May, 2015

Medica is pleased to respond to the Request for Proposal (RFP) for vendors to deliver high quality health care services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Health and Well Kids in Iowa (hawk-i) programs.

Each and every person – regardless of situation or circumstance – needs health care coverage that offers access to a comprehensive network of high-quality providers, compassionate customer service, hassle free administration and, most importantly, financial security from the significant and often unpredictable costs of needed care. These individuals need a health plan that strives – above all else – to understand their unique challenges and deliver groundbreaking and effective solutions that leverage the combined strength and skills of care providers, government agencies, social service organizations and other community resources.

Medica is such a health plan. Our work with Minnesota's Medicaid population has earned us a reputation for developing innovative solutions to the complex medical, behavioral and social problems that affect the health of vulnerable populations. For example, we were an early leader in building quality incentives into provider contracts. We were the first health plan to provide free transportation so members could keep their appointments for care. We were the first health plan to dedicate resources to secure affordable housing for individuals whose chronic homelessness is a barrier to their health. And we remain committed to paying mental health providers more to care for members with complicated and time intensive needs.

In Iowa, we will utilize our organizational strengths to meet the State's goals and become a key contributor to the overall health and well-being of Iowa's Medicaid populations. Our strengths - passion, commitment, clinical integration, collaboration and innovation – come from 30 years of service to the state of Minnesota's Medicaid population. Combined with a non-profit culture of commitment to the community, our strengths enable Medica to:

- Listen to our members and stakeholders
- Engage the community to create change
- Integrate medical care, behavioral health care and social services
- Promote healthy lifestyles
- Reduce barriers to care
- Invest in the communities we serve
- Undertake research to foster improvement

We will work to understand and serve the unique needs of the Iowa Medicaid, Iowa Health and Wellness Plan and hawk-i populations. We will leverage our experience and expertise, but are also excited to learn from and build off of the knowledge and successes in Iowa to best serve these populations.

We know our success in improving the health and well-being of our members comes from the commitment we have made to them and the trust we built with our partners and the community to always put our members first. We believe it is our responsibility to continually strengthen that commitment and the trust that it earns in order to serve low-income and vulnerable populations well.

We propose and hope to bring this commitment and passion of our organization to the State of Iowa, the Iowa health care community and, most importantly, the members who we would be privileged to serve.

Sincerely,

Geoff Bartsh

VP & GM, Medica, State Public Programs

3.2.5.1 Experience

Medica has a 30-year history of distinguished service to participants in Minnesota Health Care Programs (MHCP). From the earliest days of managed care when our predecessor, Physicians Health Plan, became one of the first participants in the demonstration phase of the Prepaid Medical Assistance Program (PMAP), through the 2013-2014 implementation of the Affordable Care Act (ACA), we have maintained our commitment to understanding and meeting the health care needs of low-income and disabled individuals.

Our work has earned us a reputation for developing innovative solutions to the complex medical, behavioral and social problems that affect the health of vulnerable populations. For example, we were an early leader in building quality incentives into provider contracts. We were the first health plan to provide free transportation so members could keep their appointments for care. We were the first managed care organization to dedicate resources to securing affordable housing for individuals whose chronic homelessness is a barrier to their health. And we pay mental health providers well to care for members whose needs are more complicated and time-intensive.

Today, our State Public Programs (SPP) division serves nearly 162,000 people in the Medical Assistance (MA) and MinnesotaCare programs. We have an additional 33,000 members in the Special Needs Basic Care (SNBC), Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO) programs. Our SPP enrollment has grown 59% since January 1, 2014, with the expansion of Medicaid eligibility due to the ACA.

3.2.5.1.4 Letters of Reference

Please see the 3 attached letters of reference from:

- **MNSure**
- **Multisource**
- **University of Minnesota**

MNsure
Where you choose health coverage

May 11, 2015

To whom it may concern,

On behalf of MNsure, Minnesota's state health insurance exchange, I would like to recognize Medica for their commitment to improving the health care system in Minnesota and to lowering the number of uninsured Minnesotans.

As an ambitious project to build a state based health insurance exchange, MNsure encountered a number of expected difficulties in automating the eligibility and enrollment process for Minnesota consumers. Medica, along with other Minnesota health plans, worked tirelessly alongside MNsure to address these difficulties always with the priority to minimize disruption for consumers. I have stated publicly that Minnesota health plans, including Medica, deserve tremendous credit for helping MNsure enroll over 200,000 Minnesotans in health coverage during our first two years, including over 157,000 Minnesotans in our state public health care programs. Without Medica's support and leadership MNsure and Minnesota would not have reached our levels of success.

I can personally attest to Medica's commitment to their members, their culture of collaboration and partnership, and their willingness to tackle challenges large and small in order to improve the health care experience for consumers.

Sincerely,

Scott Leitz
Chief Executive Officer

MultiSource
MANUFACTURING LLC

10310 Bren Road East
Minnetonka, MN 55343
www.multisourcemfg.com

May 13, 2013
Ms. Mary Beth Galey
Director, Client Services
Medica
401 Carlson Parkway, CP265
Minnetonka, MN 55305

Dear Mary Beth,

I am writing to you about our My Plan by Medica experience, having implemented the plan in January 2013. As the President of MultiSource Manufacturing LLC, I was faced with the challenges of rising healthcare costs and employee preference for more insurance coverage options. MultiSource gives great thought to strategies that support employee choices while tapping into self-directed consumerism for cost control. The decision to offer My Plan by Medica aligned with our priorities to provide employees the ability to make personal choices with regard to their health care coverage, while also providing comprehensive medical insurance plans.

The My Plan private exchange allowed us to offer a variety of high-deductible plans alongside a selection of traditional copay plans. Many of our employees also took advantage of the cost savings available through the Accountable Care Organization plans offered exclusively by Medica. The My Plan decision making tools offered our employees the support they needed to make the best decisions for their own needs. My Plan gave each employee a highly personalized outcome to help them select the option that best matched their overall health, financial risk tolerance and benefit needs.

The Medica team provided excellent assistance to our employees and ensured a smooth transition for our growing organization. With nearly 250 staff members in multiple sites, the decision to move to My Plan was positively accepted by our employees.

We believe that My Plan by Medica is a powerful and progressive way to leverage defined contributions to better plan for our employees' health care needs and budget for the long term financial strength of the company. We have an excellent working relationship with the Medica team and our employees have been very satisfied. Thank you again for your continued partnership.

Sincerely,

Michael W. Schuffenhauer
President

UNIVERSITY OF MINNESOTA

Office of the Sr. Vice President for System Administration

Office for Business and Community Economic Development

University Office Plaza Ste.136
2221 University Avenue SE
Minneapolis, MN. 55414

Office: 612-624-0530
Fax: 612 –625-9056

July 5, 2014

To Whom It May Concern

On behalf of the University of Minnesota's Office for Business & Community Economic Development (BCED) it gives me great pleasure to write this letter in support of Medica. Let me begin by saying that Medica has demonstrated exemplary 'corporate social responsibility' through its partnership with the University. Their leadership and commitment has produced a positive impact on our community, the environment, the University of Minnesota and its students and many other stakeholders within the public sphere. I am confident that building upon our existing relationship with Medica is not only a prudent business decision that will serve the long term interests of the University well, but it will produce additional benefits and value, that you will find unmatched by their competition.

As you know, the University strongly supports and encourages its prime vendors to purchase from women and minority owned businesses and/or to support community development strategies that help to stimulate economic growth or, address critical social-economic problems in our urban areas. With that being said, there are few companies that BCED has partnered with that have embodied the true spirit and intent of the Regents' policy on 'small business and urban community economic development', when demonstrating their commitment to support urban areas, or strategies that help to strengthen our community's assets, build its capacity and support our student population.

In 2006, Medica partnered with BCED to create the Community Health Initiative (CHI). The CHI is now in its eighth year and has been a robust partnership that has produced significant benefits for University students and the external community. It is also a world-class model that successfully demonstrates the far-reaching impact of a true University-Corporate partnership.

Simply put, CHI seeks to improve public health disparities and issues by providing resources that help support sustainable solutions and opportunities for underserved communities and populations. CHI provides the following: 1) scholarships to students from historically underrepresented groups who are enrolled in the medical school, the school of public health or the school of social work, 2) paid full-time summer internships for University of Minnesota students with healthcare and social service organizations that support underserved communities, 3) opportunities for our students to work as consultants with local non-profit or for-profit organizations involved in addressing public health issues and 4) grants to programs or organizations focusing on health disparities research in underserved communities.

Through the generous financial contributions made by Medica, the CHI has provided over **200 scholarships, 90 full-time summer internships, 50 student consulting opportunities/projects**, and several grants to University-driven programs that conduct health disparities research. The

total amount Medica has invested in the Community Health Initiative over the past eight years has been just over **1.7 million dollars**. However, the benefits and impact of Medica's commitment on our community stakeholders, our non-profits and the University of Minnesota students whose lives have been transformed by this extraordinary program, has been unprecedented.

Not only has Medica been an outstanding corporate partner, but they have raised the bar and set the standard by which all partnerships will be measured. Medica is also the only service provider for the University that has won the University of Minnesota's Corporate Star Award twice. This distinguished award is designed to recognize majority corporations that have demonstrated exemplary efforts to support the Universities' public service and outreach mission through partnerships that help to build stronger and healthier urban communities.

In closing, I would like to summarize my comments by stating that doing business with Medica is more than just business as usual. It is about building a partnership that is producing the type of transformative outcomes that help to make us a world class institution and a stronger community.

Sincerely,

D. Craig Taylor, MPA
Executive Director Office for Business & Community Economic Development and the Business & Technology Center (UROC)
University of Minnesota

3.2.5.1.5 Description of experience managing sub-contractors

Prior to delegation, Medica evaluates the prospective subcontractor's ability to perform the activities to be delegated, including firm and staff qualifications and policies and procedures related to the delegated functions. When we initiate a contract with a new first tier, downstream, or related entity (FDR), we send the vendor a copy of Medica's Standards of Conduct, Compliance Reporting Policy, and Compliance and Fraud Waste and Abuse (FWA) training. We also collect signed Vendor Compliance Program Attestation and Disclosure of Ownership forms. Contract addenda covering regulatory compliance, Qualified Health Plan requirements for delegated entities and business associate responsibilities are attached when applicable. These addenda are reviewed and updated by Medica's Law Department on a recurring basis.

During the contracting phase, Medica enters into a written agreement with the subcontractor that specifies the deliverables and reporting responsibilities and provides for terminating delegation or imposing other sanctions if the subcontractor's performance is inadequate. We enter into subcontract agreements that mitigate risk and provide for industry standard protections for our members and providers. All subcontracts will meet the requirements of 42 CFR 434.6 and will incorporate by reference the applicable terms and conditions of the Contract. We will notify the Agency in writing of all subcontracts relating to deliverables provided under this Contract prior to the time the subcontract(s) become effective.

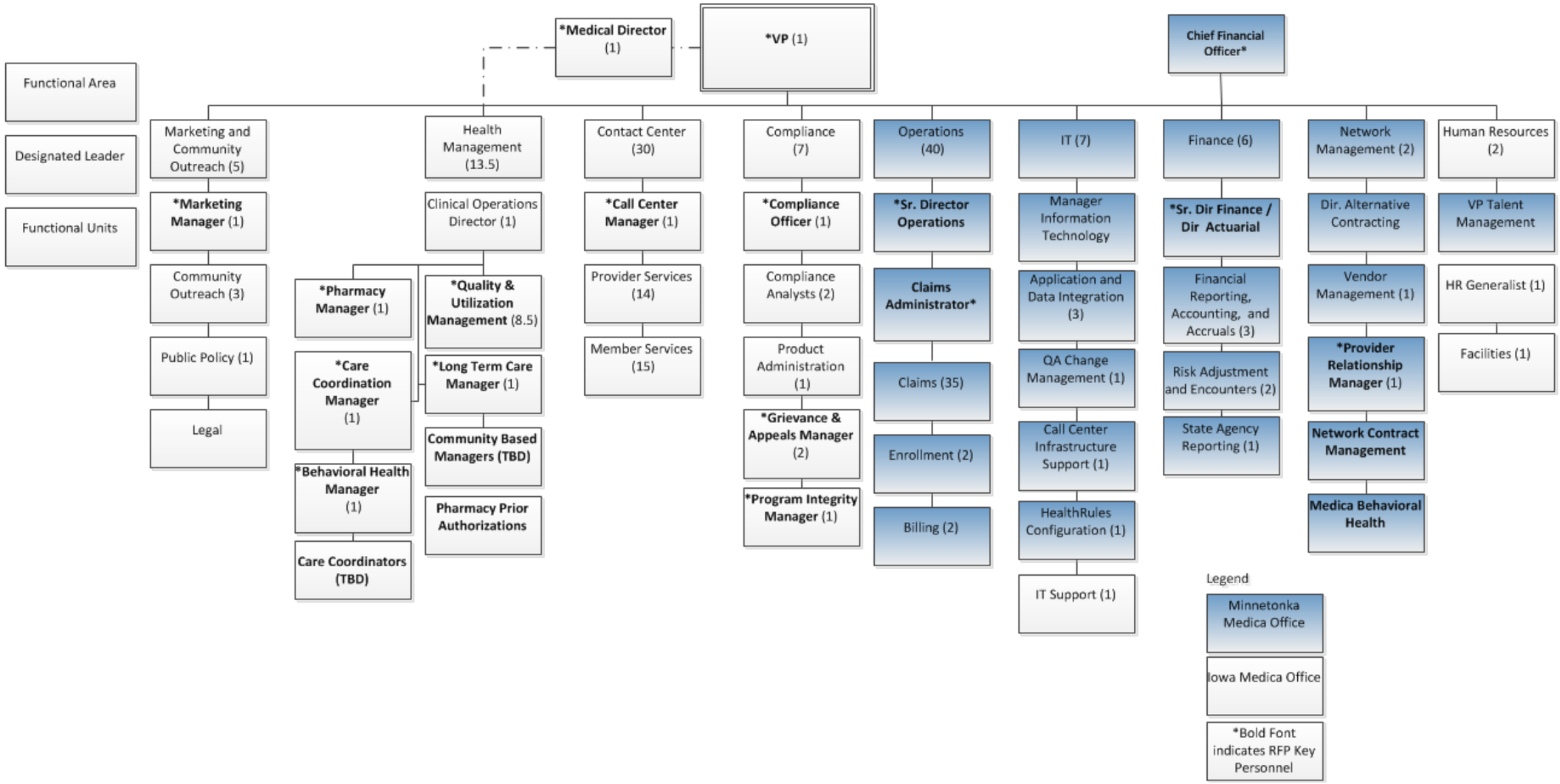
Medica's Vendor Management Office, in conjunction with the Corporate Compliance Department, oversees the management of subcontractors through a series of internal policies and procedures establishing standards and practices for auditing and monitoring subcontractors' data, data submission and performance to ensure compliance with Contract requirements on an ongoing basis. Formal reviews are conducted quarterly and corrective action is taken in the event deficiencies are identified. The Vice President of Compliance and Privacy provides regular updates on monitoring and auditing results to Medica's Compliance Committee, CEO, senior leadership, and Board of Directors. Our Special Investigations Unit conducts surveillance, interviews, and investigations related to potential fraud, waste and abuse among Medica's contracted vendors. As part of a quarterly review, we collect the following information from each subcontractor:

- A statement of revenues and expenses
- A balance sheet
- Cash flows and changes in equity/fund balance
- Incurred but not received (IBNR) estimates

All Medica policies and procedures regarding the management of subcontractors are available for Agency review and approval. Any change to Medica policies or procedures relating to management of subcontractors will be submitted to the Agency for approval prior to implementation. We will make available all subcontractor performance monitoring data and reviews upon request by the Agency and will notify the Agency any time a subcontractor is placed on corrective action. It is understood that the Agency reserves the right to audit all subcontractor data and that the Agency will notify Medica of any reporting requirements incorporating subcontractor performance necessary for State reports.

Medica – Iowa Medicaid Business Operations and Services Model

This table represents both the overall Operations model and the staff who will provide services under the RFP.



3.2.5.2.2 Names and credentials of key corporate personnel

Medica Health Plan Board of Directors:

John Buck, CEO, Whitefish Ventures

John Buck, the Chair of Medica's Board of Directors and the Medica Foundation Board of Directors, joined the Board in 2001 and serves on Medica's Audit, Community & Public Affairs, Finance, Governance, and Technology Committees. Mr. Buck is Chief Executive Officer of Whitefish Ventures, which provides financial services and general business expertise to other companies. Mr. Buck's previous business experience includes serving as President and Chief Operating Officer at Fingerhut Companies; Vice President of Administration at Alliant Techsystems; and Vice President of Administration at Honeywell, Inc. Mr. Buck previously served as Chairman of the Board of Blue Cross and Blue Shield of Minnesota, and currently serves on the boards of ValueVision Media/Shop NBC and Patterson Companies, Inc.

Mr. Buck supports several charities in the Minneapolis and Naples areas, including the United Way Foundation and the American Diabetes Association. He is a member of the Halo Innovations Board of Directors, which develops products to prevent SIDS. Mr. Buck is also a member of the Naples Education Foundation.

Peter Kelly, M.D., Surgeon, HealthEast Surgery

Dr. Peter Kelly joined the Medica Board in 2001 and serves as Chair of the Medical Committee and as a member of the Audit and Personnel & Compensation Committees. Dr. Kelly practices general, vascular and thoracic surgery as a member of HealthEast Surgery. He has served as Chief of Surgery at St. Joseph's Hospital and at HealthEast, served as Chair of the Surgery Department at Divine Redeemer Hospital and St. John's Hospital, and served as Chief of Staff at St. Joseph's Hospital and as President of HealthEast Medical Staff. He also served as President of the Ramsey County Medical Society and is active in numerous professional associations. Dr. Kelly also has served as Clinical Assistant Professor at the University of Minnesota and has authored several articles for medical journals.

Dr. Kelly has been involved in numerous community activities, in addition to his service in medical organizations. He has served as a medical volunteer on missions to Guatemala and has volunteered for the Courage Center by teaching skiing to handicapped skiers.

Earl Stratton, Retired Executive Vice President and Chief Information Officer, TCF Financial Corporation

Earl Stratton joined the Medica Board in 2009 as a Consumer Director and serves as Chair of the Technology Committee and also as a member of the Finance Committee and the Personnel & Compensation Committee. Prior to his retirement in 2015, Mr. Stratton served as Chief Information Officer for TCF Financial Corporation which is headquartered in Wayzata, Minnesota. He also serves on the Board of Directors of TCF National Bank headquartered in Minneapolis, Minnesota and C Financial Corporation, an Ohio Bank Holding Company headquartered in Columbus, Ohio. Mr. Stratton had been with TCF since 1985 and prior to that worked at Huntington National Bank in Columbus, Ohio for 15 years.

Mr. Stratton supports several charities in the Minneapolis area including Hope for the City, March of Dimes, Memorial Blood Centers, and Breast Cancer Research.

David Tilford, President and CEO, Medica
David Tilford is President and Chief Executive Officer (CEO) of Medica. He also is a member of the Board of Directors of Medica Holding Company (MHC), which oversees Medica's family of businesses including: Medica Health Plans, Medica Health Plans of Wisconsin, Medica Affiliated Services, Medica Insurance Company, Medica Self-Insured, and Medica Health Management, LLC. He joined the company in 2001.

Mr. Tilford has more than 25 years of industry experience, beginning in 1980 with Transamerica Occidental Life Insurance Company. He moved on to management and executive positions at Blue Cross of California and was part of the team that guided the formation of WellPoint Health Networks, now the nation's largest health benefits company. He later led a business/information technology consulting practice serving the insurance and health care industries.

Esther Tomljanovich, Retired Associate Supreme Court Justice
Justice Esther Tomljanovich joined Medica's Board in 2001 and has served as a Consumer Director since June 2002. Justice Tomljanovich is Chair of Medica's Governance Committee and also serves on the Community & Public Affairs and Medical Committees. She also serves on the Medica Foundation Board of Directors. She previously served the State of Minnesota as a Supreme Court Justice from 1990 to 1998 and as a trial judge from 1977 to 1990. Before earning her law degree, Justice Tomljanovich spent seven years working for Minnesota Mutual Life Insurance Company. In 2007, Academy of Trial Lawyers presented Justice Tomljanovich with its Distinguished Jurist Award.

Justice Tomljanovich has held leadership positions in numerous public, community and non-profit organizations, including serving on the Board of Trustees of the William Mitchell College of Law and chairing the Governor's Judicial Selection Committee. She was a founding member of Minnesota Women Lawyers.

Additional Key Corporate Personnel:

Glenn Andis, Senior Vice President, Government Programs
Glenn Andis is responsible for directing the development, customer service and operations of all of Medica's state and federal government-related (Medicaid and Medicare) products. These include the state-subsidized MinnesotaCare and Choice Care products for low-income residents, short and long-term individual products, and products for seniors offered through the Medica Center for Healthy Aging. He also oversees the behavioral, dental and chiropractic network management for Medica.

Previous to this position, Glenn was Vice President of Regional Operations for Medica. This position involved the development of regional offices in Duluth, St. Cloud and Fargo, North Dakota.
Prior to joining Medica, Glenn served as Operations Director for United Behavioral Systems in Minneapolis, Minn. He has been employed as a mental health clinic manager and as a practicing psychologist licensed in Minnesota, Kentucky and Indiana.

Glenn received a Bachelor of Science Degree in psychology from the University of Evansville, Evansville, Ind. He also earned both a Master's and a Doctorate Degree in psychology from Indiana State University in Terre Haute, Ind.

Mary Lippert, Vice President, Compliance and Privacy
As vice president for Compliance and Privacy, Mary Lippert is responsible for the strategy, design and execution of Medica's regulatory compliance activities. Her responsibilities include implementation of new laws that affect Medica's business operations, regular compliance training for all Medica employees, administration of a comprehensive privacy program, and response to legal, ethical and regulatory concerns. The director of Medica's Special Investigations Unit reports to Ms. Lippert.

Ms. Lippert joined Medica as associate general counsel in September of 2004. In that role, she managed Medica's response to complaints from regulators and provided consultation to the Special Investigations Unit and the Minnesota Comprehensive Health Association. Prior to joining Medica, she was part of the regulatory community, serving as attorney for the Minnesota Department of Commerce for 13 years. Mary received her Juris Doctor degree from the University of Minnesota Law School and is a graduate of St. Olaf College in Northfield, Minnesota.

Mark Baird, Chief Financial Officer
Mark provides leadership for a variety of Medica's analytical and financial activities. He serves as a key business partner to the business segment Vice Presidents and General Managers in developing operating plans, identifying opportunities and risks, establishing and achieving financial targets, and analyzing operating results. He provides the analytical support for provider contracting. Mark is also responsible for identifying and analyzing healthcare cost drivers to ensure that medical expense trends are appropriately reflected in pricing.

Prior to joining Medica, Mark was Vice President and Chief Financial Offer of IHC Health Plans, a 500,000-member HMO in Salt Lake City. He was also responsible for all managed care contracting activities for the Intermountain Health Care Hospital system.

Mark received an MBA and a Bachelor's Degree in economics from Brigham Young University.

Geoff Bartsh, Vice President and General Manager, State and Public Programs
Geoff is responsible for the vision, strategy, planning, performance, compliance and communication related to Medica's SPP business. He is a member of Medica's leadership team and is engaged with the overall strategic direction of the organization. Prior to his current role, Geoff served as the Vice President of Public Policy and Government Relations for Medica. In this role he led Medica's public policy and advocacy efforts in alignment with Medica's mission and vision. Prior to joining Medica, Geoff was Director of Government Relations at HealthPartners

Geoff received a Bachelor of Science Degree in Political Science from the University of Wisconsin, Madison.

3.2.5.2.3 Information about key project personnel

We understand that a staffing plan, including resumes for Key Personnel members, are to be provided within ten (10) calendar days of the execution of the Contract.

TITLE	NAME	ROLE	YEARS OF EXPERIENCE	LOCATION
Chief Executive Officer (CEO)	David Tilford	The Chief Executive Officer is responsible for overseeing the entire operations of the Contractor. This role has full and final responsibility for contract compliance.	25+ years	Minnesota
Vice President of Iowa Medicaid	Not Yet Identified	The Vice President of Iowa Medicaid will be responsible for divisional profit and loss, operations and compliance. The Vice President will serve as the face of the Iowa Health Plan to the State and key stakeholders and will be supported by a leadership team consisting of the Medical Director, Clinical Operations Director, Compliance Officer, Community Outreach Manager, Call Center Manager, and Policy Manager.	10+ years	Iowa
Medical Director	Not Yet Identified	The Medical Director, reporting to the Medica Chief Medical Officer, will be an Iowa-licensed physician in good standing and will have oversight of all clinical functions. The Medical Director will serve as the face of Medica in Iowa to the provider community and will participate in any scheduled quality committee meetings as directed by Iowa Department of Health Services.	7+ years	Iowa
Chief Financial Officer	Mark Baird	Responsible for overseeing the health plan budget, accounting systems, and financial reporting and will be based at Medica's headquarters in Minnesota and will have a matrixed relationship to the Medica Iowa VP.	20+ years	Minnesota

TITLE	NAME	ROLE	YEARS OF EXPERIENCE	LOCATION
Compliance Officer	Not Yet Identified	The Compliance Officer will report to the Vice President of Iowa Medicaid and will be the primary liaison with the State of Iowa. The Compliance Officer will maintain a current knowledge of federal and state legislation, legislative initiatives and regulations that may impact the program and will be responsible for ensuring compliance with all HIPAA and privacy regulations while coordinating required reporting. They will also be responsible for ensuring overall compliance (regulatory quality) with terms of Contract. The Compliance Officer will be supported by a staff consisting of one (1) Product Administration Manager, two (2) Compliance Analysts, one (1) Program Integrity Manager, and one (1) Appeals and Grievances Manager.	10+ years	Iowa
Iowa Pharmacy Director/Coordinator	Not Yet Identified	The Pharmacy Manager, reporting to the Director of Clinical Operations, will be an Iowa-licensed pharmacist with experience as a Medicaid Pharmacist (or equivalent). The Pharmacy Manager will be responsible for oversight and coordination of all Contractor and Pharmacy Benefit Manager (PBM) pharmacy requirements including drug rebate and will attend all Iowa Department of Health Services Pharmaceutical & Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Commission meetings.	5+ years	Iowa
Grievance and Appeals Manager	Not Yet Identified	The Grievance and Appeals Manager will report to the Compliance Officer and will manage the grievance and appeals process and the consumer affairs staff.	5+ years	Iowa

TITLE	NAME	ROLE	YEARS OF EXPERIENCE	LOCATION
Utilization Management and Quality Manager	Not Yet Identified	The Utilization Management and Quality Manager will report to the Director of Clinical Operations and will be an Iowa-licensed registered nurse, physician or physician's assistant. This role will combine the traditional roles of Utilization Management (UM) and Quality Management. Responsibilities will include management of all elements of the UM program and staff under the supervision of the Medical Director and oversight of the Quality Management and Improvement programs to ensure compliance with quality management/improvement requirements. A staff of four (4) Utilization Management nurses, two (2) review coordinators, and one (1) quality analyst is proposed.	5+ years	Iowa
Behavioral Health Manager	Not Yet Identified	The Behavioral Health Manager will report to the Care Coordination Manager and will be an Iowa-licensed behavioral health professional with experience in both mental health and substance abuse disorder services. The Behavioral Health Manager will be responsible for ensuring compliance of Behavioral Health operations, coordinating with all functional areas, including quality management, utilization management, network development and management, provider relations, member outreach and education, member services, and contract compliance and reporting. They will also serve as the liaison with the Iowa Department of Health Services and Medica Behavioral Health.	7+ years	Iowa
Provider Services Manager	Not Yet Identified	The Provider Relationship Manager, reporting to the Vice President of Network Management, will be responsible for oversight of provider relationships and contracting functions, provider recruitment, contracting, and claims dispute process, provider education materials and provider outreach programs.	5+ years	Iowa

TITLE	NAME	ROLE	YEARS OF EXPERIENCE	LOCATION
Information Systems Manager	Not Yet Identified	The Information Technology Manager will serve as the liaison with the Iowa Department of Health Services regarding data transmissions and will ensure that all information system security and controls, program data transactions, data exchanges other information system requirements are in compliance with Contract requirements. A staff of three (3) Application Integration Specialists, one (1) Data Integration Specialist, one (1) QA Change Management Specialist, and one (1) Call Center Technology Specialist is proposed with one (1) IT Support Specialist located on-site at the Iowa facility.	7+ years	Minnesota
Claims Administrator	Colleen McKenna Shaw	The Claims Administrator will ensure prompt and accurate provider claims processing while leveraging Medica's existing claims team to administer Iowa claims. A staff of one (1) Manager, two (2) Supervisors, three (3) Quality and Audit Analysts, thirty (30) Claims Specialists, two (2) Enrollment Specialists, and two (2) Billing Specialists is proposed to support Iowa enrollment, claims, and billing operations.	7+ years	Minnesota
Care Coordination Manager	Not Yet Identified	The Care Coordination Manager will report to the Director of Clinical Operations and will be a registered nurse or other medical professional with extensive experience in providing care coordination. Responsibilities will include oversight of the coordination and community-based case management programs, care coordination, community-based case management teams, care plan development and care plan implementation. The Care Coordination Manager's staff will include a Behavioral Health Manager.	7+ years	Iowa

TITLE	NAME	ROLE	YEARS OF EXPERIENCE	LOCATION
Program Integrity Manager	Not Yet Identified	The Program Integrity Manager will report to the Compliance Officer and will be responsible for the oversight of the special investigations unit (SIU) activity. The Program Integrity Manager will also serve as the liaison between the MCO and state agencies, law enforcement, and federal agencies and will be knowledgeable of current trends in fraud, waste, and abuse as well as mechanisms to detect such activity.	10+ years	Iowa
Long Term Care Manager	Not Yet Identified	The Long Term Care Manager, reporting to the Director of Clinical Operations, will have a minimum of five (5) years of experience in long term care policy and a comprehensive understanding of CMS rules and regulations. Responsibilities will include oversight of the State's community-based and facility programs and managers and oversight of long-term care provider reviews, utilization reviews, member satisfaction surveys, and member health and welfare.	5+ years	Iowa

3.2.5.4 Termination, Litigation and Investigation

Medica has no material litigation to report that is related to services sought in the RFP. Refer to responses for question 3.2.7.4.2 of the RFP for information related to regulatory actions, deficiencies and corrective actions.

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Public Copy

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SECTION 1: RFP PURPOSE AND BACKGROUND

ABOUT MEDICA

Medica has a thirty (30) year history of distinguished service to participants in Minnesota Health Care Programs (MHCP). From the earliest days of managed care when our predecessor, Physicians Health Plan, became one of the first participants in the demonstration phase of the Prepaid Medical Assistance Program (PMAP), through the 2013-2014 implementation of the Affordable Care Act (ACA), we have maintained our commitment to understanding and meeting the health care needs of low-income and disabled individuals.

Today, our State Public Programs (SPP) division serves nearly 162,000 people in the Medical Assistance (MA) and MinnesotaCare programs. We have an additional 33,000 members in the Special Needs Basic Care (SNBC), Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO) programs. Our SPP enrollment has grown 59% since January 1, 2014, with the expansion of Medicaid eligibility due to the ACA.

Culturally similar to Iowa, our values are grounded in a Midwestern philosophy focused on service to members and stewardship. Our vision is to partner with the State of Iowa, as we have with the State of Minnesota, and be the community's health plan of choice, trusted for our integrity, respected for our service and admired for our commitment to innovation and efficiency.

OUR EXPERIENCE

We understand our members' needs. We have a strong history of developing programs that maximize integration of primary health, behavioral health, public health and social services. Members come to our system based on their unique needs and the "doorway" that best addresses their most pressing needs. Regardless of how a member enters our system we work to integrate all aspects of care, develop relationships with stakeholders that further enhance this integration and meet the member at the right place for them.

We understand that our members' needs are often complex. To ease this complexity, it is our goal to serve members in the least restrictive environment in their community of choice by providing open access and overall flexibility within our network.

Innovation is a natural outcome of understanding the drivers of the stakeholders we support. The following are examples of innovative programs that highlight Medica's considerable engagement with the communities and members we serve.

Preferred Integrated Network (PIN) Model - brings together the Minnesota Department of Human Services (DHS), Dakota County, Medica's Behavioral Health Team and four community mental health providers to improve and coordinate the physical, mental health and social support service needs for people with mental illness:

- **Intensive Community-Based Services (ICBS)** - provides both case management and direct care to address the specific barriers facing individuals whose needs often include mental health, chemical health, psychosocial issues, housing and medical issues.
- **Hearth Connection** - partnered with Medica to launch the Medica Supportive Housing Project. This collaboration among supportive housing providers

> ***"We recognize that it takes the entire community to develop effective solutions to the complex issues that negatively affect health and quality of life for low-income and disabled people. By looking beyond our own walls and capabilities, and recognizing the strengths and skills that community partners can bring, we are free to think outside the box and develop creative solutions to issues that may be very upstream from the member's medical condition, but nonetheless have a big impact on it."***
>
> Glenn Andis, PhD, senior vice president of government programs

and a health plan was the first of its kind in Minnesota. The goal of this program is to help stabilize housing and reduce the risk for health crises that lead high-need people in the program to use more expensive health care resources.

- **HealthChoices** - provides time-limited, intensive outreach, home visiting and case management services to Hennepin County Minnesota Family Investment Program (MFIP) clients.

Our comprehensive provider network

Our comprehensive provider network is our most valuable asset. We pay close attention to the composition of this network and, in Minnesota, have successfully partnered to establish an extensive network that serves a complex population. Applying the same principles in Iowa, we will build a comprehensive network to ensure members have access to needed services. If gaps exist, we will be proactive in our recruitment efforts, and will work collaboratively with the State of Iowa and counties to reach out to preferred providers whenever possible. We have already begun the collaborative process of building provider relationships in Iowa.

In addition to providing core provider network capabilities, Medica has a depth of experience in partnering with Minnesota providers to form an accountable care organizations (ACOs). These joint partnerships have resulted in better risk management, coordination of care for defined populations, and improvement of care, service and cost. We understand that the ACO model is evolving in Iowa as well and would welcome the opportunity to leverage our experience with Iowa ACO entities, such as UnityPoint Health or the University of Iowa.

Our responsive services for members

We credit our growth as an organization to our sincere and unwavering commitment to listening and responding to the needs of our members, business partners and community stakeholders across all markets. Each and every person — regardless of station or circumstance — needs health care coverage that offers access to a comprehensive network of high-quality providers, hassle-free claims processing, compassionate customer service and, most importantly, financial protection from the significant and often unpredictable costs of needed care. This overarching philosophy drives how we develop and enhance services for members.

We've done in-depth customer experience research and have found that Medica Medicaid members want peace of mind more than anything else. Simply stated, they want us to help them understand the benefits they have, and how to get the most out of them.

Our commitment to quality of care

Medica has been National Committee on Quality Assurance (NCQA) Accredited since 1992. We continue to maintain an Excellent rating, the highest possible, from the NCQA for our Medicaid plan. We are ranked first in Minnesota and 18th in the nation (NCQA's Medicaid Health Insurance Plan Ranking. 2014- 2015). We take significant pride in all of the '5' ratings we received and especially those we received for member service, heart disease and diabetes treatment measures. In addition, we are committed to delivering on IHI's Triple Aim promise to provide quality healthcare at the best possible cost.

Our commitment to outcomes

Achievement of the best outcomes requires a multi-faceted approach. It is truly a community of vested parties coming together with one common goal that produces the best outcomes. Our success has been driven from an integrated health management approach, a commitment to cutting-edge research, thought-leadership and investment in innovative programs in the community.

For example, we partnered with a larger provider system (Hennepin County Medical Center) in the fall of 2014 to contact "invisible" members – those who had no medical claims for at least 12 months and offer them a gift card incentive to complete a check-up appointment with a primary care provider. Of the 19,000 "invisible" members identified, we were able to reach 10,207 members and schedule 2,087 appointments.

We provide all covered benefits and administrative functions. As an experienced non-profit MCO working in the Medicaid space in Minnesota for more than thirty (30) years, we have a great deal of experience working with all federal and state mandated benefits. We are continually evaluating our programs and services for all products to ensure they meet the needs of our members and the necessary regulatory requirements. In addition to the mandated benefit sets, we also provide a variety of value-added services for our membership. We seek feedback on these services from a variety of stakeholders to maximize the impact they make on our membership.

The Medica Research Institute (MRI) conducts leading edge research to generate meaningful evidence-based information that can be translated by the health care community at large into activities that promote health and improve lives. MRI's PhD-level investigators are deeply connected to the issues affecting health care delivery through regular interactions with stakeholders including government agencies, health plan and health system business leaders, and health policy experts and academics. MRI continues to contribute to the body of knowledge that leads to health care quality.

We operate and deliver in an efficient and quality manner. Good stewardship is at the forefront of how Medica approaches investment and development of operational processes and technologies. The member's experience is at the heart of how we deploy new capabilities. We ensure that new capabilities are streamlined and scalable so that we can quickly flex to meet the changing demand of our membership while maintaining a high level of customer service.

CONCLUSION

Thank you for the opportunity to respond to the Iowa Department of Human Services Request for Proposal (RFP) to contract for delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (hawk-i) programs.

As a non-profit managed care organization with more than thirty (30) years of experience in the Medicaid space, we believe that we can play an important role in bringing managed care to Iowa. We do not take this role lightly. As you'll see in the letters of reference we've provided, Medica is an active and engaged partner and known for our collaborative thought-leadership with providers, county and state colleagues.

Our proposal explains in detail our understanding of the services requested and our solutions to the challenges of providing care to vulnerable populations. We appreciate the opportunity to demonstrate our firm commitment to listening and responding to the needs of DHS, counties, members, business partners and community stakeholders with programs and services that are innovative, effective and member-focused.

We are excited about the opportunity to become a health plan of choice for Iowa residents.

SECTION 2: ADMINISTRATIVE REQUIREMENTS

2.1 Licensure/Accreditation

1. Indicate if you are currently licensed as an HMO in the State of Iowa. If you are not currently licensed, describe your plan to achieve licensure.

Although Medica is not currently licensed as an HMO in the State of Iowa, our Department of Records and Information Management has submitted an HMO application with the Iowa Insurance Department as of April 10, 2015.

We have reviewed the licensure process specified in Iowa Administrative Code 191 Chapter 40 and Iowa Code Chapter 514B and, barring any unforeseen circumstances, we are confident that HMO licensure will be completed prior to the Contract effective date.

2. Indicate whether you are currently a qualified health plan (QHP) issuer certified by the Iowa Healthcare Exchange.

Although Medica is not currently a qualified health plan (QHP) issuer certified by the Iowa Healthcare Exchange, we have chosen to apply and have received our QHP licensure from the state of Iowa. This allows us to begin offering services through the Exchange starting January 1, 2016.

3. Indicate whether you are currently accredited by the NCQA. If you are not currently accredited, describe your plan to achieve accreditation.

Medica is currently accredited by the National Committee for Quality Assurance (NCQA) in the state of Minnesota. Medica has the highest accreditation status, Excellent, from the NCQA for its Minnesota Medicaid HMO plans and commercial fully-insured health plans in Minnesota, Wisconsin, North Dakota and South Dakota.

Upon award of contract, we will begin the application process to become accredited by NCQA in the state of Iowa. We will maintain NCQA accreditation for the term of the Contract. We also acknowledge and understand that when accreditation standards conflict with the standards set forth in the Contract, the Contract terms will prevail unless the accreditation standard is more stringent.

2.2 Subcontracts

1. Summarize your proposed subcontracts and key work to be delegated under the subcontracted relationship.

Medica anticipates subcontractors to be utilized for the following functions:

- Medical Provider Network Services
- Behavioral Health Network Services
- Home-Based and Community Services
- Encounter Submissions and Management

Medica has a standard Master Service Agreement (MSA). If awarded the Contract, the MSA will be modified to include applicable Iowa related law. Medica's MSA includes non-disclosure language, a regulatory addendum, and a business associate addendum. A draft regulatory addendum incorporating integrity requirements related to the Iowa Medicaid Program is being included with Medica's document submission. (Refer to Tab 5, Regulatory Addendum, submitted with the provider contract letter of intent.)

We take every opportunity to secure our member and provider data by having stringent security and disclosure language embedded within our contracts. We will comply with and will ensure that our subcontractors comply with any audit and review requirements provided by the state of Iowa.

2. Indicate if any of the subcontracts are expected to be worth at least five percent (5%) of capitation payments under this contract.

Medica does not anticipate any subcontracts to be worth five (5) percent or more of capitation payments under this contract. If we do, we will submit for Agency review and approval all subcontractor agreements for any subcontractor whose payments are equal to or greater than five (5) percent of capitation payments under the Contract.

3. Describe the metrics used to evaluate prospective subcontractors' abilities to perform delegated activities prior to delegation.

Prior to delegation, Medica will evaluate a prospective subcontractor's ability to perform the activities to be delegated, including organization and staff qualifications and policies and procedures related to the delegated functions. When we initiate a contract with a new entity, we send the vendor a copy of Medica's Standards of Conduct, Compliance Reporting Policy, and Compliance and Fraud Waste and Abuse (FWA) training. We also collect signed Vendor Compliance Program Attestation and Disclosure of Ownership forms. Contract addenda covering regulatory compliance and business associate requirements are attached as applicable. These addenda are reviewed and updated by Medica's Law Department on an ongoing basis.

During the contracting phase, Medica negotiates and enters into a written agreement with the subcontractor that specifies the deliverables and reporting responsibilities and provides for terminating the agreement or, in certain circumstances, imposing other sanctions if the subcontractor's performance is inadequate. We enter into subcontract agreements that mitigate risk and provide for industry standard protections for our members and providers. All subcontracts will meet the requirements of 42 CFR 434.6 and will incorporate by reference the applicable terms and conditions of the Contract with Iowa.

4. Describe the policies and procedures used for auditing and monitoring subcontractors' performance.

Medica's Vendor Management Office, in conjunction with the Corporate Compliance Department, will oversee the management of subcontractors through a series of internal policies and procedures establishing standards and practices for auditing and monitoring subcontractors' data, data submissions, and performance to ensure compliance with Contract requirements on an ongoing basis. Formal reviews will be conducted quarterly to the extent required under the Contract and corrective action will be taken in the event deficiencies are identified. Our Special Investigations Unit will conduct surveillance, interviews, and investigations related to potential fraud, waste and abuse among Medica's subcontractors. As part of at least a quarterly review, Medica will collect the following information from each subcontractor that accepts financial risk for services performed under the Contract and whose payments are equal to or greater than five percent of premium/revenue:

- A statement of revenues and expenses
- A balance sheet
- Cash flows and changes in equity/fund balance
- Incurred but not received (IBNR) estimates

All Medica policies and procedures regarding the management of subcontractors under the Contract will be available for Agency review and approval. Any change to Medica policies or procedures relating to management of subcontractors will be submitted to the Agency for approval prior to implementation. We will make available all subcontractor performance monitoring data and reviews upon request by the Agency and will notify the Agency any time a subcontractor is placed on corrective action. It is understood that the Agency reserves the right to audit all subcontractor data and that the Agency will notify Medica of any reporting requirements incorporating subcontractor performance necessary for State reports.

5. Describe the enforcement policies used for non-performance, including examples.

In written agreements with all subcontractors, Medica will retain the right to terminate the agreements in the event of contractual breach, and may impose liquidated damages for non-performance or failing to perform below the standards set forth in the agreement. For example, Medica has Service Level Agreements with key vendors that establish specific data transfer turnaround times in order to enable Medica to comply with regulatory requirements. A vendor's failure to meet the established turnaround times can result in liquidated damages or service credits. The following are excerpts of performance language within our standard MSA:

> **1.1 General Performance Standards**. Except where more specific performance standards are required under a service level agreement or other performance guarantees in a Statement of Work (SOW) related to certain Services or Deliverables, Vendor will use Vendor's best efforts to perform Services and create Deliverables under this Agreement. Time is of the essence with respect to delivery of Services and Deliverables.
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> **1.2 Performance Guarantees.** If the parties have included a service level agreement or some other form of performance guaranty related to Vendor's performance under a SOW, vendor must comply with all stated performance guarantees. If Medica earns service credits or some other stated remedy related to Vendor's failure to meet its performance guarantees, this is not Medica's exclusive remedy and Medica may pursue other remedies against Vendor.

1.3 Compliance with Medica Policies. Vendor must comply with all Medica policies that Medica shares with Vendor relating to health, safety, information technology, privacy and security, and any required training that Medica may require Vendor to attend in order to comply with either Medica's internal compliance policies or Medica's obligations under state or federal law.

3.7 Software, Hardware, or Hosting Obligations. Where Vendor's Services or Deliverables include the licensing or development of computer software, the sale or lease of computer hardware or other peripherals, or any type of hosting services, the parties must fully define and describe all applicable supplemental technology-related terms in a supplemental attachment to the applicable SOW that includes details on the supplemental information technology-related terms set out in the IT Terms addendum attached to this Agreement as Appendix A.

3.8 Government Programs Obligations. Where Vendor's Services or Deliverables are related to Medica's participation in Medicare, Medicaid, or other state government program products, the parties must comply with the Regulatory Addendum, attached to this Agreement as Appendix B.

6. Describe how subcontracting relationships will provide a seamless experience for members and providers.

Medica's relationships with subcontractors will provide for a seamless experience for members and providers. In particular, claims processing will be seamless for providers and providers will receive clear information about where to submit claims for payment. As noted above, Medica will be using subcontractors to provide direct services to members, including medical services, behavioral health services, and home based and community services. Subcontractors providing direct services to members will be required to meet the same requirements as Medica under the Contract, and Medica will demonstrate its oversight and monitoring of subcontractor compliance with the requirements.

In order to ensure that our members and providers have access to vital information and services, with as little confusion as possible, we work closely with subcontractors to manage integrations, branding, interfaces and communications. Medica works tirelessly to ensure that we have a single face to our members and providers. In addition, we are entering the second year of our company-wide initiative to promote awareness of the importance of clear communications and enhanced accountability, at every level, with respect to members and providers.

2.3 Financial Stability

1. Provide verification of the financial requirements described in the subsections of Section 2.3.

Medica will maintain a fiscally solvent operation in accordance with all federal requirements and Iowa Insurance Division requirements for minimum net worth, and will comply with the federal requirements for protection against insolvency pursuant to 42 CFR 438.116, the Iowa Insurance Division solvency standards, and the laws of the State of Iowa.

Financial statements verifying that Medica meets the requirements of Section 2.3 are included in Tab 6 of the RFP binder. It is understood that an annual audit must be performed by an independent Certified Public Accountant on the Iowa Insurance Division's list of approved auditors within six (6) months following the end of each calendar year at our expense. In addition to the annual audit, we will also submit to the Agency copies of the quarterly NAIC financial reports as required by the Contract.

2. Describe how you will comply with the requirements for reinsurance. Will you obtain reinsurance contracts or submit a plan of self-insurance?

We will comply with the reinsurance requirements specified in Iowa Administrative Code 191 Chapter 40.17 and will file with the Agency all contracts of reinsurance or a summary of the plan of self-insurance for approval. Upon request, we will provide the Agency with the risk analysis, assumptions, cost estimates and rationale supporting our proposed reinsurance arrangements. Depending on the results of the proposal, we will purchase reinsurance in an amount appropriate for the risk that will be assumed. We will work with the State of Iowa to ensure compliance with all Agency requirements.

2.4 Maintenance of Records

1. Describe your system for maintaining financial and medical records that fully disclose the extent of services provided to members.

Medica's Records and Information Management Department has developed our Records and Information Management Program ("RIM Program"), an organization-wide program that applies to all Medica business units.

PURPOSE

The purpose of our RIM Program is to ensure that we maintain, protect, retain, and dispose of records in accordance with state and federal law, fiscal requirements, historical and administrative/operational needs. This includes:

- A consistent and authorized process for the classification, storage and retrieval of records
- The protection of vital records
- The protection and preservation of historical records
- Only appropriate access to records with sufficient protection of the information contained therein
- A consistent and authorized process for records destruction

PRACTICE/PROCEDURE

Our RIM Program is a systematic approach to controlling all of our records, regardless of media, beginning with the creation or receipt of a record, through the processing, distribution, organization, storage and retrieval of a record, and ending with the destruction of a record or the identification of a record for permanent retention.

The RIM Program applies to, but is not limited to, active records, inactive records, vital records, record retention and record destruction.

Records exist in many forms. They include but are not limited to paper and electronic forms such as data in computer systems, spreadsheets, computer printouts, e-mail, graphical images, and voice or data transmissions. Information can be stored on a variety of storage media, such as microfilm, microfiche, disk, CD-ROM, videotape, and paper.

Legal Hold – Litigation, Investigation, Audit

There may be circumstances that require a legal hold to be placed on certain categories of information. Documents that are not otherwise subject to retention for business reasons might need to be retained because of unusual circumstances, such as litigation, a government investigation or an audit. When litigation or an investigation or an audit occurs, or is pending, the Records Management Office and Law Department will notify the appropriate business units and direct which, if any, relevant categories of documents be labeled for retention until further notice.

GENERAL REQUIREMENTS

All records are retained for the period required by applicable state and federal law and regulation, and our records retention schedule. All Medica employees are responsible for ensuring that all records are created, used, maintained, preserved and destroyed in accordance with the RIM Program, including but not limited to our records retention schedule.

All records are retained for a period of time that will reasonably ensure the availability of those records when needed. Records are retained in active office areas as long as they serve an immediate administrative/operational, fiscal, legal or historical purpose. When a record no longer serves one of these immediate purposes, the record is transferred to the designated records retention storage facility until the prescribed retention period has expired and then be appropriately destroyed.

All records not necessary for legal or business reasons and not required to be retained by law or regulation are destroyed in order to reduce the high cost of storing, indexing and handling the vast amount of documents that would otherwise accumulate.

Destruction of records occurs only in compliance with the standard written procedures regarding destruction to avoid any inference that any document was destroyed in anticipation of a specific problem. Authorization must be received from the Records Management Office prior to destruction.

The unauthorized destruction, removal or use of records is prohibited. No one may falsify or inappropriately alter or conceal relevant information in any record. Anyone possessing information pertaining to unauthorized destruction, removal or use of records, or regarding the falsification or inappropriate alteration or concealment of information in a record, must report this information to the Records Management Office, either directly or through the Medica Integrity Line.

The privacy and security of information in all records must be ensured. Records containing confidential and proprietary information are securely maintained, controlled and protected to prevent unauthorized access. Records maintained in shared space, individual offices, employee homes, or other offsite locations are managed consistent with the RIM Program.

MEDICA'S RECORDS MANAGEMENT OFFICE RESPONSIBILITIES

The responsibilities of Medica's Records Management Office include:

- Maintaining adequate records to document Medica's compliance with all relevant laws and regulations
- Providing a records retention schedule that all business units must use in managing their records effectively
- Providing guidance on how and where records should be organized and stored to ensure appropriate protection and timely and efficient retrieval
- Identifying vital records and ensuring that they are appropriately retained and protected to ensure continuity of Medica's operations in the event of a natural or man-made disaster
- Ensuring the functionality of the RIM Program and monitoring and auditing the Program enlisting the assistance of other areas of the organization as appropriate
- Interpreting RIM policy and the records retention schedule as it may apply to specific situations
- Developing specific procedures regarding records and information management, including but not limited to, record retention, record destruction, confidential records, electronic records and records subject to litigation, investigation or an audit
- Reviewing RIM policy and the records retention schedule annually or more frequently as needed
- Communicating changes to RIM policy that are necessitated by law or regulation, or the existence of litigation, an investigation or an audit

BUSINESS UNIT RESPONSIBILITIES

Business units are responsible for assisting in the development, implementation and maintenance of the RIM Program is delegated to those individuals ("Records Leads") identified by their respective executive officers. Each business unit within the organization is responsible for the actual implementation and maintenance of the Program as part of its daily operations.

POLICY EXCEPTIONS

Requests for exceptions from the RIM policy must be submitted to the Records Management Office for approval before implementation. In order to obtain an exception from the RIM policy, the requestor must demonstrate that a process exists that will ensure compliance with the basic objectives stated in the RIM policy. The Records Management Office and Senior Vice President and General Counsel must review and approve all changes or revisions to the RIM Program prior to implementation of any such changes.

2.5 Disclosures

1. Provide disclosures as described in the subsections of Section 2.5

PERSONS CONVICTED OF CRIMES

Upon award of the contract, Medica will provide the Agency information related to any person convicted of a criminal offense including but not limited to offenses under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as required by 42 CFR 455.106.

INFORMATION RELATED TO BUSINESS TRANSACTIONS

Medica does not have direct or indirect ownership of five (5) percent or more in any current subcontractor or supplier and does not anticipate taking ownership positions in any subcontractors or suppliers in support of the Contract requirements.

Should the Agency request it, within thirty five (35) days we will provide full and complete information about significant business transactions between Medica and any subcontractor for the prior five (5) years and any ownership of subcontractors or suppliers with information regarding any significant business transactions.

OWNERSHIP DISCLOSURES

For the purposes of this proposal, we will provide all required ownership disclosures within Tab 3.

Upon Contract execution and within thirty five (35) days after any change of ownership, we will make full disclosure of Medica ownership, management and control information, any subcontracting entities or providers as required by 42 CFR 455.100 through 455.106 and will submit financial statements for any individuals or corporations with five percent or more of ownership or controlling interest. Prior to any contract renewals, we will provide a report to the Agency confirming ownership information has been requested and reviewed and disclosing any changes in ownership information.

TRANSACTIONS WITH PARTIES OF INTEREST

We will provide disclosures of transactions with parties of Interest meeting the following profile as defined in 42 USC sec 300e-17(b):

- Any director, officer, partner or employee responsible for management or administration of Medica; any person who is directly or indirectly the beneficial owner of more than five (5) percent of the equity of Medica; any person who is the beneficial owner of a mortgage, deed of trust, note or other interest secured by, and valuing more than five(5) percent of Medica; and an incorporator or member of Medica under applicable state corporation law
- Any entity in which a person described above is director or officer, is a partner, has directly or indirectly a beneficial interest of more than five (5) percent of the equity of Medica; or has a mortgage, deed of trust, note or other interest valuing more than five (5) percent of the assets of Medica
- Any person directly or indirectly controlling, controlled by or under common control with Medica
- Any spouse, child or parent of an individual described above

As for Medica, the following are accurate statements regarding Parties of Interest:

- No person with an ownership or control interest in Medica is related to any other person with an ownership or control interest in Medica as a spouse, parent, child or sibling
- No person with an ownership or control interest in Medica also has an ownership or control interest in another disclosing entity

TYPES OF TRANSACTIONS WHICH MUST BE DISCLOSED

For any business transaction with a Party of Interest, Medica will disclose:

- Any sale, exchange or lease of any property between the Medica and a party of interest
- Any lending of money or other extension of credit between Medica and a party of interest
- Any furnishing for consideration of goods, services (including management services) or facilities between Medica and the party of interest, excluding salaries paid to employees for services provided in the normal course of their employment

FINANCIAL DISCLOSURES FOR PHARMACY SERVICES

We will disclose all financial terms and arrangements for remuneration of any kind that apply between Medica and our Pharmacy Benefit Management (PBM) subcontractor and any prescription drug wholesaler, manufacturer or labeler, including, without limitation, formulary management, education support, claims processing, pharmacy network fees, drug product sales or pricing agreements, data sales fees, and any other fees.

