➤ Participates in the development and modifications of unit programs and development and monitoring of unit budget ➤ Interprets and enforces department and institution policies ➤ Directs preparation and maintenance of members' clinical records ➤ Assists in investigations of member complaints ➤ Accepts other assignments as needed

REVIEWED BY	<i>Title</i>
APPROVED BY	<i>Title</i>
DATE POSTED	
DATE HIRED	

Insert Color Slip Sheet

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

B.1 Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

Legal Name: *Verity HealthNet, LLC.*

Trade Name: *Verity*

Physical Address: *8490 Picardy Ave, Ste 600, Baton Rouge, LA 70809*

Mailing: *PO Box 83578, Baton Rouge, LA 70884-3578*

Phone: *225-819-1135*

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Officers:

Joseph Bonsignore, President and 50% member

PO Box 83578, Baton Rouge, LA 70884-3578

Phone: 225-819-1135

Verity Health Accounts Management Services, Inc.

50% Member

8585 Picardy Avenue, Baton Rouge, LA 70809

Phone:225-237-1540

Health Professionals with at least 5% financial interest:

Verity Health Accounts Management Services, Inc. is wholly owned by General Health System located in Baton Rouge, Louisiana.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Verity is structured as a limited liability company. It's Federal taxpayer identification number is: 45-0510673.

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

Verity is a Louisiana based LLC and is domiciled in Louisiana.

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

Verity has not been engaged by DHH within the past 24 months.

PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)

B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. **Include your organization's parent organization, affiliates, and subsidiaries.**

There have been no mergers, acquisitions, or sales of the organization within the last ten years. No change of ownership is anticipated during the 12 months following the Proposal Due Date.

B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have **ever** been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. **Include your organization's parent organization, affiliates, and subsidiaries.**

No employee, agent, independent contractor or subcontractor of Verity has ever been convicted of, pled guilty to, or pled nolo contendere to any felony and/or any Medicaid or health care related offense or has ever been debarred or suspended by any federal or state governmental body.

B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. **Include your organization's parent organization, affiliates, and subsidiaries.**

There is no pending or recent litigation against Verity.

B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. **Include your organization's parent organization, affiliates, and subsidiaries.**

Verity has not filed any filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.

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

Not applicable to Verity.

B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

Verity has two LLC members, each of whom has 50% interest.

Joseph Bonsignore – 50% Member

Verity Account Management System – 50% Member

B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.

If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.

If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.

For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)****Personnel Roster:**

Joseph Bonsignore – President
Julie Morgan – Director of Client Services
Mary Jenkins – Director of Provider Relations
Sheila Blount – Client and Provider Services Support

Refer to enclosed summary resume of key personnel at the end of this document.

B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. **Include your organization's parent organization, affiliates, and subsidiaries.**

Refer to Attachment B.11 (h)_1: Identified-Managed Care Populations

B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. **Include your organization's parent organization, affiliates, and subsidiaries.**

Verity has not had any contract terminated or not renewed within the past five (5) years.

B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. **Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable

B.19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:

- AM Best Company (financial strengths ratings);
- TheStreet.com, Inc. (safety ratings); and
- Standard & Poor's (long-term insurer financial strength).

Not applicable

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? **Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable

B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.

Verity has never sought nor is current seeking NCQA or URAC accreditation status.

B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. **Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable

B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. **Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable

B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (**including your organization's parent organization, affiliates, and subsidiaries**) in response to the report.

Not applicable

B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts.

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

Include your organization's parent organization, affiliates, and subsidiaries.

Not applicable - none

B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. **Include your organization's parent company, affiliates and subsidiaries.**

Not applicable - none

B.27 Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

- a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:
 - Your/Subcontractor's name;
 - Geographic Service Area(s) for which the reference is being submitted;
 - Reference organization's name; and
 - Reference contact's name, title, telephone number, and email address.
- b. Send the form to each reference contact along with a new, sealable standard #10 envelope;
- c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;
- d. Instruct the reference contact to:
 - Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);
 - Sign and date it;
 - Seal it in the provided envelope;
 - Sign the back of the envelope across the seal; and
 - Return it directly to you.
- e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.