It is understood that the Agency or state auditors may audit such information at any time.

INFORMATION TO BE DISCLOSED

All disclosures relating to transactions between Medica and a party of interest will include the following information:

- The name of the party in interest for each transaction
- A description of each transaction and the quantity or units involved
- The accrued dollar value of each transaction during the fiscal year
- Justification of the reasonableness of each transaction

Information on business transactions for the entire year preceding the initial contract period with the Agency will be disclosed. It is understood that we may also be required to submit a consolidated financial statement for the Medica and the party in interest.

2.6 Debarred Individuals

1. Describe mechanisms to ensure compliance with requirements surrounding debarred individuals.

Medica's Compliance Department administers internal policies and procedures to ensure compliance with 42 CFR 438.610.

We do not knowingly employ, contract with, or provide reimbursement to individuals or entities that are excluded by the Office of Inspector General (OIG), General Services Administration (GSA), or DHS. Prior to entering into employment or contractual relationships and monthly thereafter, we check the exclusion status of individuals including all employees, board members, and persons with ownership and control of Medica and its contractors, and contracting entities. We also employ procedures designed to prevent reimbursement of excluded non-contracted entities.

All Medica workers and contracted entities are required to report to Medica if, subsequent to their employment or engagement through contract, they become subject to an exclusion. Workers and contracted entities must also report if they become aware that another worker or contracted entity has become subject to an exclusion.

We terminate any employment or contract with any individuals or entities found to be subject to an exclusion, and do not reimburse any individual or entity found to be subject to an exclusion. In addition, we seek to recover any payment made to an individual or entity while subject to an exclusion. We refund any funds that were received for items or services paid for by Federal funds that were ordered, furnished or prescribed by an excluded person or entity.

Various Medica business units are responsible for developing procedures for:

- Preventing Medica from entering into a business relationship with individuals and entities that are excluded from receiving payment in connection with the provision of services to Medicare and Medicaid beneficiaries
- Identifying debarred contracted individuals or entities that provide services to Medicare and Medicaid beneficiaries
- Determining whether the individuals or entities are identified on the OIG List of Excluded Individuals and Entities (LEIE) database and the GSA Excluded Parties List System (EPLS) database
- Monitoring, on a monthly basis, whether the individuals or entities are on the OIG LEIE and GSA EPLS database
- Providing notice to Corporate Compliance when an individual or entity that Medica has a business relationship with is identified on the OIG LEIE or GSA EPLS database

In addition, we determine whether participating providers are identified as excluded on the DHS provider enrollment list.

Upon notice to Corporate Compliance, a workgroup of Medica business unit owners is initiated by Corporate Compliance to:

- Establish appropriate communication with the individual or entity to verify exclusion
- Place a hold on any future payments to the individual or entity

- Report to the State information regarding individuals or entities who have been convicted of a criminal offense related to the involvement in any program established under Medicare, Medicaid, or the Title XX services program, or that have been excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act
- Identify and recover any inappropriate payments made to the individual or entity
- Identify applicable legal requirements to terminate or otherwise correct the contractual relationship with the individual or entity
- Terminate the relationship with the individual or entity

We require that entities contracted to provide items or services related to Medica's obligations under the Contract with the State screen all employees, board members, and contractors against OIG and GSA exclusion lists, and assure to Medica that no agreements exist with an excluded entity or individual.

2.8 Organizational Structure

1. Describe your proposed organizational structure and indicate which operational functions will be conducted in Iowa and which functions will be conducted out-of-state.

Medica proposes a flexible, scalable, replicable operational model to support the Iowa DHS Contract requirements. The proposed organizational structure will be staffed to meet the following objectives:

- Delivery of efficient and high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids program (hawk-i).
- Establishment of a known and respected local health plan in Iowa committed to serving Iowa members with a local presence
- Operational focus on efficiency and maximizing the experience for the Member, the needs of the population, and the requirements from the Iowa Department of Health Services

Medica recommends a hybrid operating model that leverages the experience of the current Medicaid corporate functions in our Minnetonka, Minnesota, headquarters while establishing a significant local presence in Iowa in order to provide the most cost effective and operationally efficient staffing solution. Claims and enrollment functions will be handled out of Medica's Minnesota office, leveraging our expert claims and enrollment teams. Other functions to support member services, provider services and network development will be located in Iowa. Core services that touch the members through care coordination, long term services and supports, community outreach and stakeholder engagement – anything that touches the member directly – will be located in Iowa leveraging partnerships and resources within the Iowa community.

The proposed organizational structure for the Medica Iowa office is outlined on the next page with a description of each of the major functional positions along with the proposed location of the role.

TITLE	ROLE	LOCATION
Vice President of Iowa Medicaid	The Vice President of Iowa Medicaid will be responsible for divisional profit and loss, operations and compliance. The Vice President will serve as the face of the Iowa Health Plan to the State and key stakeholders and will be supported by a leadership team consisting of the Medical Director, Clinical Operations Director, Compliance Officer, Community Outreach Manager, Call Center Manager, and Policy Manager.	Iowa
Medical Director	The Medical Director, reporting to the Medica Chief Medical Officer, will be an Iowa-licensed physician in good standing and will have oversight of all clinical functions. The Medical Director will serve as the face of Medica in Iowa to the provider community and will participate in any scheduled quality committee meetings as directed by Iowa Department of Health Services.	Iowa
Chief Financial Officer	Responsible for overseeing the health plan budget, accounting systems, and financial reporting and will be based at Medica's headquarters in Minnesota and will have a matrixed relationship to the Medica Iowa VP.	Minnesota
Compliance Officer	The Compliance Officer will report to the Vice President of Iowa Medicaid and will be the primary liaison with the State of Iowa. The Compliance Officer will maintain a current knowledge of federal and state legislation, legislative initiatives and regulations that may impact the program and will be responsible for ensuring compliance with all HIPAA and privacy regulations while coordinating required reporting. They will also be responsible for ensuring overall compliance (regulatory quality) with terms of Contract. The Compliance Officer will be supported by a staff consisting of one (1) Product Administration Manager, two (2) Compliance Analysts, one (1) Program Integrity Manager, and one (1) Appeals and Grievances Manager.	Iowa
Iowa Pharmacy Manager	The Pharmacy Manager, reporting to the Director of Clinical Operations, will be an Iowa-licensed pharmacist with experience as a Medicaid Pharmacist (or equivalent). The Pharmacy Manager will be responsible for oversight and coordination of all Contractor and Pharmacy Benefit Manager (PBM) pharmacy requirements including drug rebate and will attend all Iowa Department of Health Services Pharmaceutical & Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Commission meetings.	Iowa
Grievance and Appeals Manager	The Grievance and Appeals Manager will report to the Compliance Officer and will manage the grievance and appeals process and the consumer affairs staff.	Iowa

TITLE	ROLE	LOCATION
Utilization Management and Quality Manager	The Utilization Management and Quality Manager will report to the Director of Clinical Operations and will be an Iowa-licensed registered nurse, physician or physician's assistant. This role will combine the traditional roles of Utilization Management (UM) and Quality Management. Responsibilities will include management of all elements of the UM program and staff under the supervision of the Medical Director and oversight of the Quality Management and Improvement programs to ensure compliance with quality management/improvement requirements. A staff of four (4) Utilization Management nurses, two (2) review coordinators, and one (1) quality analyst is proposed.	Iowa
Behavioral Health Manager	The Behavioral Health Manager will report to the Care Coordination Manager and will be an Iowa-licensed behavioral health professional with experience in both mental health and substance abuse disorder services. The Behavioral Health Manager will be responsible for ensuring compliance of Behavioral Health operations, coordinating with all functional areas, including quality management, utilization management, network development and management, provider relations, member outreach and education, member services, and contract compliance and reporting. They will also serve as the liaison with the Iowa Department of Health Services and Medica Behavioral Health.	Iowa
Call Center Manager	The Call Center Manager will report to the Government Senior Director of Call Center and will be responsible for oversight of both member and provider service call center functions. The Call Center Manager will lead a team of two (2) Supervisors, two (2) Quality Analysts and thirty (30) Call Center Representatives.	Iowa
Provider Relationship Manager	The Provider Relationship Manager, reporting to the Vice President of Network Management, will be responsible for oversight of provider relationships and contracting functions, provider recruitment, contracting, and claims dispute process, provider education materials and provider outreach programs.	Iowa
Information Technology Manager	The Information Technology Manager will serve as the liaison with the Iowa Department of Health Services regarding data transmissions and will ensure that all information system security and controls, program data transactions, data exchanges other information system requirements are in compliance with Contract requirements. A staff of three (3) Application Integration Specialists, one (1) Data Integration Specialist, one (1) QA Change Management Specialist, and one (1) Call Center Technology Specialist is proposed with one (1) IT Support Specialist located on-site at the Iowa facility.	Minnesota

TITLE	ROLE	LOCATION
Claims Administrator	The Claims Administrator will ensure prompt and accurate provider claims processing while leveraging Medica's existing claims team to administer Iowa claims. A staff of one (1) Manager, two (2) Supervisors, three (3) Quality and Audit Analysts, thirty (30) Claims Specialists, two (2) Enrollment Specialists, and two (2) Billing Specialists is proposed to support Iowa enrollment, claims, and billing operations.	Minnesota
Care Coordination Manager	The Care Coordination Manager will report to the Director of Clinical Operations and will be a registered nurse or other medical professional with extensive experience in providing care coordination. Responsibilities will include oversight of the coordination and community-based case management programs, care coordination, community-based case management teams, care plan development and care plan implementation. The Care Coordination Manager's staff will include a Behavioral Health Manager.	Iowa
Program Integrity Manager	The Program Integrity Manager will report to the Compliance Officer and will be responsible for the oversight of the special investigations unit (SIU) activity. The Program Integrity Manager will also serve as the liaison between the MCO and state agencies, law enforcement, and federal agencies and will be knowledgeable of current trends in fraud, waste, and abuse as well as mechanisms to detect such activity.	Iowa
Long Term Care Manager	The Long Term Care Manager, reporting to the Director of Clinical Operations, will have a minimum of five (5) years of experience in long term care policy and a comprehensive understanding of CMS rules and regulations. Responsibilities will include oversight of the State's community-based and facility programs and managers and oversight of long-term care provider reviews, utilization reviews, member satisfaction surveys, and member health and welfare.	Iowa
Director of Clinical Operations	The Director of Clinical Operations, reporting to Medica's Senior Vice President of Clinical Operations, will be responsible for day-to-day clinical operations and will leverage Medica best practices to ensure consistency in Policy and Procedures. The Director of Clinical Operations will be supported by a staff consisting of a Utilization Management and Quality Manager, a Care Coordination Manager, a Long Term Care Manager, and a Pharmacy Manager.	Iowa
Iowa Vendor Manager	The Iowa Vendor Manager will be responsible for establishing, maintaining and managing vendor contracts in Iowa including the following networks: transportation, provider, mental health, transplant and chiropractic.	Minnesota

TITLE	ROLE	LOCATION
Product Administration Manager	The Product Administration Manager will be responsible for the oversight of product design, operational implementation and communication as well as creation, approval, and distribution of member materials.	Iowa
Community Outreach Manager	The Community Outreach Manager, reporting to the Iowa Vice-President of Medicaid, will be responsible for general community and prospect marketing and will participate in community events and health fairs as well as coordinate member communication, education, and content on our web site. The Community Outreach Manager will be supported by a team of three (3) Community Outreach Coordinators who will be geographically dispersed liaisons to county staff and will build relationships with key community stakeholders.	Iowa
Policy Manager	The Policy Manager, will report to the Iowa Vice President and GM of Medicaid, and will be the local representative to state policy makers and trade associations. This position will be supported by a limited number of staff physically located at Medica's headquarters in Minnetonka, Minnesota.	Iowa
Human Resources Generalist	The Human Resources Generalist will report into the Medica Human Resources Department and will be responsible for all HR related issues in the Iowa office including hiring support, new hire orientation and on-boarding, and employee relations. This position will be supported by a limited number of staff physically located at Medica's headquarters in Minnetonka, Minnesota.	Iowa
Iowa Facilities Manager	The Iowa Facilities Manager will be responsible for management of the Iowa office site and all facilities related activity.	Iowa
Director of Finance	The Director of Finance will be responsible for oversight of the health plan budget, accounting systems, and financial reporting. A staff of three (3) Analysts and two (2) Risk Adjustment Analysts will support the Director of Finance for Iowa operations.	Minnesota

Medica is confident that this hybrid model will enable leveraging existing corporate resources while creating a functional operating unit located in Iowa to fulfill all Contract requirements and performance standards.

2. Describe how your administrative structure and practices will support the integration of the delivery of physical health, behavioral health and LTSS.

In order to achieve optimal health, it is critical for Medica's members to have a health plan and providers that understand the importance of integrated care. Medica values integrated care and we have extensive experience integrating physical health and behavioral health services in Minnesota for our members with complex health care needs. We will apply the same strategies in Iowa to include coordination of long term services and supports (LTSS).

Today, Medica has a very established administrative structure and internal integration processes that align our staff and subcontractors to support the integration of all services provided to our members. We currently integrate our medical and behavioral clinical staff joint rounds, co-location of behavioral health staff on the medical care management and health coaching teams, and ongoing consultation and referral between teams. This provides the infrastructure to successfully implement strategies within the community to integrate care as well as support identification of opportunities to offer access to preventive care and promotion of healthy life styles and wellness. We will leverage this approach in Iowa.

Medica utilizes a system to prioritize members' needs for care management. We employ a proprietary algorithm that produces a prospective risk score based on a combination of the following: utilization, diagnosis, risk of hospitalization, medication/prescription adherence information, existence of co-morbidities, and previous cost and gaps in care. Depending on the issues identified, the member may be assigned to one of several Medica programs such as Health and Wellness Coaching, Integrated Solutions or Integrated Care Coordination.

The following are some examples of strategies we have used successfully in Minnesota and would leverage in Iowa. We look forward to collaborating with the State of Iowa and community-based providers to identify opportunities to further integrate care for our members.

ASSESSMENTS AND INDIVIDUALIZED CARE PLANS

Medica is committed to supporting our members' access to services that meet their needs, including facilitating access to and use of primary care providers and medical specialists. Members who are involved in one of our care coordination programs such as Integrated Solutions or Integrated Care Coordination complete a thorough health risk assessment. The health risk assessment includes questions related to primary care relationships, specialty medical needs and needs for durable medical equipment. Through the initial health risk assessment and subsequent periodic assessments, care coordinators identify the physical and behavioral health needs, LTSS, and psychosocial needs of the member and make referrals accordingly.

Following the initial health risk assessment, the Care Coordinator/Case Manager works with the member to create a care plan to address their identified needs including physical health, mental health, chemical health and social services. Care Coordinators/Case Managers facilitate communication and coordination between the member's health care team, any additional community supports, and the member.

INTEGRATED SOLUTIONS (I-SOLUTIONS)

Medica Behavioral Health also has Care Coordinators that work with members with high cost or complex conditions to address their mental health, medical and social service needs. "Integrated Solutions" (I-Solutions) is a telephonic program offered by Medica Behavioral Health which focuses on Medica members who have complex behavioral health clinical needs and may also have challenging physical, social or socioeconomic needs. Assigned care coordinators (licensed mental health professionals) work to identify barriers and

coordinate care with the individual, their family, providers – including both behavioral and medical providers – counties, and community resources to improve the overall health of these members.

Individuals are identified in numerous ways, including claims algorithms, screening tools, self-referral, by providers, by counties, or Medica staff. Assigned Care Advocates (licensed mental health professionals) will work with the member, their family, providers, counties or community resources to improve the overall health of these members. The frequency of contacts is determined by the complexity of the member's clinical presentation as well as his or/her preferences. Participation is not time-limited and is based on member need.

If members are not engaged, I-Solutions works with providers to support clinical interventions with these members with complex conditions. Due to the nature of these complex conditions, care coordinators engage in joint rounds that include consultation from other mental health professionals, medical professionals and MDs, including Internal Medicine physicians and psychiatrists. An evaluation of I-Solutions was completed recently which found those members' conditions improved significantly, as evidenced by reduced emergency department use and inpatient hospitalizations. In the event the member does not engage in I-Solutions, the Medica Care Coordinator works with the member's providers to support a holistic coordinated approach to care.

Medica and Dakota County received a Commissioner's Circle of Excellence Award from DHS in 2012 for the Wellness PIN. DHS is currently working with independent evaluators to complete an evaluation on the Wellness PIN.

Members engaged in I-Solutions care coordination showed the following results:

	SHORT-TERM (3 MONTHS)	LONG-TERM (6 MONTHS)
ER utilization	Decrease of 36%	Decrease of 87%
Hospitalization	Decrease of 44%	Decrease of 36%

INTEGRATED CARE COORDINATION (ICC)

Integrated Care Coordination (ICC) is a joint pilot project with Medica and Medica Behavioral Health to address the needs of members with the most complex conditions. ICC includes both telephonic and face-to-face care coordination by mental health and medical clinicians who function as care coordinators to support members and their providers in improving the members' overall health. Our goal is to engage members so we can support them in becoming and remaining stable, improving their health and acquiring healthier lifestyles. Given the success of the program, we began exploring ways to expand to additional members.

Medica partnered with Integra in 2015 to offer community-based services for hard to reach Medicaid members and ensure they are receiving needed care. We employ a team of community specialists (similar to community health workers) find and engage members, and work to stabilize their social issues such as gaining housing and connecting to work or other social support needs.

HEALTH AND WELLNESS COACHING

Medica currently offers Health and Wellness Coaching to our Minnesota members. Health and Wellness Coaching addresses the whole person and focuses on health behavior change, increasing motivation, teaching chronic condition self-management skills and giving guidance on how to become a more active health care consumer. A health coach works with the member to determine the best ways to apply to their own life, the prescriptions and recommendations made by their health care providers. A referral to Health and Wellness Coaching can also assist the member in suggested behavior modifications for a healthier lifestyle. It is a smooth hand-off from one program to another to provide sustained support for that member.

Members with complicated depression and/or anxiety diagnoses along with co-morbid medical conditions are coached by specially trained Medica staff members. These Medica coaches are also available to consult with health coaches, who may encounter members with less severe mental illness. This collaboration helps ensure that members receive the resources and support to achieve their goals and manage their condition. We will identify specially trained staff members to serve as coaches to members receiving LTSS in community-based settings.

PREFERRED INTEGRATED NETWORK (WELLNESS PIN)

Medica has had a great deal of success with a newer program integrating primary health, behavioral health and social services through a contract with the Minnesota Department of Human Services. The Preferred Integrated Network (or Wellness PIN) is a partnership between Dakota County and Medica, including our Behavioral Health Team, to provide integrated care for members who have a mental health disability or have used significant mental health services.

Throughout their enrollment in the Wellness PIN, members are assigned a Wellness Navigator who acts as a single point of contact to facilitate access to physical health care, mental health care, social services and community services. Each member completes a thorough health risk assessment with their Navigator on an annual basis. This assessment acts as the foundation for a wellness plan that will guide the referrals and coordination of services for the member. Wellness Navigators have resource partners at the health plan to assist with access to health plan resources and public health nursing services as well as the “Clinic Without Walls” (CWOW) to assist with access to medical services. The CWOW reviews health risk assessments to identify unmet needs (either blinded or with the member’s consent) and is available for home visits or coordination with medical specialists as a “bridge” to medical care.

The Wellness PIN is also an example of ways in which we assist members in increasing their preventive visits and managing their chronic health conditions. Members in the PIN receive an annual screening that includes specific questions related to preventive health and management of health conditions. The member’s Wellness Navigator assists the member in accessing services as needed. The members also have the option to attend educational groups at the Clinic Without Walls which are conducted by a physician’s assistant. An example of these groups include: diabetes education, weight loss, nutrition and smoking cessation. The physician’s assistant is also available to work with members individually on their health needs and to assist in collaboration with their primary care providers.

MENTAL HEALTH – TARGETED CASE MANAGEMENT

Another example of our focus on integrated care is our approach to MH Targeted Case Management (MH-TCM). We’ve established a tiered rate structure that supports increased payment for providing more services to complex members. Since 2009, Medica has been working with community-based providers of TCM services to increase the focus on integrated health. We encourage TCM providers to include a goal of an annual physical exam, to assist members in making arrangements to obtain their physical, and to provide follow-up

care on the case plan, if needed. Our Care Advocates are available to provide support to the TCM workers in locating in-network medical providers and also to assist the TCM in helping the member access transportation to appointments.

We believe in the importance of focusing on our members' medical and behavioral concerns. Our audits assess whether the goal of an annual physical exam for members is established and implemented.

While these are strategies that we currently utilize in Minnesota for our Medicaid population, we look forward to partnering with Iowa stakeholders on identifying new initiatives or learning about existing ones that can provide integrated care.

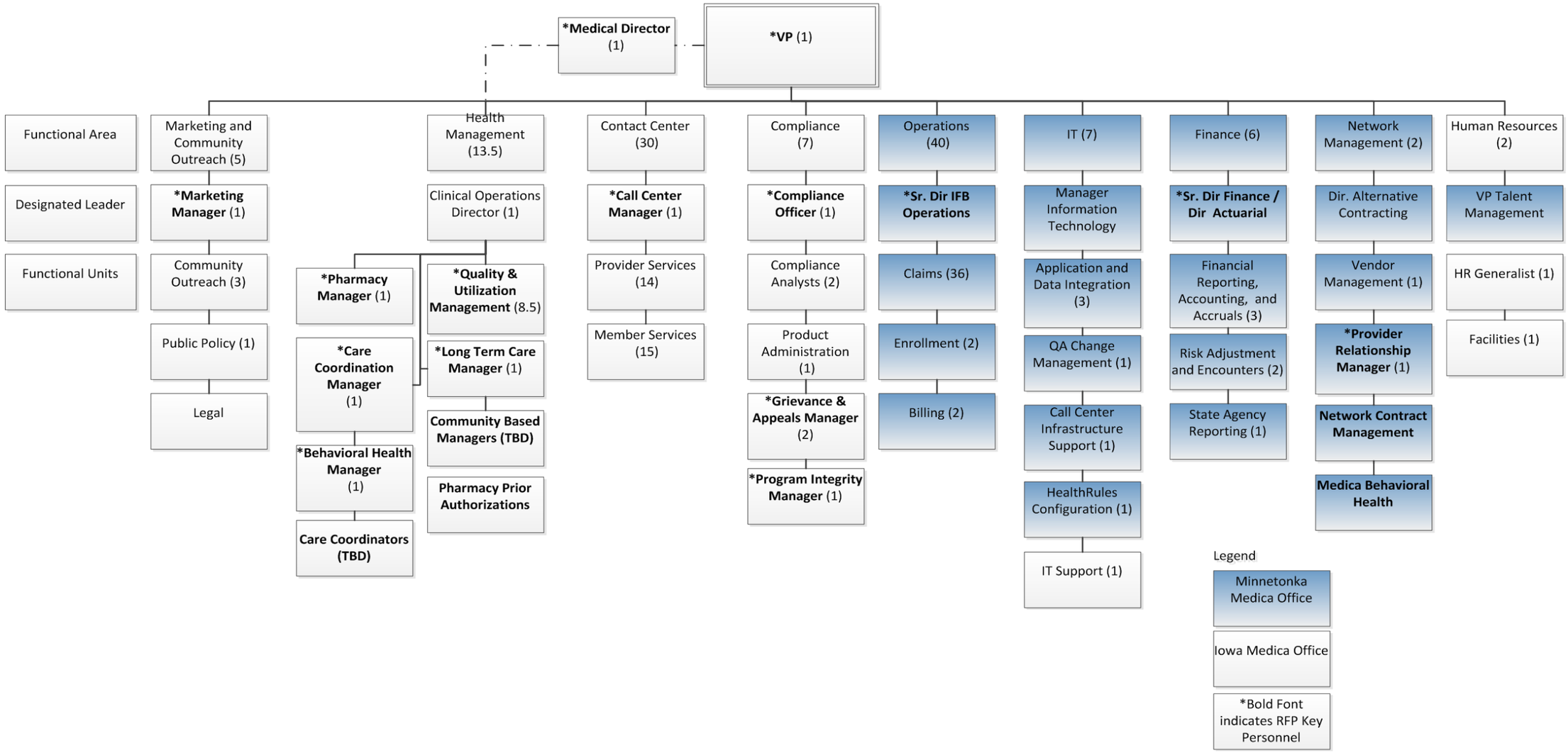
2.9 Staffing

1. Describe in detail your staffing plan and expected staffing levels.

In order to successfully support Iowa Medicaid membership, we will have a hybrid operating model, leveraging the depth and talents of resources residing within our headquarters office in Minnetonka, Minnesota, while establishing a strong local presence in Iowa. We are accustomed to continually assessing business patterns to know when to modify staffing, up and down, so that member needs are consistently met. Much of our staff is cross-trained and ancillary staff is utilized for unexpected spikes in volume. Our call center team, for example, receives support from trainers, key ancillary staff and leadership team members, when necessary. We have a member-first culture that is evidenced in how we staff and support key organizational functions.

Additional detail about the Medica Iowa staffing plan and expected staffing levels can be found in the table in Section 2.8 and addresses the requirements outlined in the proposal. We intend to maintain a level of staffing necessary to perform and carry out the functions outlined in the proposal. A high-level organizational chart of the proposed staffing model is on the next page.

Medica – Iowa Medicaid Health plan



Our staffing plan is a scalable model that allows for flexibility in staffing and leverages the experience of existing Medica Medicaid staff while building a strong presence in Iowa. Our proposed staffing model is based on an enrollment assumption of 150,000 members. The staffing model can be modified based on enrollment volumes and strives to achieve consistent, dependable service regardless of changes that may directly influence work volume. Our staffing model guiding principles for Iowa include:

- We will deliver efficient and high quality healthcare for required programs
- We will have a local presence
- Our operating model will be efficient and maximize member experience, needs of the population, and requirements from DHS
- The model is scalable based on actual enrollment
- A separate claims platform will support the business
- Community-Based Case Managers will work directly with existing Care Coordination entities in Iowa
- We will be fully operational on January 1, 2016

Variable staff is defined as those that respond directly and proportionally to changes in membership, geography, or complexity of business. Fixed staff is defined as key leadership and staff positions. We have identified approximately 27 fixed and approximately 87 variable positions to support of Iowa Medicaid.

2. For staffing positions proposed in your staffing plan, provide job descriptions that include the responsibilities and qualifications of the position, including the number of years of experience.

Job descriptions can be found in Tab 5.

3. Upon award of the Contract, the Contractor shall deliver the final staffing plan within ten (10) calendar days of the execution of the contract, including resume for each Key Personal member. The Agency will review and approve the staffing plan within (15) calendar days of receipt.

Upon award of Contract, we will immediately begin the search for staff to support the Iowa Medicaid Contract. We will strive to deliver a final staffing plan, including resumes for Key Personnel members, within ten (10) calendar days of the execution of the Contract.

4. Describe your back up personnel plan, including a discussion of the staffing contingency plan for:

a) The process for replacement of personnel in the event of a loss of Key Personnel or others.

The Medica Iowa health plan will notify the Agency, in writing, when changes to key staffing of the Contract occur. This includes changes in Key Personnel and other management and supervisory level staff. For Key Personnel and others, we will notify the Agency at least five (5) business days prior their last day of employment.

We will provide written notification to the Agency at least thirty (30) calendar days in advance of any plans to change, hire or re-assign Key Personnel. This notification will include an interim plan to cover the

responsibilities created by the vacancy. We will provide the name and resume of the candidate filling a Key Personnel vacancy within ten (10) business days after a candidate's acceptance to fill the position or ten (10) business days prior to the candidate's start date, whichever occurs first.

b) Allocation of additional resources in the event of an inability to meet a performance standard.

We proactively monitor performance relating to work loads, productivity and quality on a daily basis to identify and address fluctuations in work load. When unanticipated work load increases do occur, the direct management team leverages staff from other units, who are cross-trained, to assist with the increased workload. Management will also approve over-time when needed. This process has proven successful for Medica. For example, daily monitoring and adjusting of workloads has allowed our Billing and Claims Team to remain current with processing throughout 2014 and 2015 year-to-date.

In the event that additional resources are needed, we would leverage our deep network of staff augmentation firms, leverage headquarter staff, and/or engage delegated agencies depending on performance gaps.

c) Replacement of staff with key qualifications and experience and new staff with similar qualifications and experience.

Medica has a strong reputation as a desirable employer for healthcare professionals in the Minnesota community. We will replace staff with individuals whom have similar qualifications and experience. We have a proactive recruitment model to attract and source individuals. This includes elements of direct outreach, networking through LinkedIn/Job Fairs, and relationship building within communities to continually build and enhance the talent pool.

d) The time frame necessary for obtaining replacements.

The timeframe required to replace a role depends on the position being replaced. We will use reasonable efforts to fill Key Personnel positions within 60 calendar days of departure, unless a different time frame is approved by the Agency.

e) The method of bringing replacement or additions up to date regarding the Contract.

The method will vary depending on the position being added or replaced. In general, all Medica employees and subcontractors supporting the Iowa health plan will follow an onboarding plan and process. Onboarding will include an overview of the health plan including key Contract requirements and will require individuals to thoroughly review the Contract, policies and procedures related to their functional area and responsibilities. We will assist in transferring the knowledge from an employee leaving a position to the new employee. Ideally, this transition plan includes job shadowing to see that critical knowledge and processes are transferred and understood.

5. Describe which staff will be located in Iowa, and where other staff will be located.

We will have a hybrid operating model that leverages corporate functions in Minnetonka, Minnesota, while establishing a local presence in Iowa. The Medica Iowa health plan leadership team and core services that touch the members through care coordination and long term services and supports will reside in Iowa and will interact face-to-face with Medicaid members, providers, and DHS/IDPH staff. The Iowa office will be operational on January 1st, 2016. Readiness activities for the site build-out include procurement of an office space, furnished with all of the utilities and tools necessary for employees to be effective. In addition, equipment installation, including hardware and software acquisition and maintenance, utilities, telephone

service, office equipment, supplies, janitorial services, security, storage, transportation, document shredders, and obtaining employer insurance are other critical components that will be in-place on January 1st, 2016. The office(s) will include meeting space for the Agency to utilize when onsite in the Medica offices.

Claims, Enrollment, IT and Finance will be performed from Medica headquarters in Minnesota. All functional areas that do not reside at the Medica offices in Iowa will have toll-free communications with Agency staff to conduct business operations. For a detailed overview of proposed staffing model and locations, please refer to table Section 2.8. At a high level, we propose approximately 59 positions located in Iowa and 55 positions in Minnesota to support Medica's Iowa Medicaid population.

a) Describe how out-of-state staff will be supervised to ensure compliance with Contract requirements and how Iowa-based staff shall maintain a full understanding of the operations conducted out-of-state.

A Compliance officer will be located in our Iowa office to ensure compliance with all Contract requirements. The Officer and Vice President residing in Iowa will provide compliance oversight to all employees, both in-and out-of-state. These roles will ensure that we are in compliance with Contract requirements; deliver integrated services and provide a seamless experience for our members and providers. Out-of-state staff will report directly to Medica supervisors.

We monitor and audit performance closely to see that standards are met and compliance with the Contract maintained, regardless of location of a given function. Information pertaining to our performance and compliance will be furnished in a timeframe requested by the Agency.

Medica staff will have a full understanding of the in-state and out-of-state Iowa health plan operations and the collaboration that occurs between the two to see that our members receive outstanding care. This will be done through initial and ongoing contractual training. This information will also be included in the onboarding process which includes a health plan overview and a thorough review of applicable policies and procedures. New and updated information on in-state and out-of-state operations will be shared with employees to promote Contract compliance.

b) Indicate the location of the Iowa office from which key staff members will perform their duties and responsibilities.

We have partnered with local experts to assist us in identifying available options for a base in Iowa. Our intent is that we will identify a location in an urban region with a higher concentration of the membership.

While the headquarters will be located in an urban area we will ensure we have a face to face presence statewide such as:

- We will have care coordination staff located strategically throughout Iowa
- We will have community outreach liaisons whose primary role will be to establish face to face meetings with key stakeholders
- We will collaborate with key community partners to identify and understand the needs of the Medicaid population in Iowa.

6. Describe your process for ensuring all staff has the appropriate credentials, education, experience and orientation to fulfill the requirements of their position (including subcontractors' staff).

Our dedicated recruiting staff will ensure that candidates meet the defined minimum requirements during the initial screening and interviewing process. We use a third party background check vendor to verify education and credentials as a condition of employment. All new employees attend an orientation and are required to complete compliance training.

We maintain current records of professional licensure for nurses, pharmacists and medical directors.

Medica Human Resources verifies current licenses for nurses, MDs and pharmacists annually using recognized online web resources including USiS and www.boardcertifieddocs.com. We also maintain current records of board certification for medical directors.

Upon hire, employees and subcontractors attend a comprehensive onboarding and orientation program. The content of the onboarding plan will vary by position. This training program will generally include the following items:

- Overview of Contract requirements and State and Federal requirements specific to job function
- Review of policies and procedures, including advance directives and others related to specific job function
- Identifying and handling quality of care concerns
- Cultural sensitivity
- Fraud and abuse and the False Claims Act
- HIPAA
- Abuse, neglect, exploitation and prevention including the detection, reporting, investigation and remediation procedures and requirements
- Introductions and meetings with core resources internal and external
- Compliance and Information Security training

Clinical staff will also receive training on clinical protocols, assessment processes, person-centered planning and population specific training relevant to the enrolled populations for all Care Managers. Utilization Management staff will receive ongoing training regarding interpretation and application of Utilization Management guidelines.

Training is provided through a variety of methods including classroom style, eLearning's, and one-on-one instruction. Training is scheduled and tracked in our Learning Management System (LMS). Various reports can be generated from the system and will be furnished as requested by the Agency.

All training materials are updated as needed to reflect program changes or at least annually to meet Contract compliance. We will share training materials with the Agency as requested and will be receptive to training course recommendations from the Agency and other key stakeholders.

Medica has a solid history of selecting, hiring and educating staff and subcontractors to meet the requirements of their position. Through our onboarding and ongoing education programs, staff and contractors are well versed in operating policies and processes to promote Contract compliance and succeed in their job.

7. Describe how you will ensure that all staff is knowledgeable in Iowa-specific policies and operations.

Policies and procedures assist Medica staff and subcontractors in understanding the standards by which we operate and how we comply with applicable laws and regulations governing our business. We will develop Iowa health plan specific policies and procedures that can be accessed through Medica's intranet and are introduced to new employees and subcontractors during onboarding. Iowa health plan staff and subcontractors will be required to review the policies and operations relevant to their job function during onboarding.

Medica's Call Center Representatives, go through an extensive training program, making them highly skilled in addressing our member's needs. Our all-employee "Listen Up" program focuses on three key elements, confirming that our members are understood, assured, and unconcerned. This motif is resonated in our daily member interactions and throughout the entire Medica organization. The member experience is how our customer service team defines success.

Onboarding and training programs are comprehensive and role specific. Training includes an overview of DHS contracts, policies and procedures and other resource materials. Frequent quality checks are completed on work performed by new employees to gauge understanding, provide feedback and identify additional training needs. Training assessments are utilized for specific roles to test knowledge of state specific policies and operations.

8. Describe in detail your staff training plans (including subcontractors' staff) and ongoing policies and procedures for training all staff.

New employees receive a training and onboarding plan specific to their roles. This includes our New Employee Orientation and trainings related to compliance. A new employee is immersed in detailed role and department specific training and is often paired with a "buddy" or peer mentor to assist with questions. Policies and procedures are updated on a regular basis and reviewed with staff in a timely fashion to see that performance standards and compliance regulations are met. Medica's experienced staff look forward to the opportunity to help train and learn from stakeholders in Iowa. For example, our community programs managers would be interested in sharing their experience establishing relationships with county staff.

New-hire Customer Service Training Program includes focus in the following areas:

- Who are our Members
- Benefits, Enrollment and Claims
- Compliance Requirements
- Navigating Systems
- Resources for our members – lending a helping hand
- Appeal and Grievance Training

Ongoing learning is provided in areas of:

- Learning and mentoring programs
- Dedicated weekly meeting to review changes/updates or training
- 1-to-1 Peer/Mentor Coaching Program
- Annual continued education requirements
- Annual Fraud, Waste and Abuse Training
- Annual Compliance Program Training
- Feedback sessions with Quality Coaches based on weekly audits and monitoring

2.11 Coordination with Other State Agencies and Program Contractors

1. Describe how you propose to work with other program contractors, subcontractors, state agencies and third-party representatives.

Medica has over thirty (30) years of experience in working with the Minnesota Department of Human Services including a strong history of successfully partnering with contractors, subcontractors, state agencies and third party representatives to meet the needs of the various populations served and to advance the healthcare goals within a community. We have a dedicated team of resources that work directly with Public Health, community agencies, county human service, mental health and disability stakeholders and State Ombudsman. Medica is committed to building a strong presence in Iowa and in building solid working relationships with all stakeholders referenced in the Scope of Work. We will be establishing a home base in Iowa and will reach out to the stakeholders to schedule ongoing meetings. We value these relationships and welcome the opportunity to build our partnership network in the state of Iowa. We truly believe that coordinated efforts have a positive impact on our members.

Our collaboration approach consists of various stakeholder meetings, including, but not limited to:

- Stakeholder meetings for all of our products.
- Bi-annual community advisory meetings which includes counties, community organizations and members. The goal is to gather feedback on our programs and services, and ideas for future programs.
- County meetings at least annually for all of our county partners. With some counties, we can meet more frequently. Our goal is to have a consistent “report card” on our performance from counties.

We have started, and will continue, to establish relationships in the manner that best meets the residents and stakeholders of Iowa – whether that is county-by-county, regionally, or a metro, rural and super rural basis. We will have dedicated community programs managers who will be the liaisons between our stakeholders and the health plan. These resources will be actively engaged in building partnerships that are aligned around shared goals for the populations we serve. They will be available by phone, email and in-person to address issues and concerns and provide education on our programs and services.

We will regularly meet with stakeholders and network providers to provide education on the programs and services we provide and discuss any questions or concerns. We often include our contracted partners, including behavioral health, to assist in addressing questions or concerns.

Additionally, our community programs managers will be actively involved with collaborative groups that align with our mission and health improvement activities. This type of collaboration often leads to increased knowledge of how to access services from the health plan, and how to enroll in healthy living programs that help our members lead healthier lives. We will also learn about health concerns and initiatives specific to the region to help address the issues.

To help keep providers abreast of updated health plan information critical to administrative and clinical staff, we publish Connections, a monthly electronic newsletter. Our team invests a significant amount of time engaging with providers in their community settings to ensure the needs of members are getting met.

Medica is unique in Minnesota in our approach of establishing and maintaining long-standing relationships. Below are some examples of the type of collaborative efforts we participate in. We look forward to developing these types of efforts and relationships within Iowa.

INITIATIVE	SUCCESS
Breastfeeding education	Medica provided funding for 2015 to support the continued use of a lactation consultant to lead the Healthy Northland Breastfeeding Intervention in the 7-county Arrowhead region. The use of this consultant has contributed to increased breastfeeding rates.
Child and Teen Checkups (C&TC)	With low participation rates for teens, Medica's Community Programs Manager worked with the C&TC partnership to facilitate interviews with parents and teens in the area regarding their perception of preventive care. The results from these interviews helped direct regional C&TC outreach strategies and was shared with primary care clinics to help improve their outreach and appointment process.
Obesity initiatives	Medica is currently working with the CHB to develop and implement programs for healthy eating and increased physical activity for children at school and at home.

2. Describe how you propose to work with IDPH related to IDPH-funded substance abuse services.

We have a long history of promoting effective collaborative partnerships with state agencies and look forward to our active participation in and support of the Iowa Department of Public Health's (IDPH) substance abuse services initiatives, leveraging our experience and existing partnerships to serve our Iowa members. We understand that substance use disorder (SUD) issues are on a continuum, and that having a diverse plan is the optimal strategy for success. We also believe that SUD issues for some can be chronic. It is essential to provide programs that recognize and provide services in a longitudinal format. We look forward to supporting, collaborating and enhancing Iowa's comprehensive array of substance abuse programs and services.

The following are two examples of partnerships in Minnesota that Medica Behavioral Health (MBH) has actively engaged in specifically to address the needs of members and their communities related to SUD concerns.

- MBH has a long history of working very closely with the **Center for Alcohol and Drug Treatment** (CADT- an SUD provider). MBH has supported their development of a new Medication Assisted Treatment (MAT) Program. The Medica Foundation awarded CADT with a grant to support the hiring of a physician as part of their new MAT program. MBH shares CADT's vision of providing members with opioid addictions an alternative treatment model that supports the member's recovery and treatment. The new model that CADT will be opening is not just a methadone treatment distribution center, but instead is a comprehensive treatment model. They also plan to support the use of suboxone as an alternative to methadone treatment. Medica has been working within the provider community to increase access to suboxone providers as a preferred alternative to MAT dispensation, in conjunction with the member's overall quality of life. We will continue to identify methods to support CADT's efforts, and look forward to this new option for Medica members in that region of the state.
- MBH partnered with a CADT and a group of providers in Minnesota to implement another pilot to provide treatment and care coordination for people with chronic, relapsing chemical dependency issues. The program provides a longitudinal approach to treatment. Members in the pilot have a navigator who works with them while in treatment and for a minimum of six (6) months post treatment to support their recovery efforts.

Iowa has a vast array of IDPH-related substance abuse programs and services, including:

- Access to Recovery
- Community Coalition
- Comprehensive Substance Abuse Prevention
- County Substance Abuse Prevention
- Cultural Competency Treatment Project
- Families in Focus – Adolescent Treatment
- Iowa Youth Survey
- ISMART
- Program Licensure and Regulation
- Prevention Through Mentoring
- Strategic Prevention Framework State Incentive Grant (SPF SIG)
- SBIRT
- Youth Development
- Youth Mentoring
- Youth Suicide Prevention

The programs and services listed above fall into several categories: Prevention, Supportive Services, Services for Adolescents and Families, Oversight of Programs including quality standards, Culturally Specific Services, Technology Based Services, Screening, and Suicide Prevention. This comprehensive list illustrates an understanding of the challenges and importance of covering the breadth of strategies to address these issues that affect both members and their communities. Engaging communities in prevention and education, through schools, community agencies, congregations of faith, and local leadership will be key in carrying out these strategies.

Offering unique programs that address specific needs of special populations (for example: adolescents, families, culturally specific, specialty) is critical to our success. In our current market this would include age specific programming including an intensive family programming for adolescents, and specialty programs such as those for GLBT members. In the age where technology is an integral part of daily life, it is critical to have online options for people to utilize during assessment, treatment and support. In addition to collaborating on local efforts in Iowa, we will offer additional support through Live and Work Well.com which is the member portal available to Medica members.

Medica Behavioral Health has promoted the use of Screening, Brief Intervention, Referral and Treatment (SBIRT) in emergency rooms and primary care, and other screening and assessment tools to help identify those who may need a more intensive intervention. MBH participates in groups addressing crisis and suicide prevention, including the Mental Health Crisis Alliance, the Children's Mental Health Crisis Alliance, the use of Mobile Crisis teams, and development of unique services such as TXT4Life. TXT4Life is a unique service designed specifically for children and adolescents who may be more inclined to reach out electronically versus making a phone call.

The Medica Foundation has offered significant grant money to different types of

Case Study: We have been an active participant in the Opioid Abuse Response Strategy (OARS) workgroup hosted by St. Louis County since the early stages of this group. Jane reached out to St. Louis County to offer assistance by participating in any workgroup dedicated to address the challenges of the opioid epidemic. Collaborators include representatives from the county, the local hospital and healthcare system, an SUD treatment program that provides comprehensive services, local law enforcement, representatives from the local tribe, University of Minnesota Pharmacy School, a local dental provider, and a consumer. The work of this group is focused on the overall problem of opioid abuse in this region both for prescribed and illicit substances. The workgroup is multi-intervention focused on preventative efforts and treatment needs. To date, this group has helped a provider agency initiate an alternative treatment option and worked with the prescriber community to change the prescriptive patterns within the healthcare community.

nonprofit agencies. Grants have been used to support innovative care across the spectrum from prevention, to specialty care, to enhanced integrated care models, to helping to support new innovative programming to meet an identified need. From 2003 – 2014, approximately $5.6 million has been given to organizations to support innovative behavioral health care.

We realize the importance of collaboration between program contractors, subcontractors, state agencies and third party representatives in delivering the right services and supports to the states most vulnerable populations. By recognizing and leveraging the strengths of our community partners, we can strive to build effective solutions for our members. We look forward to the opportunity of partnering with the various contractors and agencies in Iowa.

2.13 Written Policies and Procedures

1. Describe your process for developing and maintaining written policies and procedures for each functional area.

Policies and procedures assist Medica employees and subcontractors in understanding the standards by which we operate and comply with applicable laws and regulations governing our business. Policies provide a philosophical and ethical framework for how Medica operates, both internally with one another and externally with our business affiliates. Medica's Corporate Standards Policy outlines our approach to the development process of written policies and procedures at the corporate and functional area-level. Functional area-level policies are developed, administered and maintained by department management in that area. Management will see that department policies correlate to related policies and procedures in other departments to promote consistency and clarity when possible. Functional area-level policies require the approval of that department's senior-most Officer (vice president or above) and are maintained by a central resource within the department. The Medical Director reviews and approves all medical and quality management policies. We follow NCQA requirements to review policies annually. Policies are updated as needed to reflect changed business practices or new laws and regulations.

We use an innovative approach to manage the comprehensive process for the development, review, revision, and approval of policies and procedures. Our Compliance 360 software takes advantage of a workflow setup to complete the policy and procedure development and review process. Staff from each department have designated roles to review and update policies and procedures. The completed, reviewed documents are saved and locked in the C360 library.

We will submit all draft policies and procedures to the Agency within thirty (30) days of execution of the Contract. Final versions of the policies and procedures will be submitted to the Agency within thirty (30) days of receiving Agency comments on draft policies and procedures. We will work with the Agency if it is determined that a Medica policy requires revision and will strive to revise the document within the timeframes specified. If the Agency determines that we are lacking a policy or process required to be in compliance with our Contract, we will adopt a policy or procedure as directed by the state. We have experience developing policies and procedures that align with the expectations of the State of Iowa. We developed new policies and procedures to address the Minnesota Department of Human Services' expectations regarding exceptions to pharmacy restrictions and timing of entries into MMIS.

Policies and procedures are accessed internally on Medica's intranet and are introduced to new employees and subcontractors during onboarding. Policy and procedures changes are communicated to the appropriate staff and subcontractors impacted by that policy. Annually, all Medica employees are required to review

corporate policies and complete an acknowledgement form indicating their compliance with Medica's standards.

To assess that our policies and procedures have been fully implemented, we review metrics obtained through monitoring and auditing practices specific to the policy and procedure. For example, the Restricted Recipient Program (RRP), managed by the Medica Special Investigative Unit (SIU) team, creates a monthly dashboard regarding the number of calls handled by the RRP team, SIU conducts regularly scheduled audits to verify that no inappropriate searches have occurred in the Prescription Monitoring Program database, and conducts a daily audit to ensure that all necessary entries have been made.