Refer to Attachment B.11 (h)_2: Sealed References for Verity HealthNet, LLC.

PART II: TECHNICAL APPROACH**B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)**

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

Each completed questionnaire should include:

- Proposing Organization/Subcontractor's name;
- GSA (s) for which the reference is being submitted;
- Reference Organization's name;
- Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;
- Date reference form was completed; and
- Responses to numbered items in RFP Attachment # (as applicable).

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

Verity HealthNet Summary Resumes

Name	Joseph A. Bonsignore
Company	Verity HealthNet, LLC, Baton Rouge, LA
Position	President
Term of Employment	May 2002 to present
Duties and Qualifications	<ul style="list-style-type: none"> • Responsible for initial start up of company • Responsible for strategic direction and goals of organization. • Responsible for implementation of all processes necessary to achieve overall goals of organization • Oversaw growth of company to current membership of 50,000 • Oversaw financial growth of company, with 32 consecutive quarters of financial growth and profitability

Name	Julie Morgan
Company	Verity HealthNet, LLC, Baton Rouge, LA
Position	Director of Client Services
Term of Employment	May 2002 to present
Duties and Qualifications	<ul style="list-style-type: none"> • Oversees interaction between client and Verity data systems and maintains responsibility of managing the relationship with Verity clients. • Implemented and Oversees procedures to implement and maintain necessary provider data elements • Maintains individual provider data demographics as necessary to ensure accurate contracted provider information • Ensures other departments are collecting data as necessary for client systems to ensure accurate provider claim payments.

Name	Mary Jenkins
Company	Verity HealthNet, LLC, Baton Rouge, LA
Position	Director of Provider Relations
Term of Employment	May 2002 to present
Duties and Qualifications	<ul style="list-style-type: none"> • Responsible for implementation and management of provider contracting strategy • Responsible for receipt and maintenance of all necessary provider contracts and documentation • Coordinates with other departments to provide necessary data to ensure accurate and timely provider demographic information.

Identified Managed Care Populations

Ten Largest Verity Contracts in Last 5 years						
Name	Description	Duration of Contract	# of Members	Population Type	Contact Name	Phone Number
LSU System Health Plan	Access to Contracted Provider Network	July 2007 to Present	28,000	Commercial	Jennifer Christian	(225) 578-7438
Baton Rouge General Medical Center	Access to Contracted Provider Network	May 2002 to Present	3,800	Commercial	Stacey Nolan	(225) 237-1555
LSU Student Health Insurance	Access to Contracted Provider Network	Jan 2009 to Present	2,500	Commercial	Shelby Conway	(225) 578-8410
Lafayette General Medical Center	Access to Contracted Provider Network	Jan 2004 to Present	2,100	Commercial	Don Authement	(337) 289-8624
Louisiana Health Plan	Access to Contracted Provider Network	July 2005 to Present	1,700	Commercial	Leah Barron	(225) 926-6717
Assurant Health	Access to Contracted Provider Network	March 2006 to Present	1,200	Commercial	Corinna Novak	(414) 299-6320
Louisiana Police Jury Association	Access to Contracted Provider Network	Jan 2003 to Present	1,000	Commercial	Yvette Murphy	(504) 888-3555
Chitimacha Employee Health Plan	Access to Contracted Provider Network	Jan 2004 to Present	900	Commercial	Charles Dupuy	(337) 923-4343
Iberia Medical Center	Access to Contracted Provider Network	Jan 2004 to Present	700	Commercial	Stephanie Kirk	(337) 374-7107
IBEW Local 995	Access to Contracted Provider Network	Jan 2005 to Present	650	Commercial	K.E. Russell	(225) 927-6340

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