2.14 Participation in Readiness Review

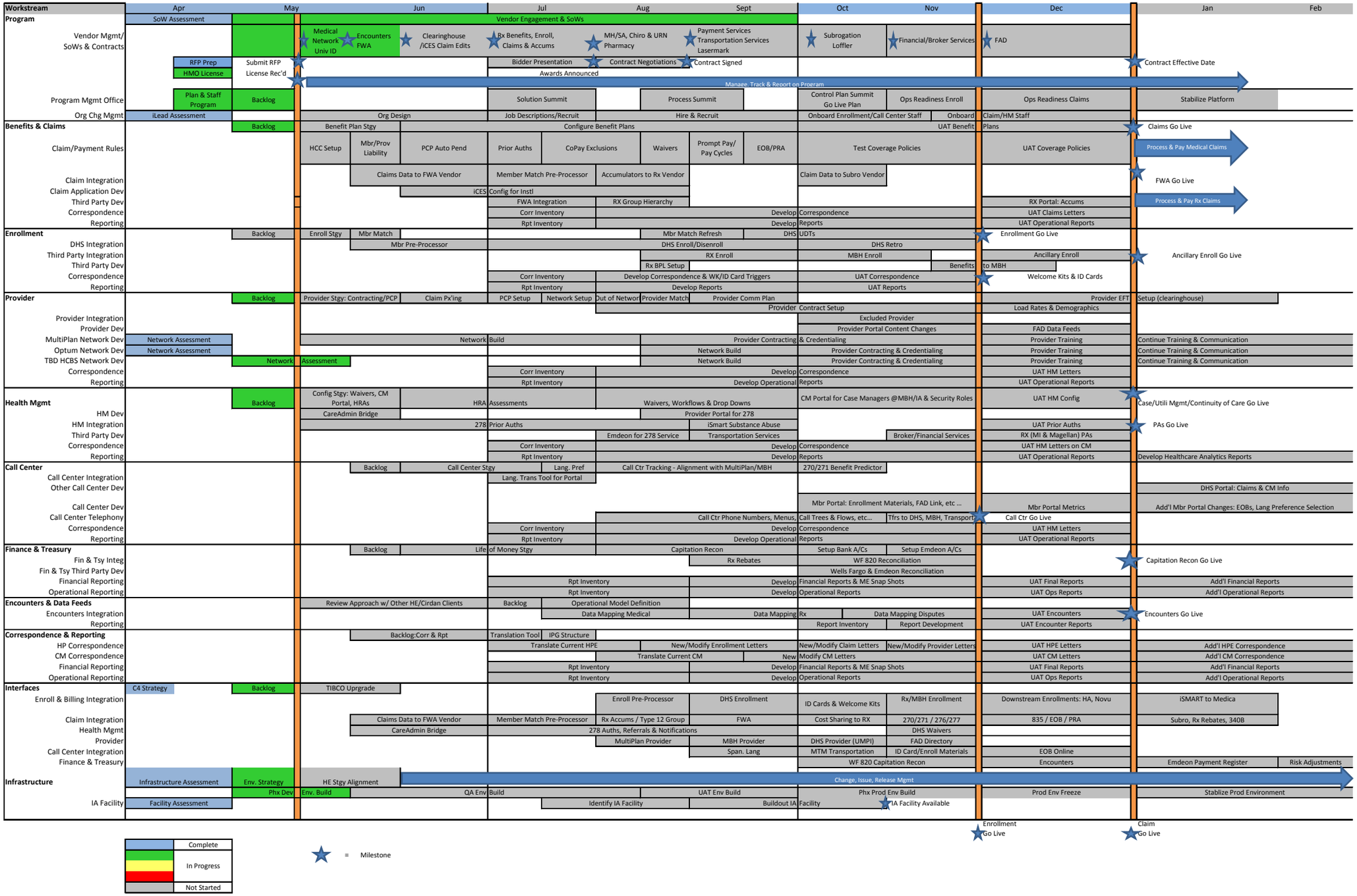
1. Submit a detailed implementation plan which identifies the elements for implementing the proposed services, including but not limited to:

- **a. Tasks;**
- **b. Staff responsibilities;**
- **c. Timelines; and**
- **d. Processes that will be used to ensure contracted services begin upon the Contract effective date.**

Medica has provided an implementation plan with this proposal that meets the Scope of Work requirements. The implementation plan includes, but is not limited to, the tasks, staff responsibilities, timelines and processes to see that contracted services begin upon the contract effective date.

a. Tasks

The exhibit on the next page shows the implementation tasks on a timeline for the Medica Iowa Medicaid project:


Workstream
Apr
May
Jun
Jul
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Program
SoW Assessment
Vendor Engagement & SoWs
Vendor Mgmt/ SoWs & Contracts
Medical Network Univ ID
Encounters FWA
Clearinghouse /iCES Claim Edits
Rx Benefits, Enroll, Claims & Accums
MH/SA, Chiro & URN Pharmacy
Payment Services Transportation Services Lasermark
Subrogation Loffler
Financial/Broker Services
FAD
RFP Prep
Submit RFP
Bidder Presentation
Contract Negotiations
Contract Signed
Contract Effective Date
HMO License
License Rec'd
Awards Announced
Manage, Track & Report on Program
Program Mgmt Office
Plan & Staff Program
Backlog
Solution Summit
Process Summit
Control Plan Summit Go Live Plan
Ops Readiness Enroll
Ops Readiness Claims
Stabilize Platform
Org Chg Mgmt
iLead Assessment
Org Design
Job Descriptions/Recruit
Hire & Recruit
Onboard Enrollment/Call Center Staff
Onboard
Claim/HM Staff
Benefits & Claims
Backlog
Benefit Plan Stgy
Configure Benefit Plans
UAT Benefit Plans
Claims Go Live
Claim/Payment Rules
HCC Setup
Mbr/Prov Liability
PCP Auto Pend
Prior Auths
CoPay Exclusions
Waivers
Prompt Pay/ Pay Cycles
EOB/PRA
Test Coverage Policies
UAT Coverage Policies
Process & Pay Medical Claims
Claim Integration
Claims Data to FWA Vendor
Member Match Pre-Processor
Accumulators to Rx Vendor
Claim Data to Subro Vendor
FWA Go Live
Claim Application Dev
iCES Config for Instl
Third Party Dev
FWA Integration
RX Group Hierarchy
RX Portal: Accums
Process & Pay Rx Claims
Correspondence
Corr Inventory
Develop Correspondence
UAT Claims Letters
Reporting
Rpt Inventory
Develop Reports
UAT Operational Reports
Enrollment
Backlog
Enroll Stgy
Mbr Match
Mbr Match Refresh
DHS UDTs
Enrollment Go Live
DHS Integration
Mbr Pre-Processor
DHS Enroll/Disenroll
DHS Retro
Third Party Integration
RX Enroll
MBH Enroll
Ancillary Enroll
Ancillary Enroll Go Live
Third Party Dev
Rx BPL Setup
Benefits to MBH
Correspondence
Corr Inventory
Develop Correspondence & WK/ID Card Triggers
UAT Correspondence
Welcome Kits & ID Cards
Reporting
Rpt Inventory
Develop Reports
UAT Reports
Provider
Backlog
Provider Stgy: Contracting/PCP
Claim Px'ing
PCP Setup
Network Setup
Out of Network
Provider Match
Provider Comm Plan
Provider Contract Setup
Provider EFT
Setup (clearinghouse)
Load Rates & Demographics
Provider Integration
Excluded Provider
Provider Dev
Provider Portal Content Changes
FAD Data Feeds
MultiPlan Network Dev
Network Assessment
Network Build
Provider Contracting & Credentialing
Provider Training
Continue Training & Communication
Optum Network Dev
Network Assessment
Network Build
Provider Contracting & Credentialing
Provider Training
Continue Training & Communication
TBD HCBS Network Dev
Network Assessment
Network Build
Provider Contracting & Credentialing
Provider Training
Continue Training & Communication
Correspondence
Corr Inventory
Develop Correspondence
UAT HM Letters
Reporting
Rpt Inventory
Develop Operational Reports
UAT Operational Reports
Health Mgmt
Backlog
Config Stgy: Waivers, CM Portal, HRAs
HRA Assessments
Waivers, Workflows & Drop Downs
CM Portal for Case Managers @MBH/IA & Security Roles
UAT HM Config
Case/Utili Mgmt/Continuity of Care Go Live
HM Dev
CareAdmin Bridge
Provider Portal for 278
HM Integration
278 Prior Auths
iSmart Substance Abuse
UAT Prior Auths
PAs Go Live
Third Party Dev
Emdeon for 278 Service
Transportation Services
Broker/Financial Services
RX (MI & Magellan) PAs
Correspondence
Corr Inventory
Develop Correspondence
UAT HM Letters on CM
Reporting
Rpt Inventory
Develop Reports
UAT Operational Reports
Develop Healthcare Analytics Reports
Call Center
Backlog
Call Center Stgy
Lang. Pref
Call Ctr Tracking - Alignment with MultiPlan/MBH
270/271 Benefit Predictor
Call Center Integration
Lang. Trans Tool for Portal
Other Call Center Dev
DHS Portal: Claims & CM Info
Call Center Dev
Mbr Portal: Enrollment Materials, FAD Link, etc ...
Mbr Portal Metrics
Add'l Mbr Portal Changes: EOBs, Lang Preference Selection
Call Center Telephony
Call Ctr Phone Numbers, Menus, Call Trees & Flows, etc...
Tfrs to DHS, MBH, Transport
Call Ctr Go Live
Correspondence
Corr Inventory
Develop Correspondence
UAT HM Letters
Reporting
Rpt Inventory
Develop Operational Reports
UAT Operational Reports
Finance & Treasury
Backlog
Life of Money Stgy
Capitation Recon
Setup Bank A/Cs
Setup Emdeon A/Cs
Fin & Tsy Integ
Rx Rebates
WF 820 Reconciliation
Capitation Recon Go Live
Fin & Tsy Third Party Dev
Wells Fargo & Emdeon Reconciliation
Financial Reporting
Rpt Inventory
Develop Financial Reports & ME Snap Shots
UAT Final Reports
Add'l Financial Reports
Operational Reporting
Rpt Inventory
Develop Operational Reports
UAT Ops Reports
Add'l Operational Reports
Encounters & Data Feeds
Review Approach w/ Other HE/Cirdan Clients
Backlog
Operational Model Definition
Encounters Integration
Data Mapping Medical
Data Mapping Rx
Data Mapping Disputes
UAT Encounters
Encounters Go Live
Reporting
Report Inventory
Report Development
UAT Encounter Reports
Correspondence & Reporting
Backlog:Corr & Rpt
Translation Tool
IPG Structure
HP Correspondence
Translate Current HPE
New/Modify Enrollment Letters
New/Modify Claim Letters
New/Modify Provider Letters
UAT HPE Letters
Add'l HPE Correspondence
CM Correspondence
Translate Current CM
New Modify CM Letters
UAT CM Letters
Add'l CM Correspondence
Financial Reporting
Rpt Inventory
Develop Financial Reports & ME Snap Shots
UAT Final Reports
Add'l Financial Reports
Operational Reporting
Rpt Inventory
Develop Operational Reports
UAT Ops Reports
Add'l Operational Reports
Interfaces
C4 Strategy
Backlog
TIBCO Uprgrade
Enroll & Billing Integration
Enroll Pre-Processor
DHS Enrollment
ID Cards & Welcome Kits
Rx/MBH Enrollment
Downstream Enrollments: HA, Novu
iSMART to Medica
Claim Integration
Claims Data to FWA Vendor
Member Match Pre-Processor
Rx Accums / Type 12 Group
FWA
Cost Sharing to RX
270/271 / 276/277
835 / EOB / PRA
Subro, Rx Rebates, 340B
Health Mgmt
CareAdmin Bridge
278 Auths, Referrals & Notifications
DHS Waivers
Provider
MultiPlan Provider
MBH Provider
DHS Provider (UMPI)
FAD Directory
Call Center Integration
Span. Lang
MTM Transportation
ID Card/Enroll Materials
EOB Online
Finance & Treasury
WF 820 Capitation Recon
Encounters
Emdeon Payment Register
Risk Adjustments
Infrastructure
Infrastructure Assessment
Env. Strategy
HE Stgy Alignment
Change, Issue, Release Mgmt
Phx Dev
Env. Build
QA Env Build
UAT Env Build
Phx Prod Env Build
Prod Env Freeze
Stablize Prod Environment
IA Facility
Facility Assessment
Identify IA Facility
Buildout IA Facility
IA Facility Available
Enrollment Go Live
Claim Go Live
Complete
In Progress
Not Started
= Milestone

SECTION 2:

b. Staff Responsibilities

This is a high level view of the responsibilities for the implementation program:

This table shows the more detailed roles and responsibilities that will be used to implement Iowa Medicaid:

ROLE	RESPONSIBILITIES
Program Management Office (PMO)	• Standardizes Solution Delivery Lifecycle (SDLC) Framework Structure including defining standard deliverables, program roles & responsibilities • Maintains (& Version Control) all assets (Templates & Tools) for the Iowa Medicaid Implementation Program • Establishes, monitors & tracks program milestones & status • Facilitates weekly CPRB & program level meetings • Participates in weekly project meetings & ESC meetings as necessary • Participates in standup meetings and/or key sprint planning & review meetings as necessary • Manages the overall program resource strategy and staff planning • Manages the overall program budget & actuals reporting with IT Finance & the Controller • Resolves & escalates cross program issues with work streams, vendors & support teams

Program Delivery Leads: **Compliance** **Configuration** **Ent. Arch (EA)** **Org Change Mgmt (OCM)** **Vendor Mgmt Office (VMO)** **Quality Assurance & Testing (QAT)** **Business Integration**	• Provides input into the SDLC framework for specific knowledge area • Reviews and contributes to weekly program milestones & status • Provides direction and support to work streams • Develops and recommends cross program policies and procedures • Provides specific knowledge area training for core resources and work streams as appropriate • Sets up program tools for specific knowledge areas (i.e. testing tools) • Provides leadership daily across the program; assists work streams with cross-program priorities • Assigns resources and plans staffing across the work streams • Provides communication & training plan input & content • Becomes the practice expert: tools, processes, & people • Facilitates governance/quality reviews: publish results & approve deliverables • Removes barriers for work streams • Identifies required decisions and enables quick decision making • Identifies items for SWAT/Blitz and facilitates their resolution
Project Controller	• Financial management and tracking across the program • Establishes & manages the cost centers • Represents office of the CFO
Advisory Committee: CPRB	• Provides strategic consulting to the Steering Committee • Participates in vendor selection process; • Escalation point for project/vendor issue resolution and decision making. • Understands cross program and Medica corporate dependencies; • Advocates for the program both internally and externally;
Vendor Management	• Leads vendor selection process; • Defines and sign vendor agreements, service levels, SOWs, etc… • Ensures vendor resource, deliverable and quality agreements are met.
Business Lead/s	• Serves as primary business owner for the Medicaid discovery, build and operational readiness; • Reports in matrix between SPP Medicaid and Business Integration; • Articulates, designs and delivers the people, process and technology vision of Medicaid on the HR platform; • Ensures business and compliance requirements are fully represented on the program;
Core Workstream Members	• Provides business subject matter expertise; • Defines business needs; • Performs daily sprint management; • Reports status & progress; • Verify sprint results; • Promotes configurations/code development, etc… • Reflects on iteration successes & lessons learned; • Assesses results against definition of done & decision readiness; • Provides training plan/content input and transition knowledge to operational teams;

Product Owner	• Delivers on commitments to meet minimally viable product by required schedule; • Acts as 'Voice of the Customer'; • Sets direction for project based on the long term vision, as well as the Go Live Minimally viable need; • Serves as primary functional decision maker; • Owns the backlog as the primary customer including the priority, work items & more; • Reviews the project reports; understands the metrics and their implications, including % of work completed, remaining, burn down, velocity and more…). • Partners with the Solution Architect on design approach, ensuring Medica standards are followed and more; • Oversees User Story/Requirement definition and translation to ensure accurate requirement definition and appropriate solutions; • Approves core project deliverables including: user stories, acceptance criteria, release plans, sprint results, and more; • Provides business domain knowledge & expertise to direct the team; • Identifies competing business interests and manages other linkages and dependencies; • Outlines the key features/capabilities and prioritizes according to business value/strategic goals; • Provides input to the overall program business case and value stream approach; • Removes barriers for the project teams; • Participates in sprint planning & kickoff, demos & reflection meetings; • Ensures a collaborative work environment for the team; • Collaborates with the PM, PMO and the business support groups on resource planning & needs; • Communicates with a variety of audiences representing the project scope, status, progress, issues, and more; • Collaborates with other product owners, PMO and the integration leads. • Understands and utilizes the Program SDLC Framework, including release planning, sprint planning, quality reviews, document & deliverable approval, etc…
Advisory	• Available 10-25% to the program depending on role; • Provides project guidance & support product owner; • Ensures project team engagement with appropriate internal resources/departments • Gathers applicable reference materials; • Shares business segment knowledge and/or provides the appropriate SME resources; • Attends governance meetings, program sprint demos and other appropriate program meetings (i.e. IRAAD and other status updates).

Subject Matter Expert	• Available 25-50% dedicated to the program depending on role; • Provides detailed Business subject matter expertise on applicable business/industry domain • Provides and review applicable reference materials (e.g. contracts, regulatory guidelines, existing business process, etc…) • Defines business needs and ensure requirements are accurately captured; • Attends daily standups for specific discussion topics as required; • Attends program demos and cross program meetings. • Provides direction/ resolution for topics • Actively participates in user acceptance testing and test result approval

Project Manager	• Ensures quality controls over the project, including:
	  o Sprint iteration planning, tracking & reporting
	  o Conducts retrospectives, captures lessons learned and implements improvements.
	  o Provides weekly status updates, demo materials and other information as appropriate
	  o Manages issues to resolution, mitigates risk and ensures quick decision making
	  o Captures approvals and maintains project documentation in the program repository
	  o Completes quality reviews (generally lead by PMO Leads)
	• Manages and maintain the project backlog in the requirement management tool
	• Provides a resource/staffing plan for core team and IT support resources.
	• Acts as key point of contact for the work stream;
	• Enables & empower the scrum team;

Operations Analyst	• Fully dedicated to the program depending on role & program schedule. • Provides detailed knowledge of business, processes & requirements; • Attends daily standups as a core team member; • Participates in design, configuration & testing; • Becomes a system SME; • Drives innovation & change through the work stream delivery; acts as a change agent with business and operational teams;
Business Analyst	• Elicits, prioritizes, specifies and models requirements; • Attends daily standups; • Creates user stores/work Items; • Ensures appropriate detail is provided and documented; • Performs traceability/tracking of backlog items through testing; • Conducts impact analysis on change requests, external requests and/or test defects; • Oversees and gains approval on user acceptance results;

Config Analyst	• Participates with the business in the creation of the business requirements utilizing standard templates; • Creates prototypes and mockups as necessary; • Translates requirements into high level conceptual design; • Performs system configuration based on business requirements; • Actively seeks out information necessary to perform the work and initiate quality checks with business partners; • Completes creation of templates in HPE; • Maintains accurate and up-to-date configuration information; • Unit tests changes to ensure acceptance criteria are met; • Provides technical support and assistance to users to resolve problems and issues; • Maintains a library of support and operation procedure documentation;
Technical Leads/SMEs/ Analysts (Various Roles)	• Provides various technical services, including system analysis, service management reviews, providing non-functional requirements, providing design alternatives, etc… • Attends daily standups; • Manages the technical deployment across the various environments; • Oversees the transition to production support; • Leads the technical knowledge transfer to production support; • Reviews vendor service level agreements; • Supports the technical warranty / monitoring phase.

c. Timelines

High Level timelines are depicted below (for detailed timeline & tasks please see picture in 2.14 a.):

TASK NAME	START	FINISH
RFP review & response	Mon 3/2/15	Tue 5/27/15
Project planning & start-up	Mon 4/13/15	Fri 5/15/15
Analysis & design	Mon 5/18/15	Fri 7/10/15
RFP response due	Tue 5/27/15	Tue 5/27/15
Build	Mon 7/13/15	Fri 9/11/15
RFP bid winners announced	Fri 8/7/15	Fri 8/7/15
Test	Mon 9/14/15	Fri 12/18/15
Implementation	Mon 12/21/15	Fri 1/1/16
Go Live	Fri 1/1/16	Fri 1/1/16

d. Processes that will be used to ensure contracted services begin upon the Contract effective date.

The implementation program for Iowa Medicaid will have a structure that includes executive oversight along with rigorous governance processes managed by the Medica Project Management Office. Medica brings experience with building new business models in aggressive timeframes while achieving a high quality delivery.

At a tactical level, the exhibit below shows a sample 'Go Live' readiness checklist that will be used to ensure contracted services begin on the Contract effective date.

WORKSTREAM		OPS GROUP/S	
PRODUCT OWNER		PROJECT MANAGER	
TARGET END SPRINT		GO LIVE DATE	

GO LIVE CRITERIA	DELIVERABLE TYPE	DESCRIPTION	DAY 1A OR 1B	STATUS	COMMENTS & FINDINGS
Work stream Deliverables Complete	Business Processes			**Red**	
	Policies & Procedures			**Yellow**	
	Control Plan			**Green**	
	Controls Available				
	HPE Correspondences				
	Other Correspondences				
	BI Reports				
	Other Work Items				
	Additional Items				
Testing Results	Functional Testing				Defects Addressed?
	Integration Testing				
	End-to-End Testing				
	UAT Testing				
	Critical Open Defects				
	Additional Testing				
Technology Deliverables Complete	HR Configuration				
	Other Configuration				
	Medica Development				
	Third Party Development				
	Third Party Reports				
	Interfaces				
Vendor Management Deliverables	Contracts Signed				
	Business Owner Defined				
	Service Level Agreements				
	Support Model In Place				
	Vendor Go Live Ready?				

Business Deliverables Complete	Mail Stops				
	Additional Tools				
	Ops Training				
	Other Business Deliverables				
Staffed & Ready to Support	Impacted Teams Identified				
	Impacts Understood				
	Support Staff Identified				
	Support Staff Trained				Classroom, Webinar, Just in Time, Hands On
	Go Live/Implementation Plan				
	Staff Readiness				Training, Business Process, Control Plans, Mentoring & Support in place.
Communication Complete	Internal Group/s Communication				
	External Group/s Communication				
	Go Live Communication Plan				
	Additional Items				
Other Considerations	Compliance Adherence				
	Open Key Decisions or Issues				
	Manual Workarounds In Place				
	Fast Followers Required				

2. Confirm that you will revise the implementation plan and keep it updated throughout the readiness review process.

We will use our implementation plan to guide us through readiness review. We will revise the implementation plan and keep it updated throughout the readiness review process.

2.15 Confidentiality of Member Medical Records and Other Information

1. **Describe your plans to ensure that health and enrollment information is used in accordance with the requirements set forth in the Health Insurance Portability and Accountability Act and other applicable federal and state privacy laws and regulations.**

Medica takes the privacy and security of our members' protected health information (PHI) seriously. The nature of our business as a health plan means that our members entrust us with the most personal details of their physical and mental health, as well as financial data. We implement and maintain policies, processes, tools, and training necessary to see that all member data is appropriately used and safe from inappropriate disclosure.

The requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state privacy laws provide the framework for our privacy program. Our staff is educated about their duty to protect member data, and business processes are designed to ensure that privacy and security can be maintained. New programs and vendors are vetted to ensure their conformance with standards of privacy and security. We review our policies annually and update them as necessary to comply with changing laws and evolving technology.

We develop, document and implement policies and procedures addressing compliance with privacy-related laws and regulations. These policies will include the items in the table below.

POLICY NAME	PURPOSE
Breach Assessment and Provision of Required Notifications	Provides guidance for breach assessment and notification by Medica when a breach of protected health information occurs. Breach assessment and notification will be carried out in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended, as well as any other applicable federal and state laws.
Privacy Incident Procedure	Describes the process for intake, investigation and notifications in connection with Privacy Incidents.
Notice of Privacy Practices	States the practices of Medica concerning the content and distribution of Medica's Notice, as well as the right of an individual to be informed of Medica's privacy practices.
Privacy Notice	Describes how Medica protects members' personal health information.
Individual Rights Under HIPAA: Access, Amendment, and Accounting	Explains Medica's policy with respect to the right of an individual to obtain access to health information, to request amendment of health information and to receive an accounting of disclosures of health information under applicable privacy laws.
Individual Rights: Privacy Related Complaints	Describes the right of an individual to submit a complaint relating to the privacy of protected health information.
Individual Rights: Restricted Requests and Requests for Confidential Communications	States Medica's policy with respect to requests from individuals for confidential communications or for restrictions on the use and disclosure of protected health information.

Minimum Necessary Policy	Explains the practices of Medica concerning "need-to-know" or "minimum necessary" limitations on Medica's uses and disclosures of, and requests for, protected health information.
Personal Representatives and Privacy Rights	States Medica's policy concerning the rights of personal representatives with respect to protected health information.
Use and Disclosure of Protected Health Information	Describes the use and disclosure of protected health information including medical records, substance abuse treatment programs records and psychotherapy notes.
Verification of Persons' Identity and Authority	Explains the verification of the identity and authority of persons seeking disclosure of protected health information concerning present, former or prospective Medica members.
Disclosure of Protected Health Information to Group Health Plans	Communicates the disclosure of protected health information to group health plans and their plan sponsors and to other entities on their behalf.
De-identification of Information	States Medica's policy pertaining to the creation, use and disclosure of de-identified health information.
Marketing	Explains the practices of Medica concerning the marketing of protected health information.
Privacy Documentation Standards	Provides a summary of the policies and standards of Medica with respect to documentation required for compliance with HIPAA.
HIPAA Privacy Designations	Pertains to appropriate designations required by the HIPAA privacy rule.
Responding to DHHS Reviews and Investigations	States Medica's policy concerning cooperation with Department of Health and Human Services privacy compliance reviews and investigations pursuant to the Health Insurance Portability and Accountability Act of 1996.
Responding to Privacy Violations	Reflects Medica's commitment to comply with all federal and state regulations, Centers for Medicare and Medicaid Services (CMS) and other Medica service agreements pertaining to responses to violations of Medica policies and procedures relating to privacy of protected health information.
Safeguards for protecting member privacy	States Medica's policy concerning the protection of member privacy through procedural, physical and technical safeguards.

Our privacy program safeguards our members' protected health information. This includes de-identifying PHI, using and disclosing only the minimum amount of PHI necessary for treatment, payment and operations, or to comply with legal or similar requirements. Our privacy program is driven not only by the need to comply with state and federal requirements, but by our commitment to our members.

2.16 Material Changes to Operations

1. Describe how you will inform DHS in advance of any materials changes, and how far in advance DHS will be informed.

Medica will collaborate with the Iowa Department of Human Services on material changes and will provide advance notice to ensure appropriate coordination. Per Attachment 1, Scope of Work, a material change to operations is any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent of our members or provider network. We will use reasonable efforts to inform DHS in advance. We intend to notify DHS sixty (60) days in advance of a business process change and one-hundred twenty (120) days in advance of a change to the provider network. We will notify members as far in advance as possibly but at least thirty (30) days prior to implementing any material changes. Medica will make a good faith effort to provide written notice within as expeditiously as possible to any member impacted by a provider's disenrollment. We have provided a sample of how we propose to notify Iowa of material changes that impact overall business operations.

We will notify the State in writing utilizing the sample form included within Tab 5.

Notification of material changes will include:

- Information regarding the nature of the change
- Rationale for the change
- Proposed effective date
- Sample member and provider notification materials

2. Confirm that DHS may deny or require modification to proposed material changes if, in its sole discretion, it determines that such changes will adversely impact quality of care or access.

We will collaborate with Iowa DHS on all material changes. It is our understanding that DHS reserves the right to deny or require modification to proposed material changes if it is determined that such change will adversely impact quality of care or access for our members or provider network.

3. Describe your ability to communicate material changes to members or providers at least thirty (30) days prior to the effective date of the change.

We will use reasonable efforts to communicate material changes to members or providers as soon possible but no later than thirty 30 days prior to the effective date of the change to avoid disruption to members and providers. We will utilize multiple methods of communication depending on the nature of the change. Our primary method of communications will be via a pre-approved letter to members but we may also consider utilizing a website notification and phone calls. We currently provide a monthly connections article to the provider community and issue individual notices to providers to communicate changes.

SECTION 3: SCOPE AND COVERED BENEFITS

Please explain how you propose to execute Section 3 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Medica has a thirty (30) year history of distinguished service to participants in Minnesota Health Care Programs (MHCP). Our work has earned us a reputation for developing innovative solutions to complex medical and behavioral conditions, as well as complicated social situations that affect the health of vulnerable populations. We were an early leader in building quality incentives into provider contracts.

We were the first health plan to provide free transportation so members could reach and attend their appointments for care. We were the first managed care organization to dedicate resources to securing affordable housing for individuals whose chronic homelessness is a barrier to their overall health and accessing health care.

Medica has been a leader, recognized for passion for member's health and commitment measured by results. We have undertaken numerous projects either through the Medica Foundation, which for instance, provided a grant for Mental Health Resources to reach out to high-risk people with complex medical conditions and help them find stable housing, or by contracting directly with social service providers to locate homeless, transient and shut-in members to assess and find solutions for their housing needs and other psychosocial challenges.

INTEGRATION OF CARE AND SERVICES

The word "health" is defined as "freedom from disease or ailment," which implies that the challenge of improving the health of populations is straightforward. Treat the disease or ailment, or prevent it from occurring, and the mission is accomplished. In practice, it is not that simple, particularly for vulnerable populations. They are more likely to face issues such as multiple chronic diseases, mental illness, substance use, homelessness, hunger, distressed relationships, and language differences, lack of transportation and unemployment or low wages that interfere with good health.

Our experience serving members has taught us that integrated, holistic, collaborative approaches are the most effective and appropriate. Some examples of our leadership in the integration of care include our Integrated Care Coordination (ICC) program, Intensive Community-Based Service (ICBS) services and the Substance Use Disorders (SUDs) pilots.

These three (3) examples share several core components;

- A mechanism for identifying members who are struggling or at risk, outreach to the members to establish a clear understanding of the challenges they face and their goals, and intensive, coordinated, integrated service delivery by Medica;
- Relevant health care providers;
- Public health or community services.

All three (3) programs include a strong behavioral health component. Members identified for these programs are followed closely until their situations stabilize.

MENTAL HEALTH AND CHEMICAL DEPENDENCY

Mental illnesses and chemical dependency are more prevalent in low-income and disabled populations. Together with our delegated partner, United Behavioral Health, which in Minnesota is branded as Medica Behavioral Health (MBH), Medica is tackling these issues in several ways.

First, we pay close attention to the composition of our network. MBH ensures access to an extensive network of adult and child mental health (MH) and Substance Use Disorder (SUD) professionals and facilities across the state. Medica members have access to the entire network regardless of where they live and transportation is available as needed. Our network management team meets monthly to review provider needs and proactively recruit providers to underserved geographic areas, including by developing such services as telemedicine.

Second, we assist members in securing mental health appointments. Our expectation is that for a routine appointment, a member should be able to see the appropriate mental health professional within ten (10) days. If the member is having difficulty obtaining an appointment, MBH staff will assist the member in securing an appointment. Also, due to the shortage of psychiatrists, MBH pre-purchases appointments with psychiatrists and prescribers to ensure that members with urgent needs are able to access appropriate care in a timely manner.

Third, we are pursuing creative options to ensure quality care is available when and where it is needed. Medica has established higher reimbursement rates for situations in which our network mental health providers are treating more complex, time-consuming cases, so providers are able to give those members the extra time and attention they need. We are also providing various types of support to encourage the development of telehealth capabilities that will enhance members' access to mental health providers, particularly in rural areas.

We recognize our members health conditions may coincide with social problems like homelessness, hunger and family distress. The complexities of these cases make it more difficult to achieve a good outcome. MBH and Medica have met this challenge head-on by working closely together and in creative partnerships with medical providers, counties and community organizations. It is also important to note that MBH and Medica collaborate on joint quality improvement projects, cross-train our clinical teams, and ensure that MBH's mental health professionals are available to Medica case managers and care coordinators for consultations, and vice versa.

3.2.2 Benefit Packages

1. Describe your proposed approach to ensure benefit packages will be delivered in accordance with a member's eligibility group.

The State of Iowa has designed a comprehensive and generous benefit package for the Medicaid and Children's Health Insurance Program (CHIP) populations, as well as those individuals qualifying for substance abuse services funded through the Iowa Department of Public Health (IDPH). Because members are assigned to various funding streams and may concurrently have other sources of commercial coverage, in order to:

a. Provide services in accordance with the member's assigned eligibility group
b. Ensure that costs to the program are mitigated in a manner that guarantees the State of Iowa is the payer of last resort. Medica will develop a system of care capabilities to provide medically necessary services to enrollees in accordance with 42 CFR 438.210(a)(3).

Medica's Information System will define benefits packages per Exhibit D of the RFP, assign members to the appropriate benefit group per their 834-eligibility record, and limit services to the maximum allowable amount identified in the RFP. Furthermore, Medica will adjudicate all encounters against the member's allowable billable benefits package as of the date of service and deny encounters submitted to the contractor in which the service was not a covered benefit, exceeded the permissible allowable amount, or in which an identified responsible commercial carrier was not first billed.

Members enrolled in the Iowa Health and Wellness Plan or the Iowa Family Planning Network will be provided services commensurate with the Alternative Benefit Plan benefits outlined in the State Plan, or those detailed in Iowa's 1115 waiver – as applicable. Those in the Presumptively Eligible Pregnant Women Medicaid coverage group will be permitted ambulatory prenatal care.

2. Describe your ability to provide covered benefits and services.

Prior to contract start, and throughout the contract period, Medica will establish and maintain a comprehensive treatment network that offers our members a choice of multiple, highly-qualified provider organizations, able to offer care in a variety of settings as necessary to address the members physical and/or behavioral health needs. Our contracted continuum of care includes services that are highly restrictive, such as secured inpatient facilities, to the least restrictive environments, such as outpatient clinics or peer support providers.

Furthermore, as part of our ongoing efforts to promote continuous improvements to the system, we will consistently evaluate the established network against the need of our members to identify opportunities for improvement and expansion into new treatment modalities.

3.2.4 Integrated Care

1. **Describe proposed strategies to integrate the delivery of care across the healthcare delivery system.**

Integration of primary health, behavioral health, public health and social services is an important strategy to improve health outcomes for patients. Integrated health care delivery can improve care and reduce costs by ensuring that people with chronic and complex conditions have ready access to coordinated care. With the complexities of the Medicaid population, it's critical that health plans not only support this integration of care, but function as a single unit to support the whole person.

Medica has a strong history of developing programs that maximize integration. Members come to our system based on their unique needs and the "doorway" that best addresses their most pressing needs –physical health, behavioral health, public health or social services. Regardless of how a member enters our system we work to integrate all aspects of care and meet the member at the right place for them. There are no wrong doors at Medica. Examples of integrated programs that highlight this approach include:

BEHAVIORAL HEALTH DOORWAY

Preferred Integrated Network (PIN) Model. The Wellness PIN program, launched in 2009, is an integrated program in Dakota County. It brings together the Minnesota Department of Human Services (DHS), Dakota County, Medica's Behavioral Health Team and four community mental health providers to improve and coordinate the physical, mental health and social support service needs for people with mental illness, up to age sixty-five (65), living in Dakota County. The Wellness PIN members are identified based on behavioral health needs and their behavioral health care becomes the focus and center for integration.

Through the Wellness PIN we have done simple things like bringing medical and dental services to meet members at their behavioral health home, a place that they are familiar with and is comfortable for them.

There is a two (2) year independent evaluation being completed on the Wellness PIN. Preliminary results at this time show:

- **Inpatient services**: Use of inpatient services by members enrolled in the Wellness PIN declined by five percent (5%) more than the comparison group.
- **Emergency services:** The proportion of Wellness PIN enrollees using the emergency room decreased over time while use by the comparison group increased.
- **Intensive Residential Treatment Services (IRTS):** The Wellness PIN and comparison group were quite similar in their utilization in the baseline period (8% and 7%, respectively) of IRTS utilization.

Intensive Community-Based Services (ICBS): ICBS is a short term (1-6 months), intensive program provided by community mental health providers serving Medica MHCP members with complex conditions. It provides both case management and direct care to address the specific barriers facing individuals whose needs often include mental health, chemical health, psychosocial issues, housing and medical issues. ICBS centers on a member's relationship with their behavioral health providers to integrate care. This approach focuses on the most pressing needs of the member and allows the

behavioral health provider to structure the integration of other care supports with the knowledge of how a member's behavioral health condition will be impacted. ICBS is available in twenty-five (25) Minnesota counties.

In a 2012 evaluation, ICBS was shown to have a significant impact (30% decrease) on member's overall behavioral health spend in the months after receiving ICBS.

> "It was a shock to me that my health insurance found me a place to live. Now I'm stable. I got my own place. Everything is all right with me."
>
> *Clyde,*
>
> *Medica MHCP Enrollee*

SOCIAL SERVICES DOORWAY

Medica has several programs that support integrated care for members experiencing homelessness.

Hearth Connection. Hearth Connection is a nonprofit organization that acts as an intermediary, collaborating with a diverse group of stakeholders, nonprofits, government, and health care entities to offer solutions to homelessness. In 2012, Hearth Connection partnered with Medica to launch the Medica Supportive Housing Project. This collaboration among supportive housing providers and a health plan was the first of its kind in Minnesota.

This project brings services and new housing opportunities to people with chronic medical conditions and long histories of homelessness. Focused primarily in Hennepin County (the largest urban county in Minnesota) , the goal of this program is to help stabilize housing and reduce the risk for health crises that lead high-need people in the program to use more expensive health care resources.

Hearth Connection locates members, and engages them first to address the immediate needs of housing. Through the process of obtaining permanent housing, Hearth Connection and their partner agencies work with the member to connect with behavioral and physical health providers to address health care needs. Most participants in this program were unknown to Hearth Connection, other housing organizations and the Targeted Case Management (TCM) agencies until identified by Medica.

Evaluation of Hearth Connection includes the following metrics:

- 75 members are in a permanent housing situation
- 70% of members in the program have been involved for 18 months or longer
- 94% of those in the program have a mental health condition
- 51% also have a Substance Use Disorder (SUD) diagnosis
- 59% have a chronic health condition

St. Stephen's Human Services In 2012 and 2013, the Medica Foundation provided funding to implement a pilot project to work with fifteen (15) Medica members experiencing homelessness on housing interventions paired with behavioral health care education. In 2015, Medica will continue to fund this program. The project was designed to:

- Allow fifteen (15) people to transition from homelessness into permanent housing with support
- Reduce emergency room utilization
- Provide for earlier intervention for mental health and medical health treatment
- Improve access and connection to Medica Behavioral Health services

PUBLIC HEALTH DOORWAY

Returning to work is a critical strategy for families to move off of Medical Assistance. For many of these families however, mental health and chemical dependency can be barriers to a successful return to the workforce. For more than a decade, Medica has collaborated with HealthChoices, a program of Spectrum Community Mental Health, to provide time-limited, intensive outreach, home visiting and case management services to Hennepin County Minnesota Family Investment Program (MFIP) clients. Both Hennepin County and Medica continue to fund this program to provide aggressive case management services.

HealthChoices also has come to recognize the need to effectively and actively coordinate services for clients across multiple systems, particularly the MFIP, behavioral health, physical health and child welfare service sectors.

> **HealthChoices intensive case management services for Medica enrollees with mental illness or chemical dependency reduced hospital bed days of participants by 44%.**

PRIMARY HEALTH DOORWAY

Integrated Care Coordination (ICC) is a face-to-face care coordination model with a high frequency, short duration approach to engage the member in their social needs as well as empowering them to take better control of their health. Members are identified for the ICC program through the analysis of medical claims information that shows high utilization or indicates complex heath cases. A team of six (6) clinicians (independently licensed mental health professionals and nurses) work with the identified ICC population to stabilize the member's current situation, as well as to establish a more effective plan for the management of overall health of the member.

> **ICC has yielded a savings of over $2,100 per member per month.**

Under the ICC umbrella, we have recently begun pairing a Community Health Worker model with our care coordinators. This team approach focuses on member stability and addressing their immediate social needs - prior to bringing in clinicians to address their higher acuity physical and behavioral health needs and overall care planning.

Using Community Coordinators to Engage Members

In 2015, Medica established a partnership with Integra ServiceConnect® to ensure its most vulnerable Medicaid members get the care they need. Integra ServiceConnect community coordinators help members connect to medical care, identify and close gaps in care and address social and environmental issues that affect health.

Integra works with vulnerable members that may not be reached with regular phone calls and mailings. It is a complementary, community-based extension of Medica's clinical staff and programs. Specially trained non-clinical community health workers are hired from within members' neighborhoods to work face-to-face in the community with Medica members daily.

High-Risk Pregnancy Program: Medica uses an algorithm to identify high risk pregnancies and support members through the Healthy Pregnancy telephonic program. Referrals to the ICC program noted

above are made if an in-person visit is needed. The goal is to find resources or support needs in the community, as well as integrate behavioral health support. A key aspect of this program is identifying and providing postpartum depression support.

HOW WE CONTINUE TO EVOLVE OUR INTEGRATION MODEL

PRIMARY HEALTH DOORWAY

Medica focuses on internal infrastructure efficiencies that maximize a single point of access approach for members and stakeholders. Some examples include:

- Our Health Management Department is placing greater emphasis on programs that support high risk members and members with complex conditions than in the past. This strategic decision to move resources from an emphasis on health coaching to an emphasis on complex case management aligns with the needs of MHCP enrollees.
- Our transportation team is housed under Medica's Government Programs Customer Service Department, physically located within the department and a full participant in all customer service meetings. This structure maximizes customer service best practices to enhance the transportation experience for members.
- Medica is the only health plan to have a Director of Public Health role – providing directed resources to align state-wide public health initiatives, county public health needs and health plan goals. Our Director of Public Health is a part of our State Public Programs leadership team. This structure highlights Medica's view on the important role public health can play in the health of MHCP enrollees.
- Medica has an in-house Pharmacy Team comprised of pharmacists and individuals with deep industry knowledge. This team provides oversight of our subcontracted pharmacy vendors and works to maximize the best interest of our members. Our in-house team of pharmacy experts allows Medica to make informed decisions about pharmacy management independent from and absent of any conflict of interests with clinicians, pharmaceutical companies and our pharmacy benefit manager or their other clients. Our in-house team plays a key role in the management of complex members and they work daily with Medica case managers and care coordinators to address member pharmacy needs.

> **"We take a very integrated approach to health management, especially in highly-complex cases and when behavioral health issues are involved. We have a multidisciplinary team of professionals from mental health, care coordination, case management, pharmacy and social work disciplines that meets every week to review individual cases and really think creatively together from many distinct vantage points about what we can do to help this individual through a complicated crisis in their life."**
>
> Dan Trajano, MD, MBA,
> vice president for population health,
> Medica

BEHAVIORAL HEALTH DOORWAY

Collectively, Medica and Medical Behavioral Health (MBH) continue to implement integration processes to better align our staff to address the holistic needs of our members and providers. Examples of integration include:

- Using a single health record platform across the enterprise allows behavioral health and physical health case managers to see the full picture of a member's health condition and care plan
- Integrating data sources that improves the ability of data analytics to identify members with certain specialty needs
- Using shared algorithms to identify gaps in care across the spectrum of services for follow up (i.e. medication refills, lab work, condition specific education)

PUBLIC HEALTH AND SOCIAL SERVICES DOORWAY

We believe it's critical to participate in and lead community efforts focused on public health and social needs in the community. Our integrated approach provides a single point of contact for our county and community partners. For example:

- We have three (3) dedicated Community Programs Managers who are assigned to specific counties to develop and maintain relationships with county and community partners
- Medica participates on a variety of county committees, state committees and community collaboratives to assist in identifying gaps in services and planning and implementing new initiatives to close those gaps.
- Medica Community Programs Managers bring the voice of the community back to Medica to inform our planning on member outreach and health improvement. They not only participate in community collaboratives, they often play a direct role in helping members or community advocates connect to health improvement services available through Medica. Medica is truly present in the communities we serve and members know they can connect with a Medica employee at any time in any place for support and direction.

3.2.5 Emergency Services

1. Describe your strategies to reduce inappropriate use of the emergency room and to address members who frequently utilize emergency services

Medica's approach to reduce inappropriate use of the emergency room and to address members who frequently utilize emergency services is multi-pronged. Our strategies will include:

- Contracting with PCPs and Primary Care Practices will include incentives and disincentives regarding emergency use of our members that they serve.
- PCPs will be encouraged to offer open-appointment scheduling, or maintain emergent slots for members needing urgent appointments. We also will discuss incentivizing PCPs by extending office hours during the week and on weekends.
- Our comprehensive provider network in Iowa will include contracts with available urgent care centers.
- Our predictive modeling software, the Johns Hopkins ACG tool, is designed to identify members with three emergency or more visits per year. These members will be flagged and reviewed by the Health Management Team monthly, when appropriate, based on diagnosis and presenting problem. They will be referred for assessment to determine the appropriateness of care coordination.

Care Coordination for members with historically avoidable emergency room use, will include:

1. Prudent layperson education concerning emergency room usage
2. The creation of an emergency diversion plan and transportation
3. Evaluation of the PCP member relationship and creation of approaches to look at options when there is a barrier to that relationship
4. On-going review of the member's emergency room utilization with subsequent follow-up

- We will provide education in our member handbook and on our website regarding access to our Nurse Advice Line that is available 24/7 – 365 days per year.

Medica will collaborate with providers and the State of Iowa to coordinate strategies related to Emergency Services. Current examples of such strategies used by Medica in Minnesota are referenced below:

- In 2015, Medica added Virtuwell as a benefit for Medical Assistance and MinnesotaCare members. Virtuwell is an online clinic that treats everyday illnesses as an alternative to office visits, the urgent care or ER. Members can get a personalized diagnosis, a treatment plan and a prescription in about 30 minutes, all online. Medica is currently tracking utilization of this online tool.
- Medica has a directed initiatives partnership for State Public Programs members with St. Luke's and its affiliates in the northeast region of Minnesota. Directed Initiatives places financial incentives towards the three Minnesota Department of Human Service (DHS) utilization measures:
    - 10% reduction in emergency department admissions
    - 10% reduction in hospital admissions
    - 10% reduction in hospital readmissions

  Medica shares in the savings 50/50 on each dollar reduced towards these goals. In this manner, success is an incremental experience and Medica rewards the providers for such work towards the goals and not an all or nothing approach. In 2014, we provided $243,044 in value based payments to St. Luke's for their improvement in the three DHS measures.

- Preferred Integrated Network (Wellness PIN) and the Clinic Without Walls is a creative medical and behavioral integrated service delivery model developed in partnership with DHS of Minnesota, Dakota County, Medica and Medica Behavioral Health. One component of the Wellness PIN includes access to a Clinic Without Walls (CWOW) model, which co-locates physical health care services at mental health drop in centers. CWOW provides primary care including lab draws, medication reviews and educational groups. There is a two year independent evaluation being completed on the Wellness PIN. Preliminary results show:
    - Inpatient services: Use of inpatient services by members enrolled in the Wellness PIN declined by five (5%) more than the comparison group.
    - Emergency services: The proportion of the Wellness PIN enrollees using the ER decreased over time while use by the comparison group increased.

Medica plans to use partner with stakeholders and explore using similar strategies in Iowa to reduce inappropriate use of the emergency.

2. Describe your plans to ensure a response within one (1) hour to all emergency room providers twenty-four (24)-hours-a-day, seven (7)-days-a-week.

Medica's Health Management Department will be open 24/7; 365 days per year and in this capacity will be available to respond to emergency room providers within one hour of their initial request.

3. Describe your plans to track emergency services notification of a member's presentation for emergency services.

Our emergency services provider contracts require notification of emergency room visits within ten (10) days of the member's discharge from the emergency room. To accomplish this, Medica will facilitate several options for provider notification including: 1) Fax; 2) secure email; 3) entry via our provider web-portal; and 4) telephonically.

4. **Describe your plans for reimbursement of emergency services; including what processes will be implemented to determine if an emergency condition exists.**

Medica will reimburse all emergency services that meet the Prudent Layperson definition as described by the Balanced Budget Act (BBA). The BBA defines an "emergency medical condition" as: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

Medica will adopt a comprehensive Emergency Claims Review process utilizing a team of non-medical staff auditors who shall determine if the services rendered in the emergency room were truly necessary based on the prudent layperson standard as part of data validation exercises. Auditors will review claims and all associated medical records for the following criteria:

- An emergency medical condition existed resulting in acute symptoms of sufficient severity to the extent that an absence of immediate medical attention would place the member in serious jeopardy or impairment -or
- The member had been instructed by a Medica representative to see emergency services

This review process shall be applied retroactively to claims processing to ensure that the rendering physician and hospital are reimbursed in a timely manner as required by statute. Due to volume, auditors will review a random sample of claims from emergency rooms on a quarterly basis to determine if the services billed for were indeed emergent and necessary given the patient's status upon presentation and admission to the emergency room. Each emergency room in the state system shall be subject to this retrospective review not less than once per year, and may be audited more routinely should it be determined by the claims review team that the emergency room has billed Medica for non-emergency services. Medica will seek reimbursement from the hospital in all cases in which claims were inappropriately submitted for payment.

5. **Describe your plans to document a member's PCP referral to the emergency room and pay claims accordingly.**

Medica will monitor PCP referrals to emergency rooms by reviewing required referral notifications, as well as daily hospital admission and discharge data. As such, this procedure controls both the front and back ends of the referral process and ensures that the relevant staff at Medica are aware of ER referrals and act accordingly.

Our referral program is strictly regulated to ensure members receive care from network contractors, unless their clinical team determines that no provider is available to meet the member's ongoing medically necessary treatment needs, or the member's chronic or acute illness is so severe that the likelihood of them experiencing an adverse health event warrants their referral to an emergency department. Importantly, our notification and review process is designed to operate as a background function, and in no way will prevent or delay a member in need of emergent services from receiving care should they present in an emergency room setting.

We require our providers to notify the Medical Referral Department of any referral made for a member which would result in said member receiving medically necessary care or services from a provider outside of the member's primary care clinic or care system, including an emergency room. This notification can be made through an Electronic Referral Submission process, or by fax, 24-hours a day. Our referral process requires that:

- A referral request must be authorized in advance by the member's primary care physician/clinic
- All referrals must originate from the Medica member's primary care physician/clinic
- Approved referrals are valid for the date(s) of service specified on the referral request form
- All referrals are subject to the member's Medica eligibility status and plan benefits for the date(s) of service indicated on the referral
- A referral request is valid for a period not to exceed six months

These referrals are tracked by our Medical Referral Department, in coordination with Network Management and Utilization Management; collaboratively, these teams stratify referral notifications by source, reasoning, and disposition in order to identify trends and opportunities for network improvements, as well as a potential need for technical assistance to providers found to be inappropriately referring members out of network or to emergency rooms.

In order to ensure services are reimbursed in a timely manner, and at the appropriate benefit level, emergency departments are required to notify Medica's Utilization Management Department within twenty-four (24) hours of a member's emergency admission, and upon discharge. This notification can be completed via the Provider Portal, or by phone or fax. This notification process requires the hospital to indicate the patient's referral source. Therefore, should a provider not send the aforementioned referral notification to Medica, it is likely this will be captured when the hospital contacts Medica. As noted in an earlier section, Medica's internal Emergency Claims Review process will review an emergency room's claims and medical records no less than annually to ensure proper billing and reimbursement for services.

3.2.6 Pharmacy Services

1. Describe your proposed approach for delivering pharmacy benefits, including the use of any subcontractors.

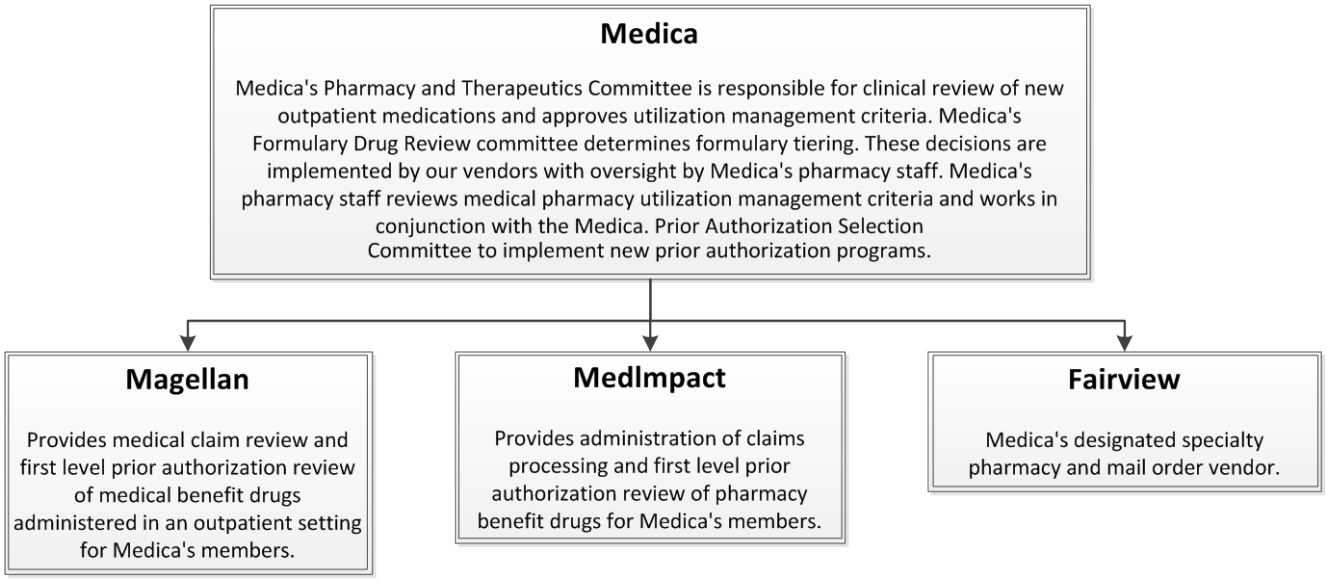
Medica will hire a Pharmacy Coordinator that is an Iowa licensed pharmacist to oversee the pharmacy benefits requirements including oversight and coordination of our Pharmacy Benefit Manager (PBM) and drug rebates. The pharmacist will have experience as a Medicaid Pharmacy Director or equivalent Medicaid pharmacy experience and will attend DHS Pharmaceutical & Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Commission meetings.

Medica's Pharmacy Coordinator will lead our in-house pharmacy team comprised of pharmacists and individuals with pharmacy expertise. Our team of pharmacy experts allows Medica to make informed decisions about pharmaceutical care independent from and absent of any conflict of interests with clinicians, pharmaceutical companies, and our pharmacy benefit manager or their other clients. Our utilization management of pharmaceutical products leverages national expertise but is custom-tailored to our membership. This team is supported by several of our cross-functional committees including:

- Pharmacy &Therapeutics Committee
  - External, independent panel of sixteen (16) members including pharmacists and physicians from the community.
  - Responsible for clinical review of new outpatient medications and approving utilization management criteria. Custom oversight of the drug formulary.
- Formulary Drug Review Committee
  - Internal group of departmental leads including medical director, finance, marketing, Medicaid business unit, legal and pharmacy staff.
  - Determines formulary placement. Uses the guidance of the Pharmacy & Therapeutics Committee to make a decision about the placement of the drug on the formulary.

Medica's fulltime pharmacists are available to consult with Care Coordinators on any pharmacy issues. Resources are also available through Medica's pharmacy benefit manager, MedImpact. Medica processes claims for Minnesota credentialed (DHS) MTM pharmacists. Our care coordinators work closely with these pharmacists for referrals.

The diagram on the next page describes Medica's pharmacy benefits structure and operations. Medica subcontracts with three vendors and each has distinct roles and responsibilities in delivering pharmacy services or administering pharmacy functions.



PHARMACY BENEFIT MANAGER (PBM) MEDIMPACT

MedImpact has served as Medica's PBM since 2001. MedImpact Healthcare Systems is an independent, privately held PBM, headquartered in San Diego, California MedImpact is fully delegated to administer Medica's retail pharmacy contracts through its national retail pharmacy network across all Medica business lines. MedImpact manages contract negotiations with pharmacy chains and associations using a single-point-of-responsibility model, with appointed MedImpact liaisons working with each pharmacy chain and association. When contractual changes are required, the applicable terms and conditions are identified and negotiated collaboratively, including performance guarantees, quality standards and deliverable requirements. Once full agreement has been reached, MedImpact's Contracts Department administers the changes to pharmacy agreements through an amendment process. Medica's in-house Pharmacy Services department develops and manages all clinical, formulary and utilization management services except for the administration of the prior authorization program, which is delegated to MedImpact.

SPECIALTY PHARMACY SERVICES

With values ranging between 15-20%, prescribing specialty drugs continue to be a strong trend that drives overall pharmaceutical expenditures. Furthermore, out of 39 new molecular entities and new therapeutic biologics approved by the FDA in 2014, 19 could be classified as specialty under commonly used definitions.

At the end of 2014, Medica attributed to specialty nearly 0.5% (accounting for 23.44% of total spend) of total prescriptions for Medicaid members. The rapid expansion of the specialty market has had a direct impact on the management of Medica's Specialty Drug Program.

Medica understands the clinical importance of properly managing members that require specialty drugs. Many of these members have complex medical conditions that can only be treated with multifaceted drug therapies. Last year we partnered with Fairview Specialty Pharmacy--who is fully prepared to operate in the State of Iowa—to administer a specialty drug program that provides high-touch, personal pharmaceutical care for Medica members. This change of vendors in 2014 resulted in a multi- year contract with Fairview that consolidated specialty medication services and prescription mail services under one vendor. This consolidation creates cost efficiencies through a network that offers deeper discounts, exceptional customer service and clinical expertise.

Another benefit realized through its exclusive partnership with Fairview, is consolidated reporting. Examples of reports include utilization trends, stability and attrition rates of patient cohorts, as well as adherence information. These reports provide Medica's Pharmacy Services Department with information to monitor specialty programs by using performance benchmarks, which allows for comparison and analysis of trends against various books of business.

Prior Authorization – (Does not include Medical Pharmacy Drugs)

Physicians in Medica's provider network have the ability to request an exception to both the formulary and utilization management criteria. All clinical exception requests are carefully reviewed for clinical validity and are approved or denied in a timely manner so that members will receive medically necessary medication without delay.

Over the past four (4) years, Medica and MedImpact have maintained a strong focus on improving and streamlining the Prior Authorization (PA) process. We leveraged the best-of-breed technologies available in the marketplace and collaboratively re-engineered and refined the PA process by using MedImpact's MedResponse™ automated platform for increased accuracy, efficiency, compliance with regulatory requirements and optimal member care.

MedImpact is responsible for the day to day operations of the PA program such as reviewing each PA request, rendering an approval decision, and communicating the decision to appropriate stakeholders. All denial recommendations are fully vetted through an appropriately licensed Medical Director. Through the aforementioned processes, Medica retains clinical oversight over the PA program.

Prior Authorization – Medical Pharmacy Drugs

Medical pharmacy drugs include medications administered in a hospital outpatient infusion center, provider office, or home infusion setting. Medica has effectively managed medical pharmacy drugs for many years, yet, due to increased costs for medical specialty drugs as well as an increase in the number of new drug approvals, the medical pharmacy drug trend continues to rise.

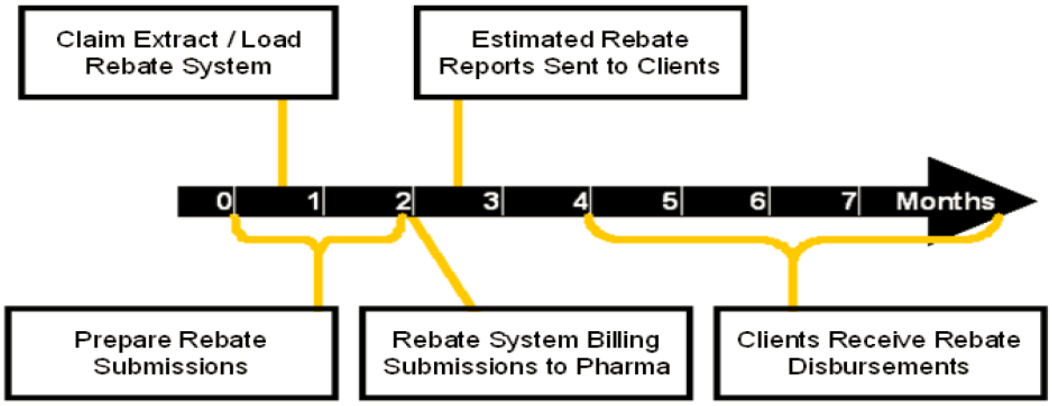
In response to this trend, and to maintain and increase our robust medical pharmacy management strategy, Medica recently partnered with Magellan Rx to administer an enhanced PA program for medical pharmacy drugs. Our program maximizes adherence to evidence-based medicine and member-specific clinically appropriate therapies, and minimizes our drug spend on inappropriate, duplicative, or over-utilized therapies. Medica and Magellan Rx work collaboratively to identify future drug candidates for the enhanced PA program. When a new candidate is chosen, Magellan's team of clinical pharmacists create UM policies, which are reviewed and approved by the Magellan Pharmacy & Therapeutics Committee. Medica's clinical pharmacy and medical teams then review these policies, and revise them, when indicated, based on local prescribing patterns and market need, and then bring the candidate policies for final approval by Medica's multidisciplinary Prior Authorization Selection Committee**.** Medica's partnership with Magellan Rx has proven to be an effective integrated solution that combines each company's pharmacy benefit and specialty pharmacy expertise.

MedImpact submits invoices to the pharmaceutical manufacturers 60 days after quarter-end. The invoice payment terms average 60 to 90 days; therefore, most payments will be received 120 to 150 days after quarter end. After invoicing, Medica receives quarterly estimated rebate payment reports.

Quarterly payments from pharma are received, reconciled, and processed. Most manufacturer contracts allow for some amount of data scrubbing, reversals, and exclusions. These actions taken by the manufacturers can

decrease or increase the amount of payment and thus decrease or increase the monthly distribution amount to Medica. Additionally, adjustments for past quarters are frequently incorporated into each payment; this may also decrease or increase the monthly distribution amount to the client. Report data for a particular quarter may change, depending on the date the report is generated.

At month end, the MedImpact Rebate Operations Team issues Medica a wire transfer of funds along with a distribution report with an accounting of the distributed funds. A visual representation of this process is provided in the diagram below.



2. Describe your ability and experience in obtaining and reporting drug rebates.

Medica and MedImpact have a strong collaborative relationship in managing rebates. MedImpact's Rebate Management department is an industry leader in the following areas:

- Expertise in rebate negotiation;
- Flexible rebate invoicing system;
- Rebate administration options;
- Overall processes transparency;
- Accurate billing;
- Outstanding rate of collections; and
- Sophisticated net cost modeling tool.

Our rebate program supports the State of Iowa's overall goals to lower total costs and optimize rebate yield. The MedImpact rebate team discloses information about the rebate administration program, including sharing contractual information. Medica receives monthly updates on rebate contracts and negotiations to stay current on any changes and eligibility terms. MedImpact sends manufacturers invoices that match the reports received by Medica, which provides Medica with highly accurate billing. The transparency of MedImpact's rebate processes and reports also support clean audit processes.

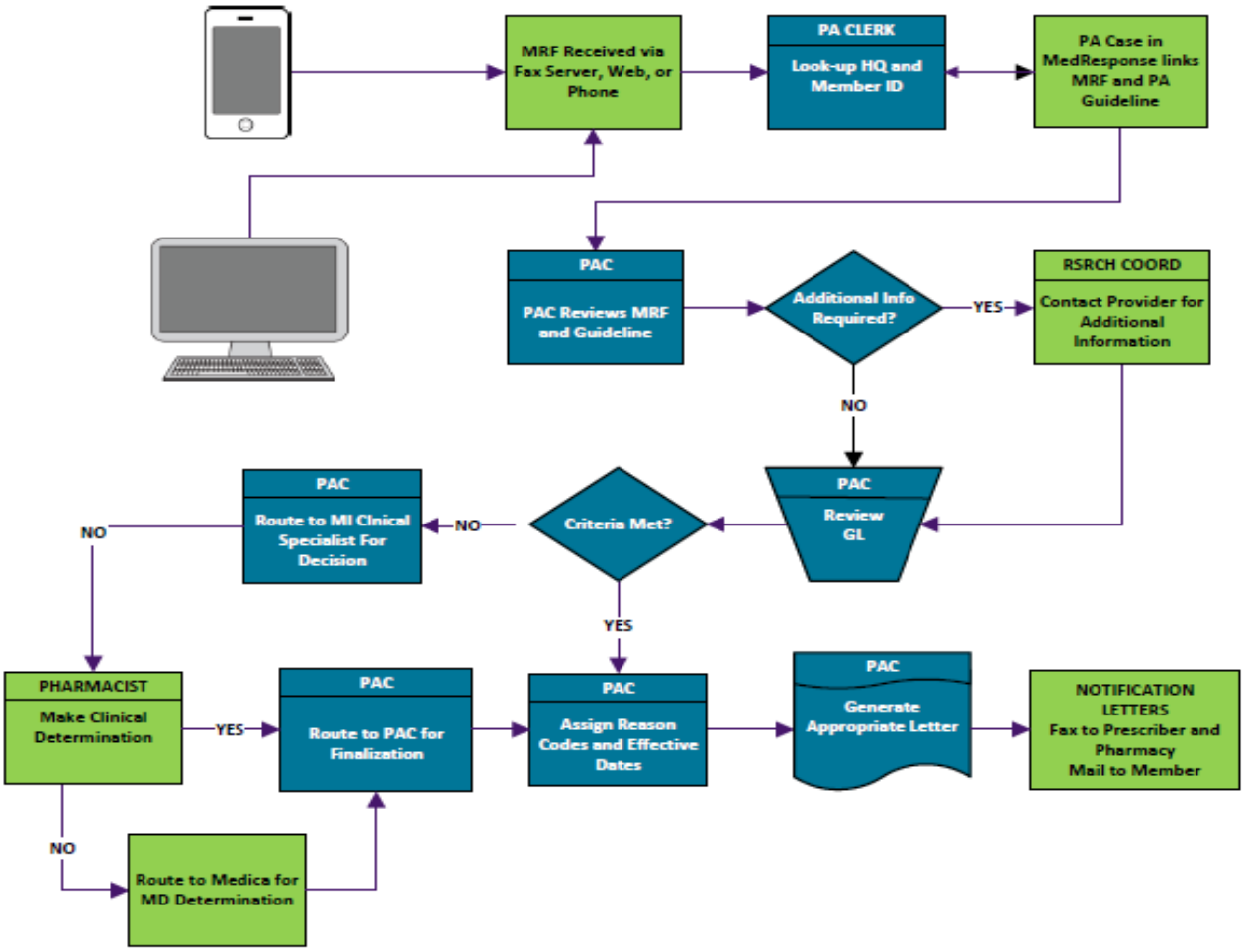
3. Describe any relevant experience resolving drug rebate disputes with a manufacturer.

Medica's rebate disputes are managed by MedImpact. MedImpact works proactively to reduce the incidences of rebate disputes before the fact. Measures taken include verification of data received by pharmaceutical manufacturers and careful tracking of payment terms. Additionally, a good dispute management process promotes accurate future billing submissions. MedImpact reconciles the money received and follows up on any short payments. MedImpact tracks all outstanding payment items in a database and generates reports on an ongoing basis, which are used to monitor outstanding payments and to facilitate management of contracts across billing cycles. MedImpact assigns dedicated staff to manage the dispute resolution process with the pharmaceutical companies. On average, MedImpact collects more than ninety eight percent (98%) of aggregated billed amounts each quarter.

4. Describe your plans for responding to all drug prior authorization requests within twenty-four (24) hours and dispensing at least a seventy-two (72) hour supply in an emergency situation.

Medica's prior authorization process—except for medical pharmacy drugs—is fully delegated to MedImpact. MedImpact will comply with all applicable Medicaid regulations including the twenty-four (24) hour turn around timeliness requirement as it currently supports the same standard for Medicaid programs in other states. Prior authorization requests are managed through MedResponse, MedImpact's proprietary system. MedResponse utilizes customized timer configurations that set the due date of the request based on time of receipt. The prior authorization team manages requests in each work queue within MedResponse based on the displayed due date. The team supervisor is able to view all work in progress from the MedResponse dashboard and escalate individual requests as required to manage issues that affect timeliness.

Medica's current MedResponse workflow is shown on the next page.



MRF = Medication Request Form; PA = Prior Authorization; PAC = Prior Authorization Coordinator at MedImpact; HQ = Header code, a subset of membership in the MedImpact claims processing system; GL = Medication request clinical guidelines

In the event of an emergency during or after business hours, MedImpact is authorized to enter a 72-hour override. MedImpact also has the ability to configure its adjudication system to allow pharmacies to dispense emergency supplies at point of sale based on their professional judgment.

5. Describe your method for providing online and real-time rules-based point-of-sale claims processing for pharmacy benefits.

MedImpact's claims processing solution is delivered in a single, integrated platform. This eliminates the technical complexities that plague many PBMs who are forced to operate multiple systems brought on by acquisitions and mergers. A single platform delivers a higher degree of claims processing accuracy and efficiency at a lower total net cost to the State of Iowa. The MedImpact adjudication system is available 24 hours a day, 7 days a week.

The overall capacity of MedImpact's claims adjudication architecture is unlimited, subject to scalability enhancements. MedImpact's technology plan requires that the system operate with a minimum of 50% headroom to allow for new and expanded business. We review system capacity and performance quarterly to

ensure Medica is poised to meet emerging and future user requirements. We are able to quickly expand processing and storage capabilities to satisfy any new or existing performance requirements.

In contrast to many other pharmacy benefit management programs, Medica, and its delegated PBM, MedImpact, are adaptable, flexible and agile enough to meet the State of Iowa's unique requirements. MedImpact's claims processing system provides flexible benefit designs through the deployment of a data-driven, parameter-based infrastructure. This structure allows us to implement a benefit without the need for software customization. Because this system is highly flexible, we can facilitate unlimited benefit design requirements. MedImpact has thousands of benefit edits in place that are available for the State of Iowa's use. We have the ability to implement existing edits within a few working days and can create new benefit edits based on the State of Iowa's specific needs. We have the capability through the proprietary point-of-sale system to return hard or soft messages to the member's pharmacist. Our system also supports edits to warn pharmacists of the potential harm involved in dispensing particular medications. Hard messages accompany a rejected claim, while soft messages contain information regarding an approved claim. These messages can be customized to meet specific member needs.

For example, MedImpact's system can notify a pharmacist at the point-of-sale whether it is appropriate to re-fill a prescription. The system can be custom programmed so that members will need to use 85% of a prescription medication before a new refill can be processed. For instance, Sally has a prescription for a 30 day supply of Lipitor and takes one per day. She will need to use 26 pills before a refill can be processed. If she only uses 23 and tries to obtain a refill, it will reject as a "refill too soon" and the pharmacist will get a message with the "correct date of refill."

6. Describe your plans to implement retrospective drug use review to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits, or associated with specific drugs or groups of drugs

Medica uses a proactive approach that includes concurrent and retrospective reviews to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and individuals receiving benefits, or associated with specific drugs or groups of drugs.

While there is no crossover in the Medica claims system between pharmacy and medical claims, certain medical drugs are excluded from the pharmacy benefit to prevent potential duplicative billing. Additionally, the pharmacy adjudication system prevents duplicative billing for pharmacy drugs with the refill-too-soon edit denial.

Medica uses IT systems that include medical claims, pharmacy claims and care management databases. These are all fully integrated to support the proper processing of all encounters and claims. Member eligibility is managed within the claim system and exported to pharmacy and care management systems to ensure consistency in eligibility information. All utilization review and benefit determination information documented by clinical staff is exported to the claim system. As claims are received and processed, they are screened against previous authorizations. Medica's medical claim processing coordinates with MedImpact to accurately manage deductibles and out-of-pocket maximums.

Medica's proactive approach assures that our drug coverage list and our PBM and claims system is streamlined to ensure accurate processing. The pharmacy billing system is set up in accordance with retail agreements

through our PBM, which applies processing edits to identify claims processed at the point of sale in a retail setting and claims processed through the claims system based on coverage criteria. We eliminate or reduce duplication by using well-developed claims edits. As an added measure, we conduct periodic queries on a random sample of claims, including pharmacy and medical, to check for accuracy and data integrity.

In addition, Medica's Pharmacy Department manages utilization management guidelines and processes for all of Medica's covered medications, whether they are covered through pharmacy benefits or under medical benefits. We use a two-tier review process to determine which medications are appropriate for coverage policies or utilization management. Having our expert committees and pharmacy team responsible for all medication coverage allows us to review the entire member experience relating to medications. We are able to have clinically appropriate and evidenced-based medicine guidelines consistently applied for a member, whether that member is receiving an intravenously infused drug in the physician's office or a medication for self-administration in a home setting. Although Medica has utilization management programs in place to ensure the efficacy and safety of medications, there are processes in place to allow exceptions to these programs due to medical necessity.

Utilization management exceptions for medications are reviewed and managed by licensed pharmacists in good standing in the state or jurisdiction of licensure. Under no circumstances may they independently deny a service determined not to meet medical necessity criteria. All potential denials require review and oversight by an appropriately licensed physician. Utilization management exceptions are based only on the appropriateness of service and existence of coverage.

Our Pharmacy and Therapeutics (P&T) Committee is responsible for advising Medica on issues related to appropriate use of prescription medication therapies. The committee reviews pharmacy benefit drugs and gives a therapeutic designation of essential, equivalent, or not essential; and reviews the policies and practices for medication management activities to ensure they are clinically appropriate. All of Medica's prior authorization, step therapy, and quantity limit programs are reviewed and approved by the P&T Committee.

7. Describe your plan for monitoring your PBM as described in Sections 3.2.6.6.1.3 and 3.2.6.6.1.4

Medica will submit a plan for oversight of MedImpact's performance for DHS' approval prior to the implementation of Medica's PBM. The plan will comply with all pharmacy requirements in the contract and Medica will require our PBM to be available to DHS staff. Medica's plan to monitor our PBM will be based on a three-pronged approach of data collection; data analysis and decision-making by our established quality and utilization management committees; and delegation monitoring.

DATA COLLECTION

Medica collects, manages and integrates data from a variety of sources and systems for its quality improvement programs; this includes sub-contractor data. Medica uses both purchased and internally-developed software products including, but not limited to:

- HealthRules Care Manager: Used for utilization management, complex case management, Health and Wellness Coaching, and appeal and complaint management (select products)
- COR: Internally-developed software application for documenting and analyzing data collected through medical record review.

- EBM Gaps in Care: Claims analysis algorithm built into CCMS that identifies potential gaps in members' disease management, medication adherence, care patterns and safety.
- Johns Hopkins ACG Case-Mix System: Risk assessment software that processes medical, behavioral and pharmacy claims to identify potential Health and Wellness Coaching and case management participants, as well as Special Needs Plans (SNP) members at high risk for hospitalization.

The collection of sub-contractor performance data is crucial in determining areas of improvement and opportunities to reevaluate processes. The data will assist with decision making and effective system reviews. Data will be collected using our Enterprise System Platform, combined with PBM claims data and reviewed on a reoccurring basis; this allows Medica to make decisions concurrently.

One of the unique and innovative features of Medica's Enterprise System Platform is an advanced service-oriented technology based on patented architecture and logic. Our platform supports key business functions using enterprise health data across the 28 integrated service oriented modules including: member services, utilization management (includes prior authorizations), provider relations (includes contract management, billing and payment), clinical Information (includes medication), and claims adjudication.

DATA ANALYSIS AND DECISION-MAKING - UTILIZATION MANAGEMENT COMMITTEE STRUCTURE

The delegation oversight process is managed by Health Management Compliance through oversight workgroups comprised of UM subject matter experts with clinical and regulatory backgrounds. The oversight workgroups report their activities monthly to Delegation Committee, who reports to Medica's Quality Improvement subcommittee, who in turn, reports to the Medical subcommittee of the Board. Medica requires delegates to comply with all applicable regulatory, accreditation and performance standards. Medica's Pharmacy Oversight Team is responsible for monitoring MedImpact. The Team is led by our Pharmacy Coordinator, an Iowa licensed pharmacist, to oversee the pharmacy benefits requirements including oversight and coordination of our PBM and drug rebates. Examples of activities performed by workgroups and subcommittees include:

- Medica monitors and analyzes its utilization data to detect potential under, over and mis-utilization of services. Data are sorted according to Medica's product lines of Commercial, Medicaid and Medicare. Within each product line, demographics, utilization and cost data are sorted in various ways to monitor the various utilization indicators. Benchmark targets and thresholds are used to identify areas of variation. Thresholds for the various product lines are determined annually and reviewed quarterly to determine if utilization variance warrants further analysis and/or program implementation. Areas of variation are analyzed to identify areas of opportunity.
- Medica's Measurement Work Group provides detailed data analysis on the areas identified by the Health Management department, the Utilization Management Subcommittee and the Trend Work Group. These committees then provide input into the data monitored for quality and utilization. The analysis conducted by these committees provides an opportunity to validate the effectiveness of current interventions programs and identify potential areas for additional opportunities for intervention as well as process and quality improvement.

Utilization management decisions for medications are reviewed and managed by licensed pharmacists in good standing in the state or jurisdiction of licensure. Under no circumstances may they independently deny a service determined not to meet medical necessity criteria. All potential denials require review and oversight by a Medica licensed physician (referred to as a physician advisor or medical director). Utilization management decisions are based only on the appropriateness of service and existence of coverage. Utilization management

decision-makers do not receive financial incentives from Medica as a means of encouraging them to make decisions that result in the under-utilization of services.

DELEGATION MONITORING

Medica monitors delegate UM activities, specifically PBM prior authorization determinations, in compliance with NCQA standards (UM 15) by conducting an annual audit of applicable UM policies and reviewing files using NCQA 8/30 methodology. Any findings require a corrective action plan. Medica requires all delegates to provide us with quarterly UM reports, which permit us to monitor utilization trends and complaints. An overview of our delegation program can be found in the attached Delegation Manual. We also conduct annual letter review workshops to ensure UM decision notifications sent by delegates are consistent with Medicaid requirements and Medica member letters.

Medica receives a quarterly reconciliation report from MedImpact, outlining billed verses collected rebate dollars. In addition, MedImpact provides an aging report of past due rebate amounts. In turn Medica's finance department utilizes these aging and reconciliation reports to identify discrepancies that warrant further investigation by Medica.

3.2.7 EPSDT SERVICES

1. Describe your plans to ensure the completion of health screens and preventive visits in accordance with the Care for Kids periodicity schedule.

Medica has more than thirty (30) years of experience ensuring the completion of preventive visits for Medicaid enrolled children through the Early Periodic, Screening, Diagnosis and Treatment (EPSDT) program. In Minnesota, this program is called Child and Teen Checkups (C&TC) – similar to Iowa's Care for Kids program.

For many years, Medica's C&TC rates have been at least 80% or more. These rates for Minnesota children have remained high by working closely with the local public health agencies, the Departments of Health and Human Services, providers and community organizations in developing and maintaining a variety of strategies including:

- Increased reimbursement for complete C&TC services (versus just a well-child visit),
- Specific provider education around C&TC services,
- Member education about the importance of these services.

Several additional strategies that Medica will bring to Iowa are described in more detail below.

PROVIDER FINANCIAL INCENTIVES

Medica's Pay for Performance (P4P) initiative is targeted to primary care clinics that meet certain thresholds for Prepaid Medical Assistance Program (PMAP) and MinnesotaCare services billed in a given year. Clinics with improvements in specific quality metrics earn financial rewards above and beyond their billable revenue. In 2014, our P4P metrics included improved rates for C&TC screenings**.**

The table below provides Medica's provider incentive model for screening completion:

PROVIDER INCENTIVES FOR SCREENINGS		
AGE	**DESCRIPTION**	**INCENTIVE**
Birth – 14 months	**Six recommended visits**	**10 per visit** **$15 additional if all 6 visits completed**
15 months – 20 years	**Annual C&TC Screening**	**$25**

MEMBER INCENTIVES TO ENCOURAGE PREVENTATIVE VISITS AND HEALTH SCREENINGS

Medica's comprehensive My Health Rewards program provides incentives to encourage Child & Teen Checkups with a child's primary physician. This program helps children from birth through age twenty (20) stay healthy. These regular checkups can help health care providers identify potential health problems or handicapping conditions, provide diagnosis and treatment of health problems or conditions, and encourage the development of healthy habits.

- Medica offers up to $75 in gift cards to children from birth through fourteen (14) months if they receive all six (6) required C&TC screenings. Each year, children fifteen (15) months through age twenty (20) years can earn a $25 gift card when they receive a C&TC screening.

Medica prides itself in working with key stakeholders, including providers, public health, members, community agencies, schools and the state health department to solicit input and feedback. In 2014, Medica staff met with more than thirty (30) counties throughout Medica's Minnesota service area to get feedback on what is working well, areas for improvement and our member incentive program. Feedback from counties led to an increase in the incentive amount for children ages fifteen (15) months to twenty (20) years who receive EPSDT services from $10 to $25. Medica also expanded the age range for members to be eligible for a car safety seat, from up to two (2) years to up to eight (8) years of age. In 2014, members earned nearly $175,000 in gift card incentives through this program.

Medica has been partnering with Hennepin County Medical Center since the fall of 2014 to contact "invisible" members -- those who had no medical claims for at least 12 months. The goal of this pilot was to offer these invisibles a gift card incentive to complete a preventive health screening with a primary care provider. Of the 19,000 "invisible" members identified, we were able to reach 10,207 members and schedule 2,087 appointments. Some cancelled and some didn't show, but 1,226 completed their appointments to earn the incentive.

REPORTS FOR CLINICS AND COUNTIES

Medica makes available clinic and county-level reports specific to C&TC services. These reports will be reviewed and analyzed to ensure the completion of health screenings and preventive visits in accordance with the Care for Kids periodicity schedule.

- Biannual clinic reports provide claims-level information on the number of Medica members at the regional and local clinics who are receiving C&TC services and blood lead testing at the appropriate ages.
- Monthly county reports are provided to state and public health agencies about the number of C&TC services provided.

These reports are used to promote targeted outreach by the appropriate resources to these families.

2. Describe your proposed outreach, monitoring and evaluation strategies for EPSDT.

Medica will bring proven outreach, monitoring, and evaluation strategies to an already successful Care for Kids (EPDST) program.

REGIONAL OUTREACH FOR EPSDT SCREENING

Medica is an active participant in regional C&TC groups throughout the state of Minnesota. We believe this is a critical part of becoming aware of community-level issues related to preventive health screenings, and finding collaborative solutions to continually improve the rates of EPSDT.

Medica Community Program Managers are actively involved in EPSDT collaborations in all regions of our service area. We work collaboratively with county public health agencies, providers, other health plans and community organizations to educate families on the benefits of this comprehensive exam and help to reduce barriers to care. We also work closely with clinics to ensure the administration of all exam components as well as providing them resources to offer their patients. Key components of the exam include developmental, social and emotional mental health screenings. If a child is identified as being at risk through a mental health screening, Medica Behavioral Health is available to provide timely, appropriate care to help families and children with mental health needs.

MONITORING

Medica will implement successful monitoring strategies developed in Minnesota for use in Iowa. Medica designed its own review program; Clinical and Service Quality Review (C&SQR), a continuous quality improvement program that evaluates record-keeping systems, medical record contents and practice patterns. C&SQR supports patient care and desirable health outcomes by ensuring availability of complete medical record documentation. The program includes on-site provider education to improve documentation and reduce practice variability. C&SQR site surveys and data-gathering also support Medica's access and availability and credentialing programs.

Complete EPSDT screenings are an area of focus for C&SQRs. The data pull includes all children on Medical Assistance who had a preventive care exam, regardless of how it was billed. Medica expects all preventive care exams for this population to include complete EPSDT screenings. Clinics not meeting standards receive education and are placed on improvement plans.

EVALUATION STRATEGIES

Medica will use overall EPSDT outcomes and regionally-specific outcomes, along with member and provider feedback from outreach and clinic based monitoring activities to evaluate our strategies. The results of this information will enable us to develop separate culturally appropriate education and training programs for parents/guardians and providers. Medica's education and training programs will be targeted regionally to the areas of need identified through our EPSDT outcomes.

We will take the information we learn from providers and share with public health agencies and the Department of Human Services to determine if there are ways we can help reduce provider barriers in completing EPSDT screenings.

Finally, Medica will ensure that all requested records, including medical and peer review records, will be available for inspection by State or Federal personnel or their representatives. Medica will record health screenings and examination related activities and will report those findings in an approved format in a frequency prescribed by the Agency.

3.2.8 Behavioral Health Services

1. Describe your proposed approach for delivering behavioral health services, including the use of any subcontractors.

Medica will ensure the delivery of high-quality behavioral health services throughout the state of Iowa that are evidence-based, comprehensive, client centered and free of stigma. We define a model behavioral health system as one with a comprehensive provider network that utilizes a multi-disciplinary team approach to providing a robust, integrated service array.

MEDICA BEHAVIORAL HEALTH

Medica Behavioral Health (MBH) is a health services business dedicated to making the health system work better for everyone. Medica contracts with United Behavioral Health (UBH) to provide a network of high quality chemical health and mental health clinicians and facilities as well as to manage behavioral health (both chemical health and mental health) benefits. In Minnesota, the care advocacy team for United Behavioral Health is dedicated to serving Medica members only and is branded as Medica Behavioral Health (MBH).

MBH works collaboratively across the health system to improve care delivery, quality and cost-effectiveness, and focuses on three key drivers of transformative change: engaging the consumer, aligning care delivery and modernizing the health system infrastructure.

- We are engaged with and collaborate on important decisions across the health care spectrum.
- We help individuals and families make benefit choices and manage their health care dollars.
- We support doctors and patients make informed treatment decisions.
- We help communities balance quality health services with sustainable costs.
- We create solutions that work together, for the good of the health care system.

Comprehensive Behavioral Health Provider Network

Written agreements will be established with a network of approved providers throughout the state that will conduct services in accordance with contract requirements. United Behavioral Health has an established provider network in Iowa historically largely targeted for a commercial population. We will expand this network to meet the needs of the Medicaid population. When choosing these providers, MBH will consider the anticipated Medicaid enrollment, expected utilization of services, and accessibility for members, among other criteria to ensure a comprehensive, competent service array offering. Policies and procedures will be set forth for the responsible selection, credentialing and retention of providers in accordance with federal and state regulations. All approved mental health and substance abuse treatment providers will work to meet the needs of adults and children in Iowa as part of a recovery-oriented care system that welcomes and engages members in their personal recovery efforts. Preferences of individuals and families in the design of the services will be at the core of the network. Consumer-operated programs and the use of peer supports will also be prioritized along with the utilization of natural supports and activities that promote development and maintenance of healthy social networks, employment, school performance or retirement activities. In addition to contracting for traditional behavioral health services, MBH will work with the Iowa Department of Human Services and Iowa counties to identify where there may be potential gaps in services and work together to implement solutions that may include contracting for alternative services.

MBH has experience and has a reputation for developing creative contracts and services in the state of Minnesota to meet the needs of the population. The following are two examples:

Intensive Community-Based Services (ICBS) is a short term (1-6 months), intensive program provided by community mental health providers serving Medica members with complex conditions. Many of the people receiving this service have chronic conditions leading to intensive county resource utilization of legal and chemical health services.

ICBS provides both case management and direct care to address the specific barriers facing individuals whose needs often include mental health, chemical health, psychosocial, housing and medical issues. It began as a pilot in 2002 in one Minnesota County with collaborative support from MBH, the MN Department of Human Services (DHS) and two community mental health centers. Due to the success of this service in helping members to receive services in their communities and decrease higher levels of care, the service has been expanded and is now provided in twenty-five (25) counties in Minnesota.

This service is periodically evaluated to review the return on investment. In a 2012 evaluation, ICBS was shown to have a significant impact (30% decrease) on member's overall behavioral health spend in the months after receiving ICBS.

Substance Use Disorder Pilots

One of the ways Medica has addressed the provision of individualized treatment for members with chronic and relapsing SUD is through our development of SUD pilots. We currently have five pilots, which are in an initial evaluation phase. One example of such a pilot is the MN Alternatives Pilot, which is designed to support the needs of members with chronic substance use issues who have had repeated episodes of higher levels of care within twenty-four (24) months. Key components of this program include:

- Providing a harm reduction framework
- Including an Intensive Case Manager/Navigator for at least six (6) months, including engagement throughout intensive treatment time and as well as traditional treatment tapers
- Addressing and facilitating care where there are gaps in service
- Facilitating medication management (2 of the 5 pilots have a medication management component)
- Coordinating with physical health providers
- Coordination specific to issues if the member is on a Restricted Recipient program (RRP)
- Using medication to address cravings and to ensure mental health medication management issues are addressed
- Enabling access and coordination with mental health providers for needed Services
- Ensuring that the member maintains their eligibility for health plan benefits.

Interdisciplinary Team Approach

We utilize a prospective and retrospective approach to identify and engage members, and to refer them to identified providers who can support their individualized treatment needs. Medica has found that the use of an interdisciplinary care team is most effective, with an ultimate goal to engage all providers, as well as the member, and his/her support system, in identifying and addressing the member's goals. Motivational interviewing skills are actively used in this process, which is person-centered, with a focus on recovery and resiliency.

MBH's care advocacy program includes teams of Care Advocates (independently licensed mental health professionals) organized to address specific clinical specialty areas. The current specialty areas are child and adolescent services, eating disorders, inpatient adult mental health, adult SUD treatment, short term case management and complex case management. Team structures change over time based on emerging needs of our membership identified through a recurring evaluation process. This team structure was set up following an intensive evaluation of the membership and utilization of services, and where health plan resources could have the greatest impact.

Specialty team members have knowledge and expertise about clinical specialty, as well as community resources, provider specialties, and provider availability.

MBH Care Advocates are part of a multidisciplinary team of mental health and SUD professionals who review treatment plans and follow special populations, including those with depression, substance abuse, and individuals recently discharged from the hospital. The care advocate is also responsible to promote coordination of medical and social service needs, in collaboration with providers and county case managers. MBH also has Care Advocates who act as resource partners to county and agency case managers who need assistance accessing health plan resources.

Identification and Outreach of Members Using Data

Medica intends to utilize demographic information from the state to feed into our IT systems for use by our Care Advocates to determine potential outreach opportunities based on eligibility, including focusing on those with a general delivery address which is a high indicator of homelessness.

We also use a system to prioritize members' needs for care management. Many of these members have had inconsistent involvement in health plan services. We currently employ a proprietary algorithm that produces a prospective risk score based on a combination of the following: utilization, diagnosis, risk of hospitalization, medication/prescription adherence information, and existence of co-morbidities, previous cost and gaps in care. Depending on the issues identified, the member may be assigned to one of several programs to engage them in additional services and supports, such as the Pregnancy Program, Health and Wellness Coaching, Tobacco Cessation, Complex Case Management (both medical and behavioral). An enrollee with ongoing mental health and substance use disorder challenges would be identified through this algorithm and managed by Care Coordinators who are mental health professionals who would also consult with and co-manage the physical issues the enrollee is experiencing. This co-management would ensure gaps in care are addressed. Within the IT systems, , these algorithms are run behind the scenes to identify members for a variety of different programming , including the Special Health Care Needs (SHCN) algorithms, which are run on a biweekly basis for identification of members for outreach, for both medical as well as behavioral health issues. Those members identified through this process for behavioral health concerns are evaluated by the Complex Case Management team for outreach and assistance with resolution of any immediate, as well as ongoing needs.

One of the ways we use the address data provided is to identify those members with a general delivery address who may be homeless. We strive to house and treat persons with mental illnesses who are experiencing homelessness. Two great challenges facing the Medicaid population are employment and housing. Individuals and families experiencing homelessness, have significant impact on their physical and mental health. Lack of stable housing can also result in use of inpatient or residential treatment services for individuals whose treatment needs have been addressed, but barriers to housing result in longer stays. This places additional burdens on a health care system of limited resources and creates barriers to recovery for individuals living with mental illness. Securing affordable, permanent housing is a critical first step in assisting our members in achieving optimal health outcomes. For example, Medica has partnered with Hearth Connection and St. Stephens in Minnesota since 2013 to assist in locating members who may be homeless,

helping to house them and then assisting them in getting their behavioral health and medical needs met as well as providing ongoing support. Many of these members have not had routine health care for a very long time, if ever. The Case Managers at these programs coordinate with Medica Behavioral Health to assist in locating resources to address these needs.

To be more specific about the Hearth Connection model, there is a contract with Medica to provide support services for high expenditure cost Medica members who are experiencing long term or chronic homelessness. Hearth Connection contributes rental assistance for permanent housing for participants with histories of long-term or chronic homelessness and residential instability. Medica covers the costs for an assigned intensive case manager to work with the member. Medica will partner with local agencies in Iowa to provide similar services.

COMPREHENSIVE SERVICE ARRAY

In the Minnesota marketplace, MBH reimburses for a broad variety of services including the following:

MENTAL HEALTH	
Outpatient therapy including family therapy and in-home therapy	Rehabilitation program services
Medication management	MN has mandated an intensive benefit for autism which is currently in the process of being implemented
Services to meet the needs of individuals with a co-occurring MH and SUD conditions	Stabilization services
Community-based and facility-based sub-acute services	In-home therapy and skills training services
Care consultation by a psychiatric physician to a non-psychiatric physician	Behavioral Aid Services through Children's Therapeutic Support Services (CTSS)(currently being implemented)
Behavioral Health Homes are being developed by MN DHS in conjunction with health plan and provider partners	Mental Health Residential Treatment for Children
Crisis Services, including but not limited to: • 24-hour crisis response • Mobile crisis services • Non-hospital facility based crisis services • 23-hour observation in a 24-hour treatment facility	Intensive Community-Based Services which includes: • Assistance with adherence to medication regime • Assistance with setting up and attending appointments including transportation if needed • Connection to community resources pertinent to the member's needs • Coordination with providers
Peer support services when a part of ACT, ARMHS, IRTS and Crisis Services	

MH SERVICES THAT WOULD ALSO BE COVERED IN IOWA	
Coordination with children's mental health waiver services	Integrated health home mental health services and supports
Behavioral interventions with child and with family including behavioral health intervention	Intensive psychiatric rehabilitation services
Community support services, including but not limited to: • Monitoring of mental health symptoms and functioning/reality orientation • Transporting to and from behavioral health services and placements • Establishing and building supportive relationships • Communicating with other providers • Ensuring member attends appointments and obtains medications, crisis intervention, and developing a crisis plan • Developing and coordinating natural support systems for mental health support	Peer Support services as delivered in Iowa

SUBSTANCE USE DISORDERS	
Outpatient treatment	Medically monitored intensive inpatient treatment
Emergency services for substance abuse conditions	Medically monitored inpatient detoxification
Intensive outpatient	Medically managed intensive inpatient services
Partial hospitalization	Evaluation, treatment planning and service coordination
Clinically managed low intensity residential treatment	Ambulance services for substance abuse conditions
Clinically managed medium intensity residential treatment	Opioid /Medication Assisted Treatment
Clinically managed high intensity residential treatment	Evaluation, treatment planning and service coordination

ADDITIONAL SERVICES THAT WOULD BE COVERED IN IOWA	
PMIC substance abuse services consisting of treatment provided by a substance abuse licensed PMIC and consistent with the nature of care provided by a PMIC as described in Iowa Code chapter 135H	Intake, assessment and diagnosis services, including appropriate physical examinations, urine screening and all necessary medical testing to determine a substance abuse diagnosis, identification of medical or health problems, and screening for contagious diseases
Substance abuse treatment services determined necessary subsequent to an EPSDT screening	Court-ordered treatment which meets criteria for treatment services
Court-ordered testing for alcohol and drugs	Court-ordered evaluation for substance abuse
Substance abuse screening, evaluation and treatment for members convicted of Operating a Motor Vehicle While Intoxicated (OWI), Iowa Code Section 321J.2 and members whose driving licenses or non-resident operating privileges are revoked under Chapter 321J, provided that such treatment service meets the criteria for service necessity	Second opinion as medically necessary and appropriate for the member's condition and identified needs from a qualified health care professional within the network or arranged for outside the network at no cost to the member
Ambulatory Detox	Clinically managed residential detoxification

Telehealth

Medica supports the use of telehealth to assist with access to services for members; this is especially a concern in rural areas. Medica will work with rural regions of the state to address gaps in services that may be improved through the use of telehealth.

INTEGRATED CARE APPROACH

Integrated Solutions (I-Solutions)

Medica Behavioral Health offers a telephonic care coordination program called Integrated Solutions (I-Solutions) which focuses on members who have complex behavioral health clinical needs and may also have challenging physical, social or socioeconomic needs. I-Solutions was established internally to engage members who frequently/repeatedly utilize higher levels of care, receive high cost care, and/or have chronically unstable conditions. Members are assigned Care Coordinators (independently licensed mental health professionals) who work to identify barriers and coordinate care to improve the overall health of the member by engaging with the member, their family, mental health, chemical health and medical providers, and county and community resources. If a member is not engaged, the I-Solutions Care Coordinator will work with providers to support clinical interventions with I-Solutions identified members who have complex behavioral and medical conditions. Due to the nature of these complex conditions, Care Coordinators engage in case consultation with other mental health professionals, medical professionals and MDs, including Internal Medicine physicians and psychiatrists.

MBH completed two (2) cycles of analysis of member outcomes of members in the I-Solutions program, both of which showed significant cost savings in utilization and members' conditions improved significantly, as evidenced by reduced emergency department use and inpatient hospitalizations (on average a decrease in medical and behavioral health claims expenses by 40%).

Collaboration

MBH has a long standing history of collaboration with the Minnesota Department of Human Services, counties, substance use disorder and mental health providers and hospitals, as well as advocacy groups, to create model programs to support members. Please see program highlighted throughout the behavioral health questions including: ICBS, SUD pilots, Autism supports, and Children's Collaborative Bridging Model.

2. Describe how your proposed approach will incorporate the values outlined in Section 3.2.8.

Delivery of behavioral health services will fully incorporate the following five (5) identified values into its policies and practices: (i) hope based in the knowledge that personally-valued recovery is possible; (ii) member self-determination; (iii) empowering relationships; (iv) members having meaningful, productive roles in society; and (v) eliminating stigma and discrimination.

Medica Behavioral Health's values of Integrity, Compassion, Relationships, Innovation and Performance align nicely with the identified values above. Our care management model is developed based on these values and is incorporated into our daily work. With each interaction we have with our members and providers we are focused on recovery and resiliency, member choice, helping members to lead their lives to the fullest and receiving care without discrimination. Relationships are at the heart of every interaction that we have with our members and it is through these relationships that we assist them with achieving their goals for improved health and wellness. Engaging the involvement of the member, as well as his or her supporters, in service decisions will be required of behavioral health providers. Strategies will be established to engage members with histories of inconsistent involvement in treatment and instill a new sense of hope. Services for adults who have a serious mental illness and children with a severe emotional disturbance will focus on helping the member maintain their home environment, education/employment and on promoting their recovery. In addition, emerging technology will be explored as a way to expand access to and engagement in services.

Individualized service plans will be established through a person-centered process that is led by the member whenever possible. Our Care Advocates use motivational interviewing to work with the member at whatever stage of change they may be at. Some members are ready to enter into treatment, while others are at the precontemplation stage. We have a dedicated team that works to engage members who may have a history of inconsistent treatment and have significant challenges to achieving improved health. These Care Advocates are skilled at forming relationships with these members and over time are able to engage them in services. Our Care Advocates also use these same values in their interactions with the member's providers, families and informal supports and work together to help the members in their recovery.

3. Describe how your proposed approach will engage families, natural supports, advocacy organizations and network providers in the behavioral health care planning and care delivery process.

Families, natural supports, advocacy organizations and network providers will be engaged in every step of the behavioral health care planning and care delivery process. At the highest level, these stakeholders will be invited to join committees that are responsible for making decisions in the development of policies and procedures which guide behavioral health care services. At an individual care level, the expectation will be that the appropriate parties are engaged in the care planning and delivery process.

In the design and authorization of behavioral health services, Medica will plan jointly with members, family members and representatives of other service delivery systems. Families and natural supports will be encouraged to actively participate in treatment planning and in the development of successful interventions. Medica expects its providers to respect the opinions of families and natural supports; their strengths are explored and validated; and they are given opportunities to choose the best course of care for their loved one. Informal support services provided by family members, friends and community-based support services will be integrated into each member's behavioral health treatment plan, especially for those who can benefit from services and supports designed to assist members in maintaining or returning to their home.

In addition to families and natural supports, input from network providers will be sought in instances where a change in the protocol for delivering behavioral health care services is being considered. MBH has a quarterly Community Advisory Network meeting in which providers, counties and advocacy organizations, such as NAMI, are represented. This group offers feedback and suggestions related to the delivery of behavioral health services. MBH also conducts provider and member satisfactory surveys on an annual basis. These results are also shared in this meeting.

Medica will also work with consumer and family advocacy organizations, providers and other appropriate groups and individuals to help promote the understanding and acceptance of integrated behavioral health services. This is accomplished through community forums, special events and tailored marketing materials including electronic mediums such as a website and social media platforms.

4. Describe your proposed peer support/counseling program.

Facilitation of the development of consumer-operated programs and use of peer supports is viewed as a core activity by Medica. We believe in the value of peer support programs and currently pay for these services in our Minnesota service delivery network. We are excited about working with the state of Iowa to support and develop peer support services in the state.

Medica will implement certified peer support/counseling programs in which certified peer specialists will provide services such as: recovery self-help groups and peer support/counseling. Some of the ways that peer supports are used in Minnesota may also be beneficial in Iowa, such as, the use of these unique services with mobile crisis and crisis stabilization, with adult mental health rehabilitation services and with intensive residential treatment.

Peer support and counseling services will also be developed specifically for members with substance use disorders. Medica currently supports the use of Recovery Coaches for members with substance use disorders and will work to develop qualifications for substance abuse peer support/counseling and will establish service descriptions.

5. Describe your services for prevention and early intervention.

Medica uses several strategies for prevention and early intervention including:

Proactive Education and Screenings
We educate our primary care provider network about the importance of evidence based screening for mental health conditions, such as depression, through the use of the Patient Health Questionnaire (PHQ-9). We also support screenings for SUD through the use of the Screening, Brief Intervention, and Referral (SBIRT) to Treatment), which is reimbursable. Currently, there are efforts underway with hospital providers to extend the use of SBIRT in emergency rooms. We are also evaluating an increase in provider payment for completing SBIRT as an incentive to increase use of the tool.

Behavioral Health Toolkit
Because of the critical role that many PCPs play in both the physical and mental health of our members, we have created a behavioral health toolkit for the health care professional that will be available via our provider portal and is free for their use. The toolkit contains easy-to administer screening instruments for the identification of potential issues related to mental illness and substance use, including depression, attention deficit hyperactivity disorder (ADHD), postpartum depression and substance use. The toolkit also includes key considerations for treatment, key messages to the parent or member, educational websites for member and parents and how to refer to treatment services

PCP Chart Audits
Medica works to improve mental health screenings for adults by conducting on-site medical record reviews, broken out by patient population at participating clinics in each of the primary care specialties. The reviewers, registered nurses from Medica's Quality Improvement Department, compare medical record documentation to measurable criteria based on ICSI guidelines. Medica designed its own review program, Clinical and Service Quality Review (C&SQR), for this purpose. C&SQR is a continuous quality improvement program that evaluates record-keeping systems, medical record contents and practice patterns. C&SQR supports member care and desirable health outcomes by ensuring availability of complete medical record documentation. The program includes on-site provider education to improve documentation and reduce practice variability. C&SQR site surveys and data-gathering also support Medica's access and availability and credentialing programs. The C&SQR review is administered to established clinics in the Medica network; there is also a comprehensive

initial site survey performed at new or relocated PCP sites. Areas of focus include: adult preventive care exams, metal health assessment, advanced care plans for ages 18 and above, ADHD, continuity of care, screening for depression, prenatal care, chronic pain and opioid usage and general chart documentation. Clinics that do not meet standards for receiving education are placed on improvement plans.

Care Advocate
Through our community, county and medical provider relationships, we encourage members to call us so we can assist with timely access to mental health services for children and youth. If someone calls our intake area asking for child psychiatry referrals, the call is transferred to a Care Advocate (independently licensed mental health clinician) who will assist the caller with timely psychiatric access.

Child Adolescent Care Advocate Team
Medica Behavioral Health (MBH) has a dedicated Child Adolescent (CA) Care Advocate Team. Because of their expertise and knowledge of resources, they are able to immediately direct members to the mental health resources that exist in the region. CA Care Advocates also act as a resource to child and adolescent providers conducting early intervention screenings to identify resources and coordinate care for the child or adolescent. Due to the shortage of psychiatrists, many children or adolescents have their psychotropic medications prescribed by their primary care physician (PCP). To assist these PCPs we offer consultation with our MBH psychiatrists to PCPs.

Education to Providers
Medica provides education to providers who perform Child and Teen Checkups (C&TC) of which developmental and social-emotional and mental health screenings are required. Providers who perform C&TC screenings include:

- Primary care clinics
- Head Start
- School-based clinics
- Public health, including in the home
- Behavioral health providers

Screenings
Medica encourages use of standardized screening instruments for developmental and mental health and social emotional screenings and encourage maternal depression screening as part of a C&TC screening. We also track the outcomes of mental health screenings for children and adolescents.

Another strategy that supports provider awareness about the importance of mental health screenings for children and youth is information on the Provider Express portal. Via the portal, providers are able to receive education and access evidence-based medicine through posted clinical practice guidelines adopted from the American Academy of Child and Adolescent Psychiatry. Our behavioral health toolkit for primary care providers and pediatricians also includes access information to the clinical practice guidelines and evidence-based screening tools providers can use free of charge. Through the provider portal and behavioral health toolkit we are able to improve mental screening for identifying of child and youth mental health conditions.

Mental health, as well as substance use disorder (SUD) screens are also available through our member portal, www.liveandworkwell.com for parent and youth self-use. These online tools improve parent and member self-identification and support mental health service referrals. MBH is committed to continue our efforts to increase the number of children receiving developmental and social emotional and mental health screenings using standardized screening instruments at the appropriate ages.

Medica's current incentive to parents for children who receive C&TC screenings is $10 for each visit. If children birth through fourteen (14) months receives all recommended C&TC screenings, they will receive an additional

$15 toward their gift card. Starting on June 1, 2015, children between fifteen (15) months and twenty (20) years will receive a $25 gift card for having a C&TC screening.

In 2015, Medica will be providing clinics reports on the percentage of children who receive a development and social-emotional and mental health screening using standardized screening instruments at the recommended ages.

School Based Mental Health Services

Medica Behavioral Health was specifically approached at the early rollout of these school-based services because of our history of supporting innovative efforts, and so became the first health plan in Minnesota to support school-based services. MBH contracts with providers serving children and adolescents in day treatment programs, including those provided in a school based setting. MBH participates in initiatives to increase access to services for children and adolescents in schools, thereby supporting the goals of increased access for students who might otherwise not get services, and reducing barriers that prevent children and families from being engaged in needed services. MBH would become involved in supporting these services in Iowa. MBH will collaborate with providers in Iowa to understand the gaps of specialty children's services that they have identified and to strategize on ways to ensure the availability of child and adolescent school-based services in Iowa.

Provider Training

Ensuring local providers have the training necessary to offer new and needed services in their county or region. For example, in Minnesota more than eight-hundred and fifty (850) clinicians have received training in diagnostic assessment of young children through DHS training programs. The link to these programs is http://bit.ly/1BnaBEl

These programs provide critical education to clinicians about the early identification and treatment planning for children with special health care and behavioral health care needs. Many of the clinicians who have received training are MBH network providers.

Physical Health Prevention and Wellness Efforts

The Minnesota Department of Human Services, in conjunction with the Institute of Clinical Systems Improvement (ICSI), sixty (60) health care entities, and five (5) health plans, came together to support the MN 10 x10 Project. The goal is to improve longevity of people living with serious and persistent mental illness by ten (10) years within ten (10) years.

As active participants in the MN 10x10 initiative Medica and MBH recognize that:

- Regular screenings for early signs of heart disease and diabetes are critically important. Heart disease and diabetes are among the leading causes of death among Americans.
- With regular screening, these diseases can often be prevented by lifestyle changes or can be detected early so treatment can control these health conditions.
- Annual physical exams and ongoing relationships with Primary Care Physicians support effective treatment and increased longevity. Through our participation in the 10x10 initiative, we educate mental health professionals about the importance of medical screenings. We also work with providers to increase the number of members with behavioral health issues to engage with a PCP.

TCM requirements for preventive health exams

MBH was the first health plan in Minnesota to require Targeted Case Management (TCM) to include an annual physical and dental exam on the Individual Community Support Plan (ICSP) and to assist the member in making these appointments. The MBH Quality Assurance Department monitors compliance with this requirement through provider site audits and clinical record reviews.

Wellness Programs

Medica wellness programs are available to members at no cost. These wellness programs include tobacco cessation, pregnancy program, and wellness coaching to name a few. Medica educates providers regarding the availability of these free wellness programs so they can make referrals as well.

Medica also offers a Health and Wellness Coaching program which is a whole-person approach to helping members achieve their wellness goals. Medica Health Coaches have a variety of backgrounds that provide a tailored approach to each member's needs.

Online materials for members on promoting healthy lifestyles and wellness: Live and Work Well

We understand that finding credible, evidence-based online health and wellness information can be an overwhelming and time-consuming undertaking. Medica staff, members and family members have confidential access to information and tools developed by internal professional staff, doctors, clinicians, industry experts and respected external content providers (e.g. Johns Hopkins University and Thomson Micromedex) through our emotional, behavioral and wellbeing member portal, **liveandworkwell.com**.

The **liveandworkwell.com** portal focuses on mind-body integration for a practical, low-cost approach to wellness and well-being. The portal provides member access to care and benefit self-management tools, prevention programs, searchable directories, educational materials, calculators, videos and more. There are specific tools developed for members with dual diagnosis including member self-screening and management tools.

A companion website, MenteSana-CuerpoSano.com (Healthy Mind-Healthy Body), is the award-winning affiliated site to liveandworkwell.com, for Spanish speaking Members. MenteSana-CuerpoSano.com is not simply a Spanish translation of liveandworkwell.com but rather a site focused on providing culturally relevant material for Hispanic or Latino members. Users access a link through liveandworkwell.com for this extensive Spanish language content, which uses a community and family-focused approach to help remove cultural stigmas to seeking behavioral health care.

6. Describe how you will ensure providers conduct outreach activities for IDPH participants who are IV drug users.

Medica will partner with counties and agencies to develop outreach activities for members who are IV drug users. Providers will encourage IV drug users to undergo treatment and provide awareness about the relationship between IV drug use and communicable disease. We are aware of the use of needle exchange programs in Minnesota as an effective tool in decreasing communicable diseases and also as a doorway to engaging people in treatment. We will also work with health care organizations and public health to provide education and other preventative activities regarding associated concerns such as Hepatitis C.

HOW WE ADDRESS THE NEEDS OF MEMBERS WITH OPIATE ADDICTIONS

Medication Assisted Treatment (MAT)

We work diligently with our SUD and medical provider networks to increase the number of providers available to provide Suboxone (buprenorphine) for both induction and maintenance treatment of opioid dependence in appropriate patients. For dependence on short-acting opioids, like heroin or prescription painkillers, buprenorphine may be recommended to help members begin and maintain continuity of treatment and is a

less intrusive option for the member's daily lives. MBH supports MAT integrated into the SUD treatment continuum of care.

Local and Regional Work on Opiate Abuse Issues

The participation by our clinical leaders in local solution-focused work groups is a key strategy to address the issues of opiate abuse. We welcome the opportunity to participate in existing work groups or the development of solution-focused teams across the state of Iowa. A few examples of our current and past participation in work groups follow:

Opiate Abuse Response and Strategies (OARS) – In Northeast Minnesota, the OARS work group has been developed to address the opioid problem in the region. Collaborators include representatives from St. Louis County, Essentia, Center for Alcohol and Drug Treatment, St. Louis County Law Enforcement, Tribal Representatives, University of Minnesota Pharmacy School, a Local Dental Provider, and a Consumer. Over two (2) years ago, Jane Welter-Nolan, MS, LP, MBH Clinical Liaison, outreached to St. Louis County leadership to inquire if there were opportunities to work with the community to address the ongoing concerns. Jane was invited to participate as the sole health plan representative. One outcome of the group is that a local provider agency has been supported to initiate an alternative treatment option for people with these specific challenges. The work group has also worked with the local prescriber community to address the issues by changing the opioid prescriptive patterns.

Methadone and Transportation – In 2014, Medica and MBH participated in a Minnesota DHS work group with other health plans to address transportation issues, specifically related to the Medication Assisted Treatment services (methadone clinics). With the rising heroin and opioid addictions issues in Minnesota communities and due to service provider licensure issues, transportation costs associated with these services have risen dramatically over the previous twenty-four (24) – forty-eight (48) months. The group problem solved both short term and longer term solutions, and invited MAT providers to participate in the conversation.

MBH has been successful in developing partnerships with SUD providers to better serve this population.

- MBH has developed a specific SUD pilot to address the needs of members with opiate addictions. This is a harm reduction model which includes outpatient treatment, medications assisted treatment and care coordination and support.
- Medica actively supported an SUD provider in Minnesota implementing a new model in providing members with opioid addictions an alternative treatment model that supports the member's recovery and treatment. Medication Assisted Treatment is a service in their continuum of care, so that it will be part of the comprehensive treatment model offered by this non-profit organization, not just a methadone distribution center. They also plan to support the use of suboxone as an alternative to methadone treatment, and will look to actively taper members when appropriate. The Medica Foundation has also provided funding to support these new innovative services.
- We work within the provider community to increase access to suboxone providers as a preferred alternative to only methadone treatment for opiate issues to improve the member's overall quality of life. We will collaborate with partners throughout the state of Iowa as we problem solve to address these issues.

We utilize a prospective and retrospective approach to identify members with addictions and IV drug use, engage those members, and refer them to identified providers who can support their individualized treatment needs. Medica has found that the use of an interdisciplinary care team, including dedicated Substance Use Disorder Health Plan Care Advocates, is most effective, with an ultimate goal to engage all providers, as well as the member, and his/her support system, in identifying and addressing the member's goals. Motivational

interviewing skills are actively used in this process, which is person-centered, with a focus on recovery and resiliency.

7. Describe how you will support IDPH-funded Women and Children services

Medica is committed to ensuring all members have access to effective, integrated quality health care in order to achieve the highest wellness outcomes possible. We will support the IDPH-funded Women and Children's Services by:

- Educating members and the public regarding these services in order to facilitate easy access and positive outcomes
- Working collaboratively with community and stakeholders to maximize and leverage benefits
- Directly providing services to Women and Children in need

We will assist families to access support services including transportation and interpreter services for their mental health services and providing telephonic care advocacy follow up to children and their families who have accessed higher levels of care such as mental health inpatient or residential care. This includes assisting families to schedule appointments, follow up on if appointments were attended and assisting with setting up additional recommended services. MBH also has telephonic care coordination available to adult members who are identified as having significant mental health needs through our claims algorithm.

The provider network will make substance abuse services available to IDPH-funded participants based on a sliding fee scale. Income and family size determine the sliding fee scale, and it is standardized for all IDPH-funded treatment service providers. IDPH-funded women who are pregnant and have a substance use disorder will be given priority and entered into treatment by a network provider within 48 hours of referral. Children who are funded by IDPH will follow the assessment and service plan protocols.

8. Describe your screening and treatment protocol for children with serious behavioral health conditions. Provide a sample crisis plan and describe how you will work in collaboration with local school systems.

Medica and MBH support early intervention through ease of access to screening and treatment and engage in community collaborations to develop and implement innovative solutions at the community level. The provider network will be required to implement the State-approved screening protocol and comprehensive treatment approach for children with serious behavioral health conditions.

SCREENING AND TREATMENT FOR CHILDREN WITH SERIOUS BEHAVIORAL HEALTH CONDITIONS:

Following are approaches we have developed to support youth with mental health issues:

- Assistance in finding clinicians and access to outpatient care, including open access to a quality network of outpatient clinicians.
- Application of claims-based algorithms to identify individuals at higher risk and help us reach out to those members and their providers to offer support.
- A dedicated child/adolescent team of Care Advocates who work with families and providers to meet the needs of our child and adolescent members. Care Advocates collaborate with child providers conducting early intervention screenings as needed to coordinate care for the child.
- Creative Contracts with Intensive in home providers and individual providers specialized in treating children with serious mental health issues and their families.

- Telephonic consultation with MBH psychiatrists
- One of the providers in the MN Network, with the support of key partners such as MBH, as developed a program called TXT for Life which is specifically targeted to be available to support adolescents experiencing a crisis

Autism Screening and Services

The increase in autism diagnoses and difficulties with rapid access to assessment and treatment prompted MBH to work with two (2) community providers in Minnesota to meet increased needs. Fraser and St. David's Center provide rapid assessment and a comprehensive multimodal individualized treatment option for children with autism and their families. These providers are able to start the assessment process within ten (10) days of request for services. Treatment plans are individualized for the member and family. By developing this multimodal treatment approach, MBH has ensured treatment for children with autism, resulting in high member satisfaction, increased timely access in a cost effective manner.

St. David's Center and Fraser have comprehensive programs serving the entire family of a child with autism. They evaluate the needs of the child and the family, develop a care plan and work with the family to coordinate services. Depending on the level of need, they also provide direct intervention therapies and skills development.

Alternative to long term residential treatment for children and adolescents

The Intensive Collaborative Bridging program was developed by a Minnesota county who later approached MBH to help expand this model for broader access. In this model, work is done with the family as well as the youth to address the youth's mental health needs, keep the family relationships and professional relationships intact, and integrate case management. The service components include:

- Intensive in-home therapy with the youth and family, including during the brief residential
- Individual therapy for the youth
- Short-term stabilization residential treatment placement for the youth, stay 30-45 days
- Integrated case management and coordination of services

The model has shown the following positive results; shortened out-of-home placement, longer community tenure, and decreased costs. Many other counties have expressed interest in adopting this model.

Crisis planning

MBH is acutely aware of the importance of a good crisis plan and utilizes our Care Advocates to ensure that one is in place and has been reviewed with the child and family. In Minnesota, crisis plans are usually developed with the child's individual providers or targeted case managers. Even though MBH is not usually the author of the crisis plan, we are actively involved in ensuring that one is in place. The MBH Care Advocate's role is unique in being able to stay involved with members over time. These individuals act as a liaison between members, counties, and providers to increase continuity of care and enhance the overall experience for children and their families. Part of their role is to work with the child's providers to ensure that there is a comprehensive active crisis plan in place for the child and the family.

If the child has been in an inpatient hospital stay, the MBH child/adolescent care advocate will work with the youth's family and providers to help the family identify informal and natural community supports that can help stabilize the child's behavioral health symptoms as part of discharge planning. The care advocate will call the

parents after the child's stay to make sure that they have follow up appointments scheduled, an adequate supply of medications, transportation to appointments and a crisis plan including specific steps to take.

Also, these specialized Care Advocates are able to immediately direct members to the mental health resources that exist in the state. Any member who is having difficulty seeking a mental health service is directed to a care advocate who will work with the family to identify and schedule an appointment with appropriate resources

Minnesota also has Children's Mobile Crisis Teams throughout the state that should be part of a child's crisis plan. The MBH Care Advocates provide families the phone number and information for their local crisis team. MBH has participated in the Minnesota seven (7) county metro children's crisis services workgroup on a twice monthly basis for over six (6) years. MBH supports the use of children's crisis services both through payment for these services and active involvement in their development and sustainability. MBH staff also actively participated in a MN DHS workgroup to focus on the coordination of care following discharge for children and adolescents being discharged from an inpatient mental health stay.

We would work with Iowa to make sure crisis plans are developed and implemented according to Iowa procedures including the implementation of a health plan crisis plan document if desired.

COLLABORATION WITH SCHOOLS

School-Based Services

Medica was one of the first health plans to support school based mental health services in Minnesota. In 2004, Minneapolis Public Schools contracted with community mental health providers to bring mental health treatment into the school setting. There was an initial group of four (4) mental health providers from the community with goals were to improve access to care and remove barriers interfering with engaging in needed services. The partnership includes the individual school, teachers, school system and the therapy providers. In order to pursue sustainable funding, there was a three-pronged approach; funding through the Health Plan, the school system and the county.

In 2011, MBH served on the School Mental Health Strategic Leadership Committee that included schools, consumer advocates, counties, Department of Human Services (DHS), health plans and providers working together to develop a strategic plan for sustainable school linked mental health services. Since that time, DHS has provided $45.4 million in grants that will increase access to mental health services for Minnesota's children. Medica will work with the state of Iowa, providers and schools to implement school based mental health services.

Medica will also be available to the child welfare and juvenile justice providers to develop effective trainings, interventions and supports for child welfare and juvenile justice providers and systems to respond effectively to the needs of children with behavioral health issues.

9. Describe how you will ensure compliance with the Mental Health Parity and Addiction Equity Act

Medica will ensure compliance with all five components included in the Mental Health Parity and Addiction Act as described below:

a. Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits. Medica and MBH employees are trained

in the Mental Health Parity and Addiction Act and medical management techniques are in compliance with Parity. Periodic reviews are conducted to ensure that the medical management techniques are applied consistently and fairly.

b. Ensuring compliance with MHPAEA for any benefits offered by the Contractor to members beyond those specified in Iowa's Medicaid state plan – All members beyond those specified in Iowa's Medicaid state plan will receive care in compliance with MHPAEA. The strategies set forth in this section describing compliance with MHPAEA will be applied to all members regardless of their Medicaid status.

c. Making the criteria for medical necessity determinations for mental health or substance use disorder benefits available to any current or potential member or contracting provider upon request – Criteria for medical necessity determinations for mental health or substance use disorder benefits will be made available to any current or potential member, or contracting provider upon request. This information can be accessed electronically by all contracted providers for conveyance to any current or potential member. It will also be included in the Provider Manual.

d. Providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members – Members will receive written reason for any denial or reimbursement or payment with respect to mental health or substance use disorder benefits.

e. Providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits – Out-of-network coverage for mental health or substance use disorder benefits will be made available for medical and surgical benefits.

10. Describe how you will provide care that addresses the physical and behavioral health needs of members in an integrated manner.

Integration of primary health, behavioral health, public health and social services is an important strategy to improve health outcomes for patients. Integrated health care delivery can improve care and reduce costs by ensuring that people with chronic and complex conditions have ready access to coordinated care. With the complexities of this population, it's critical that health plans not only support this integration of care, but can function as a single unit to the extent possible to support the whole person.

Medica has a strong history of developing programs that maximize integration. Members come to our system based on their unique needs and whatever "doorway" that best addresses their most pressing needs –physical health, behavioral health, public health or social services. Regardless of how a member enters our system we work to integrate all aspects of care and meet the member at the right place for them. There are no wrong doors at Medica. Examples of integrated programs that highlight this approach include:

BEHAVIORAL HEALTH DOORWAY

Preferred Integrated Network (PIN) Model

The PIN program, launched in 2009, is an integrated program in Dakota County, Minnesota. It brings together MN DHS, Dakota County, Medica, MBH and four community mental health providers to improve and coordinate the physical, mental health and social support service needs for people with mental illness, up to age 65, living in Dakota County. PIN members are identified based on behavioral health needs and their behavioral health care becomes the focus and center for integration. Through PIN we have done things like

bringing medical services to meet members at their behavioral health home, a place where they are comfortable and familiar with.

There is a two-year independent evaluation being completed on the PIN.

Preliminary results at this time show:

- Inpatient services: Use of inpatient services by members enrolled in the PIN declined by 5% more than the comparison group.
- Emergency services: The proportion of PIN enrollees using the emergency room decreased over time while use by the comparison group increased.
- Intensive Residential Treatment Services (IRTS): The PIN and comparison group were quite similar in their utilization in the baseline period (8% and 7%, respectively) of IRTS utilization. With the implementation of the PIN program, however, the proportion of PIN enrollees using this service declined while the proportion among the comparison group remained fairly stable.

Intensive Community-Based Services (ICBS):
ICBS is a short term (1-6 months), intensive program provided by community mental health providers serving Medica members with complex conditions. It provides both case management and direct care to address the specific barriers facing individuals whose needs often include mental health, chemical health, psychosocial issues, housing and medical issues. ICBS centers on a member's relationship with their behavioral health providers to integrate care. This approach focuses on the most pressing needs of the member and allows the behavioral health provider to structure the integration of other care supports with the knowledge of how a member's behavioral health condition will be impacted. ICBS is available in 25 Minnesota counties.

In a 2012 evaluation, ICBS was shown to have a significant impact (30% decrease) on member's overall behavioral health spend in the months after receiving ICBS.

SOCIAL SERVICES DOORWAY

Medica has several programs that support integrated care for members experiencing homelessness:

Hearth Connection
Hearth Connection is a nonprofit organization that acts as an intermediary, collaborating with a diverse group of stakeholders, nonprofits, government, and health care entities to offer solutions to homelessness. In 2012, Hearth Connection partnered with Medica to launch the Medica Supportive Housing Project. This collaboration among supportive housing providers and a health plan was the first of its kind in Minnesota. This project brings services and new housing opportunities to people with chronic medical conditions and long histories of homelessness. Focused primarily in Hennepin County (the largest urban county in Minnesota), the goal of this program is to help stabilize housing and reduce the risk for health crises that lead high-need people in the program to use more expensive health care resources. Hearth Connection locates members, and engages them first to address the immediate needs of housing. Through the process of obtaining permanent housing, Hearth Connection and their partner agencies work with the member to connect with behavioral and physical health providers to address health care needs.

Most participants in this program were unknown to Hearth Connection, other housing organizations and the TCM agencies until identified by Medica.

Evaluation of Hearth Connection includes the following metrics:

- 75 members are in a permanent housing situation
- 70% of members in the program have been involved for 18 months or longer

- 94% of those in the program have a mental health condition
- 51% also have a Substance Use Disorder (SUD) diagnosis as well
- 59% have a chronic health condition

St. Stephen's Human Services

In 2012 and 2013, the Medica Foundation provided funding to implement a pilot project to work with 15 Medica members each year, experiencing homelessness on housing interventions paired with behavioral health care education. In 2015, Medica will continue to fund this program in partnership with Hennepin County (Minneapolis) in Minnesota.

The project was designed to:

- Allow fifteen (15) people per year to transition from homelessness into permanent housing with support
- Reduce emergency room utilization
- Provide for earlier intervention for mental health and medical health treatment
- Improve access and connection to Medica Behavioral Health services

MEDICAL DOORWAY

Integrated Care Coordination (ICC) is a face-to-face care coordination model with a high frequency, short duration approach to engage the member in their social needs as well as empowering them to take better control of their health. A team of six (6) clinicians (independently licensed mental health professionals and nurses) work with the identified ICC population to stabilize the member's current situation, as well as to establish a more effective plan for the management of overall health of the member. In an ROI evaluation, ICC has yielded a savings of over $2,100 per member per month.

Under the ICC umbrella, we have recently begun pairing a Community Health Worker model with our care coordinators. This team approach focuses on member stability and addressing their immediate social needs - prior to bringing in clinicians to address their higher acuity physical and behavioral health needs and overall care planning.

High Risk Pregnancy Program: Medica uses an algorithm to identify high risk pregnancies and support them through the Healthy Pregnancy telephonic program. Referrals to the ICC program noted above are made if an in-person visit is needed. The goal is to find resources or support needs in the community, as well as integrate behavioral health support. A key aspect of this program is identifying and providing postpartum depression support.

We support medical providers through education about and payment for screening using the SBIRT (Screening, Brief Intervention, Referral and Treatment) protocol.

PUBLIC HEALTH DOORWAY

Returning to work is a critical strategy for families to move off of Medical Assistance. For many of these families however, mental health and chemical dependency can be barriers to a successful return to the workforce. For more than a decade, Medica has collaborated with HealthChoices, a program of Spectrum Community Mental Health, to provide time-limited, intensive outreach, home visiting and case management services to Hennepin County Minnesota Family Investment Program (MFIP) clients. Both Hennepin County and Medica continue to fund this program to provide aggressive case management services.

HealthChoices also has come to recognize the need to effectively and actively coordinate services for clients across multiple systems, particularly the MFIP, behavioral health, physical health and child welfare service sectors.

Spectrum intensive case management services for Medica enrollees with mental illness or chemical dependency reduced hospital bed days of participants by forty-four (44) %.

Collectively, Medica and Medica Behavioral Health (MBH) continue to implement integration processes to better align our staff to address the holistic needs of our members and providers. Examples of integration include:

- Using a single health record platform across the enterprise which allows behavioral health and physical health case managers to see full picture of a member's health condition and care plan,
- Integrating data sources that improves the ability of data analytics to identify members with certain specialty needs,
- Using shared algorithms to identify gaps in care across the spectrum of services for follow up (i.e. medication refills, lab work, condition specific education)

Actively Monitoring Expectations of Providers

Medica provides our network primary care providers (PCP) with education regarding mental health conditions and screening, and has incorporated mental health screening expectations in PCP chart audits since 2009. Medica and MBH partner on joint initiatives to ensure collaboration between medical and behavioral health providers. Both our provider contracts and our active quality improvement monitoring focus on:

- Bi-directional exchange of information; improving care coordination for our members
- Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care – providing our members with improved access to behavioral health care
- Appropriate use of psychotropic medications
- Management of treatment access and follow-up for members with coexisting medical and behavioral disorders
- Primary or secondary preventive behavioral health care program implementation
- Special needs of members with severe and persistent mental illness

11. Describe your mechanisms for facilitating the reciprocal exchange of health information between physical and behavioral health providers and methods for evaluating the effectiveness of such strategies.

Medica facilitates provider communications regarding the members physical and behavioral health needs. Chart audits are conducted to monitor this expectation and correct deficiencies as identified.

Our Care Advocates also play a vital role in connecting providers with each other so that they can coordinate the members care. Care Advocates facilitate coordination with providers and have discussions with them about the members physical and behavioral health needs. For members with complex needs, the care advocate is able to organize and participate in a multidisciplinary team meeting with all of the member's providers to address treatment planning and care for the member.

In northwest Minnesota, Medica is a member of the Northwest Region e-health initiative. This initiative includes primary care clinics, counties, health plans, mental health and SUD providers. We are working together to facilitate electronic exchange of health information. Seamless sharing of health information is a key component of integrated care. It allows providers to focus collectively on the member's identified goals, and to each provide the services necessary to support the individual's recovery plan. We will use the learnings from this initiative to advance the sharing of health information across our provider network.

INTERNAL OPERATIONAL INTEGRATION

Medica has implemented internal integration processes to better align our staff to address the holistic needs of our members. Some examples of this internal integration include medical and behavioral clinical staff joint rounds, co-location of behavioral health staff on the medical care management and health coaching teams, and ongoing consultation and referral between teams. This alignment of our internal organizational processes, as well as a rich data set allows us to successfully implement strategies within the community to integrate primary care and behavioral health care. For the management of Medica's Minnesota membership, both the medical teams and the behavioral health teams utilize the same electronic medical records, which support the management of the member's health holistically.

Medica will evaluate and monitor the effectiveness of policies and procedures regarding coordination of physical health, substance abuse, and behavioral health providers on a regular basis. Data used to measure outcomes will be accessed, analyzed and scrutinized quarterly at the provider and Contractor levels. Consistent monitoring of outcomes will result in the implementation of mechanisms designed to improve coordination and continuity of care.

3.2.9 Health Homes

1. Describe your proposed approach for implementing health homes.

Medica believes health homes offer individuals the ability to receive necessary services from a wide range of qualified providers in an efficient, expedited, coordinated manner to achieve the highest level of health and wellness outcomes possible. As such, Medica health home providers will be required to provide or to arrange care for individuals in all stages of life, including acute care, chronic care, preventive services, long term care, and end of life care. Medica will seek additional feedback from Iowa DHS about implementation of successful health home models and we will align our model with established best practices in Iowa. For example, In Minnesota our health care homes have a dedicated Care Coordinator for assisting our members with complicated issues such as tracking appointments and referrals, medications, transitions of care, as well as support for health and lifestyle changes. We will explore expanding this model to the health homes in Iowa, based on feedback received from Iowa DHS and providers of health home services.

Medica will work collaboratively to structure all our health home model requirements to meet Iowa standards. Medica values the work done by Iowa in the creation of the health homes model and would work to allow for integration of Medica data to help promote coordination of care for the member while eliminating the possibility of duplication.

Medica shares relevant data with network providers to support their management of these high-risk patients. We also measure program enrollment, clinical outcomes, utilization and satisfaction to determine impact on care, costs and medical trends.

Our integrated health home (IHH) model focuses on adults and children with serious and persistent mental illness and is offered virtually, through co-location or via full integration as best fits the member.

All three models are based on:

- **Provider identification and support**: Medica will examine and expand the provider network in order to include providers that can sufficiently meet the IHH standards. Medica will provide targeted education and technical assistance to help providers achieve and maintain these standards, which will be closely monitored for successful outcomes for the individual. We select providers who can demonstrate a capacity for:
    - Collecting data, exchange information and monitor population health
    - Tracking progress and outcomes
    - Providing wellness resources
    - Having a culture that supports integration
- **Participant identification and referral:** Staff use several methods to identify potential participants in Medica clinical programs. Program staff run member identification reports from a claims database which is updated at least monthly with new medical, lab, pharmacy and behavioral health claims. Health assessments may prompt a program referral if the respondent reports referral triggers. The programs also accept direct referrals from members and providers, from Medica's contracted health information line, behavioral health vendor and EAP services, and from internal referrals from utilization management, case management and customer service staff. Medica's internal data systems, and its external data feeds with the health information line service, facilitate case identification and referral. Programs are offered on an opt-in basis, so members are not enrolled without their consent. All members are screened for health indicators including BMI, personal/family history, waist circumference, blood pressure, fasting plasma glucose and fasting lipid profiles.
- **Risk stratification and program customization**: Risk stratification begins when participants are first identified for a program. Medica stratifies all members based on an initial risk score. Risk stratification

may identify additional opportunities for intervention; for example, participants needing pharmacy advice and support receive a clinical pharmacy review intervention, participants with congestive heart failure may be offered a home weight scale using the remote health monitoring intervention, and participants with an identified complex behavioral health condition are assigned to an appropriately-qualified staff person who can also authorize behavioral health services as needed. Our Health home model contains identification, stratification, monitoring and evaluation features for all patients, including the gathering and analysis of the Continuity of Care Document (CCD), which outlines all important aspects of the member's treatment.

- **Member and provider information**: Medica informs members about available programs through our website, in member mailings and in new enrollee materials, as well as through interactions with Medica Staff. Providers learn about programs through newsletter articles, clinic-specific education, and meetings with physician groups. Integrated care and case management calls include advice to participants to help them communicate with their providers. Coaches can also provide participants with a letter to share with their providers about Integrated Care and about the participant's individual health goals.
- **Program evaluation**: Program staff monitors member participation and participant satisfaction through member surveys and complaint monitoring. Using a pre-and post-program matched control study design, staff can compare results to previous performance. Effectiveness measures vary by program and may include, but are not limited to:
    - Clinical outcome statistics
    - Cost and utilization statistics
    - Participant goal achievement
    - Participant work history and productivity
    - Participant readiness, activation, motivation and confidence levels

2. Describe strategies proposed to increase health homes participation.

Medica will identify key health home providers and coordinate an introductory training with them so that they are well-versed on providing services as a health home contracted through Medica. Appropriate providers will demonstrate a capacity for implementing the elements and standards required of a health home, including:

- Collecting data, exchanging information and monitoring population health
- Tracking progress and outcomes
- Providing wellness resources
- Having a culture that supports integration

We will provide education and resources, and continue on-going training and technical assistance through regular collaborative meetings to discuss progress and resolve barriers. We will ensure all of our Health home providers adhere to strict quality standards in service delivery and data collection and reporting as well as state and federal compliance criteria, including attaining NCQA and other national accreditations.

We will identify ways to share Medica member level data with health home providers to optimize member care and eliminate the possibility of duplication. Medica will share data available using our algorithm that looks at: utilization, diagnosis, risk of hospitalization, medication/prescription adherence information, and existence of co-morbidities, previous cost and gaps in care data. Medica will ensure that health home providers can accept direct referrals from members and providers, from Medica's contracted health information line, behavioral health vendor and EAP services, and from internal referrals from utilization management, case

management and customer service staff. Medica's internal data systems, and its external data feeds facilitate case identification and referral. Programs are always offered on an opt-in basis, so members are not enrolled without their consent.

Medica proposes to work with the health home providers and leverage opportunities to increase participation in the Health home program. It would be Medica's desire to allow the providers to focus on all the case management, medical and behavioral health responsibilities which allows for the member to receive the most comprehensive holistic care. If health homes are unable to do the outreach to members who have been identified as a good candidate, we outreach to the individual and counsel them on the benefits of enrolling in our health homes to receive all their care in an integrated, cohesive approach which will help facilitate the best health and wellness outcomes. Medica will ensure the health homes work with the participants and allow them to choose the intensity of intervention they would like, such as length and frequency of visits, calls and number of goals to work on. It is our expectation that all health homes will ensure on-going communication with the member and others authorized in their care to ensure they make informed decisions about their wellness and receive the identified supports needed.

Medica also informs members about available programs on its website, in member mailings and in new member materials. Providers learn about programs through newsletter articles, clinic-specific education, and meetings with physician groups. Integrated care and case management calls include advice to participants to help them communicate with their providers. Coaches can also provide participants with a letter to share with their providers about Integrated Care and about the participant's individual health goals.

3. Describe your proposed reimbursement structure for health homes.

Medica proposes a reimbursement structure similar to what the state utilizes today with health homes. We would like to work closely with Iowa stakeholders to learn more about the opportunity to move away from coding payments to a more tailored reimbursement methodology. We envision this to allow providers to be reimbursed using a case rate methodology to manage the entire member that would incorporate the acuity of the population which the provider serves.

Additionally, Medica would ensure that quality is embedded in agreements with health home providers. We would explore the possibility of providing an additional incentive payment to the health home provider for the gathering, tracking, monitoring of data and conducting continuous quality improvement activities identified by the trends of the data. These requirements will be outlined in the Quality Management/Quality Improvement Plan for the providers and will be paid annually if thresholds are met or exceeded.

4. Describe how you will ensure non-duplication of payment for similar services.

All health home associated providers will submit encounters through Medica's claims system, which is programmed to flag erroneous billings, such as duplication of payment for similar services. Medica would build reporting capabilities to ensure members are not receiving same/similar services that are being provided by the health home. We would provide full integration of Medica member data with the health home so members care can be well coordinated in a structured health home.

3.2.10 Chronic Condition Health Homes

1. Describe how you will fulfill the requirements of this section in addition to the general Health home Requirements.

Medica's Chronic Condition Health home (CCHH) model is designed for effective service delivery for adults and children who are identified through predictive modeling as at risk for gaps in care due to having at least one chronic condition and the risk of developing a second condition. "At-risk" members are those with chronic diseases and/or multiple health conditions who are likely, according to predictive modeling, to consume a disproportionate amount of health care resources in the coming year. The nurses and health coaches on the Integrated Care Team work with each member individually, building rapport while identifying and addressing the member's unique health needs. Medica shares relevant data with network providers to support their management of these high-risk patients. We also measure program enrollment, clinical outcomes, utilization and satisfaction to determine impact on care, costs and medical trends. This information assists Medica in creating disease specific programming and helps drive quality projects as we are able to look at the population as an aggregate as well as member level.

As with our Integrated Health Homes, our Chronic Condition Health home model is based on proper identification of skilled providers matched with members in need, using predictive modeling of claims data, member analyzer queries and health assessment data to identify the most prevalent chronic conditions, such as diabetes, asthma and cardiovascular disease, as well as the diagnoses that qualify members for condition-specific programs. Eligible members may also be identified through referrals from providers, health information line or business partners, or by member self-referral.

Medica will ensure an appropriate network of Chronic Condition Health home providers is available to meet the needs of this population. We will provide hands-on education, training and technical assistance in order to support and monitor the providers. Using our data, including the member's CCD, we will ensure continuous quality improvement of the processes and services delivery system to achieve the highest outcomes possible.

3.2.11 1915(i) Habilitation Services and 1915(c) Children's Mental Health (CMH) Services

1. Describe your proposed approach for delivering these services.

The Habilitation Services 1915(i) program allows Medica to provide Home and Community-Based Services (HCBS) to individuals with chronic mental illnesses. This will enable us to assist members in attaining successful outcomes in self-help, socialization and adaptive skills in the least restrictive settings. The 1915(c) Children's Mental Health waiver will allow Medica to offer a variety of home and Community-Based services to children with emotional disturbance (SED) including case management, personal care, habilitation and respite care.

Medica will seek to contract with existing Habilitation Services and Children Mental Health Waiver providers, including targeted case management or community-based case management providers. It is our intent to make this transition to managed care as seamless as possible from a member/ family perspective. Medica values the established relationships providers have with these members and will strive to maintain continuity of care as much as possible. Medica has an established, robust, delegation oversight process which will be utilized with these community providers. This process, which includes an annual audit and ongoing training for case managers, enables us to ensure that services are being provided consistent with Medica's high quality standards and State of Iowa requirements.

Medica will utilize existing claims data, as well as referrals from providers, case managers, member/family and the daily hospital admission report as a means of identifying members who might be eligible as potentially meeting an Institutional level of care and in need of institutional placement or in need of Habilitation Services or Children's Mental Health Waiver Services. Members identified will receive outreach from Medica staff.

ASSESSMENT

Member's identified as potentially eligible for Habilitation Services or Children's Mental Health Waiver Services will be initially assessed with thirty (30) days by a Community-Based Case Manager or Targeted Case Manager as appropriate, using the State designated and approved InterRAI Tool, or other assessment tools as developed and approved by the State of Iowa. The assessment includes a face-to-face interview of the member, member's family and others as appropriate. In some instances, the member's medical record is also available for review. Results from the assessment are used to build the member's person centered plan of care. In addition to the face-to-face assessment, Community-Based Case Managers make contact with the primary care physician, mental health providers, Community-Based providers, caregiver and others involved as needed to obtain relevant information.

If a member is assessed as needing additional assistance from home and Community-Based services, the Case Manager can assist the member in applying for and accessing services through the 1915(c) HCBS waiver program and/or community services. Those members who decline services that could reduce safety risks must have a Risk Management Plan developed as a part of their plan of care; these individuals are considered vulnerable. A full reassessment occurs at least annually with all members or with a members change in condition. Change of condition reassessments will be completed within five (5) business days of the change or hospital discharge. Case Managers will reach out to members within one (1) business day of any transition in care. Medica will track assessment dates and eligibility expiration dates to ensure that members remain eligible for the program and their needs are being met in a safe manner. Medica will submit all assessments to the State of Iowa using the system determined by the State for final determination and will comply with all DHS findings. Medica will maintain all documentation of all assessments and will make it available to the State upon request.

In the event that there is a waiting list for the Children's Mental Health waiver, the Case Manager will provide the member with information about the waiting list and will assist the member and member's family to identify and obtain alternative Community-Based resources to meet the member's needs and ensure safety.

BALANCING INCENTIVE PROGRAM

We congratulate Iowa on its proactive approach to implementing the Balancing Incentive Program (BIP) requirements of the Affordable Care Act. This work aligns with efforts currently underway in Minnesota that we are participating in. We value the right of each individual to remain in their community in the least restrictive environment. We look forward to collaborating with the State to structure a health care system for members in need of Long Term Services and Support (LTSS) in compliance with the following requirements of the (BIP). We will establish policies and procedures for State approval that align with these requirements and will educate our staff, members, providers, and community stakeholders as appropriate.

NO WRONG DOOR/SINGLE ENTRY POINT SYSTEM (NWD/SEP)

Community-Based Case Managers and Medica staff will partner with no wrong door staff and programming to ensure member's needs are met in a timely, seamless and appropriate manner. We have a long history in Minnesota of working with the Senior and Disability Linkage Lines, which have similar functions as the no wrong door system.

- Increase the accessibility of LTSS by providing information to individuals about programs and linking them to services.
- Offer a community LTSS enrollment system that increases uniformity across the state regarding how individuals are evaluated for services and how service needs are assessed.
- Provide a more streamlined experience for individuals using the system regarding information collection and exchange.

CONFLICT-FREE CASE MANAGEMENT

- There is separation of case management from direct service provision.
- There is separation of eligibility determination from direct service provision.
- Case managers do not establish funding levels for the individual.
- Individuals performing evaluations and assessments or developing plans of care cannot be related by blood or marriage to the individual or any of the individual's paid caregivers with certain responsibilities.

A CORE STANDARDIZED ASSESSMENT INSTRUMENT

We have experience partnering with Minnesota DHS in the development and implementation of a new assessment tool being utilized across the Medicaid program. Medica would be happy to work in a collaborative nature with other MCO's and the State to implement a core assessment instrument. We feel that a standardized assessment tool should include elements that address the individualized needs and supports of each member, and should be person centered in nature written in plain language.

- Determining eligibility for Medicaid-funded LTSS
- Identifying individuals supports needs/assessment
- Providing information to identify and inform beneficiary's service and support planning needs (plan of care)

PERSON CENTERED SERVICE PLAN

The InterRAI, in addition to being used to determine eligibility for Habilitation Services and Children's Mental Health waiver, is used to develop the member's person centered service plan. The person centered planning process will include member, member's family, integrated health home staff and others as identified and chosen by the member/member representative. The service plan includes the risks and needs identified through the assessment process and includes the unique primary care, acute care, long-term care, mental health, and social service needs of the member. The service plan includes interventions, based on prioritized member goals, designed to mitigate risks and special needs identified through the assessment process. The service plan should also address the underlying barriers to meeting the member's prioritized goals or complying with the service plan and will include an emergency back-up plan and crisis response plan. The plan should also include the member's emergency plan to ensure members health and safety needs are identified and covered in the event of an emergency. The service plan will incorporate covered benefits and services available through the formal, informal, and quasi formal community services needed as identified by the InterRAI. For members in a home based habilitation service will include the members living environment, number of hours per day of on-site staff supervision, number of other waiver consumers who will live with the member and identification and justification of any restriction of the member's rights. Analysis and discussion with the member/member representative will occur prior to finalizing the service plan.

The Community-Based Case Manager/Targeted Case Manager shares the documented service plan with the member/responsible party and the member's team at least annually and as needed when the member's condition changes. Case Managers assess progress toward goals during telephonic consults and face-to-face visits. If the member is not making progress, the Community-Based Case Manager will consult with the member and/or other members of the ICT to determine if the goal is still relevant, if the interventions need to be changed, if the goal has been achieved, and/or how best to reach a goal.

Medica values the person centered planning process, and will ensure case managers have the necessary training and expertise to follow the Iowa DHS requirements of establishing a person centered service plan.

FREQUENCY OF CONTACT

At minimum, Members enrolled in the Habilitation Services program or the Children's Mental Health Waiver, will be contacted at least monthly either through in person or telephonic contact. Face-to-face visits will occur at least quarterly as per the requirements listed in the scope of work.

MONITORING OF SERVICES

Case managers will contact members within five (5) business days of service implementation to ensure that services have started and are meeting the member's needs. Medica will utilize its documentation system to document service referrals and alert the case manager of the required outreach with the member.

2. Describe your experience serving similar populations, if any.

Medica has extensive experience in serving adults with chronic mental illness and children with serious emotional disturbance through our qualified network of providers, clinicians, programs and facilities to serve the health needs of our members in the most effective manner in the least restrictive setting. Given our prior experience in this area, Medica understands that members often have co-occurring disorders that require attention and support. Medica has a long-standing history of contracting with community partners who have knowledge to provide the necessary services for members with unique needs, and who understand the geographic resources and limitations encountered by members in the community. Medica uses an individualized, out-of-the-box approach to meet member's needs when resources are not readily available in

the member's community. For thirty (30) years, we have provided services and supports to these populations in prevention, self-assessment, education, self-management, coordination of care, transition, psychosocial support and emergency care. We contract with psychiatrists, licensed psychologists, clinical social workers, clinical nurse specialists, substance abuse programs, residential and acute care mental health and substance abuse facilities to provide services such as:

- Individual, family and group therapy
- Psychiatric evaluation and medication management
- Hospitalization when medically necessary
- Attention deficit disorder diagnostic evaluations and testing
- Assessment
- Individual treatment planning
- Outpatient and residential substance abuse programs

3.2.13 Iowa Health and Wellness Plan Benefits

1. Describe how your proposed approach will ensure Medically Exempt members will receive State Plan benefits.

Ensuring that members receive their rightful benefit package in a safe and clinically appropriate manner is a central tenet of Medica's approach to managing health care operations for the State of Iowa. We will develop and implement a system of care that not only offers all necessary services to members, but also has strict internal controls to guarantee the program remains fiscally prudent in order to meet our fiduciary obligations to the State.

The State Benefit Plan, also known as the State Medicaid Plan, offers an array of services to eligible members as indicated in Exhibit D of the RFP; individuals who do not qualify for the State Medicaid Plan may be enrolled in the Alternative Benefit Plan (ABP) approved by the Secretary as required by the Affordable Care Act (ACA). While not quite as comprehensive as the State Medicaid Plan, ABP members will have access to a generous set of covered services. These individuals will be uniquely identified in Medica's state-of-the-art enrollment and eligibility system, which will assign them to the associated covered services group allowable per the ABP. The Provider Portal will reflect the member's assigned benefits group in real time, and link the provider to resources detailing which covered services are permissible under each plan type. Furthermore, marketplace members will have their commercial payer identified as a form of Third-Party Liability (TPL) in the eligibility system for encounter adjudication. All incoming service claims and encounters will first be vetted against the member's corresponding benefits package and maximum service limit threshold algorithms, then against National Correct Coding Initiative (CCI) standards, prior to adjudication.

In order to proactively ensure that no member is denied essential services, all Medicaid-eligible members will be defaulted into the State Medicaid Plan, as detailed in the RFP. However, should the State determine that a member meet's the criteria to be determined 'Medically Exempt', Medica will formally contact the member within thirty (30) days of the State's determination to discuss the member's right to opt-out of the Medicaid Plan and instead receive services through the Iowa Wellness Plan. The member shall retain the right to opt-out of the State Medicaid Plan so long as they retain 'Medically Exempt' per the State of Iowa. Should a 'Medically Exempt' member choose to opt-out of the State Plan, the member will be auto-enrolled into the Iowa Wellness Plan and Medica will notify the State of this action. Similarly, should a member lose Medicaid coverage, or experience an enrollment gap in their Medicaid eligibility, the member's benefit package assignment will be updated in our enrollment system to reflect the services, if any, now available to the member based on the state's determination of their current or prospective eligibility.

2. Describe your proposed strategies for implementing retrospective claims analysis to determine if a member is Medically Exempt.

Medica will implement retrospective claims analysis system to identify members who may fit the criteria of 'Medically Exempt' but have not yet been given deemed status by the State of Iowa. This process will be redundant, and comprised of the following activities:

- Ninety (90) days prior to a non-Medically Exempt member's Medicaid renewal date, as indicated on the 834 HIPAA transaction, Medica's information management system will conduct an automated review of services administered during the current contract year in which the service suggests the member may meet the standards to be determined as 'Medically Exempt'. This includes, yet is not limited to claims with an ICD-9 or ICD-10 code referencing any Disabling Medical Disorder as indicated in table 3.2.12.1 of the RFP; multiple claims with a primary ICD-9 or ICD-10 code referencing substance

dependence, and claims for Hospice care. Should a member be identified through this monthly process, their Care Coordinator or Case Manager shall be instructed to review the record and determine if, based on their sound clinical judgment, the member should be deemed as 'Medically Exempt' pursuant to 42 CFR §440.315(f). The provider must indicate this review in the member's medical record and complete the Medically Exempt attestation and referral form, and submit to the state for final determination.

- All non-Medically Exempt members who meet the criteria of a high-utilizer of services will be flagged for potential medical exemption. These are individuals receiving services in an amount exceeding three (3) standard deviations from the mean service volume of the overall population, placing them in the top ninety-seven percent (97%) of utilizers. Individuals in this category are using care at a significantly higher rate, statistically, than their peers – which is indicative of extreme need for services. Similar to those in the earlier group, the provider will be instructed to review the record and determine if, based on their sound clinical judgment, the member should be deemed as 'Medically Exempt' pursuant to 42 CFR §440.315(f). The provider must indicate this review in the member's medical record and complete the Medically Exempt attestation and referral form, and submit to the state for final determination. Furthermore, cases falling in this category will be closely scrutinized by the utilization management committee, in close collaboration with the Medica's Program Integrity unit, as these cases are often signs of fraud or program abuse.
- A review for 'Medically Exempt' status shall be included in all routine clinical case audits performed by Medica's Quality Management, Utilization Management and Grievance and Appeal teams. Team members will receive training on the criteria for 'Medically Exempt' status and will identify members who may qualify during the case review process. The information will be relayed to the respective provider who will be instructed to review the record and determine if, based on their sound clinical judgment, the member should be deemed as 'Medically Exempt' pursuant to 42 CFR §440.315(f). The provider must indicate this review in the member's medical record and complete the Medically Exempt attestation and referral form, and submit to the state for final determination.

The above actions represent our commitment to identifying members who may meet the criteria to be considered Medically Exempt and subsequently ensuring that these individuals are appropriately referred to the state for determination so they can be provided the necessary benefits to ensure their medical, behavioral and/or developmental conditions are adequately addressed.

3.2.14 Value-Added Services

1. Describe any proposed Value-Added Services.

All programs, operations and functions of Medica are focused on one primary goal - improving the health and wellbeing for our members. Our programs provide personalized solutions that focus on the whole person, and include a comprehensive set of value-added services such as:

- Gift cards for receiving certain preventive health visits
- Reduced monthly costs at Fitness centers
- Health and wellness coaching
- Care coordination programs
- Healthy food savings

We have extensive experience designing and developing value-added programs that emphasize prevention and primary care and help to avoid chronic illnesses. Value-added programs are provided free of charge to members, and program costs will not be passed down to service providers.

Medica will seek feedback and approval from the State prior to implementing any value-added programs, including the program's targeted population(s), expected outcomes, and monitoring mechanisms.

EXAMPLES OF VALUE-ADDED SERVICES

My Health Rewards by Medica: In 2001, we introduced an incentive program for members called My Health Rewards by Medica℠. It was the first comprehensive preventive health program for Medicaid members in Minnesota. Members receive gift cards for making healthy choices including EPSDT screenings, prenatal and postpartum visits, cancer and chlamydia screenings. In 2015, we made changes to the program based on feedback from county partners. We have increased the incentive amounts for several programs (including adolescent EPSDT screenings and pregnancy-related visits). We are also adding several new incentives including an adult preventive care visit and a diabetes management incentive.

Chronic conditions health care homes: Medica piloted clinic-based chronic condition care management with several primary care clinics to determine if chronic condition management, traditionally provided by health plans, could be more effective if managed by the primary care providers. Results of this pilot proved successful - emergency room visits and inpatient admissions decreased, while medication compliance and primary care office visits increased. Based on these results, Medica has expanded its chronic condition health care home program to additional clinics. Medica is currently the only health plan in Minnesota that supports both the state's health care home model and its exclusive chronic condition health care home program model.

Targeted outreach to members: We have also developed outreach plans to motivate members to make healthy choices through promotion of these incentives. We target members who are identified as high risk (such as those identified through the Pregnancy Program or Health and Wellness Coaching program). In addition, because many chronic conditions are linked to smoking, we offer a telephone-based and online tobacco cessation program at no cost to members.

Medica also offers proven **Health and Wellness programs** that support members who are at-risk for chronic diseases and multiple health conditions in developing the skills, knowledge and confidence to self-manage their health and well-being. Gift card incentives are offered for meeting milestones.

Our **liveandworkwell.com** portal is open to members and focuses on mind-body integration for a practical, low-cost approach to wellness. The portal provides member access to care and benefit self-management tools, prevention programs, searchable directories, educational materials, calculators, videos and more. There are

specific tools developed for members with dual diagnosis including member self-screening and management tools.

Additionally, as a part of our recovery-oriented care, we try to leverage natural supports for members as much as possible. Our Community Resource Database (CRDB) contains over 100,000 resources nationally and assists our staff to link members to resource needs in addressing substance use disorders and the social/environmental impacts of alcohol/drug abuse. A version of this database is available on our member portals.

2. Provide any applicable data on improved outcomes linked to Value-Added Services you have implemented in other states.

Health and Wellness Coaching program: Evaluation of the Health and Wellness Coaching program found a $343 per participant per month cost savings in health care expenditures, and a 96% of member overall satisfaction with the program.

FitChoices Utilization: Fit Choices reimburses members for health club usage. The following represents member participation in the program:

2014 FIT CHOICES UTILIZATION AMONG SPP MEMBERS		
MEMBERS ENROLLED	**QUALIFIED REIMBURSEMENT**	**% OF QUALIFIED/ENROLLED**
17,147 - all	2,887	16.8%
8,900 – non-Metro	1,321 – non-Metro	14.8%
8,247 - Metro	1,566	19.0%

Healthy Savings utilization: The Healthy Savings Program provides members with a discount card to receive healthy foods at discounted prices at local participating grocery stores. The following represents member utilization of this program:

	CARDS ISSUED	REGISTERED	REGISTERED %	ENGAGED	ENGAGED %	TOTAL SAVINGS
SPP Membership	104,251	14,742	14%	6,869	47%	$14,083
Additional request for weekly mailing		11,000				
Engaged = Members who have successfully used their card at least once.						

Medica looks forward to implementation and successful outcomes for Value-Added services provided in Iowa.

3.3 Continuity of Care

1. Describe your strategies to ensure the continuity of care of members transitioning in and out of the program, and transitioning between Contractors and funding streams.

Medica recognizes that the clinical needs and living situations of our member population are dynamic and constantly changing; as such, it is critical that robust systems be in place to address member transitions in and out of the program, across funding streams, and among the various state contractors, in a manner that respects a member's right to choose from a selection of highly-qualified providers offering medically-necessary services, while permitting new members to continue to receive services for a respectable period of time from their prior provider, even if said provider may not be contracted to render services in our network. All operations will be established and managed in accordance with, and in compliance to, the State's 1915(i) and 1915(c) waivers.

In order to promote a fluid member transition and ensure continuity of care, Medica will utilize its Information Systems, specifically an enrollment and eligibility system populated by the 834-HIPAA transaction set, to capture and rapidly analyze all pertinent member data. This system will flag members with upcoming transitions as indicated on the Health Plan Start Date and/or Health Plan End Date segments. The 834-file format provides a rich set of information on all members assigned to, or transitioning to Medica, this includes demographic data, eligibility dates, health plan assignments, commercial payers; furthermore, when a member transitions to another contractor, the 834-disenrollment file will indicate which contractor the member will be assigned to in the future and the date of transition. Medica will use this information to effectively coordinate care for the member during the transition period in order to provide the new contractor with all necessary patient related data, including existing Prior Authorizations, utilization data, the name and address of the member's primary clinical team, and the name and address of the member's PCP. Medica will work proactively with the other program contractors to develop a standardized file set to be used during a member transition to transfer this information electronically and with minimal administrative burden. Finally, the 834-file also includes eligibility rate codes – which establish the appropriate funding stream for the member and are used to determine the corresponding service benefit package available to that individual.

To begin, upon contract start date and for one (1) year thereafter, Medica will honor all existing Prior Authorizations for covered services for a period of ninety (90) days for members transitioning into the Medica system. Additionally, Medica will allow incoming members receiving services from a non-network provider to continue their treatment with that provider for a period of ninety days while making commercially reasonable attempts to contract with said provider(s).

After the first year of operation, Medica will honor all existing Prior Authorizations for covered services for a period of 30 days for all incoming members. Should the member's Prior Authorization be for services rendered by a non-contracted provider, Medica will determine if a comparable provider exists in-network and, if so, work to transition services to that provider upon the end of the ninety (90) or thirty (30) day period should the need for continued services exist at that time. However, should there be no contracted provider able to offer the services necessary to the member after the ninety (90) or thirty (30) day period, Medica will evaluate other options to ensure the member receives appropriate care, this may include developing a single-case agreement with the non-contracted provider, or adding said provider to the service delivery network.

We will appropriately coordinate care for members transitioning out of the Medica network during a period of inpatient stay, and be responsible for inpatient hospital services rendered to a patient hospitalized at the time of disenrollment for a period of sixty (60) days or until patient discharge, whichever is less, except in situations in which the member loses Medicaid eligibility. Similar to any member transition, Medica will work collaboratively with the receiving contractor to ensure they are aware of the member's inpatient status and

history, as well as notify the hospital of the change in program enrollment and to define financial responsibility.

Members receiving Residential Treatment or Long-Term Services and Supports, shall continue to receive these services post transition as prescribed by the RFP. Medica believes that inappropriately and unnecessarily interrupting care for individuals in these more regimented treatment environments can be counterproductive, and in many cases may actually cause the member to decompensate; therefore, continuity of care in these settings is of critical importance and a transition to a different provider would only be considered under certain conditions, including an explicit request by the patient or their representative.

3.4 Coordination with Medicare

1. **Describe your proposed approach and strategies for coordinating care for duals (members with both Medicare and Medicaid coverage).**

GOVERNMENT PROGRAM COORDINATION

Medica will ensure that members with concurrent Medicare and Medicaid eligibility receive high quality, effective care. Our approach emphasizes education and assistance to members regarding available programs and navigating the enrollment process. We will also prioritize maintaining a service network that offers members a choice of multiple providers capable of treating their unique needs, and reducing the procedural burden both members and providers experience when attempting to meet the various requirements of both Medicare and Medicaid. Our Community-Based Case Managers and Care Coordinators will serve as a first contact for members, providing them assistance in navigating their Medicare and Medicaid benefits.

A July 2014 study by Modern Healthcare found that members who were eligible for both Medicare and Medicaid were opting out of voluntary programs designed to effectively coordinate their care at high rates. Specifically, researchers found that dual-eligible members often struggled to navigate the rules of the two programs, were concerned they would not be permitted to remain with their trusted provider, and feared they would be eligible for fewer services if they remained in the program intended to streamline their care. Although the overall population of dual-eligible members may not be exceptionally large when compared to the overall CMS population, these members often present with higher acuity and require a more comprehensive array of services, further underscoring the need for a care coordination program to improve their health outcomes and control costs.

MEMBERS NEEDS ARE PUT FIRST

These findings provide significant warnings to any health care system attempting to manage care for dual-eligible members. It is imperative that any program for duals be seamless, simple for the member to navigate, and provide real-time assistance from a qualified Case Manager or Care Coordinator as needed to ensure positive health outcomes. Furthermore, a member should never be forced to choose between effective care and their trusted provider. Therefore, providers must be incentivized to accept dual-eligible members and the system must reduce the administrative burden of participation in the program as much as possible. It is our intention to develop a widespread network of highly qualified providers available to serve this group.

2. **Explain how your staff will be trained to assist dual-eligible members with questions about benefits, appeals, grievances, and other topics where Medicare and Medicaid policies may differ.**

EXPERIENCE WITH DUAL ELIGIBLE MEMBERS

Medica is very familiar with how to coordinate benefits with members who are dual-eligible related to products we offer in Minnesota currently. Medica will incorporate the intricacies of serving dual-eligible members into the initial and annual training requirements for customer service, quality and utilization management, grievance and appeal, network management, Community-Based Case Managers and clinical services staff. Because of the critical need to ensure the needs for these members are properly addressed, these trainings will be developed and updated as necessary to reflect any and all pertinent changes to Medicare or Medicaid rules that may impact the care provided to dual-eligible members. Our product teams

will continuously source new and relevant trainings from CMS, and other reputable organizations and incorporate that information into our internal curriculum.

In 2014, Medica contributed to a brief titled "Strategies for Hiring and Training Care Managers in Integrated Programs Service Medicare-Medicaid Beneficiaries" prepared by the Center for Health Care Strategies. The brief is located within Tab 5 of this proposal.

For members working with a Medica Community-Based Case Manager, Medica will have a process in place where the Community-Based Case Manager will know who to call at Medica to ask questions related to Medicare and Medicaid benefits. We will also provide ongoing training related to working with dual eligible members as we believe it is important to keep those working directly with the members updated and informed in order to provide the highest level of service and support to the member. Having an understanding of the difference between Medicare and Medicaid is critical so that staff working with members are able to give them all information necessary to make an informed decision.

Furthermore, all contracted providers will be supplied with informational materials related to the dual eligible population, their benefits and rights to appeal or file a grievance. We will require this information to be posted conspicuously in the patient lobby of all contracted providers and made easily accessible in plain language on our website.

SECTION 4: LONG TERM SERVICES AND SUPPORTS

Please explain how you propose to execute Section 4 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience. Provide any relevant data regarding member or provider satisfaction with MLTSS programs you operate in other states.

Medica has been a leading managed care organization in Minnesota for more than 30 years. With approximately 1.5 million members, we provide health care coverage in the employer, individual, Medicaid, Medicare and Medicare Part D markets in Minnesota and a growing number of counties in North Dakota, South Dakota and Wisconsin.

We have a long history of providing services designed to meet the enhanced needs of seniors and persons with disabilities. We also offer national network coverage to employers who have employees outside Medica's service area. Our Government Programs division (which includes State Public Programs and the Center for Healthy Aging) offers a wide range of services to make it easier for our members to access the health care they need. We do this by helping them navigate the changing healthcare landscape and providing them with the right products, services and assistance they need at the right time.

Medica has been a leader in serving Minnesota Senior Health Options (MSHO) members through our Medica Dual Solution product since 1997. When the Centers for Medicaid and Medicare Services approved the first ever state dual demo for Minnesota in 1995, we were among the first health plans to be selected to offer the product in the 7 county Metro-area. By 2010, MSHO was offered statewide; Medica was available in 33 counties.

Between 2010 and 2030, the number of adults age 65+ is expected to nearly double. This population often faces a greater number of health disparities and barriers to care. Our programs are designed to provide more seamless access to primary, acute and long term care services for seniors due to a complex set of medical, social, and long-term care needs. We will design a program to provide Long Term Services and Supports (LTSS) in Iowa based on the principles learned in Minnesota that support the Iowa Department of Human Service's objective to facilitate maximum community placement and participation for members that require LTSS.

We understand the urgent need to be innovative and collaborative in developing and enhancing programs and services for members receiving LTSS services. Through our unique member-driven, member-focused care coordination model, we have been committed to partnering with counties and community agencies to provide coordinated care to members. We believe this partnership model pairs our health plan analytics expertise with the knowledge of our community partners' resources and community needs to provide superior service. Our case management model entails providing face-to-face assessment, care planning and support to Medicaid members.

From an individual member level, health and wellness is a priority. For many years, we have offered our members access to an exercise program (currently Silver & Fit) and to Medica's Disease Management programs. More recently, we have been able to offer some valuable services outside of the typical benefit set. In 2013 and 2014, we provided access to seven Nutritional Training Counseling Sessions through a contracted provider to address general or specific nutritional issues. We have also offered our senior members coverage for an evidence-based wellness promotion class or series to promote overall health and wellness. Also offered to our senior members is a post-hospitalization stabilization benefit, including time limited "waiver like" services to non-waiver members recently discharged from the hospital with the goal of preventing re-admission. The length of these added benefits are one year, and they are reevaluated on an annual basis.

We are also able to support a great deal of community-based work through the Medica Foundation. The Medica Foundation supports activities that serve as incubators for ideas, catalysts for systemic change, and bridges to greater insight, information and understanding. The Foundation provides seed money for community-based programs that address the underlying causes and factors inhibiting optimal health. Past grant recipients include counties and, specifically, county public health departments who are doing innovative programing and services. This includes work with community members of all ages.

Medica prides itself on our work with Medicaid members, and our ability to think creatively and encourage innovation. We also take feedback from our constituents very seriously, and use it to continually improve our products and services. We look forward to the opportunity to bring this innovation to Iowa. Member feedback is obtained in a variety of ways, including stakeholder groups, member surveys, and a review of grievances. Some examples of quality improvements include:

- Access to preventive care: Education and training occurs at both the clinic and case management level about the importance of preventive care for members. We conduct chart reviews and provide education to clinics. One component of preventive visits that has shown substantial improvement for Medica members is screening for alcohol use/problem drinking using a formal screening tool.
- Advanced care planning: Medica is a part of Honoring Choices Minnesota and we have done extensive training on multiple levels about the importance of advanced care planning. Medica staff provides education for clinic staff and places underperforming clinics on Corrective Action Plans, which have contributed to improvements in our metrics in this area. In addition, we provide training to our case management teams on the importance of advance care planning.
- Follow-up after hospitalization for mental illness: Medica Behavioral Health (MBH) staff focuses on follow-up after mental health-related hospitalizations. They developed a measure that looks at appointments kept and apply that measure to facility ratings. In addition, MBH established a workgroup to evaluate processes, analyze data related to re-hospitalization, follow-up after hospitalization by providing 7 and 30 day appointments and average length of stay (ALOS), and evaluate interventions that support these measures.
- Silver&Fit®: We have improved our fitness benefit that empowers our members to improve their health through education and exercise. In addition to providing access to fitness facilities or exercise centers, an online article library, health trackers and exercise planners, this program now has the added benefit of allowing members to work out in the comfort of their own home with a selection of up to two exercise kits per year with different focuses and themes. This benefit is currently offered to seniors and persons with disabilities enrolled in Medica programs. Medica will explore the possibility of offering a similar fitness benefit to Iowa Medicaid members.

Ultimately, we believe that our communications and partnerships with the community partners are one of the most important tenets of our work. We value the expertise the counties, tribes, and community agencies have, recognizing that each area of the state, including urban and rural has unique community strengths and barriers. It's the individuals residing and working in that area that have specialized knowledge of the challenges and opportunities.

In addition, we have dedicated Medica staff to work with the community partners on items such as contracting, case management training, and general feedback and issue resolution. Having a team devoted to maintaining our positive community partnership has been critical to our success. We have received positive feedback from our partners on the value of this relationship.

EXPANDING OUR EXPERTISE IN IOWA

We are excited for the opportunity to respond to this RFP to contract for the delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (*hawk-i*) programs. The proposal that follows represents our understanding of the services requested in this RFP, our solutions to the challenges of providing care to this vulnerable population, and our commitment to being a strong partner with counties, community agencies and tribal staff as the health plan of choice for Iowa Medicaid recipients.

Medica's strengths in the implementation of our Medicaid products include our historical perspective since the launch of the program in Minnesota; our commitment to developing innovative partnerships with counties and community organizations; our unique person-centered care coordination model; and our breadth of programs and services that assist members in getting and staying healthy.

Collaborative Model

Medica has strong partnerships in order to provide LTSS in Minnesota. We will leverage our expertise in this area to create the necessary partnerships in Iowa. Our approach will be to collaborate and innovate to improve the overall health of our members.

We have been a leader in serving Medicaid members through our face-to-face case management model since 1997. Our innovative case management model embodies a very person-centered approach and assures that members and their families are involved in directing their own care. Our Case Managers work with members to build and maintain an independent and healthy life. We understand the opportunity that exists to strengthen relationships with organizations that specialize in the needs of this population, and strive to maximize these connections.

The network of case managers that has been developed by Medica with the contracted counties and agencies allows the member to be served by a case manager who resides in the community/county. Our intention is to partner with local Iowa community/county based providers. This allows the member to have a local expert who is aware of the services, providers and organizations available to meet member needs through formal, semiformal and informal service providers.

Providing Education and Support

Customer Service: We will leverage our customer service expertise to build a similar model in Iowa. Our State Public Programs customer service call center has dedicated phone lines that connect our members to English as well as bilingual staff who speak Hmong, Russian, Somali and Spanish. We can help our members arrange for transportation, interpreter services for health care visits, and answer coverage questions.

> We have a dedicated customer service line for members who have a community-based Case Manager through Medica, which is staffed by individuals with deep knowledge of Medicaid and waiver programs.

Medica Nurse Line: Registered nurses provide self-help tips and assist our members in finding a provider for their primary, specialty and urgent care needs, 24 hours a day, 7 days a week. This helps ensure our members receive health-related answers in a timely manner. Our members also can chat online with a nurse.

Member newsletters: We will develop customized newsletters specific to the needs of Iowa members. For example, Medica has a newsletter specific to case managed members. These member newsletters are published semi-annually and present health-related information from a variety of medical experts. The newsletters, one for senior members and one for persons with disabilities, are delivered by Medica's case

managers during in-person member visits, helping to reinforce the member education provided during the visit.

Supporting community-based case management: Our first priority when entering a new county or region is to contract with the county and local community agencies to provide case management. Since 2008, Medica has expanded our service area in Minnesota. We have been successful through this process in contracting with local community agencies and counties. We believe in the value of local case managers in understanding county-specific issues and opportunities and intend to build a similar model in Iowa

The Medica Foundation: The Medica Foundation funds community-based programs and initiatives that provide sustainable, measurable improvements in the availability, access and quality of health care. In addition, the Medica Foundation supports efforts that reduce health care disparities and address the social issues driving health care costs. In 2014, the Medica Foundation awarded $1.4 million in grants to 102 nonprofit organizations throughout Medica's service area, which includes Minnesota, North Dakota, South Dakota and western Wisconsin. The Foundation's 2015 funding priorities continue to address community health needs in the areas of behavioral health, early childhood health, Alzheimer's disease, organizational core mission support and general health improvement.

Health Fairs: Medica participated in the Iowa Association of Community Provider Annual Convention in May, 2015. Medica strives to play an active role in sponsoring, exhibiting and participating in community health fairs because we believe it's important to be a part of the communities we serve. In 2013, we participated in approximately 15 health fairs throughout the state. In 2014, Medica has been placing an increased emphasis on identifying and participating in seniors-focused events. We would have a strong presence at community events in Iowa.

OBTAINING COMMUNITY INPUT AND FEEDBACK

Stakeholder feedback is critical to our continued success. Medica would establish opportunities to seek community input and feedback from Iowa members and stakeholders, including specific forums for each waiver type. We have extensive experience in conducting stakeholder forums in Minnesota. Currently, we hold 6-8 member and stakeholder forums each year, targeted at a variety of groups. These are highlighted in the table below.

FORUM	TARGET AUDIENCE	FREQUENCY
Special Needs Basic Care stakeholder forum	Adults with disabilities Community and county partners that work with these members	2-3 times/year
Minnesota Senior Health Options stakeholder forum	Older, low-income adults Community and county partners that work with these members	2-3 times/year
Community Advisory Council	Members on Medical Assistance or MinnesotaCare Community and county partners that work with these members	2 times/year
Fireside chats	New initiative in 2015 focused on engaging members on a more grassroots level. Target for each meeting: 6-10 members, hosted in a variety of community settings	6-8 times/year

OUR EXPERIENCE AND RESULTS

Medica's State Public Programs (SPP) department has grown and evolved throughout the years to meet the changing needs of our members, providers and community partners. Medica's organizational culture is one that puts our members first. Our staff members are driven by a strong desire to serve our members, develop effective and impactful partnerships and improve health outcomes.

Our goal at Medica is to improve the health of our members and reduce the barriers that stand in the way of optimal health. We understand the power of collaboration as we work with stakeholders in the community to improve health outcomes and promote health literacy. We are excited to bring the expertise of our health plan to members in Iowa.

Recent accomplishments include:

- The Medica Foundation in 2013 made $1.4 million in grants to 93 nonprofit organizations throughout Medica's service area, which includes Minnesota, North Dakota, South Dakota and western Wisconsin.
- In 2012, Medica's Wellness Preferred Integrated Network program, serving persons with disabilities, was awarded the Minnesota DHS Commissioners Circle of Excellence Award. The Wellness Preferred Integrated Network (PIN) brings together resources to improve and coordinate physical and mental health care services for people with mental illness, up to age 65, living in Dakota County. The public-private model provides a wellness navigator to each client to help them attain comprehensive and individualized care planning and care coordination.
- The Medica Research Institute, launched in 2010, conducts research that can be translated into activities that protect health and improve lives. Current research is focused on three main themes: improving the efficiency and effectiveness of the provider system; improving the way consumers get involved in their own health; and the importance of creating environments that make it easier for people to make healthy choices.

Medica's Minnesota Medicaid HMO achieved the highest ranking in the state from the prestigious National Committee for Quality Assurance (NCQA®). Medica is ranked 18th of Medicaid HMO plans in the United States.

MEMBER SATISFACTION WITH COMMUNITY-BASED CASE MANAGEMENT SERVICES

We conduct a variety of surveys with our membership. For example, we complete an annual case management survey with senior members to help evaluate the effectiveness of our case management program. The survey is sent by mail to a random sample of members, with careful consideration to send to members from each contracted case management delegate, with analysis at both the plan and delegate level. For members whose primary language is not English, surveys are available via phone using bi-lingual staff members. We will work together with DHS to establish a survey for members in Iowa.

2014 Survey Results

- 89% indicate satisfaction with community-based case management services.
- 94% indicate their community-based Case Managers explain things in a way the member can easily understand;
- 91% of members know how to contact their Community-based Case Managers.

Responses are reviewed and analyzed for possible improvements. For example, after survey analysis in 2013, we made changes to a document developed for Case Managers to leave with members. This document describes the role of the case manager and helps the member understand what the case management can

help with. It provides the member with the information on their individual case manager, as well as suggestions on when to contact. The document has information that would be applicable to Iowa membership.

4.1 General

1. Explain how you will ensure that individuals are served in the community of their choice and that funding decisions take into account member choice and community-based resources.

Medica prides itself on our history and willingness to create partnerships with community providers. Through this RFP process, we've already begun networking with Iowa providers to understand the unique needs of the residents.

Medica and its contracted community partners in Iowa will establish procedures to ensure members' access to an adequate range of services, providers and Community-Based resources. We engage in numerous strategies to establish a comprehensive network ensuring choice of providers and community-based resources are available within member's communities. Identification of network gaps is an essential start to assuring network adequacy for providers, including home and Community-Based service providers. To monitor this we will:

- Conduct network sufficiency analysis
- Regularly meet with stakeholders to discuss known and perceived network gaps and problem-solve to address those gaps
- Capture access to care complaint information from members, county, state and community stakeholders
- Review and track member and family service authorizations to identify providers who are not in the network but who are providing services to our members which results in evaluation of these providers for inclusion in our network

Numerous counties within Iowa have been designated as Health Professional Shortage Areas (HPSA). We will use tactical approaches to increase the number of local LTSS providers and community-based resources who serve our Medicaid members. These efforts are based on the identified locations of service gaps and may include:

- Outreach to non-network providers to encourage them to enroll in our network
- Contacting existing providers to encourage them to expand their capacity in areas of the Counties that have needs
- Meet with providers across the state to discuss their willingness to provide services in all Counties through telehealth or by traveling to other Counties
- Participate in county-specific and regional work groups to discuss recruitment and retention of local LTSS providers
- Using innovative contracting strategies and incentives
- Using the transportation benefit, for those eligible, to support service delivery by network providers serving other regions

We will ensure access to services and supports through the work of Case Managers established in Iowa. Case Managers will give members appropriate choices among available home and community-based waiver services, if applicable, and Nursing Facility Services to meet the individual needs of members found to require

a higher level of care. The range of choices include methods for supporting and coordinating services with both formal and informal support systems provided by families, friends, and other community-based resources. Funding decisions are based on the member's individual assessed needs. The goal of this person-centered approach is to ensure that members are served in the least restrictive environment in their community of choice. During routine follow-up or annual assessments, Case Managers will assess and identify institutionalized members whose needs could be met as well or better in non-institutional settings. Case Managers will identify the steps necessary to move institutionalized members back into the community, when appropriate. Medica has worked with Money Follows the Person (MFP) demonstration in Minnesota, and will encourage Case Managers to utilize this Federal program, as appropriate, for our Iowa members.

4.2 Level of Care Assessments

1. Describe your ability and process for conducting level of care reassessments and tracking and determining when a reassessment is required.

Medica utilizes an automated software application to track when members are due for reassessment. Community-based Case Managers are responsible for populating the assessment completion dates and reassessment due dates for their assigned members within the automated application. The software generates a monthly report for each Community-Based Case Manager providing them with reassessment due dates to manage the needs of his other assigned members.

Our automated system will be available to Community-Based Case Managers providing case management services on behalf of Medica. This will allow us to have oversight, and allow members to receive annual reassessments in a timely manner. Medica will monitor reassessment completion of all Community-Based Case Managers. Partners who do not demonstrate timely completion of assessments will be placed on a corrective action plan.

ACTIVE MONITORING OF REASSESSMENTS

We will monitor case management performance through on-site assessment and care plan audits, and oversight of our Community Partner policies and procedures. In addition, our policy is that members who have a change in condition receive timely reassessment to ensure accurate planning for their needs.

Medica will utilize daily admission reports to track when a member might have had a change of condition which would warrant a reassessment. Information will be shared with community-based case managers for completion of the reassessment. We will audit partners to ensure members who have had an admission receive the appropriate follow up from their Community-Based case manager.

2. Propose the approach by which needs assessments will be administered in a conflict-free manner consistent with BIP requirements.

We appreciate Iowa's proactive approach to implementing the Balancing Incentive Program (BIP) requirements of the Affordable Care Act. This work aligns with efforts currently underway in Minnesota that we are participating in, including our collaborative work with MN DHS in the development and implementation of a standardized online assessment tool, utilized by all waivered Case Managers.

We value the right of each individual to remain in their community in the least restrictive environment. We look forward to collaborating with Iowa to structure a health care system for members in need of long-term services and supports (LTSS). We will establish policies and procedures for Iowa approval that align with BIP requirements and will educate our staff, members, providers, and community stakeholders as appropriate.

NO WRONG DOOR/SINGLE ENTRY POINT SYSTEM

Community-Based Case Managers and Medica staff will partner with No Wrong Door staff and programming to ensure member's needs are met in a timely, seamless and appropriate manner. We have a long history in Minnesota of working with the Senior and Disability Linkage Lines, which have similar functions as the No Wrong Door system. Medica supports the conflict-free case management guiding principles and will ensure that all community-based case management is provided as such.

A Core Standardized Assessment Instrument

We have experience partnering with Minnesota DHS in the development and implementation of a new assessment tool being utilized across the Medicaid program. Medica would be happy to work in a collaborative nature with other MCO's and Iowa to implement a core assessment instrument. We feel that a standardized assessment tool should include elements that address the individualized needs and supports of each member, and should be person centered in nature written in plain language.

3. Propose a timeline in which all assessments shall be completed

a. **Upon initial enrollment with the Bidder**
b. **When the Bidder becomes aware of a change in the member's circumstances which necessitates a new assessment**
c. **At least every twelve (12) months**

The name and telephone number of the Community-Based Case Manager will be provided to the member within ten (10) days of new assignment or change of Community-Based Case Manager.

ASSESSMENT UPON ENROLLMENT

Community-Based Case Managers will conduct an initial assessment upon enrollment using the designated, approved tool within 30 days of enrollment. When receiving large enrollment volumes, we will request from the State an extension to 90 days, to allow Community-Based Case Managers time to complete all necessary assessments.

The enrollment process

1. During the initial assessment, the Community-Based Case Manager will assess the member's strengths, needs, choices and preferences in life domain areas. We understand the importance of person-centered planning and strive to support the member's wishes to live as independently as possible to prevent premature institutionalization.
2. Through the assessment process, Community-Based Case Managers can quickly identify situations of risk and move to action to ensure member's safety in their current living environments.
3. The assessment will include discussion surrounding the physical, psychosocial, and functional needs of the member. It will address the following elements:
    a. Medical, social, and environmental factors
    b. Clinical history
    c. Medications
    d. Condition-specific issues including geriatric medical conditions and high health risk conditions
    e. Polypharmacy problems
    f. Activities of Daily Living (ADLs)
    g. Instrumental Activities of Daily Living (IADLs)
    h. Factors causing difficulty living independently
    i. Health and long-term care risks due to lack of social supports
    j. Mental and/or chemical dependency problems
    k. Cognitive functioning evaluation
    l. Developmental disability consideration
    m. Cultural and linguistic needs

n. Visual and hearing needs
o. Caregiver involvement and resources.

REASSESSMENT ANNUALLY AND WHEN MEMBER EXPERIENCES A CHANGE IN STATUS

Community-Based Case Managers will conduct periodic face-to-face reassessments, at least annually, within twelve months of the previous assessment. These will be conducted annually and as necessary with a change in the member's functional or medical status. It is up to the professional judgment of the Community-Based Case Manager to determine if a change in member condition, such as a decrease in functioning or need for higher level of care, merits a face-to-face reassessment.

Community-Based Case Managers use tools such as daily hospital admission reports, information from the member and/or the member's family, and communication with the interdisciplinary care team to help determine the need for a reassessment. They will conduct a reassessment in the timeframe as indicated by the State through the procurement and Contract negotiation.

4. Describe your plan to track and report level of care reassessments.

In order to track and report the level of care reassessments, Community-Based Case Managers document reassessments in the Individualized Service Information System (ISIS) and in our internal automated systems. The Community-Based Case Managers will complete assessments and ensure that ISIS updates comply with the contract and our operational requirements. The date, assessment type, and updates related to Community-Based Case Manager changes, are documented. Reassessments, completed annually or with any change in condition, result in an updated plan of care, and are also documented in ISIS and in Medica's internal document management system.

Entering initial and reassessment dates in both internal and ISIS allows Community-Based Case Managers to track and monitor when members are due for reassessment. These reports are run from our automated systems for members on their caseload to plan workflow to conduct reassessments as indicated.

5. Vendors must work with the State or its designee responsible for implementing the PASRR process. Propose strategies to ensure members receive the specialized services and supports indicated by the PASRR level 2 screening.

Our Community-Based Case Manager will be the primary staff designated to work with Iowa or its designee conducting pre-admission screening and resident review (PASRR) and will be responsible to ensure compliance with the Iowa's process. They will refer identified members, as determined necessary by assessment, for PASRR screening prior to admission to a nursing facility and when the member experiences a significant change in status. Community-Based Case Managers actively participate in the PASRR process to ensure the screening process is member focused and person centered and always seeks to identify the member's desired outcomes and goals.

The Community-Based Case Manager works with the member and member's responsible party to ensure:

- Appropriate placement
- Specialized services identified through the PASRR screening are available to members through identification of available resources within the community

The member's plan of care will indicate all specialized services and supports identified through the PASRR process so the Community-Based Case Manager can monitor adherence with the plan of care to ensure the member receives all identified services. We will conduct regular audits of Community-Based Case Managers to ensure compliance with the required PASRR process.

4.3 Community-Based Case Management Requirements

1. Describe your proposed model for delivering LTSS Community-Based Case Management services.

Medica has a well-established, community-based case management model in Minnesota. If awarded the contract, Medica would leverage our case management expertise dating back to 1997, when we were one of the first health plans to build this model. The foundation of our success has been our collaborative partnerships with experts from the local communities. Together, we've been able to ensure quality care and improve member outcomes.

A PROPOSED COMMUNITY-BASED CASE MANAGEMENT MODEL IN IOWA

As we have in Minnesota, Medica will utilize Community-Based Case Managers throughout the state of Iowa to provide comprehensive and coordinated service delivery for members enrolled in our plan. We would leverage existing service providers wherever possible in Iowa. We will provide each member an assigned Community-Based Case Manager, regardless of whether they reside in their own home or in a nursing facility. Members will be assigned to a Community-Based Case Manager who has the expertise to meet their unique needs. The role of the Community-Based Case Manager is to ensure the member has access to all benefits, understands their plan of care and that communication across the interdisciplinary care team (ICT) is ongoing. Community-Based Case Managers also assist with discharge planning if a member is going back into the community.

> Community-Based Case Managers will assess members to ensure they are residing in the least restrictive environment.

For members residing in a care facility, the Community-Based Case Manager reviews and contributes to assessments and the plan of care completed within the facility. The Community-Based Case Manager works with staff in the facility to ensure they understand services available through the health plan. These individuals are available to collaborate with facility staff by attending care conferences with the ICT, during rounds and by phone.

Annual assessments

Community-Based Case Managers complete an annual assessment, using DHS-approved assessment tools with community members. Person-centered care plans are created for each member based on the strengths, needs and concerns identified in the assessment process. The care plan documents progress towards identified goals throughout the year and, as a living document, is revised as needed.

We will leverage Community-Based Case Managers located throughout the state of Iowa with specific expertise in the populations they serve and the geographic area where their members are located. They will assess the need for other professionals to participate in the ICT based on the member's medical, cognitive, psychosocial and functional needs. In addition to accessing available community-based resources and supports, Community-Based Case Managers are able to refer members to other programs to assist in meeting their special needs.

Disease management approach

Our disease management model is based on a holistic, mind-body approach that views good health as a balance of physical and mental well-being. Members can be referred to Medica's disease management team by Community-Based Case Managers at any time. In addition, we also work to proactively identify members who may benefit from disease management services using an algorithm.

Members who are identified as high-risk or having co-morbid conditions will benefit from our comprehensive disease management program. This model offers a continuum of solutions, meeting members where they are at in terms of health status and desire to engage. We start by targeting members through outreach and program engagement, conducting the front-end member identification, intake and assessment. Utilizing our algorithm(s) and proprietary data to identify eligible members, we leverage our ability to determine appropriate interventions for the right member at the right time. This approach results in our ability to offer targeted member disease management services including education, referrals to appropriate care system resources/programs and condition-specific telephonic support.

Our disease management program staff has access to standards for care via clinical practice guidelines and Medica's Evidenced Based Medicine software that highlight gaps. We use these gaps to prompt discussion about best practices for each member's condition[s].

Additional services

Behavioral health services are also provided in our Community-Based Case Management model. Our Case Managers provided by Medica Behavioral Health (MBH). Community-Based Case Managers and other providers consult with and refer members to behavioral health and chemical dependency services as needed. Members may also self-refer to MBH for assistance in arranging these services.

Medica has a pharmacy team to consult with Community-Based Case Managers on any pharmacy issues. We will also have a Medication Therapy Management program available to members when polypharmacy or other drug regimen concerns are identified.

If a Community-Based Case Manager, or other provider, identifies the need for intensive or specialized self-management skills, referrals are made to qualified network providers, such as a diabetes nurse educator or a home health nurse promoting medication management skills.

BARRIERS TO INDEPENDENT LIVING

Our Community-Based Case Managers are skilled in removing barriers related to independent living. We will leverage this expertise when working in Iowa. Medica will use Community-Based Case Managers in local areas that have an understanding of the current benefits and resources available. They will be encouraged to think outside the box and look for creative ways to help meet an identified need. Our goal is that they are trained to deal with barriers and help members identify resources available to them.

Living in a rural area may create additional challenges as some services might not be readily available. Our clinical teams at Medica are available to assist Community-Based Case Managers with case consultation telephonically or via e-mail. For members in a rural area, we will explore the use of telehealth to meet members' needs. We will gain an understanding of resources available in Iowa to assist Community-Based Case Managers in locating providers.

InterRAI Tool

Every member is initially assessed by a Community-Based Case Manager using the State-designated and approved InterRAI Tool, or other assessment tools as developed and approved by the State of Iowa. We would be willing to be involved in any collaborative efforts as other assessment tools are developed or considered. The assessment includes a face-to-face interview of the member and others as appropriate. In some instances, the member's medical record is also available for review. The results of the initial assessment determines what services the individual needs and wants as well as the frequency of follow up contacts. The tool is used to assess the member's nursing home certifiable status as well as their eligibility for long term services and supports. Results from the assessment are also used to build the member's plan of care. In addition to the

face-to-face assessment, Community-Based Case Managers make contact with the primary care physician, caregiver and others involved as needed to obtain relevant information.

If a member is assessed as needing additional assistance from home and Community-Based services, the Community-Based Case Manager can help the member apply for and access services through the 1915(c) HCBS waiver program or community services. Those members who decline services that could reduce safety risks must have a Risk Management Plan developed as a part of their plan of care; these individuals are considered vulnerable. A full reassessment occurs at least annually with all members.

Members are strongly encouraged to participate in all assessments. In the event that a member refuses, we will follow an established protocol and will abide by any state regulations regarding member refusal of assessments. In order to access Long Term Services and Supports, such as the Elderly Waiver, members are required to receive a face to face InterRAI.

Care Plan

The InterRAI, in addition to being used to determine eligibility for long-term service and supports, is used to develop the member's care plan. The care plan includes the risks and needs identified through the assessment process as well as the unique primary care, acute care, long-term care, mental health, and social service needs of the member. The care plan includes interventions, based on prioritized member goals, designed to mitigate risks and special needs identified through the assessment process. The care plan should also addresses the underlying barriers to meeting the member's prioritized goals or complying with the care plan. The care plan will incorporate covered benefits and services available through the formal, informal, and quasi formal community services needed as identified by the InterRAI. Analysis and discussion with the member/member representative will occur prior to finalizing the care plan.

The Community-Based Case Manager shares the documented plan of care with the member responsible party and the ICT at least annually and as needed when the member's condition changes. Community-Based Case Managers assess progress toward goals during telephonic consults and face-to-face visits. If the member is not making progress, the Community-Based Case Manager will consult with the member and/or other members of the ICT to determine if the goal is still relevant, if the interventions need to be changed, if the goal has been achieved, and/or how best to reach a goal.

Interdisciplinary Care Team (ICT)

Medica policy states that every LTSS member must have an interdisciplinary care team (ICT). The composition of this team will vary based on an individual member's assessment. Community-Based Case Manager's will use professional judgment and experience when establishing an interdisciplinary team's membership. Based on the result of each member's health risk assessment, the Community-Based Case Manager identifies other interdisciplinary team members who could provide assistance in maintaining and maximizing the member's functional abilities or quality of life.

At a minimum, the ICT consists of the member responsible party, Community-Based Case Manager and primary care physician. Medica would propose in the Iowa model that every Community-Based Case Management provider group has a process for communicating with other team members unique to their system. In a care system, an electronic system where the Community-Based Case Manager and physician both have access is often the tool of choice. The communication within counties and community agencies occurs between our Community-Based Case Manager, member, physician and other members of the ICT often occurs via face-to-face meetings, faxes, and/or phone calls. In all cases, information about the member's Medicare and Medicaid services, including LTSS, are communicated by the Community-Based Case Manager to the ICT. This role remains the same whether the member lives in the community or a long term care setting.

2. Propose the required qualifications, experience and training requirements for community-based case managers.

Our approach to case management is to meet with the county social services and public health department, or local agencies, to see if they would like to contract with Medica to provide case management services rather than employing "in-house" Community-Based Case Managers. We believe this approach has set us apart from other health plans. We have extensive experience partnering with agencies and the collaboration is extremely beneficial to all involved.

Community-Based Case Managers are required to be licensed nurses or social workers. In lieu of these requirements, an individual with specialized expertise working with the populations being served may be allowed to act as a Community-Based Case Manager if they have a four-year degree in a closely related field and three or more years of experience in home and community-based services. For Community-Based Case Managers working with members who chose the self-directed option, they will have experience with self-direction and will receive specific training. All Community-Based Case Managers will receive training on person-centered planning and on applicable State benefits and initiatives.

Training

Once a county or local agency has contracted with Medica to provide case management for our members, we provide clinical training and support. Training includes topics such as:

- Medica policies and procedures for conducting required assessments and developing person-centered care plans
- Assessing natural and community social supports and environmental concerns
- Behavioral health and medical concerns
- The role of the Community-Based Case Manager in transition planning
- ICT facilitation and communication
- Advanced directive planning
- Community resources including formal, quasi-formal and informal services

We will also conduct training for Community-Based Case Managers on risk management planning and disaster planning as it affects members. Community-Based Case Managers complete risk management plans with members whose safety is impacted by refusing home and community-based services. Plans identify that members are aware of the risks and have plans to mitigate them. They also include a section, completed for every member, indicating the member's plan when a community-wide disaster occurs. Emergency and crisis plans are also completed with each member.

Ongoing training for Iowa Community- Based Case Managers will be provided through written materials, emails, one-on-one instruction, web based materials, and on-site seminars, mirroring our current training process in Minnesota. We understand the unique needs of adult learners and, as such, provide training in various modalities. We will develop a Community-Based Case Manager meeting and training schedule specific to Iowa prior to implementation of the program. Trainings may include traditional education about medical conditions or services and incorporate the LTSS content. Training on new requirements and improvement projects are provided as needed during these meetings, and updates on program or regulatory changes are provided in a timely manner via email or WebEx. Audit results that have global implications for Community-Based Case Managers are disseminated at these sessions and retraining is conducted as needed. In addition to single focus training, such as on assessments and care planning, training on the overall Community-Based case management model and its elements occurs once per year.

3. Describe your proposed staffing ratio for Community-Based Case Managers to members.

We will consult with local providers who have expertise serving the unique needs of individuals receiving services through the Medicaid benefits in Iowa to propose and develop appropriate staffing ratios. Staffing ratios will vary depending on the type of members being served. For example, a ratio of 1 case manager to 75 members age 65+ is used as a guiding best practice in Minnesota.

As part of our delegation oversight process, we ensure that partners have policies in place for oversight of staffing ratios. Policies are expected to take into consideration the complexity of the membership, geographic considerations and specific skills and knowledge of the case managers on staff. Annually, we will collect staffing ratios from our partner agencies to ensure compliance with our expectations.

4. Describe how Community-Based Case Management services will include ongoing communications with community and natural supports.

We believe that health care services are only one part of what our members need to live healthy lives in the community in which they reside. Comprehensive assessment and service planning includes an assessment of the individual's health care and holistic needs, including home, community, and natural supports. We also work to ensure access to all services and supports identified. Our approach to partnering with locally-based Community-Based Case Managers is critical to maintaining knowledge and awareness of available community supports. They will appropriately identify available community resources through annual assessments, and utilize available resources such as the LifeLongLinks website, currently available in the State of Iowa.

Member's natural supports are critical to ensuring that the member's needs are met in their local community. Community-Based Case Managers will be trained to encourage and facilitate member's natural support's participation in all aspects of coordinating the member's care such as:

- Conducting assessments
- Developing the care plan
- Discharge and transition planning
- Member consent

Identified community and natural supports will be invited to be part of the ICT, with the member's consent. Community-Based Case Managers provide notices and information related to the member's care as determined appropriate based on their participation in the ICT. Community-Based Case Managers are educated on conducting case management activities that are compliant with the member's privacy rights.

5. Describe how internal operations support communication among departments to ensure Community-Based Case Managers are aware of issues related to their assigned membership.

We recognize that it is critical for Community-Based Case Managers to have timely access to information about their assigned members as well as the population served by Medica as a whole. We will implement multiple

strategies and leverage partnerships across departments so Community-Based Case Managers are aware of critical information enabling them to effectively manage member's care.

Strategies that we have used in Minnesota to integrate communication that we would leverage in Iowa include:

- Medica.com care coordinator web pages
- Policy and procedural changes regarding Medica operations, formulary changes, and other benefit changes are shared via electronic newsletters and through Medica's website
- Daily admission reports: Medica's Health Management department shares daily admission reports with Community-Based Case Managers identifying members who have been hospitalized. Community-Based Case Managers use this information to initiate immediate discharge planning and care plan revisions to identify and arrange for post-hospitalization needs.
- Case management meetings: Other Medica department staff such as behavioral health and disease management are invited to case management meetings to share information pertinent to the Community-Based Case Manager's assigned members.
- Quality program results: Our Quality staff share program goals and results with case management staff to inform case management practices.
- Monthly all-staff meetings: Our State Public Programs staff hold multiple inter-departmental meetings each to ensure the needs of Medicaid members are included in Medica planning.

6. Describe strategies to minimize Community-Based Case Manager changes and processes to transition care when a member has a chance in Community-Based Case Managers.

Medica understands the importance of maintaining the relationships between a member and his or/her Community-Based Case Manager. When someone becomes a new Medica member, we reach out to the community partners and identify gaps to maintaining case management staffing. We work to ensure continuity of care is maintained and a seamless transition occurs.

There may be times when a transfer may be necessary, such as per member request or staff turnover. We have a member transfer policy and procedure in place to ensure continuity of care for members transferring from one care coordinator to another. We would adopt this policy to Iowa and the transfer of one Community-Based Case Manager to another. The transfer policy sets expectations such as communication between the Community-Based Case Managers during the transition, communication with the member and ICT, and updating the care plan as necessary. These expectations include the requirement that the exiting Community-Based Case Manager share member assessment, care plan and all other relevant documents to assist in the transition.

Medica has a history of partnering with Community-Based organizations that have the expertise to serve the populations in their geographic service area. We currently have over 65 Community-Based partner organizations including counties, agencies and clinic providers who provide Community-Based case management for our membership in Minnesota. We are interested in exploring opportunities to contract with current providers of Community-Based Case Management in Iowa. This will ensure members are able to maintain relationships with their current case management team as they become enrolled with Medica.

7. Describe your proposed discharge planning process.

We will provide daily admission reports to Community-Based Case Managers informing them when one of their assigned members has been hospitalized. For Medica's care coordinators in Minnesota, they are usually already aware of the hospitalization due to the close relationship they have with the member and/or family. We will require that Community-Based Case Managers reach out to hospital discharge planners and request to be included in the discharge planning process. Community-Based Case Managers will be responsible to revise the care plan, as appropriate, and secure identified post-hospitalization services for the member.

Care Transition Protocols

Transition of care services will be provided for Medica members when they move from one care setting to another due to a change in health status. The member's Community-Based Case Manager will serve as the primary point of contact for managing transitions. Members will be informed of this through use of a Leave Behind document, which is provided to the member by the Community-Based Case Manager annually as a part of the face-to-face assessment process. The document provides contact information for their Community-Based Case Manager along with suggestions on when to contact, such as when inpatient or outpatient procedures are planned and when unexpected hospital admissions occur. The goal of the Community-Based Case Manager's efforts is to reduce incidents related to fragmented or unsafe care.

Case management activities as a result of a member transition are triggered by a variety of inputs such as:

- Internal reports
- Calls from members or their family
- Reports from receiving facilities
- Medica hospital or SNF admit reports.

Community-Based Case Managers will reach out to the receiving setting and the member's usual practitioner. Communication includes sharing the member's care plan, a discussion about any changes in the member's needs, and plans for discharge. Community-Based Case Managers contact and assess member needs after notification of a transition and update the care plan as needed, whether the member returns to their original setting or moves to a new setting.

We and Community-Based Case Managers work with members to provide education and information in an effort to reduce transitions. We will implement procedures based on Eric Coleman's 4 Pillars to promote discussions on medications, follow-up visits, signs and symptoms that should prompt a call to the doctor, and maintaining a personal health record. Community-Based Case Managers will be trained in the "teach back" method, to ensure members understand signs and symptoms that require action.

We monitor the management of transitions through claims, chart audit data, and reports provided from the counties and agencies, including internal Medica reports. The results of the monitoring activities are used to identify best practices, improvement opportunities, and to provide feedback internally and externally as needed. We would provide this same monitoring in Iowa and work collaboratively to identify other monitoring opportunities.

8. Describe your process for monitoring the effectiveness of the community-based case management process. Provide outcomes from similar contracts in other states, if available.

Medica has mature quality monitoring and improvement processes, including a robust delegation oversight process. We perform a formal review of each case management entity at least annually. As a part of this review, a variety of processes and documents are reviewed to monitor:

- Timeliness and appropriateness of services (largely from the annual audit of assessments and care plans)
- Timely submission of requested materials
- Delegate attestations and documentation about processes
- Timely data entry

Following the Delegation Oversight review, recommendations or corrective action plans are initiated with the case management delegate. We will provide additional training on case management duties such as assessment, care planning, and management of conditions as needed.

Annually, we develop and implement a corporate wide performance improvement plan that incorporates the Medicaid Quality Improvement Plan. This plan addresses all levels of improvement including operational, clinical, regulatory, and describes monitoring activities. Corporate wide functions such as data infrastructure, credentialing, enrollment, and pharmacy issues are monitored at the corporate level.

Medica establishes annual Community-Based Case Management Products (CCP) program goals that drive improving or maintaining key operational, clinical, and member satisfaction areas of importance for the Medicaid case management population. These goals include community-based case management services. For each goal, a target based on local or national benchmarks and a measurement methodology is defined. Each goal is supported by key staff that monitors and intervenes as needed to achieve goals. Medica uses the Plan, Do, Study, Act quality improvement process in its quality improvement efforts.

The Regulatory Quality Manager uses program-specific data and inputs from throughout the organization, to conduct an annual evaluation of the case management program. The CCP goals set annually are used to determine effectiveness. Survey results are also reviewed for potential training opportunities for Community-Based Case Managers. The report, which includes recommendations for action, is presented to the CCP Leadership and Quality Improvement Subcommittee of the Board. The CCP Leadership group also evaluates data such as the Community-Based Case Management Satisfaction Survey and determines improvement activities.

We review multiple inputs to determine the effectiveness of its case management program and its current priority efforts. Inputs reviewed include: HEDIS/STARS results; CAHPS; HOS; Part C-Care Management Measures; HRA/Care Plan Audit results; Grievance and Appeal Analysis; and case management Delegation Oversight. Committees are in place to monitor and act upon key indicators such as CAHPS, HEDIS/Stars, grievances and appeals and quality improvement teams.

We annually assess a variety of metrics for our Community-Based Case Management program, including: operational, clinical, and satisfaction. In 2014, we fully met our goals for six (6) of the focus areas while two (2) other focus areas have goals that were not met. The Table below illustrates a sample of the outcomes included in the annual evaluation. These performance indicators demonstrate the strength of our current model.

OPERATIONAL AND SATISFACTION	GOAL	PERFORMANCE	HOW MEASURED	STATUS	ACTIONS	EVALUATION PLAN
Timely completion of initial HRA [within 30 days]	95%	100% [57/57]	Audit by Medica Staff	Met Goal has been met for past 2 years	Training by Medica staff via bi-annual Community-Based Case Management meetings or webinar On-site feedback at time of audit	Annual audit qualitative and quantitative analysis in September 2014
Timely completion of Annual Re-assessments [within 365 days]	95%	96% [205/214]	Audit by Medica Staff	Met Goal has been met for past 2 years.	Training by Medica staff via bi-annual Community-Based Case Management meetings or webinar On-site feedback at time of audit	Annual audit qualitative and quantitative analysis in September 2014
Comprehensive Care Plan [issues identified in assessment addressed]	95%	100% [275/275]	Audit by Medica Staff	Met Increase in performance from last year. Need to monitor as did not meet goal in 2013	Annual training completed on elements of comprehensive care plans Training audits for new providers and CAPs for those entities not achieving 95%	Annual audit qualitative and quantitative analysis in September 2014

8. Provide proposed strategies for ensuring a seamless transition of LTSS services during program implementation. Include a proposed strategy and timeline within which all members receiving LTSS will receive an in-person visit, an updated needs assessment and service plan. Describe how you will ensure services are not reduced, modified, or terminated in the absence of an up-to-date assessment.

During implementation in Iowa, we propose to use current Community-Based Case Management entities wherever possible. In instances where the member's case management has to be transitioned, we will work to ensure communication between the current Case Manager and the newly assigned Community-Based Case Managers is timely to ensure a smooth transition. For members with an open waiver span, we will require that the Community-Based Case Manager meet with members face-to-face and review the current assessment and care plan with the member within 90 days of initial enrollment due to volume. If the member has experienced any changes since the time of the last full assessment, the Community-Based Case Manager will complete a new assessment and update the person-centered care plan. Services will not be reduced, modified, or terminated until Medica has conducted a face-to-face assessment. We will train Community-Based Case Managers about this expectation prior to implementation. We will honor all existing service plans upon initial enrollment with Medica, regardless of in-network status. We will identify out-of-network providers and will contact them and attempt to add them to our network.

4.3.12 Nursing Facilities and ICF/IDs

1. **Describe proposed strategies for providing Community-Based Case Management services for residents of nursing facilities and ICF/IDs, including the timelines and frequency of in-person visits.**

The goal of Community-Based Case Management is to assist members in maintaining or regaining optimum health or improved functional capacity, cost effectively and in the right setting. Medica has a long history in Minnesota in providing Community-Based Case Management services and supports, including support to nursing facilities. Medica has experience providing Community-Based Case Management to members in both the senior and adults with disabilities populations, including members who are residents of nursing facilities and ICF/ID's. In Medica's current model in Minnesota, all members in nursing facilities and ICF/ID's are assigned a Community-Based Case Manager. The Community-Based Case Manager serves as an advocate and navigator for the member and facility staff to ensure the member is aware of the benefits and options available to them.

OUR COMMUNITY-BASED CASE MANAGEMENT STRATEGIES

In Minnesota, Medica provides each member an assigned Community-Based Case Manager regardless of whether the member resides in his or/her own home or in a nursing facility. The role of the Community-Based Case Manager is to:

- Ensure the member has access to all benefits
- Understands the plan of care
- Provide ongoing communication across the interdisciplinary care team (ICT)
- Assist with discharge planning if a member is transitioning back into the community.

If selected to be a health plan of choice in Iowa, we would employ a similar strategy using Community-Based Case Managers. Medica will provide training about working with members in nursing facilities and ICF/ID's, Medica benefits and Money Follows the Person Initiatives. Medica will explore outreach to nursing facilities to educate about the role of the Community-Based Case Manager, discuss the current model utilized and get input on how to best implement this model in Iowa.

Collaboration with care facilities

For members residing in a care facility, the Case Manager reviews and contributes to the assessments and care plan completed within the facility. They work with staff in the facility to ensure they understand the services available through the health plan. Case Managers are available to collaborate with facility staff by attending care conferences with the ICT, during rounds, and by phone. Case Managers work closely with the member's primary care physician to identify and manage any special health related needs.

Timeliness of in-person visits

Case Managers conduct in-person visits with the member and the care facility at least annually. Case Managers conduct in-person visits with members within 30 days of admission into a facility. One of the purposes of this visit is to explore the possibility of discharge to a less restrictive environment. If a member is living in the community and enrolled in Medica, the Case Manager will follow all applicable PASRR and assessment requirements prior to the member's admission. The Case Manager, if the member permits, will ask to participate in care conferences and attend those in person or via phone, as possible.

We are interested in exploring unique models for providing primary care to members living in residential care settings. We have experience with this in Minnesota through our *Integrated Care by Medica* model.

INTEGRATED CARE BY MEDICA MODEL

Integrated Care by Medica is our own specialized nurse practitioner model that provides integrated primary care and case management onsite at congregate living facilities (skilled nursing facilities, customized living and senior apartments). We utilize a team approach to support the member, his or/her family or support system and the facility staff. The nurse practitioner and physician collaborate in developing the member's care plan. Regular, onsite visits by the team allow us to focus attention on chronic condition management, advanced care planning and health promotion to maximize the member's quality of life. The model continues to grow in membership served and number of facilities where the service is offered. Families share positive comments on the improved accessibility and communication with providers, and focus on the member's goals of care.

This person-centered approach helps the team focus on the medical, psychological, functional and cognitive needs of our members. By understanding the member's goals, we are able to engage them in their health and improve outcomes. This helps reduce inappropriate utilization of emergency room visits and hospital visits. We collaborate with external agencies to transition members to the least restrictive setting and share health care information to maintain the member's health and wellness. Working with non-traditional providers, such as massage therapists, music therapists and volunteers, we can often minimize the use of medications.

Integrated Care by Medica utilizes data analytics to identify higher complexity members and a review process to assess the member and his/her situation. Additional review with the facility team, physician and other pertinent personnel is conducted to develop a monitoring plan of care. The physician payment system supports greater engagement of the physicians through a capitated arrangement. This arrangement allows the physician more time to spend with the member, family and staff to address the issues. Outcomes include lower inappropriate hospitalization rates and more appropriate use of onsite services and supportive services, such as hospice care.

2. Describe processes for working with nursing facilities and ICF/IDs to coordinate care.

As described in our response above, Case Managers will work closely with nursing facility and ICF/ID staff through the assessment, care plan development and discharge planning processes. This interaction is conducted both telephonically and through onsite visits to the facility. Our *Integrated Care by Medica* model offers an enhanced opportunity for integrated Community-Based Case Management through an onsite nurse practitioner/physician collaborative model.

3. Describe strategies for coordinating physical health, behavioral health and long-term care needs for residents and improving the health, functional and quality of life outcomes of members.

Our approach to case management is member-focused and strengths based. This approach ensures the member's quality of life goals and outcomes are met. Medica will implement the following strategies to coordinate physical health, behavioral health and long-term care needs for residents. These coordination strategies will target the improvement of member health, functional and quality of life outcomes.

- ***Integrated Care by Medica –*** Our own specialized nurse practitioner model that provides integrated primary care and case management onsite at congregate living facilities.
- ***Facility Minimum Data Set (MDS) Assessment*** – Case Managers review the facility MDS assessment to determine a member's physical, behavioral and LTC needs.
- ***Assessment for Discharge*** – Case Managers will complete the assessment identified by the State if a member requests a discharge in the community. The Case Manager will identify all necessary referrals for a successful transition into the community, including referral to the Money Follows the Person demonstration if appropriate.
- ***Facility Care Plan*** - For members residing in a facility, the Case Manager will review the facility care plan to ensure that all physical, behavioral and LTC needs are met. Identified gaps in care are communicated to the facility.

4. Propose institutional diversion strategies and describe successes in other states.

We have a long history of working with members in the institutional setting to transition to community- based resources. We have been doing this work through our Minnesota Senior Health Options program since 1997. We also have worked with the Minnesota Money Follows the Person (MFP) demonstration to help members transition from the nursing home to a community setting. We explore, on a case by case basis, the possibility of utilizing a benefit exception to approve services in the community, if access to a Community-Based resource is the only barrier to moving a member from an institution to the community.

If selected to be a health plan of choice in Iowa, we propose the following institutional diversion strategies to address the needs of members waiting placement in a nursing home, ICF/ID or other institutional setting, including:

- Members who may be on an HCBS waiver waitlist
- Members who have a change in circumstance or deterioration in health or functioning and request nursing facility or ICF/ID services
- Waiver enrollees admitted to a hospital or inpatient rehabilitation program
- Individuals in a nursing facility for a short-term stay

It is our goal to serve members in the least restrictive environment in their community of choice. Medica trains all Community-Based Case Managers to ensure they have an understanding of the importance of coordinating care to allow members to have opportunities to live in the least restrictive environment including knowledge of Money Follows the Person program and the Olmstead Plan as well as waivers the member may be eligible to utilize. Case Manager's will be required to assess Community-Based options for all institutionalized members, including formal, informal and quasi-formal supports to prevent placement in a facility, or allow discharge back into the community.

For members currently located in a facility, Case Managers assess the appropriateness of the placement during their in-person visit. Case Managers will explore other community resources and supports available to members on a waiver waiting list. This may include exceptions to benefits and policies in specialized situations. We will review these on a case-by-case basis.

We rely on Case Managers as the primary strategy to ensure members are receiving care in the least restrictive setting. Case Managers will be trained to identify members who could be served in the community, and will work with:

- Members waiting placement in nursing homes, ICF/ID or other institutional settings including members on HCBS waiver waitlist
- Members who have a change in circumstance or deterioration in health or functioning and request nursing facility or ICF/ID services
- Waiver enrollees admitted to a hospital or inpatient rehabilitation program
- Individuals in a nursing facility for a short-term stay

5. Propose strategies to identify members who have the ability or desire to transition from a nursing facility or ICF/ID setting to the community. Propose assessment tools, provide a sample transition plan and describe post-transition monitoring processes.

Identification of Members for Transition

Case management is our primary strategy for identifying members with the ability and desire to transition to the community. When a member is in a nursing facility, the Case Manager is involved with the member and facility and participates in care conferences, follows up on any admissions to the hospital (transitions) and continues to address, through the assessment process, the member's desire to move back into the community. Case Managers are very involved with members transitioning from a nursing facility to home to help make these transitions as positive for members as possible.

Because of this involvement, Case Managers are aware when members are planning or interested in moving back into the community. They are available to assist in the discharge planning by helping determine waiver eligibility, making referrals to programs such as MFP and identifying informal supports available such as family or community groups.

Transition Assessment

Medica will conduct a transition assessment using a pre-approved tool on members identified for possible transition. We will utilize the InterRAI assessment tool to assess a member's desire and ability to transition to the community and identify any transition risks. Based on this assessment, we will develop a care plan, utilizing the same care plan tool used for members in the community. This care plan will be developed in partnership with the member and his/her representative for members identified through the assessment process as a candidate for transition to the community. See Tab 5 for an example of the care plan being used in Minnesota. We are open to working collaboratively with DHS and the other plans in Iowa to develop a care plan to be utilized by all plans serving Iowa members.

Our care plan addresses all transition needs and services for a safe transition including; physical and behavioral health needs, selection of providers in the community, housing needs, financial needs, interpersonal skills and safety. It also identifies barriers to safe transition and strategies to overcome identified barriers. If a member is appropriate for enrollment in a 1915© HCBS waiver, the Case Manager will utilize the appropriate needs assessment and service plan tools.

Post Transition Monitoring

To ensure ongoing success for the member, the Case Manager will at a minimum conduct a face-to-face visit with the member within two (2) days of transition to the community, every two (2) weeks for the first two (2) months and on a monthly basis for the first year. Additional visits will occur as indicated by the member's

needs and risk factors. Hospitalization and nursing facility and ICF/ID readmissions will also be monitored to identify issues and implement strategies for member improvement.

6. Describe processes for interacting with the State's MFP designee and strategies to prevent duplication and fragmentation of care.

We recognize the importance of the MFP grant in supporting individuals discharged out of ICF/IDs and nursing facilities to move into their own homes. Our Case Managers working with members in facilities will refer to the MFP program as applicable. Once a member is determined eligible and enrolled in the MFP program, our Case Manager will participate in the MFP planning team and assist in the development of a transition plan. The Case Manager will work closely with the State's MFP designee throughout the process to coordinate services, and incorporate the MFP services into the members care plan. This collaboration will include a detailed review of identified services and the entity responsible for the authorization and delivery of such services to eliminate potential duplication or fragmentation.

4.4 1915(c) HCBS Waivers

1. Describe in detail how service plans meeting contractual requirements, state and federal regulations, and all applicable policies, will be developed for each member enrolled in a 1915(c) HCBS waiver.

Our intent is that every Medica member enrolled in a waiver program in Iowa will have a care plan developed based on his/her assessed needs, which includes the elements of a service plan as described in the scope of work. The care plan, outlining the services approved for that member, is developed using a person-centered approach in consultation with the member, the member's interdisciplinary care team, and where appropriate, the member's family, caregiver, or representative. The care plan will include:

- Member risks and needs identified through the assessment process.
- Member's health status and prioritized goals, preferences, and desired level of involvement
- Medical and non-medical information incorporating a holistic and preventive focus, such as:
    - A current problem list
    - Medication regimens
    - Advance directives
    - Baseline physical and cognitive function
    - Mental health
    - Specific cultural and linguistic needs
- Covered Medicaid services and services available through the formal, informal, and quasi-formal health and home based community services identified in the assessment process.

2. Submit a sample service plan.

Included in Tab 5 is a copy of a collaborative care plan, which includes the care plan and service agreement elements, currently utilized by Medica. We are open to working with Iowa DHS and the other managed care organizations to develop a collaborative care plan to be utilized specifically with Iowa Medicaid members.

3. Describe how member's expenditures are tracked against any aggregate monthly cost caps.

We have a formal process for tracking member expenditures. We utilize a tool which allows the Case Manager to input member waiver service frequency and calculate monthly costs for each member. This tool helps ensure all services are within the monthly waiver cap.

The role of the Case Manager is to monitor and modify the care plan to ensure services are provided within cost cap limitations. If a member has additional needs, the Case Manager explores other community resources or informal supports. We have a benefit exception process that allows the Case Manager to request an exception for the standard benefit set. These exceptions are reviewed on a case-by-case basis. We will establish a process to report to DHS if a member refuses to transition to a more appropriate care setting.

4. Describe proposed methods for monitoring the provision of services identified on a member's service plan.

We have a comprehensive process for monitoring the provision of services to members including:

- Real-time monitoring by Case Managers
- Regulatory quality management activities
- Retrospective data review

These processes include a mechanism for reporting to the State if a member has not received at least one billable unit of service under the waiver in a calendar quarter.

REAL-TIME MONITORING BY CASE MANAGERS

During contact with the member, the Case Manager addresses ongoing monitoring of the person-centered care plan to meet the member's needs. Case Managers monitor progress toward achieving the member-prioritized goals in order to evaluate and adjust the timeliness and adequacy of services in the care plan. This process steps are identified below.

1. Members are contacted within five (5) business days of initiation of new services to assess if the services identified in the care plan have been accessed and meet the member's needs.
2. The Case Manager assists the member with addressing any barriers to accessing services, and modifies the care plan as appropriate to meet the needs of the member.
3. Assessment of a member's care plan goal progress may be completed at each home visit, change in member condition or completed, minimally, on an annual basis
4. Annual documentation of the goal outcomes denotes if the goal has been met or if it remains ongoing and will be carried forward to the next care plan

REGULATORY QUALITY MANAGEMENT ACTIVITIES

Medica's Regulatory Quality team will conduct routine audit activities of all Community-Based Case Management providers. These audits are conducted on an annual basis with ongoing training and communication about expectations. In addition to routine audits, Medica periodically monitors claim activity to ensure that members are receiving services identified in care plans.

Retrospective Data Review

Medica has robust data warehouse capabilities that will be leveraged to review services provided to members and distribution of HCBS providers in service areas. We will work with the Community-Based Case Managers to identify gaps in services or providers.

5. Describe in detail your proposed strategy for implementing the Consumer Choices Option, including how Support Broker and financial management services (FMS) will be implemented.

Medica has deep experience working with the Consumer Directed Community Supports program as well as the Personal Care Attendant (PCA) Choice program, both offered in MN. These programs allow the member to self-direct care. In both cases, we offer training to Case Managers to ensure they have an understanding of these complex programs and offer these as a choice to all members.

In Iowa, we will develop a process to ensure all Medicaid members are offered a self-directed waiver service if eligible. This process will include:

1. Members Case Managers will be trained to discuss and offer self-directed options as a part of every initial and reassessment conducted with members. Offering the option for self-directed services is inherent in the assessment process. Per requirements of the Iowa statement of work, members who express interest in the Consumer Choices Option will complete a self-assessment to determine the member's ability to make healthcare decisions and knowledge of resources.
2. Based on the results of the self-assessment, the member will either self-direct his or/her care or appoint a representative to manage self-direction responsibilities for the member.
3. The member and the appointed representative will receive education on Consumer Choices Option program elements such as:
    - The role of members and/or representatives
    - Selecting and terminating providers
    - Employing and managing employees
    - Administrative functions such as staff evaluations and time sheet approval
    - Scheduling providers
    - Back up planning

To support the Consumer Choices Option program, we will develop relationships with existing Support Brokers and financial management service (FMS) entities in Iowa while also providing ongoing oversight and training to these providers. In addition, we will establish an audit process to ensure these providers are compliant with state regulations, including the quality of service delivery and the health, safety and welfare of the members who choose the Consumer Choices Option.

6. Provide a sample of the following tools and forms related to the Consumer Choices Option:
   a. Self-assessment tool for members seeking to self-direct services;
   b. Informed consent contract; and
   c. Risk agreement

The attached Community Support Plan is a tool provided to us by the State of Minnesota and is used for Consumer Directed Community Supports (CDCS) program. In addition, we have attached the risk agreement that was developed and is currently utilized by Medica's Community-Based Case Managers. We will explore development of tools and forms for use in Iowa's Consumer Choices Option program. We are interested in a collaborative approach with Iowa DHS, stakeholders, and other health plans to create a universal tool, informed consent contract, and risk agreement. Currently, we inform all members of the option to participate in CDCS or PCA choice. Any member who chooses this option is provided assistance by the Case Manager to implement the service. A sample Community Support Plan, Member Signature Sheet, and Personal Risk Management Plan are located in Tab 5. Upon contract award we will work collaboratively with the Agency to create approved tools and forms.

7. **Describe your approach for monitoring the quality of service delivery and the health, safety and welfare of members participating in the Consumer Choices Option.**

Our approach to monitoring the quality of service delivery and health for members who elect Consumer Choices Options is the same as it is for all other members. Medica has a quality of care process which investigates and reviews all complaints related to quality of care provided to members. The Case Managers will be educated on the formal complaints and grievance process and assist members to utilize this process. It is expected that the Case Manager will contact the member to address ongoing monitoring of the person centered care plan to meet the member's needs. Case Managers will monitor the progress toward prioritized goal outcomes in order to evaluate and adjust the timeliness and adequacy of services in the care plan. Case Managers will also monitor the ongoing ability of the member to self-direct care and continued participation in the Consumer Choices Option. The Case Manager will assist the member with addressing any barriers to accessing services, and will modify the care plan as appropriate to meet the needs of the member.

Medica would utilize the Quality of Care Medica proposes to utilize a random audit and a survey of members receiving CCO to ensure program quality. We will work with the State of Iowa to use or enhance existing state process in place for the Consumer Choices Option.

SECTION 5: BILLING AND COLLECTIONS

Please explain how you propose to execute Section 5 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Medica has successfully supported enrollment and eligibility management processes in its Medicaid programs for over 30 years. Medica's extensive experience in enrollment and eligibility includes multiple programs with varying demographics, coverage, and cost sharing provisions. Our experience demonstrates that we have the knowledge, skill, talent and technological solutions to manage complex eligibility and enrollment requirements for all populations. Because each program has unique eligibility requirements, we have created enhanced systems built on architecture to handle complex rules such as aggregate cost sharing limits and the appropriate administration of copays by population.

Medica of Iowa's (Medica's) Enterprise System Platform is designed to support the required EDI transactions and comply with all applicable HIPAA requirements, as well procedures, policies, rules and statutes in effect during the term of our contract. Accordingly, we will comply with all provisions in conformance with 42 CFR 447.50 – 447.60, the State Plan and State's 1115 waiver for the Iowa Health and Wellness Plan.

Medica's Enterprise System Platform will facilitate data exchange and data sharing of member eligibility and enrollment Information utilizing the 834 and 820 CMS-prescribed standard formats for eligible members in conformance with the MMIS and CORE technical user guides. Our system platform has the capability for data transformation services that translate data to and from the full spectrum of HIPAA transactions sets in a highly configurable, agile, and robust system environment.

Medica is poised to utilize the vast array of systems and tools we have successfully developed and refined in our 30 plus years of experience administering Medicaid programs. We have positioned our infrastructure to handle virtually any type of data transmission in a secure HIPAA compliant environment.

5.1 General provisions

1. Describe your strategy for ensuring total cost sharing does not exceed five percent (5%) of quarterly household income.

Medica's robust system platform will promote the exchange of files at both the provider and State level including data related to quarterly household income and the Iowa Wellness Plan. Medica will track a member's total cost share within the Medica Enterprise Platform Care Manager and provide internal users with access to the data. Defined system rules have been developed to post notices when a member approaches five percent of his or her quarterly household income to ensure that co-sharing amounts are no longer collected when the threshold is reached. . Real time pharmacy accumulators are utilized to ensure prompt reconciliation between medical and pharmacy data. Our proactive approach to reconciling accumulators between medical and pharmacy claims minimizes the need for provider adjustments and reduces disruptions to members

Medica understands the importance of tracking and reporting clear, concise, and timely data to all stakeholders. We are committed to maintaining a robust reporting system that will inform on the services we provide and will support future enhancements through the analysis of timely and complete data.

2. Describe processes for making information on premium and cost sharing available to both members and providers.

Medica considers the ability to view information from a provider or member perspective as a critical element in our service delivery system. Our web based provider portal will allow authorized providers to with access eligibility and benefit information including premium and cost sharing data; request or check clinical authorizations; check status of claims; view claims summary; update and submit clinical information; and conduct other functions or transactions on line.

Medica's web-based provider connectivity solution enables secure transactions and data exchange also on-line. We have programmed all systems to be HIPAA-compliant for claims inquiry information and the transfer of protected health information (PHI).

Our provider portal will foster open communication by making information available in a variety of ways. This highly secure platform will synchronize data on a daily basis with the Medica enterprise system to support provider collaboration in the following contexts:

- Medical Management (Authorization, Concurrent review, Transition Planning)
- Care Coordination and management of resources
- Benefit information
- Copayments
- Cost sharing limits
- Preventive Screenings and HEDIS Measures
- Member eligibility status inquiry
- Best practice guidelines and Evidenced Based Medicine concepts
- Enhancing provider capabilities

Achieving efficiencies and maximum communication We also have a similar web based tool for members. After logging in through a secure portal, members can access information related to improving their health and wellness such as:

- News feeds that contain timely and important health and wellness information
- Copayment and cost sharing limit information
- Condition-related community and national recovery support groups
- Members claims and membership information
- Benefit plan documents and updates to the member record

In addition to these interactive web-based portals, Medica will post and update a provider manual and member handbook which will provide all operational and benefit plan details for providers, members and other stakeholders; including information of cost sharing limits and applicable copays.

5.3 Copayments

1. **Indicate if you propose to implement State Plan copayments on populations in addition to the Iowa Health and Wellness Plan and hawk-i members.**

Medica has extensive experience in the application and tracking of copays according to defined populations based on our work with Minnesota Medicaid. Medica will implement State Plan copayments required by the State 1115 waiver and hawk-I members in accordance with the States' CHIP State Plan. Medica will ensure that copays are not imposed for exempt populations, or for exempt services.

We will hold providers responsible for collecting copayments, and will reduce the payment we make to a provider by the amount of the member's copayment obligation Medica tracks copayment data as part of the claims and encounter submission process, and periodically conducts provider audits to determine whether copayment procedures conform to the standards we will publish in our provider manual and member handbook.

2. **Describe how exempt populations and services as outlined in Section 5.3.1 and 5.3.2 will not be charged copayments.**

Our Enterprise System Platform is configured with member demographic data and benefit rules to facilitate exclusions to copayments for exempt populations. Medica utilizes the detailed member data from the enrollment file to drive members into specific group categories for determining the applicability of copays. Moreover, specific categories of services that are exempt from copays will be set up with benefit edits to ensure that copays will not be taken upon claims adjudication.

In addition, Medica publishes policies and procedures that govern these circumstances in the provider manual and member handbook to inform all parties or requirements and expectations for copayments. Copay obligations will be published on the member's identification card, and extensive provider education will be done to ensure that exempt populations are not charged copays.

5.4 Patient Liability

1. **Describe your proposed methodology for notifying providers of the patient liability amount and paying providers net of the applicable patient liability amount.**

Medica will employ several different methods to coordinate and communicate the patient liability amount to providers. Medica will require providers to collect each Medicaid member's patient liability amount. We will develop and implement policies and procedures, subject to review and approval by Iowa, to ensure that members pay their patient liability when applicable. Medica will publish requirements related to patient liability in our provider manual and member handbook. We will also make the same information available to providers and members through their respective web portals. Once a member's patient liability is determined by the State and transferred to Medica's Member Service team, Medica will ensure that the appropriate liability is applied during claims adjudication. The provider remittance advice and the member explanation of benefits will reflect the patient liability.

5.5 IDPH Sliding Scale

1. **Describe how your organization will ensure the IDPH approved sliding fee schedule is implemented among network providers.**

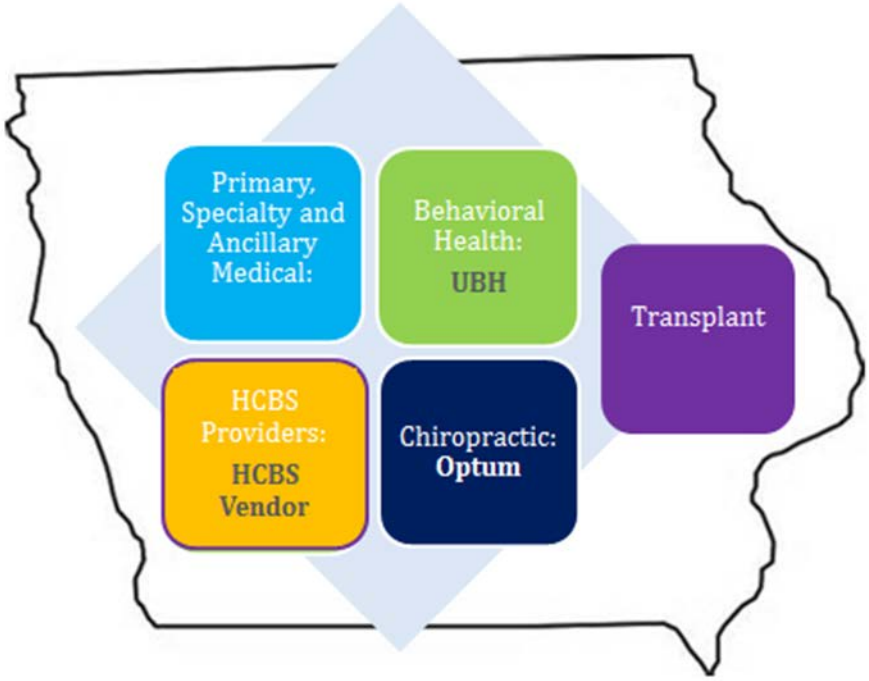
Medica will ensure that the IDPH-approved sliding fee schedule is implemented among our network providers. We will reference the IDPH sliding fee scale and its standards for qualifications as part of the provider contract and will make this information available to all providers and members through the provider manual and member handbook as well as through Medica's secure web portals. Medica will conduct ongoing provider training about the proper methods for calculation, and routinely conduct provider audits to determine whether the sliding fee scale is used properly.

SECTION 6: PROVIDER NETWORK REQUIREMENTS

6.1 General Provisions

1. Describe how you plan to meet all network composition requirements.

In order to maximize coverage and minimize provider and member disruption, Medica has developed partnerships with mature network providers who have an existing presence in Iowa. Medica brings its own deep experience in provider relations, contracting and network development in conjunction with our partners to implement and manage network solutions that are geographically and service comprehensive.



- Our Medical Network Partner will build on its existing network to develop, implement and manage Medica's Medical Provider network as described below.
- United Behavioral Health (UBH) will use the foundation of its existing network to implement a comprehensive Behavioral Health network.
- Home and Community-Based Service (HCBS) providers are unique and require a different network development approach from standard medical and behavioral providers. Medica is engaged with the Iowa Association of Community Providers (IACP) and will leverage our considerable internal experience in this area to partner with them and craft a provider network that maximizes provider retention and continuity of care.
- Optum Health will bring its expertise through management of a Chiropractic network
- Medica will establish a partnership with the primary transplant provider in the State of Iowa, the University of Iowa, for the management of transplants.

Medica will provide oversight and local (Iowa) management of our network partners through our experienced Provider Network team.

MEDICAL PROVIDERS

Medica's Medical Network Partner owns the network, which is NCQA-certified for credentialing and recredentialing. This national PPO network currently has a comprehensive network of providers in Iowa and will work with those providers to amend or negotiate new Medical Assistance Program (MAP) Agreements for inclusion in the Iowa High Quality Healthcare Initiative. Our Medical Network Partner has relationships with the predominant healthcare systems in Iowa are strong and favorable. Preliminary review of network adequacy reveals strength in Acute Care, Primary Care, and Specialty Care services. Plans for additional provider recruitment will enhance the network further and resolve any areas with existing deficiencies.

Our Medical Network Partner will also aggressively target Rural Health Clinics, Federally Qualified Health Centers, and other provider types vital to the provision of services to ensure compliance with the defined Access and Availability standards set forth in the RFP. Deficiencies revealed through analytic review, or feedback from the client, State or other sources will be addressed through gap analysis exercises and eligible providers will be recruited as applicable.

BEHAVIORAL HEALTH PROVIDERS

Medica will leverage our existing partnership with United Behavioral Health as they have an established and extensive provider network in Iowa. Referenced as Medica Behavioral Health (MBH), this network will be expanded as required to ensure the needs of the Medicaid population are fully met.

When choosing these providers, MBH will consider the anticipated Medicaid enrollment, expected utilization of services, and accessibility for members, among other criteria to ensure a comprehensive, competent service array offering. Policies and procedures will be set forth for the responsible selection, credentialing and retention of providers in accordance with federal and state regulations. All approved mental health and substance abuse treatment providers will work to meet the needs of adults and children in Iowa as part of a recovery-oriented care system that welcomes and engages members in their personal recovery efforts. Preferences of individuals and families in the design of the services will be at the core of the network.

MBH will work with the Iowa Department of Human Services and Iowa counties to identify where there may be potential gaps in services and work together to implement solutions that may include contracting for alternative services.

HCBS

Home and Community-Based Service providers include an array of specialty and niche providers. HCBS providers nationally show a 25% annual turnover rate. In order to build, retain and educate these critical service providers, Medica has established partnerships with the HCBS provider community in Iowa. Where possible we will leverage existing networks/organizations to maximize provider retention and continuity of care. Analysis is currently underway to ensure any geographic or service type gaps are identified and closed.

CHIROPRACTIC

Optum has an established network of over 700 Chiropractic providers in Iowa. Using this existing network as the foundation, they will tune the network to fit the profile of the Medicaid membership.

TRANSPLANT

The key to an effective transplant network is inclusion of transplant centers of excellence. Medica will work with the University of Iowa Medical Center to optimize transplant services for Iowa Medicaid members.

2. **Describe any counties or areas of the state and any provider types in those areas where you anticipate facing network development challenges. Discuss your mitigation strategies.**

Iowa has a demographic profile typical in many ways of the upper Midwest, and thus is familiar territory for Medica. Iowa and Minnesota, for example, both have a small number of dense urban centers, coupled with large rural areas. No matter how robust the network, there are areas where member access is constrained by distance.

Medica has over thirty (30) years of experience building and maintaining networks in this context that provide robust coverage and satisfy access to providers.

Medica has worked with its Network Partners to perform extensive analyses of network availability by county. For example, this analysis shows that the network - *as it currently exists* - provides access to members within the defined standard for Hospitals (96.5%) and Primary Care Providers (99.6%). It also shows excellent coverage for Physician Specialties.

To help mitigate access challenges in Iowa's rural counties, Medica will pursue an "open access" network model across the state to ensure all eligible providers are invited to participate, but will focus special effort on filling deficiencies in these counties by offering contracts to Critical Access Hospitals, Rural Health Clinics, Federally Qualified Health Centers, Community Health Centers, Public Health Departments and physician extenders such as Physician Assistants, Nurse Practitioners, and other allied health professionals to ensure availability of covered services within a reasonable drive time. We will work with Primary Care Providers to determine referral patterns for specialty care services and will extend our reach to bordering states for the nearest in-network provider when necessary.

Medica and its Behavioral Health Network Partner are committed to maintaining a comprehensive network that ensures ease of access to clinicians and facilities. Network managers in our behavioral network services department regularly analyze the network and recruit new clinicians and facilities to enhance the depth and breadth of our network. Network managers work continually to fill any gaps in our network that are identified.

In Iowa, the majority of time and distance access standards are being met with exception of Residential Behavioral Services and Partial Hospitalization Services in targeted regions.

In regions where access issues for Residential Services have been identified, the network analysis is complete and active recruitment is underway to close those gaps.

In regions where access issues for Partial Hospitalization Behavioral Services have been identified; there simply are no providers in those specific areas offering that level of care. Medica and our Network Partners will continue to monitor, identify and partner with providers who may be willing to develop these services in the future.

Chiropractic appears to be well-served from an access perspective. Based on analysis of chiropractic provider access for an existing Optum Network plan in Iowa, it appears that Medica's starting point for Chiropractic access is very near 100%, with the average distance to care of less than one (1) mile for Urban members, around one (1) mile for Suburban, and four (4) miles for Rural members.

The strengths of our partners' existing network footprints, combined with Medica's thirty (30) plus years of experience in creating vigorous, patient-centric and cost effective Provider Networks, will accelerate our ability to prepare a network of Providers that provides the best coverage possible to Iowa's Medicaid members.

6.1.2 Provider Agreements

- **Describe your process for reviewing and authorizing all network provider contracts.**

Medica will delegate direct contracting to our Network Partners, but maintains oversight over the process and standards applied, including ensuring adherence to Iowa DHS requirements. Medica will respond to any member or provider complaints through our established quality and service processes.

Our Network Partners have defined, end-to-end process for provider contract review, approval, and submission to ensure that all negotiated and executed contracts with providers meet established guidelines and are compliant with both Federal and State regulations.

Our Network Partners will have all contracts reviewed and approved by management to ensure compliance. Contracts containing non-standard language and rates are also analyzed and approved through a rigorous legal review.

The contract templates are revised as needed to maintain compliance with State and Federal regulatory requirements. Provider contract changes, regulatory or otherwise, require a thirty (30) day prior written notification to the provider which gives the provider the opportunity to review, and accept or challenge the contractual change.

- **Provide sample provider agreements.**
  - **Sample provider agreements are included in the original copy of this proposal and are marked as Trade Secret/Confidential in this public copy.**

- **Indicate if you propose to impose any requirements for exclusivity agreements for quality or payment purposes.**

Avoiding unnecessary provider disruption and enhancing member continuity of care will be priorities as we transition to a managed care environment. In order to support these goals, Medica does not plan to support any exclusive provider contractual arrangements for 2016, but rather, will allow “open access” to all eligible providers who meet credentialing criteria.

- **Propose the percentage of provider contracts that will be consistent with value-based purchasing by January 1, 2018 and specify the percentage annually for each year thereafter. Will you move into value-based purchasing before 2018?**

Value Based Purchasing is the natural reimbursement model in a well-managed care environment, as providers take ownership for the patient’s overall health care (as opposed to delivering discrete services).

Medica has extensive experience in value based partnerships in both the commercial and Medicaid environments. Medica developed one of the first real Total Cost of Care and Quality contracts in the country in 2007 and has since incorporated cost and quality into a variety of value based partnerships throughout Minnesota. Medica has forged unique provider partnerships in Minnesota Medicaid programs where care is directly related to shared clinic outcomes, shared financial results and over-all shared accountability for improving the health and wellbeing of the Medicaid members.

In the interests of enhancing the transition to managed care, Medica will not seek to implement VBP relationships “out of the gate” in 2016.Instead Medica will use 2016 to develop relationships and expectations with the provider community, and to focus on developing VBP arrangements with key providers later 2016 and 2017, achieving or exceeding 40% VBP requirements by 2018.

6.1.3 Provider Credentialing

1. Describe your credentialing process.

As part of our comprehensive approach to Network development and management, Medica has successfully provided credentialing services and has also delegated credentialing to our Network Partners. We have an existing, proven delegation oversight process to ensure that all providers in our networks are credentialed with rigor and consistency.

Medica's Network Partners are required to have stringent credentialing programs which follow NCQA guidelines.

PHYSICIANS

Network physicians must submit to rigorous physician credentialing processes and procedures that are certified by NCQA. Medica's partners will credential each physician who wishes to participate in the Network by obtaining the following information:

- A comprehensive physician application including the answers to professional questions attested to by the applicant
- Certification by the appropriate board of the American Board of Medical Specialties, American Osteopathic Association, the American Board of Oral Maxillofacial Surgery, or American Board of Podiatric Surgery, or verification that the physician is appropriately trained (primary source verified)
- A current, valid and completely unrestricted license to practice (primary source verified)
- Admitting privileges at a hospital participating in the network, if applicable
- A current, valid Drug Enforcement Agency certificate, if applicable (primary source verified)
- Adequate professional liability (malpractice) insurance
- Training verification for non-board certified physicians
- Five-year work history
- Acceptable malpractice claims payment history (as determined through the National Practitioner Data Bank [NPDB])
- Query for Medicare/Medicaid sanctions, state board actions, health plan or hospital sanctions and any negative action by any other professional society board or governmental agency from the NPDB report
- Query the Excluded Parties List System (EPLS) via the federal System for Award Management (SAM)
- Query the Office of the Inspector General (OIG) via the OIG website

HOSPITALS

Medica's Network Partners have rigorous hospital credentialing processes and procedures and are certified by NCQA. These partners require hospitals to have the appropriate state licensure and accreditation from approved accrediting organizations such as the Joint Commission (formerly JCAHO), the Healthcare Facilities Accreditation Program (HFAP), Det Norske Veritas (DNV), or Medicare certification. In addition to licensure and accreditation every hospital is reviewed against the OIG and EPLS listings to verify no active exclusions/sanctions exist. If the entity does not meet these qualifications, they must respond to additional inquiries. Our partners perform primary verification of a hospital's accreditation or certification before admitting new hospitals into the network. The Medical Network Partner Credentials Committee, which meets weekly, would then review this data in order to make a determination as to whether the hospital will be considered for network participation.

ANCILLARY FACILITIES

Ancillary facilities, including but not limited to home health providers, behavioural health facilities, skilled nursing facilities, and nursing homes must provide proof of general comprehensive and professional practice liability insurance and any applicable state licensure, in accordance with NCQA guidelines. They must also adhere to credentialing criteria that includes completion of a request for information and attestation of all legal requirements, including personal staff and equipment certifications, if needed.

RECREDENTIALING

Recredentialing is required every three (3) years for Practitioners and Facilities.

2. Describe your methods to streamline the provider credentialing process.

Medica's Medical Network Partner uses credentialing software to streamline the processes. They use custom software to manage credentialing information. The system allows the credentialing partner to generate practitioner listings and reports to monitor the timely completion of practitioner credentials.

In addition, Medica has extensive direct Credentialing experience and is also NCQA certified. Medica performs periodic reviews of our Partners' Credentialing processes and enforces consistency of process.

Medica participates in the Minnesota Credentialing Collaborative, which is a great example of a streamlined approach. All collaborative participants share one audit tool and the credentialing file audit results. This eliminates the need for each health plan to audit the PPO/provider system's initial and recredentialing files individually. Provider's save time because they prepare for one audit instead of three-five audits. Medica would be open to participating in a similar collaborative in Iowa, if it exists.

Medica delegates credentialing to more than fifteen (15) different provider systems. We require all delegates to comply with NCQA standards and base our delegation oversight program on Standard CR 9. We have found it to be an efficient and effective method for ensuring quality practitioners serve our members. It also maximizes timeliness for adding practitioners to our network.

Medica monitors our credentialing delegates by conducting an annual audit of the PPO/provider system's credentialing policies and reviewing files using NCQA 8/30 methodology. Any findings require a corrective action plan. Medica requires delegates to provide us with semi-annual reports, which permit us to monitor credentialing activities. If a delegate is independently accredited by NCQA, than we accept NCQA's accreditation standing. An overview of our delegation program can be found in the attached Delegation Manual.

The delegation oversight process is managed by Health Management Compliance through oversight workgroups comprised of subject matter experts with credentialing and regulatory backgrounds, and ultimate oversight by the Medical Subcommittee of Medica's Board of Directors.

3. **Describe your plans for performing criminal history and abuse checks and assuring all network providers hold current licensure as applicable.**

Medica's Network Partners perform initial criminal history and abuse checks as part of the initial credentialing process. Any identified criminal history or issues defined in section 6.1.3.1 above will result in a denial of credentialing for that provider.

Medica and our Network Partners all perform ongoing monitoring of state and federal sanction entities to review potential and current network providers. The review includes the review of state licensing boards, the OIG, and CMS. Providers reported through these sources are reviewed to determine current network participation. Participating providers are reviewed by credentialing committee for determination of continued network participation. Practitioners identified with the following are immediately removed from the network due to lack of licensure: suspended licensure, expired licensure, or revoked licensure.

4. **Describe your plans for ensuring non-licensed providers are appropriately educated, trained, qualified, and competent.**

Medica, in partnership with Iowa's LTSS/HCBS service providers (where most of the unlicensed providers will be found) are licensed to do business with the State of Iowa, as part of network engagement.

Training for these providers is integral to program success. We recognize the need to train non-traditional providers in a relevant and effective manner around a core curriculum and in a manner that includes; flexible scheduling, subject matter and peer interaction, and testing and takeaway modules.

Flexible Scheduling: Medica and its Network Partners will provide assistance in provider education and scheduling by provide training via webinar including before and after work hours and during lunch in an effort to effectively use the time of HCBS providers also delivering patient care. Hands on training and "help desk" sessions will also be available on the ground on a regional basis.

Subject Matter and Peer Training: Using a core curriculum around billing, quality, and HIPAA security and privacy, Medica and its Network Partners utilize subject matter experts and volunteer peers to help lead the training sessions. Having "real world" expertise on hand helps expedite learning and create relevancy to the providers in the training.

Training Testing and Takeaways: Following provider trainings we integrate worksheets and "test yourself" modules. Flyers with Fast Facts are provided to share with staff and flashcards with key terms and concepts can be downloaded to their PC or smartphone or tablet. Training engagement and varying modalities are an important part of our approach.

6.1.4 Cultural Competence

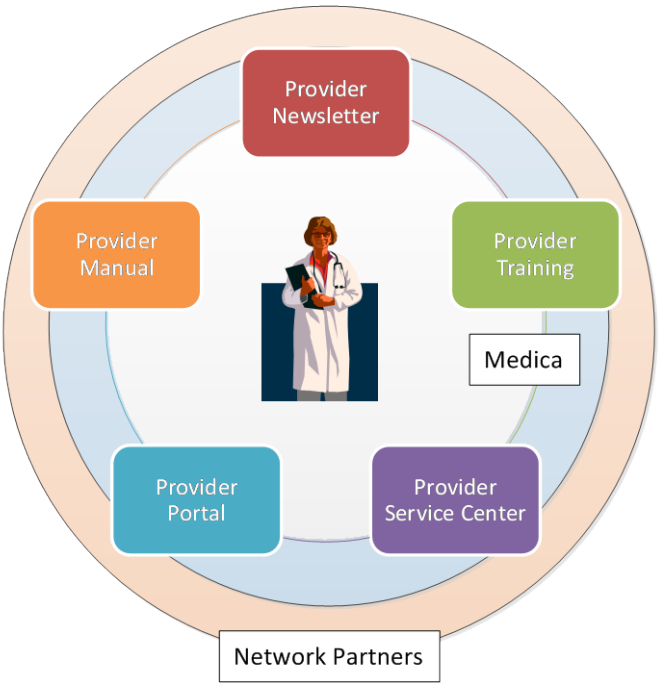
1. Describe your plans for ensuring the delivery of services in a culturally competent manner.

Delivering services in a culturally competent manner is a key strength of Medica. Medica is committed to using plain language and providing culturally competent resources to our member to reduce barriers associated with racial and ethnic disparities. Our network will include Home and Community-Based Service Providers, Federally Qualified Health Centers, Rural Health Centers and many other clinics with staff representing the foremost cultures in Iowa. We are also committed to providing culturally appropriate customer service through our call center with dedicated lines for our most commonly requested languages. In an effort to get feedback from members and the community, Medica holds language and culture-specific member input forums every year.

In addition, Medica and our Network Partners will seek out and contract with numerous healthcare providers with multilingual staff who are adept at providing a healthcare experience that supports the culture of their patients. Medica's call center staff will assist members in identifying the appropriate providers to meet their needs. However, we know there are not always opportunities to connect a non-English speaking member with same-language speaking practitioners. Therefore, Medica contracts with culturally competent interpreter vendors to provide interpreter services for our members' health care appointments. Interpreters are available to assist members by making appointments, calling members to confirm health care appointments, attending appointments with the members, and contacting the pharmacy.

6.1.6 Provider Relations and Communications

1. Describe your provider relations and communications strategy



Effective and long-standing provider relationships are at the core of Medica's success. Medica believes that the best provider relationships are built on proactive communication. To this end, at an enterprise level Medica maintains a Provider Relations Council specifically to:

- Enhance the mutual trust between Medica and network providers with accountability on both sides of the business relationship
- Support a consistent, coordinated approach to Medica's provider initiatives
- Support the development of clear service expectations that strengthen appropriate provider relationships
- Identify and reduce barriers that prevent appropriate service expectations
- Enhance operational efficiencies to prevent re-work, delays, and increased costs for Medica and providers
- Improve the dissemination and understanding of information among providers and internal stakeholders

While the Provider Relations Council provides oversight and direction, a specific Iowa Provider Relations Strategy will be developed and executed by Medica's Medical Affairs Department. Working with our Provider Services and Provider Network Teams and our Network Partners, and using our experience in delivering excellent provider relations and communications in our existing service area, we will establish a comprehensive provider relations and communication strategy for all contracted providers in Iowa. We will ensure that provider education and outreach is timely, meaningful, and consistent with client and State guidelines.

2. Describe your policies and procedures to maintain communication with and provide information to providers.

Planning and development of communication opportunities will be a collaborative process between Medica, our Network Partners and provider organizations.

Aligned with the provider relations and communication strategy, a Provider Communications Plan will be developed by Medica in coordination with our Network Partners.

Modes of delivering information and supporting Provider relations include, but are not limited to, the following:

- Face-to-face provider visits and routine contact by Provider Relations Representatives
- Regionally hosted-provider in-service/orientation meetings or "Town Hall" forums
- A comprehensive Provider Administrative Manual available either through Medica's Provider Portal or in hard copy
- Webinars
- Website materials/resources and "on-demand" training which can be distributed electronically or downloaded from website link
- Provider Newsletter

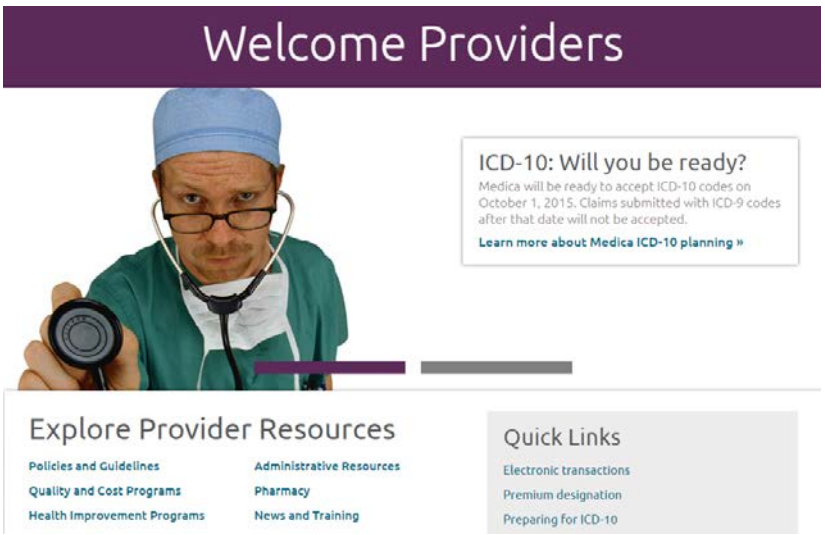
Please refer to **Tab 5** for a sample provider newsletter

The Provider Manual will be customized to include the specific requirements of Iowa DHS and of the Iowa provider community.

3. Describe your plan to develop a provider website and describe the kinds of information you will make available to providers in this format.

Medica will build on its standard Provider Portal capabilities and those of our Network Partners to give providers an all-purpose information resource and tool.

As the sample screen shot illustrates, our standard provider portal is a one-stop shop for provider information regarding programs, policies, guidelines and the Medica Provider Manual. It also provides links to other resources, and will include links to our Network Partners websites.



Our Medical Network Partner's website has resources for Providers that includes:

- Information about our health plan partners supporting Medicaid programs
- Reference guides for working with Network Partner
- Links to state websites
- Provider education schedules
- Online registration for provider education sessions
- Provider notices and bulletins from Medicaid managed care administrators

4. Describe your plans for the provider services helpline, including the process you will utilize to answer, route, track, and report calls and inquiries.

While the best provider relations are proactive, there will always be the need for a strong provider service component to provide a point of contact for provider concerns, questions, appeals and complaints.

As outlined below, Medica and our Network Partners have long maintained robust provider call centers. The goal of our Provider Service Call Centers is to address provider questions and queries in a "one and done" fashion. Where necessary, Medica and our Network Partners will warm transfer providers to make sure they get the right person to assist them.

Medica has long experience providing outstanding provider service via our Provider Service Center (PSC). Medica's PSC answers incoming provider calls and mail (both paper and electronic) from all provider types. The department answers provider inquiries regarding eligibility, benefits, claims status, claim payment issues, medica.com, provider communications, and provider education materials. It also handles general provider inquiries, such as questions about how to fill out a claim, where to send claims, and how to read a PRA. The Provider Service Center also addresses and resolves provider claim payment concerns, adjusting the provider's claim and educating providers as needed.

Medica's Provider service center is well established, with technology and processes to monitor and maintain service levels as natural fluctuations in provider call volumes occur.

Calls are routed to reflect both provider choice (via IVR and prompting) and agent availability. Managers, Team Leaders, and our dedicated PSC team monitor service levels through multiple sources.

Team leaders and managers also monitor service levels through system-generated reports. Daily, weekly and monthly reports include call volume, abandonment rates and the percentage of calls answered within one hundred and eighty (180) seconds. These reports also monitor average handle time, average speed of answer and service level. Other reports measure the productivity of individual service advisors.

Calls are audited to ensure the quality and consistency of service, and the information captured during these audits are used for training and coaching purposes. Results are tracked to make certain that service advisors reach optimal levels of performance.

5. Describe your provider training plans.

Medica will work with its Network Partners to establish a comprehensive and coordinated provider training plan to ensure that provider education and outreach is timely, meaningful, and consistent with Client and State guidelines which shall include, but is not limited to, the following:

- Face-to-face provider visits and routine contact by a Provider Relations Representative
- Regionally hosted-provider in-service/orientation meetings or “Town Hall” forums
- Webinars
- Website materials/resources and “on-demand” training which can be distributed electronically or downloaded from website link
- Provider Newsletter

In addition, Medica will create and maintain a single provider manual for all provider types.

COMPONENTS OF A SAMPLE PROVIDER RELATIONS PROGRAM

(Based on current best practices of Medica and our Network Partners)

1. Host a regional “lunch and Learn" in-service in each region on an annual basis. In-service topics will be agreed upon by Medica and our Network Partners, and appropriate support will be provided by both organizations.
2. Hold monthly webinars for key participating providers. Medica and our Network Partners will develop a schedule of webinar topics, manage the invitations and webinar set-up for providers, and provide Subject Matter Experts (SME) for clinical and operational subject matter and applicable training materials.
3. On-going training, including fax blasts, on-demand pre-recorded webinars, and educational updates to government website provided as requested/needed.
4. Medica and our Network Partners will coordinate on management of provider complaints and ensure timely response to State inquiries/complaints.
5. Provider orientations will occur for newly contracted providers (via Webinar, Face-to-Face, or regional in-service meetings, or other means such as on-demand webinars)

6.1.8 Notification of Provider Disenrollment

1. Describe the procedures for ensuring continuity of care and communication with members when a provider disenrolls.

Members are our top priority and we are committed to ensuring continuity of care and comprehensive communication upon a provider termination to maximize member outcomes. Medica has developed a detailed policy to ensure timely notification of provider terminations to affected members and regulators, including a formal continuity of care policy.

MEMBER NOTIFICATION

Participating providers are contractually required to notify affected members in the event of a termination, prior to the effective date of the termination. Medica will also notify affected members as expeditiously as possible and help them to select a new health care provider. Medica will make a good faith effort to notify the member within 15 days of receipt or issuance of the termination notice from a participating provider. Medica will ensure that the letter template used to notify members is approved in advance by Iowa DHS.

REGULATOR NOTIFICATION

Medica will notify the Iowa Department of Human services as soon as possible when there is a significant change in the provider network that would impact members. We will notify Iowa Iowa DHS one hundred and twenty (120) days in advance of the termination date or as soon as possible when prior notice is not given with enough time to permit the one hundred and twenty (120) day notice.

CONTINUITY OF CARE

Medica has a multifaceted approach to assuring continuity of care is maintained for members to continue to receive the care needed during a transition period to a new provider. Medica will promote and ensure service accessibility, attention to individual needs and comprehensive coordinated service delivery.

Upon termination of a provider contract, some members may be eligible for continuity of care. Medica will request the assistance of the provider in identifying patients who may be eligible for continuity of care. At the time of termination, Medica will that request from the provider a list of their Medica patients in order to determine if they meet any of the following eligibility criteria:

Medical Conditions: the patient is currently engaged in a course of treatment for:

- an acute condition
- a life-threatening mental or physical illness
- pregnancy beyond the first trimester
- a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last one year, or can be expected to result in death; or a disabling or chronic condition that is in an acute phase
- Cultural Scenarios: the patient has a cultural need and is receiving culturally appropriate services from their provider or, the member does not speak English

Medica will review all requests for continuity of care. If authorized, the member may be approved to continue services for up to one hundred and twenty (120) days or the rest of the member's life if a physician certifies life expectancy is one hundred and eighty (180) days or less.

Medica provides comprehensive training for customer service on provider terminations and continuity of care and will provide instructions on our continuity of care police and procedures through our provider portal. Our Health Management tracking system will track the continuity of care cases and outcomes.

6.1.9 Medical Records

1. **Describe your process for transmitting and storing medical data, including the use of technology and controls to ensure confidentiality of, and access to, medical records.**

Medica's Enterprise System Platform stores and transmits data elements in specified formats, including HIPAA 834 and 837 transactions. Our platform is powered by an EDI Gateway that serves mission critical information sharing for the state of Minnesota today. The EDI Gateway is scalable, currently processing over thirty five (35) million real-time and batch-time transactions per day. Over thirty (30) terabytes of data is exchanged monthly through the EDI Gateway in a multitude of formats compliant with HIPAA Transaction and Code Sets Standards.

6.1.10 Availability of Services

1. **Describe your plans to ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid members.**

Medica will use Network Provider Agreements and provider education to enforce provisions that govern provision of services to ensure that all providers render medical and health care services in a manner which assures availability, adequacy, and continuity of care to participants. These agreements require that no provider will differentiate or discriminate against participants in the provision of health care services, and will render such health care services to all participants in the same manner, in accordance with the same standards, and with the same availability as offered to provider's or participating provider’s other patients.

6.1.11 Provider Compliance

1. **Describe procedures for ensuring network providers comply with all access requirements and for monitoring providers for compliance.**

Medica's Network Partner's contract templates obligate a provider to offer covered services in accordance with all State and Federal guidelines as well as to abide by the MCO's provider manual terms and conditions. Education and training will be conducted pre-implementation and post-implementation to ensure provider's understanding and will support the MCO in the monitoring and enforcement of those terms and conditions throughout the contract term.

6.2 Network Development and Adequacy

1. Describe in detail your plans to develop and maintain a comprehensive provider network including goals and tasks and the qualifications and experience of the staff members who will be responsible for meeting network development goals.

Medica intends to leverage the footprint of our Network Partner's existing network in Iowa through the use of unilateral amendments as allowed and through direct negotiations with participating providers for the Iowa High Quality Healthcare Initiative program. Additional provider types such as Rural Health Clinics, Federally Qualified Health Centers, Community Health Clinics, Critical Access Hospitals, and other eligible provider types will be targeted for recruitment.

Once the Contract Template and Addendum Documents are approved by the client and HHSC for use in the Iowa High Quality Healthcare Initiative, mailings will commence to participating Network providers offering them an opportunity to participate in this new program. Follow-up activity will be conducted through a variety of means, including telephonic, e-mail, and face-to-face contact to ensure rapid return of documents and to allow providers an opportunity to ask questions and clarify materials needed for inclusion in this program. Additionally, recruitment mailings will target eligible providers that do not currently participate in the Network that are identified through external sources such as DHS website and other lists available to the MCOs.

Our goal is to have a fully contracted and credentialed network that meets adequacy standards in early Q4 2015 in preparation for readiness review activities and events, including directory submission and enrollment activities.

Medica and our Network Partners will monitor network adequacy using the published Access and Availability standards and Census data as available to ensure compliance with the network access standards. Progress will be monitored using dashboard reporting and resources will be assigned as warranted to ensure that benchmarks are met throughout readiness review, implementation and through ongoing monitoring to address network attrition as applicable.

Our Partner's Network Development Team is comprised of experienced and seasoned personnel in the managed care industry possessing at a minimum, bachelor's degrees or equivalent work experience in the healthcare industry. Each has specialized knowledge and experience with commercial, CHIP and Medicaid programs in multiple states such as Texas, Kansas, Ohio and with Medicare Advantage programs across the nation. Job descriptions for each role are available for review.

2. Describe your strategies for provider outreach and contracting in rural areas.

Medica's Network Partners will target all eligible, licensed medical professionals in rural areas with special attention and emphasis on Rural Health Clinics, Federally Qualified Health Centers, Community Health Clinics, Critical Access Hospitals, Public Health Departments, physician assistants, nurse practitioners, mid-wives, birthing centers, and other available sources of medical care that meet credentialing criteria and are willing to enter into a contract for the Iowa High Quality Healthcare Initiative.

3. Detail any way in which you propose to limit members to in-network providers.

As mentioned above, Medica will implement a PCP/PCC model based on voluntary selection and relationship development. The first goal of primary care providers in this model is to refer the member within their PCC organization, when possible. If this is not possible, they will seek to help the member find a network provider who can fill their medical needs. Member education will be used to help high utilizing members with persistent patterns of out-of-network utilization find appropriate care within our network.

4. Describe your plans to ensure providers do not balance bill its members and plans to work with members to help resolve billing issues.

Provider contracts, training and ongoing education will proactively emphasize this aspect of the program design. Any instance identified – whether through member call, provider inquiry or other avenue – will initiate immediate action with the provider to understand what occurred. If the provider did in fact balance bill the member, focused provider education will occur, and the provider will be required to make the member whole.

Repeated occurrences may be grounds for excluding the provider form the network.

Our Network Partner contract templates contain provisions prohibiting balance billing.

BILLING OF PARTICIPANTS

a. Provider will bill or collect from a Participant all Co-payments, Deductibles, and/or Co-insurance, if any, as specified in the Program for Covered Services.

b. Unless permitted by law, neither Provider nor any Participating Provider will bill or collect from the Participant (i) the difference between the Contract Rate and the Provider's Billed Charges, or (ii) for any amounts not paid to Provider due to Provider or any Participating Provider's failure to file a timely claim or appeal, or due to the application of claim coding and bundling rules.

6.3 Requirements by Provider Type

1. Indicate if you will use a primary care provider (PCP) model of care delivery.

Studies show that people who have regular visits with their primary care provider are healthier than those who don't. Medica is highly supportive of the PCP approach to care delivery, but believes that its benefits can be largely gained by using a "soft" gatekeeper approach. We encourage all Medica members to select a primary care clinic (PCC) for their care, and seek to support the development of enduring relationships between members and their PCCs.

But we are also sensitive to avoiding member disruption, especially in the transition to a managed care approach. All members will be asked to select a PCC, and that PCC will be printed on their ID Card. But this will not be a "closed" approach to gatekeeping. Members will be encouraged and supported in developing a relationship with their primary care provider that will improve the quality and cost effectiveness of their care.

2. If a PCP model will be utilized, describe the following:

a. **Physician types eligible to serve as a PCP**.

Because we will use a Primary Care Clinic as the point of entry, one of the network development priorities will be to ensure that a given provider organization/clinic has a sufficient number of primary care physicians on staff. These include; Family Practice, General Practice, Internal Medicine, OB/GYN, Nurse Practitioners and PAs (under physician supervision).

b. Any panel size limits or requirements

N/A

c. Proposed policies and procedures to link members to PCPs

Members will be asked to select a Primary Care Clinic at the point of enrollment. The PCC name and ID will be printed on the member's ID Card, included in the member Welcome Packet, and be indicated in Medica's claims adjudication/CRM system.

3. If a PCP model is not proposed, describe the methods to ensure compliance with 42 CFR 438.208 as described in Section 6.3.1

N/A

4. Describe your plan for providing a sufficient network of all provider types outlined in Section 6.3, including timelines and tasks.

Medica's Network Management Team will provide oversight and leadership to our Network Partners to ensure a consistency of approach and outcome.

Provider Type analysis has already been performed for our Medical and Behavioral Networks, and the results are available in Tab 5.

Our Network partners are committed to developing Iowa's network infrastructure for the long term, and therefore they will not be waiting for bid award to proceed with extending and supplementing there networks.

Here is how our Medical Network Partner describes the way they will navigate through this timeline:

HIGH LEVEL TIMELINE FOR PROVIDER NETWORK DEVELOPMENT

Task	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Initial Network Gap and Opportunity Assessment									
Refine Provider Agreements/Addenda as Required									
Targeted Provider Recruitment									
Re-assess gaps and Opportunitites									
Develop Provider Training Materials & Strategy									
Contract with new providers									
Provider Networks substantially complete							◆		
Execute provider training									
Directory Submission									

5. Describe your plans for meeting the requirements regarding Indian Healthcare Providers.

Medica's Medical Network Partner will offer and accept applications to all eligible providers, including Indian Healthcare Providers for participation in the Iowa High Quality Healthcare Initiative program.

SECTION 7: ENROLLMENT

Please explain how you propose to execute Section 7 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Medica has thirty (30) years of experience working with the enrollment of recipients into multiple Minnesota Medicaid programs. We can receive enrollment data electronically from the state via a medium prescribed by the state and ensure, through enrollment validation and demographic reconciliation, that recipients are enrolled timely into the correct programs utilizing the eligibility data received in the enrollment file.

Medica will accept all eligible recipients who selected or are assigned to Medica as determined by the state of Iowa. We will enroll eligible recipients in the order in which they apply or are assigned without restriction. Upon discovering a member's eligibility has changed, we will notify the state which may change their eligibility for Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (Hawk-i) programs.

Plan Selection Information

Medica will provide the state with plan-specific information available for any potential new enrollees into Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i) programs. We will present all materials intended for potential recipient communication to the state for review and approval prior to use. The materials will include:

- Comprehensive information on our service area
- Benefits
- Cost-Sharing
- Provider Networks
- Value-Added Services

In addition, we shall determine and translate vital documents and provide them to households speaking a prevalent non-English language. Prevalent non-English language refers to languages determined as five (5) percent of the population.

Upon enrollment, Medica will present a welcome packet to all new Recipients within 5 business days from the receipt of the member enrollment information via the eligibility files received from the state. . The welcome packet will include multiple materials including the information outlined in section 8.2.6.

7.4 Member Disenrollment

1. Describe your grievance process for addressing member quality of care concerns and member disenrollment after the first ninety (90) days of enrollment.

Medica will utilize its Case Managers, community outreach liaisons and dedicated customer service staff to work with our members, community stakeholders and providers to resolve service and benefit issues in a timely manner. Medica has a long history of resolving issues to the satisfaction of our members, stakeholders and providers. Because of this, our number of grievances and appeals is very low. Medica does closely follow all grievance timelines to ensure prompt response to members. In the event that a member remains dissatisfied with the outcome, Medica will direct the member to an Enrollment Broker.

Medica has a well-established process for handling member grievances and quality of care concerns. Medica has a dedicated Consumer Affairs team whose main responsibility is accepting and resolving member grievances and appeals, including quality of care concerns. Medica will provide its members, or appropriately authorized representatives, assistance with a systematic process for resolving issues of dissatisfaction. Members are informed of their right to file grievances and appeals at enrollment, and are given fair and equitable treatment. All decisions will be made with integrity, consistency and within the contractual obligations of the health plan. Determinations consider all applicable legal and accreditation requirements, including the requirements of the Iowa Department of Human Services (DHS), the Balanced Budget Act (BBA), and NCQA. All grievances and appeals will be handled pursuant to 42 CFR 438.408.

Medica has efficient, member-centered processes for handling verbal and written grievances within the call centers and Consumer Affairs Department. These departments work closely together to ensure that grievances are handled appropriately and timely. Medica will ensure that individuals rendering decisions on grievance and appeals were not involved in previous levels of review or decision-making and are health care professionals with appropriate clinical expertise in treating the member's condition or disease if the decision will be in regard to any of the following: (i) an appeal of a denial based on lack of medical necessity; (ii) a grievance regarding denial of expedited resolution of an appeal; or (iii) any grievance or appeal involving clinical issues.

Members may report grievances at any time about the quality of care they received from providers, or dissatisfaction with health plan services or processes. For all grievances, a member is offered a "Grievance Form" to provide detailed information regarding the concern; however, we will accept grievances both verbally and in written form. Members will be provided a receipt of acknowledgement for each grievance within three (3) business days. Medica will make a decision on grievances and provide written notice of the disposition of grievance within thirty (30) calendar days of receipt of the grievance. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 CFR 438.408(c). If the timeframe is extended for any extension not requested by the member, Medica will provide the member written notice of the reason for the delay.

SECTION 8: MEMBER SERVICES

8.1 Marketing

1. Describe in detail your marketing and outreach plans

Each year, Medica's Medicaid division develops a marketing and outreach plan that highlights our goals and strategies for reaching out to key stakeholders throughout the state. Through this plan, we conduct a thorough assessment of the strengths, weaknesses, opportunities and threats in the Medicaid market; we analyze the activities conducted over the previous year; and we develop goals and objectives for the current year.

Our marketing and outreach plans are based on our belief that understanding the needs of our members is critically important. We understand their situation today may not be their situation tomorrow. We've built plans with programs that grow and change just like they do— to meet their needs. Wherever our members are in life, they belong to a health plan that puts them first.

MARKETING PLANS

Managed care is new to Iowa. If chosen as a health plan in the State, Medica will work diligently, quickly and thoughtfully to launch marketing and outreach plans to reach low-income individuals to increase awareness of our programs and services among potential members and other key stakeholders. Opportunities we will leverage include utilizing traditional marketing channels to raise awareness; strategically capitalizing on community partnerships and event sponsorships; and participating in health fairs and conferences to expand awareness of Medica's value.

Key opportunities in Iowa include:

- Developing a comprehensive marketing campaign specific to Iowa that focuses on introducing Medica to potential members and other key stakeholders.
- Quickly establishing relationships with counties and community partners that serve low-income partners. We believe this is a critical component of developing a community presence.
- Identifying health fairs and other community events to participate in that build on the "get to know us" campaign.

DEVELOPING OUR MEDICAID BRAND STRATEGY

Our current Medicaid-specific brand strategy focuses on the tagline "You Belong." Through our marketing and communications efforts, we want to make sure all target audiences:

- Think about Medica and want to be a part of our plan
- Ensure they feel like "they belong" to the Medica community and want to become a member/be affiliated with our organization
- Have the most accurate, current information about Medica
- Are aware of the resources and services Medica provides to plan members (in order to help spread our message to potential members)
- Understand the benefits of being a Medica member (or using their Medica health insurance)
- Use our programs and services to help live healthier lives

MARKETING CHANNELS

We will use a variety of marketing channels to reach potential and current enrollees with the "getting to know us" marketing campaign noted above. These could include:

- Billboards
- Community newspapers
- Bus stops and bus ads
- Direct mail
- Radio
- Social media
- TV and online brand campaign (Medica-wide)
- Community health fairs

We will work closely with Iowa DHS and other stakeholders throughout the state to get recommendations on channels that would most effectively reach the Medicaid audience.

OUTREACH PLAN

We believe that health plans have a responsibility to partner with local public health agencies to maximize the health of their communities. We credit our growth as an organization to our sincere and unwavering commitment to listening and responding to the needs of our members, business partners and community stakeholders across all markets. With this commitment as our guiding principle, we believe Medica is well positioned to continue playing an essential role in the evolution of Iowa's health care landscape.

Outreach efforts and community collaborations play a role in improving the health of communities, but also build brand recognition and trust. We will actively invest in outreach and activities in Iowa that increases our presence in the state and benefits the community as a whole. We will participate in a variety of initiatives to meet the needs of the community. Examples include:

Health fairs and conferences

In Minnesota, Medica has played an active role in sponsoring, exhibiting and participating in community health fairs and conferences. In 2014, we participated in more than 55 of these events throughout the state. We will have staff dedicated to this type of outreach strategy in Iowa. During these events, staff will provide education on the programs and services Medica offers to members. When Medica participates in community events, a staff member that is representative of the community often attends.

Community grants

Since 2003, the Medica Foundation has granted $22.8 million to 358 organizations throughout Minnesota. When we enter Iowa to provide health care coverage to individuals, non-profit organizations in Iowa will be able to apply for grants through the Foundation. Our preferred approach is to provide seed money to launch new and innovative programs or expand proven programs with strong outcomes. The Foundation also looks for opportunities to collaborate and partner with community organizations because such relationships typically create a broader and more sustained impact. Priority funding areas include behavioral health, early childhood health and organizational core mission support. The foundations website, medicafoundation.org highlights the work of past grantees and our current funding priorities.

GRANT EXAMPLES IN MINNESOTA

In response to the staggering autism rates among young children in the Somali population in Minnesota, the Medica Foundation awarded a three-year strategic opportunities grant to launch St. David's Center's community-based Autism Day Treatment program geared at increasing access to early intervention services for Somali children with autism. Medica took seriously the community's call for culturally-attuned treatment options for a population with demonstrated need facing barriers to access.

Community Collaborations

Medica has a longstanding track record of working with community organizations across Minnesota that serve low-income populations. For 30 years, our community program managers have been actively engaged in building partnerships aligned around shared goals for the populations we serve.

Examples of Community Collaborations in Minnesota

HealthChoices

Returning to work is a critical strategy for parents and caregivers on Medical Assistance to gain or regain confidence, self-esteem and the ability to financially take care of their family members. For many of these individuals, however, a mental health illness (often coupled with chemical abuse or dependency) can be a barrier to stable employment.

In 2001, Medica, Medica Behavioral Health (MBH), RESOURCE, Inc. and Hennepin County developed HealthChoices. This program uses an assertive community treatment model to serve the hard-to-employ Minnesota Family Investment Program (MFIP) participants and working participants who are in need of job retention and advancement services. The goal is to identify and remove mental health, chemical abuse or dependency barriers to self-sufficiency and employment. Medica and Hennepin County equally share the program cost for Hennepin County residents who are Medica members to participate in HealthChoices.

8.2 Member Communications

1. Describe your overall strategy for communicating with members

Each Medicaid member is unique in how they want to receive communications. We strive to ensure our communications to members is not built on a "one size fits all" approach.

Our overarching communications strategy for members was developed based on three key objectives:

- Listening to our members
- Simplifying the jargon and speaking in plain language
- Offering multiple channels to receive information

LISTENING TO OUR MEMBERS

Since 2011, Medica has been engaged in an organization-wide consumer experience effort called Listen Up. This work has included in-depth research into the needs and experience of our members and independent analysis of our communications with them. As a result of this research, we learned from the Medicaid population is what they want from their health plan is to feel understood, unconcerned and assured.

We also engage in a variety of activities designed to get feedback from our members. From online surveys to fireside chats (described in more detail in Sections 8.12 and 8.13), we are continually evaluating and refining the best ways to get feedback from our members.

SPEAKING IN PLAIN LANGUAGE

One of the key objectives from the Listen Up efforts is a company-wide effort to simplifying the jargon that exists in the health insurance world and speak to our members in plain language. We have implemented new training programs for our customer service representatives and undertaken a complete overhaul of written communications to make them more understandable and actionable. To date, we have revised over 200 letters and other written communication forms. We also have embarked on an effort to understand and cater to members' preferred method of receiving various types of information or contacts from us.

EXPANDING CHANNELS OF COMMUNICATION

We believe the future state of education and communication to our members will not be as heavily reliant on print resources. One of our key strategies is to offer a greater number of options for our members to receive plan information electronically. We understand that members can be overwhelmed by the amount of plan information provided. Therefore, we want to provide our members with more choice in how they receive health plan-related information – including print and electronic formats.

For example, in 2013, we launched a Facebook page specifically targeted to Medica Medicaid members. We are also preparing to launch an initiative that gives members a choice in how they receive information from their health plan – whether in print or electronically.

2. Describe your plans to provide oral interpretation services and translated written information and how you intend to notify members of the availability of these services and how to obtain these services.

ORAL INTERPRETATION SERVICES AND TRANSLATED WRITTEN INFORMATION

Reducing barriers to care for members in Iowa that are associated with language, racial and ethnic differences is important to Medica. We will initially create member materials in English and will translate into Spanish. With any translated material, we also cover the cost to back-translate – which ensures that the original translation doesn't differ from the intended meaning. We will also identify and ensure other languages prevalent within our membership that need a written translation are provided. Written materials will include a

DHS-approved language block in prevalent languages that explains to members how to access materials in alternative languages.

In addition, we are committed to providing our members with culturally-appropriate customer service staff through our call center. We will have dedicated lines for the most commonly requested languages of our Iowa members. When a member speaks a language other than what our staff speaks, we will use telephonic interpreter services provided by TransPerfect Translations' Language Line. We will also hold language and culture-specific member input forums every year in an effort to get feedback from our members and the community.

ACCESSING INTERPRETERS FOR HEALTH CARE APPOINTMENTS

Our network will include Essential and Community Health Providers, Federally Qualified Health Centers, and many other clinics with staff representing the foremost cultures in Iowa. These providers tend to have a more diverse, low-income member base and can draw from many years of experience in providing culturally appropriate care. Upon member request, we will refer a member to a provider that can accommodate his or her cultural needs.

We will contract in Iowa with culturally competent interpreter vendors, (including sign language interpreters) to provide interpreter services for our members' health care appointments. We are contracted with TransPerfect Language Line, which is available 24 hours a day, 365 days a year for telephonic interpretation. The language line has the capabilities to meet any language requirement, with 140 different languages available. They maintain a large network of qualified language resources, ensuring that every interpreter request is matched with the ideally qualified Interpreter.

We will arrange and provide interpreters for members with no or limited English proficiency. Providers and members will be able to access interpreter services through:

- Medica's network of contracted interpreters - providers and members can call the agency directly to request an interpreter
- Medica's customer service line

3. Describe your plans to provide all written materials in alternative formats and how you will identify members needing alternative formats.

We will make all written materials available in alternative formats and in an appropriate manner that takes into consideration the needs of our members. These written materials include but are not limited to marketing, new enrollee information, member handbooks, and Grievance, Appeal and State Fair Hearing information and health promotion. We provide written information to potential enrollees including hearing-impaired members.

We will continue to explore other means of communication besides written, as some of the cultures we will work with are verbal communicators. As an example in Minnesota, we have been a collaborative partner in creating videos with Emergency and Community Health Outreach (ECHO) Minnesota in English, Spanish, Somali and Hmong. These videos explain how to access the health care system and the importance of preventive care to families.

We can also arrange sign language interpreters to go along with members for medical, dental and mental health appointments. Members can self-identify through several channels including by phone, email or TTY to request materials that best fit their communication needs. This information is stored and subsequent communication will be provided in the format requested on file.

4. Describe your policies and procedures for ensuring materials are accurate in content and translation.

It is important that Medica ensures that all members have access to information about our programs and services that is not only accurate but also available to them in the language they comprehend. We use a translation company when materials need to be translated; we typically translate select items into the top languages that our members speak. We also pay for the costs of back-translations to ensure accuracy of original content. We also use staff from the same cultural background as our targeted audience to review the translated document for content accuracy and provide suggestions on making the content culturally specific.

5. Provide sample member enrollment materials as described in Section 8.2.6.

Sample member enrollment materials are provided in Tab 5.

6. Describe your processes for identifying significant changes as described in Section 8.2.8 and notifying members of such changes.

TRANSPARENCY

We believe in the value of open communication with our members and key stakeholders. We have developed multiple ways of communicating with our members about process changes and updates to programs and services. We strive to ensure that communications happen before changes occur.

Member-specific communications channels include a biannual newsletter, targeted mailings, and messaging on our phone lines. We share upcoming program changes, the latest information on member benefits and other health care-related information in our biannual member newsletter. In the event of a significant change that may impact member accessibility to services, we send letters to affected members notifying them of changes or any actions a member would need to take.

Significant changes are defined as:

- Restrictions on the member's freedom of choice among network providers
- Member rights and protections
- Grievance and fair hearing procedures
- Amount, duration and scope of benefits available
- Procedures for obtaining benefits, including authorization requirements
- The extent to which, and how, enrollees may obtain benefits from out-of-network providers
- The extent to which and how after-hours and emergency coverage are provided
- Policy on referrals for specialty care and for other benefits not furnished by the member's primary care provider
- Cost sharing

Medica understands that significant changes to our programs and services directly impact our members and stakeholders and we are committed to communicating those changes in an accurate and timely fashion.

8.3 Member Services Helpline

1. Describe your plans for the member services helpline, including the days and hour of operation.

Our dedicated State Public Programs (SPP) customer service representatives answer member questions, provide support, arrange interpreter services and schedule transportation. Our representatives receive special training to help them understand, empathize with and meet the unique needs of low income and disabled individuals. They see each call as an opportunity to educate the caller on how to most effectively use his or her health care benefits, to give the caller confidence in the answers or solutions that were provided and to demonstrate that Medica truly cares about the caller as an individual.

The Medica Contact Center leadership team brings over 50 years of experience in Contact Center Operations, a passion for coaching and developing as well as a true understand and desire to serve this demographic and membership. The average tenure of our Health Plan Specialists is 5 years, with 3 of our team members having been with us for over 15 years each. Our staff is driven by our mission of service this population and providing them with a channel for us to educate and ensure they our members understand their benefits and how to utilize them.

Medica enrollees and potential enrollees residing in Iowa will have access to our toll-free customer service line and get that same level of service. We will have our customer service phone numbers printed on member ID cards and every piece of material we send to members.

Medica's call center hours of operation will be from 7:30 a.m. to 6:00 p.m. CST, Monday through Friday, excluding State holidays as outlined in the statement of work. Members that need to reach Medica after-hours will be provided a voicemail option. They will receive a response as soon as possible and no later than 24 hours of receipt.

Our helpful customer service staff will have the ability to warm transfer members to outside entities, such as provider offices, and internal departments, such as maternal and child health nurses, to facilitate the provision of high quality customer service. Outside of business hours, we will provide a Nurse Line 24 hours a day, seven days a week and 365 days a year to assist members with accessing appropriate care including urgent transportation.

We plan to staff our call center with individuals who represent the demographics of our members. U.S. Census Bureau information indicates the following:

DEMOGRAPHIC	IOWA	US
White	92.5%	77.7%
Black or African American	3.3%	13.2%
American Indian or Alaska Native	0.5%	1.2%
Hispanic or Latino alone	5.5%	17.1%
Asian	2.0%	5.3%
Native Hawaiian and Other Pacific Islander	0.1%	0.2%

We will strive to staff the customer service line with representatives from the most common languages spoken in Iowa.

2. Describe the process you will utilize to answer, route, track and report calls and inquiries. Indicate if an Interactive Voice Response (IVR) system is proposed.

Medica's Medicaid Customer Service Team answered more than 508,000 calls in 2014. Call volumes typically increase an average of 10-15% per year, based on membership growth.

Medica has invested significantly in a system called AVAYA to ensure we utilize best-of-class telephony solutions that make our interactions with members as responsive, flexible and personalized as possible. This system is used to route, report and monitor call volumes.

We use a menu system for routing calls that allows our members to reach us quickly through the use of phone prompts. When calling the customer service line, members will be prompted to indicate the reason for the call. For example "if you are calling regarding benefits - press 1; interpreter services - press 2." This routes the caller to the most qualified health plan specialist to address their concerns. We do not propose an Interactive Voice Response system.

After each call a Customer Service Representative takes, members have an opportunity to participate in an after-call survey. In 2014, the Customer Service Team ended the year with a quality score of just over 97%.

Customer Service Member Quotes

- *I am very glad that I chose Medica to be my primary health care along with my MA. Because they have fully ensured good service for me. Thank you for looking out for people with medical issues. Medica is a good insurance.*
- *As far as I am concerned, Medica is totally awesome. I have several friends on Medica and I have some friends on BCBS and the ones on BCBS the only thing I say to them is like WHY?? When Medica can do so much for you. Thank you for listening and thank you for being the good providers that you are!*
- *Hi, I have called Medica on several questions because I can't find things in the book and they are so helpful and so kind. I just want to let you know that I really appreciate them. Thank you very much!*

3. Describe your plans to provide services for the hearing impaired and non-English speaking population.

In Minnesota, we currently contract with the National Relay Center so that our members with a hearing impairment can connect with our customer service staff. Text Telephone (TTY) phone numbers and instructions are provided on all written materials. We will utilize this service in Iowa as well.

In addition, we will offer direct access to customer service representatives who speak languages representative of the demographics of our members residing in Iowa. When a member speaks a language other than what our staff speak, we will use the telephonic interpreter services through the TransPerfect Translations' Language Line.

4. Describe your training program curriculum and training process for call center staff.

Medica is keenly focused on the member experience, which is the touchstone of our call center training and quality assurance program. Medica's Listen Up initiative focuses on three key elements of the member experience, ensuring that our members are understood, assured, and unconcerned. This motif is evident in our daily member interactions and throughout the entire Medica organization. The member experience is how our customer service team defines success and it will be incorporated into the training program for our employees in Iowa.

Customer Service Representatives are held to the highest quality standards, which is also the most heavily weighted objective in the employee performance structure. Upon hire, customer service staff participates in an intensive five-week training program. We also have a rigorous mentoring program in place for new trainees and provide our staff with immediate access to an internal quality resource.

TRAINING FOR NEW HIRES

Our customer service new-hire training program includes focus in the following areas:

- Who are our members
- Benefits, enrollment and claims
- Compliance requirements
- Navigating systems
- Resources for our members – lending a helping hand
- Appeals and grievance training

ONGOING TRAINING

We hold weekly customer service staff meetings that provide continued education on benefits, programs and services, cultural awareness and more. We also have available:

- Dedicated weekly meeting to review changes/updates or training
- 1-to-1 Peer/Mentor Coaching Program
- Annual continued education requirements
- Annual Fraud, Waste and Abuse Training
- Annual Compliance Program Training
- Feedback sessions with quality coaches based on weekly audits and monitoring

5. Describe your call center monitoring process to ensure helpline performance metrics are achieved.

Medica monitors all performance metrics in real-time through dedicated staff and tools that ensure that all service levels are achieved. Through disciplined forecasting and monitoring of “real-time” call activity, including optimal staff utilization, to ensure that service level requirements are achieved.

6. Describe your plans for a backup solution for phone service in the event of a power failure or outage or other interruption in service.

As part of Medica’s comprehensive business continuity plan, our contact centers are equipped with backup generators in the event of power failure. This provides seamless uninterrupted service to our members if a power failure or other interruption in service occurs.

We have dual data center redundancy for our phone system which provides the menuing and routing for this contact center - automatic failover, without manual intervention. We have invested in a duplicate disaster recovery location and have provided the ability for customer service representatives to work from home. This also aids continuous coverage to members in the event of a service disruption.

7. Describe if any separate member services lines or staff will be used to address member needs by service type (i.e. physical health, behavioral health and long-term care services.)

If a Medica member has questions about his or her health care coverage or how to access health plan services, schedule transportation or other general questions, he or she can contact customer service or visit our website at medica.com for more information.

For specific health-related questions, quick help is only a phone call away with the Medica Nurse Line. Our nurses answer thousands of calls each year from our members and are staffed 24 hours a day, 7 days a week. The Nurse Line toll-free phone number is located on the back of the member's Medica ID card. These nurses can answer health care questions and provide self-care tips. They can also recommend when a member should make an appointment with his/her doctor, or go to an emergency room or urgent care center.

For mental health or behavior questions or concerns at any time, our customer service team can warm transfer members to the Medica Behavioral Health line.

8. Describe proposed entities to which you will be capable of warm transferring member calls.

To provide seamless service, Medica has the ability to warm transfer members to any outside entities. Some examples of warm transferred calls include:

- Medica's health and wellness coaches
- Medica's case management team
- Medica's healthy pregnancy team
- Provider offices
- Maternal and child health nurses

8.4 Nurse Call Line

1. Describe how the Nurse Call Line will be publicized to members.

We provide our members a toll-free nurse line which is available 24 hours a day, seven days a week. The nurse line phone number is printed on every member ID card, virtually every piece of material we send to members and on our website. Comprehensive information on how to access and utilize the nurse line will be included in a welcome packet that will be sent to new members upon enrollment.

Members who call the nurse line will talk with a registered nurse who will provide compassionate and professional health advice and answers to questions. A nurse from the call line can:

- Discuss symptoms
- Answer concerns about health conditions
- Discuss medication
- Offer self-care tips
- Explain treatment options, including when to go to the doctor or emergency room
- Help a member find a physician, hospital or other facility in the Medica network

2. Describe the credentials Nurse Call Line staff must possess.

Nurse line calls are answered by licensed registered nurses who follow standard of care algorithms. They obtain a caller's pertinent medical history, which leads to an assessment and further care recommendations.

The registered nurses generally have more than 10 years of clinical experience. Most have worked for physicians, in hospital settings, or at health plans, and many have backgrounds in case management. The nurse line team also includes specialists in social services, behavioral health, wellness coaching, nutrition, exercise physiology, pharmacy issues and substance abuse management.

3. Describe processes and protocols for when a physician must be consulted.

As part of our clinical advocacy program, physicians are consulted when needed to approve sharing of clinical information, and to suggest possible solutions that may be discussed with attending physicians. Nurse line calls that need immediate physician intervention are referred to the appropriate provider or facility. The nurse line algorithm incorporates the recommendations for when a nurse should consult with a physician or make the recommendation for the member to seek care from a physician.

8.5 Electronic Communications

1. Describe how technology will be leveraged to communicate with members.

Ensuring access wherever the member is in life

Medica's membership is diverse in age, geography, education and their access to and ability to use technology. This creates a great opportunity for us to reach members in many different ways to ensure they receive the best access to care at any given time they need it. Incorporating technology with more efficient delivery methods are top priorities at Medica.

The Medica website, medica.com, offers access to many of the basics, but also goes above and beyond to make sure our members have the information they need to be well. Through our website, they can find:

- A doctor or doctor's office
- Pharmacies and prescriptions
- Multicultural health resources
- Mental health resources

Live and Work Well website for behavioral health and wellness

Through our behavioral health partner, Medica Behavioral Health (MBH), members, families, providers and other stakeholders have access to our award-winning behavioral health website, liveandworkwell.com. This website provides information on a variety of topics, including recovery, well-being support and health management. In 2013, the livendworkwell.com portal was used by 4 million visitors, who accessed 118 million page views and conducted 7.5 million transactions.

A companion site, MenteSana-Cuerposano.com (Healthy Mind-Healthy Body) is the award-winning, affiliated site to livendworkwell.com for Spanish-speaking members. MenteSana-Cuerposano.com is not simply a Spanish translation of liveandworkwell.com but rather a site focused on providing culturally relevant material for Hispanic/Latino Members. Users access a link through liveandworkwell.com for this extensive Spanish language content, which uses a community and family-focused approach to help remove cultural stigmas to seeking behavioral health care.

Expanding programs through technology

The following programs are offered currently today for Medica's Minnesota membership. They've been extremely successful in helping our members with their overall health and wellness. If selected as a health plan of choice in Iowa, we would explore launching these programs to members in Iowa.

PREGNANCY PROGRAM

An expecting mother can receive support through the Medica **Pregnancy Program** in ways she finds most convenient or useful. We offer telephonic health coaching, a library of materials online and deliver timely information by text message.

One of our most exciting partnerships, Text4Baby, is a free service for expecting mothers. Participants receive three free text messages each week, with timely reminders that coincide with their due date. Text message topics range from labor signs, nutrition, and overall safety during pregnancy.

Every youth with thoughts of depression or suicide should have access to a resource that meets them in their comfort zone when they need it. Medica is an active partner and sponsor of the TXT4LIFE Program. It operates in most of northeastern Minnesota and is expanding throughout Minnesota by legislative decree.

HEALTHY SAVINGS

The Healthy Savings Program is currently offered to Medica Medicaid members and provides access to discounted healthy foods at partnering grocery stores. They receive a weekly email that outlines a variety of

healthy food options available to them with the swipe of their Healthy Savings card. The Medica Healthy Savings website works on a mobile platform and optimizes no matter the device a member is using. The discount information is also available online through the member's Healthy Savings account.

NEW TECHNOLOGY OPPORTUNITIES

Medica is continuously looking for opportunities to enhance delivery to our members through the best people, process and technologies. Our technologies are centered around providing our members with an intuitive user experience.

NOVU

In July 2015, we will launch Novu, an online health and wellness tool, specifically focused on supporting Medicaid members. This interactive experience begins with a Health Risk Assessment (HRA) which leads members through a personalized journey to manage their specific health needs. This tool is mobile and desktop friendly, but is also available in print or telephonically as requested. Members will receive incentives for completing various preventive health resources

VIRTUWELL

In 2015, Medica added Virtuwell as a benefit for Medical Assistance and MinnesotaCare members. Virtuwell is an online clinic that treats everyday illnesses as an alternative to office visits, the urgent care or ER. Members can get a personalized diagnosis, a treatment plan and a prescription in about 30 minutes and all online. Medica tracks utilization of this online tool for MA and MinnesotaCare members.

TELEHEALTH SERVICES

Our delegated partner for mental health and chemical dependency is Medica Behavioral Health (MBH). MBH uses telemedicine and telehealth services to enhance the availability of behavioral health assessment and treatment services. Services with live audiovisual interaction can provide information and a feeling of connection that is not available through telephone contact only. We participated in early workgroups to establish technology and processes to support telehealth and we continue to reimburse providers for telehealth services. As technology continues to develop, the cost associated with telehealth is going down, which continues to support the availability of these services. Also, MBH has a limited number of computers, webcams and speakers available to donate to providers willing to establish new telehealth services. We have achieved positive results utilizing advanced telehealth technologies to broaden our ability to reach many rural communities to ensure access to information and care.

The Medicaid member is constantly changing. We thrive on pushing ourselves to constantly be nimble in order to best serve our customer. If selected as a health plan of choice in Iowa, we would leverage these existing technologies to communicate to members. We would also work closely with community partners to learn about other technology opportunities we could leverage.

2. Describe how information on member's preferred mode of receipt of communications will be collected and how information will be sent in accordance with such selection.

PREFERRED METHOD OF CONTACT

We are committed to delivering more personalized benefit and health information to our members. The first wave of implementation of our "Preferred Method of Contact" initiative will launch in spring 2015 and will deliver a new centralized consumer contact database that will have the ability to be populated with multiple physical addresses, email addresses, and phone numbers. Once this is implemented, we will develop a new interface for members to let us know how they prefer to receive information and create and deliver communications that take advantage of additional channels (e.g., email, text).This will give members the authority to opt in and out of how they prefer to receive information.

As we begin to expand our use of email for consumers who indicate they would like this, one of our first areas of focus will be a series of messages to make their start with Medica easier and more useful. This may include:

- “Welcome to Medica” message
- “How to get the most of your plan and/or New Member packets
- “How to prepare for your first doctor visit and filling your first prescription”
- “Learn about the extra features available to you” (i.e., Novu, My Health Rewards, Dental coverage)

Our goal is to improve the member service experience and to lower the cost and waste of printing materials where possible.

3. Describe how electronic communications will be received.

Electronic communications is one of the many different ways to ensure that Medica members efficiently receive personalized benefit and health information. Members will receive emails alerting them anytime an electronic notice is posted to the member portal. No confidential information will be included in emails. In the event such a notification email is returned as undeliverable, Medica will send the notice by regular mail within three (3) business days of the failed email. Members will be able to communicate with Medica electronically via email and the member website.

8.6 Member Website

1. Describe your plan to develop a member website and mobile applications in English and Spanish and the kinds of information you will make available to members in these formats.

We understand that finding credible, evidence-based online health and wellness information can be an overwhelming and time-consuming undertaking. Medica has a multi-channel member communication strategy. We offer several member websites, a provider portal and utilize mobile technology to interact with our members. Medica's membership is diverse in age, geography, education and their access to and ability to use technology. This creates a great opportunity for us to reach members in many different ways to ensure they receive the best access to care at any given time they need it. Incorporating technology with more efficient delivery methods are top priorities at Medica.

We believe that the future state of education and communications to our members will not be as heavily reliant on print resources. Additionally, we are committed to making communications with our members clear and easy in their language of choice. We offer translation and interpreter services in more than 140 languages, and strive to make vital information available in multiple languages.

MEDICA.COM

The medica.com website is very robust and designed to communicate with a variety of audiences including members, potential members, providers and brokers. The "Find a Physician" tool on medica.com specifically translates into Spanish. A number of other vital documents and pages are also available in Spanish.

In addition, all Medicaid plan home pages on medica.com have a 'mini' language block at the footer of the page. The Spanish icon links members directly to a Spanish language line.

LIVE AND WORK WELL WEB SITE FOR BEHAVIORAL HEALTH AND WELLNESS

Members, families, providers and other stakeholders have access to our award-winning behavioral health website, liveandworkwell.com, which provides information on a variety of topics, including recovery, well-being support and health management. In 2013, the liveandworkwell.com portal was used by 4 million visitors, who accessed 118 million page views and conducted 7.5 million transactions.

A companion website, MenteSana-CuerpoSano.com (Healthy Mind-Healthy Body) is the award-winning affiliated site to liveandworkwell.com for Spanish speaking members. MenteSana-CuerpoSano.com is not simply a Spanish translation of liveandworkwell.com but rather a site focused on providing culturally relevant material for Hispanic/Latino Members. Users access a link through liveandworkwell.com for this extensive Spanish language content, which uses a community and family-focused approach to help remove cultural stigmas to seeking behavioral health care.

THE MEDICA MEMBER PORTAL

At its core, the Medica Member Portal is designed to provide useful, actionable information to members in a very consumable way consistent with our mission to simplify and improve the health care experience. The platform is built to be scalable and flexible to accommodate the many ways in which our members wish to access and receive information. Recognizing that members have a variety of methods available to connect to our online content, our site is built to be responsive to device type and can be easily viewed on laptops, desktops, tablets and smart phones. Medica currently has mobile technology implemented to support our Individual & Family business in Minnesota. This technology can be leveraged for use with Iowa members. Our goal when designing new content is to make sure that there are no technical barriers between members and their health benefits.

While this page isn't translated into Spanish, there is a tutorial on the home page that guides members through the logon and registration process.

Features and Content

The Medica portal site offers access to many of the basics, but also goes above and beyond to make sure our members have the information they need to be well. The core offering includes:

- Find-a-Doc which helps members to locate a practitioner or health care facility
- Access to information on pharmacies and prescriptions
- Claims summary information
- Benefit plan information including cost sharing and accumulators

MOBILE TECHNOLOGY

While Medica doesn't currently offer any mobile technology directly to members, we have partnered with two initiatives that focus on texting to our members:

- **Text4Baby**, is a free service for expecting mothers. Participants receive three free text messages each week, with timely reminders that coincide with their due date. Text message topics range from labor signs, nutrition, and overall safety during pregnancy.
- **The TXT4LIFE Program** focuses on suicide prevention for tends and young adults. It operates in most of northeastern Minnesota and is expanding throughout Minnesota by legislative decree.

8.7 Health Education and Initiatives

1. Describe your proposed health education initiatives including topic areas and strategies for communication. Provide sample materials.

We believe that education and overall support of moving communities from a focus on sickness and disease to one based on prevention and wellness is key to achieving healthy communities. We understand that finding credible, evidence-based health and wellness information can be an overwhelming and time-consuming undertaking. Medica offers a number of ways to access health education and prevention support and provides a variety of programs and services that promote wellness and healthy lifestyles. In addition, we are committed to collaborating with the State and community stakeholders to develop and implement educational opportunities and prevention strategies tailored to their communities.

Currently, Medica provides health education in the following ways:

- At Medica
  - Web-based education
  - Newsletters, fliers, booklets and brochures on a variety of health topics including preventive health visits (i.e. prenatal and postpartum care; child and teen checkups (C&TC); cancer screenings, car and booster seats, adult preventive care visits), dental care, tobacco cessation, health and wellness coaching, and where to go for care
  - Individual education and support (i.e. health coaching and healthy pregnancy)

- In the community
  - At health fairs and community events
  - In collaboration with counties and community partners
  - Through provider-specific trainings (such as C&TC trainings)

Sample member education materials are included within Tab 5.

EXAMPLES OF WEB-BASED EDUCATION IN MINNESOTA

Live and Work Well: Members, families, providers and other stakeholders, have access to our award-winning behavioral health website, liveandworkwell.com. This site provides information on a variety of topics, including recovery, well-being support and health management. In 2013, the livendworkwell.com portal was used by 4 million visitors, who accessed 118 million page views and conducted 7.5 million transactions.

Mente Sana-Cuerpo Sano: A companion site, MenteSana-Cuerposano.com (Healthy Mind-Healthy Body) is the award-winning, affiliated site to livendworkwell.com for Spanish-speaking members. MenteSana-Cuerposano.com is not simply a Spanish translation of liveandworkwell.com but rather a site focused on providing culturally relevant material for Hispanic/Latino Members. Users access a link through liveandworkwell.com for this extensive Spanish language content, which uses a community and family-focused approach to help remove cultural stigmas to seeking behavioral health care.

HEALTH AND WELLNESS COACHING

Personal health and wellness coaches provide support and information to help members achieve personal health goals. This program is especially valuable for individuals who are managing ongoing health conditions. Health coaches can help address issues such as treatment compliance and follow-up care. Conversations can consist of educational information on behavioral change, physical activity, nutrition, tobacco cessation, medication adherence, preventative care screenings, condition management, self-efficacy, and many other

health related topics. Coaches partner with members on improving their self-management skills and empowering them to become a more active health care consumer.

PREGNANCY PROGRAM

Through Medica's Pregnancy Program, an expecting mother can receive support through the in the way or ways she finds most convenient or useful. We offer telephonic health coaching, a library of materials online and deliver timely information by text message. One of our most exciting partnerships, Text4Baby is a free service for expecting mothers. Participants receive three free text messages each week, with timely reminders that coincide with their due date. Text message topic range from labor signs, nutrition, and overall safety during pregnancy. Through the Pregnancy Program, our nurses provide educational information on a variety of topic such as: Preterm labor, smoking cessation, hypertension, hyperemesis, c-section births, breastfeeding, birth control/contraceptive methods/family planning and much more.

HEALTH FAIRS AND COMMUNITY EVENTS

Medica plays an active role in sponsoring, exhibiting and participating in community health fairs. We believe this is an important role in being a part of a community. In 2014, we participated in approximately 55 health fairs throughout the state. During these events, staff members will provide education on the programs and services Medica offers to members in addition to relevant health care topics specific to the event.

We look forward to the opportunity to learn more about community events in Iowa, and partnering with the State and community stakeholders to develop a strategy for playing an active role in the community.

Medica recently partnered with Stearns County on an initiative that addresses smoking prevention, targeted to women smokers. Community Health Assessment Data shows almost twice the number of women than men smoke in Stearns County, identifying it as a prevalent issue in Stearns County. The Medica Foundation provided funding to support tobacco cessation education through a radio and billboard campaign.

EXAMPLES OF COLLABORATION WITH COUNTIES AND COMMUNITY PARTNERS IN MINNESOTA

Medica has worked very closely with the counties in Minnesota to align our public health and educational goals with those of the county. This is a key part of our approach to the education we provide. It's not based solely on what we as a health plan believe is important, but also how we partner with counties to better serve the community. This collaboration becomes an opportunity for us to showcase how we support the county-identified needs for education.

In addition, Medica is an active participant in a variety of collaborations throughout the state of Minnesota – from Child and Teen Checkups (C&TC) workgroups to mental health initiatives, to healthy food access. Our approach to health education is not done in a vacuum but through an active partnership with the community. We believe this is the best way to assess the various educational needs of the counties we serve. We would work closely with stakeholders in Iowa to identify ways to be participants on various collaboratives throughout the state.

EXAMPLE OF PROVIDER-SPECIFIC TRAINING IN MINNESOTA

Medica provides education to providers who perform C&TC of which developmental and social-emotional and mental health screenings are required. Providers who perform C&TC screenings include: Primary care clinics, Head Start, school-based clinics, public health, including in the home and behavioral health providers.

C&TC provider training is often in collaboration with counties, the Minnesota Department of Health and other health plans. Medica encourages use of standardized screening instruments for developmental and mental health and social emotional screenings and encourage maternal depression screening as part of a C&TC screening.

If selected to be a health plan of choice to provide Medicaid services in Iowa, Medica would seek to gain a better sense of population health issues and needs to determine the educational opportunities that exist and to develop a strategic plan for education to address those needs.

2. Describe how you would propose to participate and interface with the Healthiest State Initiative.

Medica believes that health plans have an opportunity and a responsibility to partner with local public health agencies and community organizations to support healthier lifestyles and to maximize the health of their communities. Medica is committed to working in collaboration with local public health agencies and other health plans to address the specific needs of communities within Iowa and to actively participate in the Healthiest State Initiative.

In Minnesota, Medica has participated in the Statewide Health Improvement Program (SHIP) which has been a catalyst for improving the health of communities by creating programs that support better health. Much like the Healthiest State Initiative, many of the SHIP initiatives focus on healthier eating and more physical activity. Medica has been active participants in SHIP planning groups throughout the state. This enabled us the best opportunity to learn more about community needs and find ways to collaborate and support these local initiatives. As a result, Medica currently offers a variety of programs and initiatives focused on supporting healthier lifestyles. We have also sponsored numerous initiatives throughout greater Minnesota to benefit the overall health of the community.

Examples of current Medica programs and initiatives that support healthy lifestyles in Minnesota:

- Our Health and Wellness Coaching program is a whole-person approach to helping members achieve their wellness goals. Medica health coaches have a variety of backgrounds that provide a tailored approach to each member's needs. The most recent evaluation of the program has found a $343 per participant per month cost savings for Medicaid members in health care expenditures, and a 97% of member overall satisfaction with the program.
- FitChoices is Medica's health club discount program available to MinnesotaCare enrollees. Members receive a $20 discount on monthly membership fees. Nearly 9,000 MinnesotaCare members were enrolled in FitChoices in greater Minnesota (outside the Twin Cities metro area) in 2014.
- New diabetes incentive: Medica is offering a new diabetes incentive as part of our comprehensive My Health Rewards incentive program. This incentive will roll out in June 2015. It offers eligible members a $25 gift card for members who have having 3 key diabetes monitoring tests – an A1C, LDL cholesterol, urine micro albumin OR positive urine macro albumin.

EXAMPLES OF COMMUNITY-SUPPORTED INITIATIVES IN MINNESOTA

Medica is an active collaborator and sponsor of a variety of healthy lifestyle programs throughout the state of Minnesota.

- **NuVal sponsorship:** Schools in Sartell, Minnesota recently took a huge step to improve the eating habits of their students. The Medica Foundation helped launch the NuVal project which was the first implementation in a Minnesota school and only the second in the nation. With the help of CentraCare Health Foundation, these schools implemented the NuVal nutritional food scoring system in ala carte food lines and vending machines. NuVal displays the nutritional scores of foods to assist students in making healthier food choices. Education is also provided to encourage students to select more nutritious foods. The overall findings of this pilot program have been astounding. A promising 96 percent of the youth surveyed indicated their awareness of NuVal. Over half, 51%, of the students reported modifying their behaviors to consciously make healthier choices.

- **Mobile edible wall:** Medica collaborated with the PartnerSHIP 4 Health in Northwestern Minnesota to support the purchase of a **Green Living (mobile edible wall) from Green Living Technologies**. The unit is used to extend the season of the Lake Region Takes Root community garden which provides access to fresh fruits and vegetables to families in need in Otter Tail County (WIC program and community food shelves). The mobile edible helps to extend the growing season by producing leafy greens year round and share the produce that is grown with various partners who serve populations that have a greater risk of health disparities.

FUTURE MEDICA PROGRAMS AND INITIATIVES

Medica continues to collaborate with and invest in initiatives that support greater access to healthy food and decrease obesity.

Medica values the collaborative partnerships it has been a part of over the past 20 years. These collaborations have resulted in innovative programs and services for the members we serve. We look forward to continuing our existing partnerships and exploring new ones as we look to expand our service delivery into Iowa.

In Iowa, we would work closely with Iowa's Healthiest State Initiative participants and sponsors to understand current challenges and opportunities for collaboration. Our proposed staffing model includes Community Outreach Coordinators, who would be assigned different areas of the State in order to develop relationships with community groups.

8.8 Cost and Quality Information

1. Describe proposed strategies to provide price and quality transparency to members.

Making cost and quality information available to members increases transparency and has the potential to reduce costs and improve quality. In Iowa, Medica will implement innovative strategies to provide price and quality transparency to members in order to facilitate more responsible use of health care services and inform health care decision-making. Examples of cost information that will be made available include average costs of common services and the cost of urgent versus emergency services.

Main Street Medica is an online and mobile tool for Medica members to help them learn more about the cost and quality of care available to them. Through this resource members can:

- Compare the cost of prescriptions at different pharmacies
- Find locations to buy medical supplies or services
- Research the cost of clinics and facilities by zip code, name or specialty
- Rate their experience with a physician or clinic

This resource is available at mainstreetmedica.com.

COMMUNITY MEASUREMENT

Medica has extensive experience in community measurement and cost transparency that we would bring to our Iowa membership. For example, we were instrumental in establishing Minnesota Community Measurement (MNCM), a nonprofit organization that works to increase the quality and value of health care in Minnesota by making comparative quality and cost information available to consumers.

For years, Medica and other health plans collected data from network providers to support our internal programs. This data collection was an arduous process for both payers and providers and was captured inconsistently across care systems. In 2002, the Minnesota Council of Health Plans (MCHP), which is comprised of the nonprofit health plans in the state (including Medica), launched MNCM. Our work with MNCM demonstrates our willingness to partner with providers to improve quality and share information with members so that they can make informed choices about their health care.

Medica.com provides up-to-date information for Medica Medicaid members about their pharmacy and prescription benefits. By choosing the “Pharmacy and Prescription” link on the member home page, members can view a list of covered prescription drugs and a list of over-the-counter drugs. In addition, the copay (if applicable) is clearly defined.

2. Provide sample EOBs as an exhibit or attachment.

See Tab 5 for a sample EOB.

3. Describe processes for making provider quality information available to members.

Our Iowa provider network would be one of our most valuable assets. Medica is committed to making provider quality information available to members to help them make informed decisions when choosing care.

Currently, we support our members by providing a variety of resources, including easy-to-use reports on the quality of care provided by physicians, primary care clinics and hospitals. Medica’s website includes information on physician quality. Some of these resources include:

- HowWasYourCare.com: This online survey allows members to rate the service and care their physician provides and to see ratings for their own and other physicians.

- Recognized Physician Directory: This directory identifies physicians who have been recognized for performing well in diabetes, heart/stroke and back pain programs created by the National Committee for Quality Assurance (NCQA). NCQA established these programs to identify physicians that meet standards of care.
- Licensing/Sanction Information: This resource provides the licensing background and disciplinary information of physicians and other health care practitioners in the Administrators in Medicine's (AIM) DocFinder.

Medica monitors and evaluates practitioner and facility-specific data including a variety of quality indicators such as utilization trends, claims submission, and demographic information about members served. We also generate reports to assist in monitoring providers on administrative and clinical measures. We analyze the data to identify trends and variance from expectations, and use them for provider training, evaluation of the community norms about provision of specific services, and identification of any areas of concern.

8.10 Member Rights

1. Describe your process for ensuring member rights as described in section 8.10.

Medica takes pride in the services we provide and strives to maintain the highest standards of care and service provision. We work to ensure services are provided with dignity, respect and complete adherence to privacy and confidentiality practices.

Members are provided a copy of their rights upon enrollment. Our staff will allow the member time to review their rights to ensure a complete understanding as well as encourage the new member to have any questions regarding their rights answered. Both *Evidence of Coverage* and *The Member Handbook* include a copy of their rights to allow for review in their leisure or at times when they may need to refer back. The Medica website has easily identified access to the complete list of member rights and references included. Should members find themselves in the grievance or appeals process, they will be reminded and provided copies, if requested, of their rights. Members will always be free to exercise their protected rights without fear of discrimination or retaliation. At a minimum, our member rights policy will include the right to:

- Receive information in accordance with 42 CFR 438.10
- Be treated with dignity and respect and with due consideration for their dignity and privacy
- Receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand
- Participate in decisions regarding their health care, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion
- Request and receive a copy of their medical records, and request that they be amended or corrected, as specified in 45 CFR 164
- Receive treatment in the least restrictive setting
- Fully participate in the community and work, live and learn to the fullest extent possible
- Be furnished health care services in accordance with 42 CFR 438.206 through 438.120

8.11 Redetermination Assistance

1. Describe in detail your plans to assist members in the eligibility redetermination process and control against prohibited activities.

Continuous eligibility is an important factor in the health and well-being of members and their family. Medica will play an active role in working with the Iowa DHS and the appropriate enrollment representatives to assist in the eligibility redetermination process.

To ensure continuity of care and maintain member baseline health, we understand the necessity of keeping member eligibility current. Medica is committed to providing clarification and assistance to members in the redetermination process.

MEMBER ASSISTANCE

Medica customer service representatives are thoroughly trained to answer questions about eligibility redetermination from members. Our staff is knowledgeable about the specific requirements for different programs and the steps an individual must take, including whom they need to contact at the state or county, in order to fulfill their redetermination requirements.

In addition to assisting individuals who contact us with questions, we will make multiple efforts to support eligibility redetermination proactively by contacting individuals prior to their redetermination date to assist them with their renewal. In order to assist individuals in the redetermination process, we will work with Iowa DHS to ensure we have access to all of the necessary information to engage in direct outreach activities. These activities have and can include mailings, and direct phone outreach with a specially trained eligibility specialist.

We believe there is a great opportunity to work with navigators and other community stakeholders as partners in helping members in the redetermination process. Similar to the training we have done with our own customer service representatives, Medica has worked to support and train navigators in our communities to assist with eligibility redeterminations. Our approach is to work with the community and organizations that support members, wherever they are, to understand the process and importance for redetermination.

We understand with the transition to managed care there is the potential for gaps and errors in the eligibility and redetermination information shared between the Iowa DHS and managed care organizations. We are committed to working with DHS to resolve any issues with an emphasis on minimizing any difficulties for members. We worked very closely with the state of Minnesota and with MNsure, Minnesota's health insurance exchange, on temporary and long-term solutions to eligibility and renewal issues. We are proud of the work we have done on behalf of both individual market and Medicaid members to minimize disruption regardless of technical challenges. We will bring this same commitment to members in Iowa.

Established policies and procedures are in place to assist members completing initial eligibility and redetermination applications. For all submissions, we will observe the use of a single streamlined application when applying online or using paper forms.

Medica will assist members in the redetermination process by:

- Conducting outreach calls or mailings to remind them to renew their eligibility
- Reviewing determination requirements with the member
- Answering questions about the redetermination process
- Assisting the member obtain documentation and collateral verification needed to process the application

DETERMINING FINANCIAL ELIGIBILITY

For members whose financial eligibility is based on the applicable modified adjusted gross income standard, redetermination will be conducted at a minimum once every 12 months and will be consistent with the requirements specified in 42 CFR 435,916. When possible, this redetermination will be conducted without requiring additional information from the member but based on reliable information contained in the members account or other more current information available to Medica. In cases where Medica cannot determine eligibility solely on the basis of the information available, or otherwise needs additional information to complete the redetermination, Medica will provide the member with the renewal application form pre-populated with the information already available, allowing the member to update and fill in only the fields requiring completion.

Redetermination of eligibility for members whose financial eligibility is not based on the applicable modified adjusted gross income standard will be performed once every 12 months and will be consistent with the requirements specified in 42 CFR 435,916.

CONTROLLING PROHIBITIVE ACTIVITIES

In observance of member rights, Medica will not engage or condone any of the following activities regarding the provision of redetermination assistance:

- Discrimination against members, including particularly high-cost members or members that have indicated a desire to change contractors
- Discussion with members about changing contractors as these discussions shall be referred to an Enrollment Broker
- Discussion with the member as to their eligibility status as this decision is at the sole discretion of the State
- Participation in fraudulent activity when helping the member complete the redetermination process
- Signing the member's redetermination form
- Submission of redetermination materials to the State on behalf of the member

We will provide assistance whenever necessary to ensure benefits and eligibility are accurate and up to date ensuring continuity of care for our members.

8.12 Member and Stakeholder Engagement

1. Describe in detail your member and stakeholder education strategy.

Members and stakeholders are valuable partners in our efforts to integrate care, improve quality outcomes and recognize efficiencies. We believe health plans have a responsibility to collaborate with local stakeholders to maximize the health of their communities. We do so in Minnesota by actively engaging with and educating stakeholders in a variety of ways.

We are constantly reviewing and updating our educational strategy, particularly for members, in order to best meet the needs of a complex population. We strive to offer a tailored approach to education to meet the unique needs of each individual. The following are strategies we currently utilize and may be leveraged for Iowa membership:

- **Information in plain language**: Medica undertakes a number of initiatives to simplify the distribution of information to members. We are committed to using plain language and providing culturally competent resources to our stakeholders, and we undertake several trainings each year to increase our knowledge in these areas. Company-wide, Medica recently conducted consumer research that asked about perceptions of the health plan experience. The results from this research have provided valuable insight into how to communicate with our members more directly with greater impact, and these findings have been rolled into all communications with our members and stakeholders.
- **Online and social media education:** We also believe that the future state of education and communications for our members will not be as heavily reliant on print resources. The "digital divide" refers to the unequal access to the Internet, and has long been associated with medically underserved populations. We have a variety of educational topics at our website, medica.com, available to members and stakeholders. In 2014, we launched a Facebook page targeted to our Medical Assistance members, which provides education and information on many health-related topics.

  Members, families, providers and other stakeholders also have access to our award-winning behavioral health website, liveandworkwell.com, which provides information on a variety of topics, including recovery, well-being support and health management. In 2013, the liveandworkwell.com portal was used by 4 million visitors. A companion website, MenteSana-CuerpoSano.com (Healthy Mind-Healthy Body), is the award-winning affiliated site to liveandworkwell.com, for Spanish-speaking members.
- **Education in other languages:** Medica recognizes that our members come from diverse cultural backgrounds and may speak languages other than English. Educational materials are available in several different languages, including priority languages of Spanish, Somali, Hmong and Russian. When needed, our case managers and pregnancy nurses use the TransPerfect Translations Language Line to talk with members whose native language is not English. All materials sent to members include a language block providing instructions to the members on how to get the information interpreted into other languages.
- **In-person education**: Medica regularly meets with county human services staff and network providers to offer education and the opportunity to discuss and ask questions about the programs and services we provide. When meeting with county human services, we often include our delegated services staff from Medica Behavioral Health and Delta Dental to address questions or concerns. We currently offer a variety of educational resources provided in different formats for our members and stakeholders, which are highlighted in more detail below.

  Our care coordinators also provide in-person education to members during their annual visits. For example, in Medica's Health Risk Assessment, questions regarding a member's preventive care activity

are included. The care coordinator will use that opportunity to provide education and resources to promote early intervention and prevention.

- **Telephonic education:** Our Medica staff will provide one-to-one educational support to members. For example, our Healthy Pregnancy Program is designed to identify members who are pregnant, encourage early and ongoing prenatal care, and increase members' access to pregnancy-related educational information. In addition, our call center staff will identify opportunities to provide member education when members call in.
- **Community education:** Medica participates in many health and resource fairs in the communities we serve. During these events, staff members provide education on the programs and services Medica offers to Minnesota Health Care Programs members.
- **Stakeholder forums:** Medica has established several working groups that offer guidance and feedback on our Medicaid products. These groups meet throughout the year and are comprised of members, community nonprofits and county health care leaders. Topics of discussion range from feedback on member materials and their experience interacting with Medica. These discussions empower our members and community partners and develop loyalty to Medica. More details about these forums can be found in Question 2 below.
- **Grassroots outreach:** In 2014, Medica launched a new initiative called Fireside Chats. These member-focused feedback sessions are held in community locations throughout the state, and provide an opportunity for member education in a more intimate setting.
- **Strategic partnerships:** Medica is an active collaborator in the community, partnering with organizations that also serve low-income populations. These partnerships provide another opportunity for education to members and stakeholders.

  For example, Medica partnered with the Healthy Northland Breastfeeding Strategy in Northeastern Minnesota to sponsor an International Board Certified Lactation Consultant (IBCLC). This person's role is to work with clinics, hospitals and public health to increase the rates of breastfeeding and provide education for babies and mothers. This group has partnered with Medica to help continue the program in 2015 and to explore additional incentive opportunities for mothers and young children in this region.

EXAMPLES OF MULTI-CHANNEL EDUCATION EFFORTS

When focusing on a specific priority topic, such as emergency room utilization, we offer multiple channels to deliver messaging. Examples of this multi-channel educational strategy include:

- Targeted mailings and member newsletters that highlight appropriate emergency room use, emphasize preventive services and use of Medica Nurseline for questions regarding illnesses and where to get care.
- *When and Where to Get Care* is a simple educational tool outlining when it is appropriate to use the emergency room, primary care, urgent care and convenience care. This handout, offered in several languages, is brought to community fairs and events, member input forums, county meetings, blood lead testing events and clinic training programs. It is also distributed by our health coaches, customer service representatives and care coordinators.
- Automated phone calls are made to members during flu season referring them to Medica Nurseline for help with home remedies or determining when they should see their primary care physician.
- Collaborating with a community partner, ECHO, to produce a video in four languages (English, Spanish, Hmong and Somali) on the topics of Understanding the Emergency Room and Navigating the Healthcare System.

IOWA-SPECIFIC STRATEGY

If selected as a health plan of choice in Iowa, we would work closely with stakeholders in order to:

- Identify priority educational areas throughout the state
- Adopt existing educational pieces and trainings for members and stakeholders in Iowa
- Create new resources to meet gaps and identified needs

2. Submit your Stakeholder Advisory Board strategy and discuss how meaningful representation from member stakeholder groups will be ensured.

Medica will actively invest in outreach and activities in Iowa to benefit the community as a whole and will participate in a variety of initiatives to meet the needs of the community as outlined below. Advisory Committees establish and strengthen connections to our stakeholders and members to obtain feedback on programmatic improvements and offerings. Our current Minnesota strategies and proposed Iowa strategies are noted in more detail below.

MEDICA'S CURRENT MEMBER AND STAKEHOLDER FORUMS

We have extensive experience in conducting stakeholder forums in Minnesota. Currently, we hold 6-8 member and stakeholder forums each year, targeted at a variety of groups. These are highlighted in the table on the next page.

FORUM	TARGET AUDIENCE	FREQUENCY
Special Needs Basic Care stakeholder forum	Adults with disabilities Community and county partners that work with these members	2-3 times/year
Minnesota Senior Health Options stakeholder forum	Older, low-income adults Community and county partners that work with these members	2-3 times/year
Community Advisory Council	Members on Medical Assistance or MinnesotaCare Community and county partners that work with these members	2 times/year
Fireside chats	New initiative in 2015 focused on engaging members on a more grassroots level. Target for each meeting: 6-10 members, hosted in a variety of community settings	6-8 times/year

PROPOSED STAKEHOLDER ADVISORY BOARD IN IOWA

In today's world of health care reform and rising health care costs, we understand the urgency to be an innovative collaborator in efforts to develop and enhance programs and services for our members. The current and pending changes within health care represent an opportunity for us to strengthen our relationships with our stakeholders – members, purchasers, providers, stakeholders and community organizations in hopes of better coordination of care and improved outcomes. Our desire is to work collaboratively with others to better engage our membership and develop solutions to the many challenges of providing services.

The Stakeholder Advisory Board in Iowa will be vital to build, strengthen and shape the managed care system. The Board will be comprised of members, family members, stakeholders, community-based agencies, health care providers and our staff. The role of the Board is to provide advice and guidance to Medica regarding health care delivery to our members.

In order to build a representative Board, we will work with stakeholders in Iowa to first identify a list of organizations, collaboratives and community groups that should be included. Members will also be identified and invited to participate in the Board.

The proposed timeline for implementation of the Stakeholder Advisory Board is noted on the next page.

TASK	CONTRACTUAL REQUIREMENT	PROPOSED MILESTONE DATE
Anticipated contract execution	January 1, 2016	
Identify and invite Stakeholder Advisory Board members		January 2016
Establish agenda		Early February 2016
Convene and facilitate Quarterly Stakeholder Advisory Board Meetings Meetings minutes as well as handouts or other information disseminated at the meeting will be co**Network Partnerled and emailed to all Board members, even those who were not able to attend. These minutes will also be available to Iowa DHS upon request		April, July and October 2016 Future years will include January Regional meetings will also be considered

Medica will notify Iowa DHS at least fifteen (15) calendar days in advance of the scheduled meeting date, arrange for transportation and interpreters to facilitate member participation, maintain written documentation of all attempts to invite and include members, and report to Iowa DHS on participation rates, engagement strategies and outcomes of the committee process in accordance with the Iowa DHS Reporting Manual.

3. Describe how feedback obtained from the Stakeholder Advisory Board will be utilized.

Transforming member experiences at every touch point within the organization is our goal. The organizational employee engagement initiative, entitled "Listen Up," has resulted in a variety of proposed projects that address helping members feel understood, assured and unconcerned. This level of organizational "listening" will carry over into our work with the Stakeholder Advisory Board. The Stakeholder Advisory Board will allow all departments the opportunity to garner and act upon feedback about our delivery of health care services from members, schools, counties, providers and community partners. It is also serves as an informal "meet and greet" opportunity between Medica staff and stakeholders and members.

Feedback from the Advisory Board will be used to:

- Inform internal policy
- Guide quality assessment and performance improvement program activities
- Improve program offerings
- Identify new programmatic opportunities

We will also develop an ongoing list of feedback, and will report back to the Stakeholder Advisory Board on the status of feedback made. While we recognize that not all feedback provided will be implemented, we will seek to have as much transparency as possible between Medica and the Board on how we are implementing specific feedback.

8.13 Stakeholder Education

1. Describe your plan for stakeholder engagement including proposed timelines and topics.

The role of stakeholder engagement is critical in to increasing awareness of Medica's programs and services, and in developing meaningful dialogue with consumers and stakeholders to improve the health of communities. As a new managed care plan in Iowa, it will also be important to establish relationships and build trust in the community.

STRONG RECORD OF SERVICE

Medica has a strong history of identifying, engaging and collaborating with stakeholders throughout the state. We have been conducting member input forum for more than 15 years, holding stakeholder forums for all products for the past 3 years, and have a 30-year history of working with county staff and community partners throughout the state.

We engage with stakeholders in a variety of ways including:

- Stakeholder forums (described in more detail below)
- Provider trainings
- County meetings
- Partnerships with organizations that serve low-income members
- Professional conferences
- Member forums

Medica's Current Member and Stakeholder Forums

We have extensive experience in conducting stakeholder forums in Minnesota. Currently, we hold 6-8 member and stakeholder forums each year, targeted at a variety of groups. These are highlighted in the table below.

FORUM	TARGET AUDIENCE	FREQUENCY
Special Needs Basic Care stakeholder forum	Adults with disabilities Community and county partners that work with these members	2-3 times/year
Minnesota Senior Health Options stakeholder forum	Older, low-income adults Community and county partners that work with these members	2-3 times/year
Community Advisory Council	Members on Medical Assistance or MinnesotaCare Community and county partners that work with these members	2 times/year
Fireside chats	New initiative in 2015 focused on engaging members on a more grassroots level. Target for each meeting: 6-10 members, hosted in a variety of community settings	6-8 times/year

Through these forums, we are able to share information, learn about concerns in the community and help devise initiatives specific to those concerns for an improved system of care. This collaboration often leads to increased and shared knowledge.

The proposed timeline and implementation plan for the stakeholder forums in Iowa were noted in more detail in Section 8.12.

PROPOSED FORUMS FOR STAKEHOLDERS IN IOWA

Access to providers trained to deliver high-quality health care is essential to improving health. It is our responsibility to provide access and availability of high quality health care services to our members and to help maintain a viable network of quality health care providers in the community.

If selected to be a health plan of choice in Iowa, initial introductory forums will be scheduled with providers and members throughout the state. These forums will be facilitated by high level Medica staff and include delegates from member services, provider relations, and other representatives as necessary. As the agenda dictates, representatives from Iowa DHS and other stakeholders will be invited to participate and present.

Timelines

Hosting frequent member and provider community forums will be paramount in our work to build cohesive relationships. From contract execution date through the first year of implementation we will hold scheduled forums to provide system updates, education on services, policy and procedural updates as well as gather input on current issues and concerns. Our initial proposal to Iowa DHS as to the frequency of these forums is monthly, to be held at varying locations throughout the State. Interpreter and transportation services will be made available to members at their request to encourage and enhance member participation. While they will each be held on separate meeting days/times, they will share a similar monthly agenda. All meetings are open for providers or members to attend.

The agenda will be posted on our website and emailed to anyone who has requested to be on the listserv to receive the invitation and all related communications. Meeting minutes will be kept for all forums and posted to the member and provider websites within 10 days of the meeting date.

Topics

The agenda for these forums will be a dynamic document and will be driven by the current education, information and issue resolution needs each month. While the agenda will be similar for both forums, the Provider Community Forums will often include policy, process and procedural items. An example of agenda items for the first Community Forums could include:

- Welcome from Medica
- Introductions of participants and presenters
- Overview of our mission, vision and values
- Highlights of our successes in Minnesota and opportunities in Iowa
- Implementation plans and processes
- Questions, concerns, answers, and items for follow up
- Next meeting date, time and location

We are committed to building collaborative relationships to ensure clear streams of communication are established and maintained.

2. Describe how you will identify and outreach to stakeholders.

We view our relationships with stakeholders in the community as a key to success in improving the overall health of communities. We have a proven track record in Minnesota in identifying a variety of stakeholders who mutually serve low-income populations, and establish long-term relationships with these stakeholders. We credit our growth as an organization to our sincere and unwavering commitment to listening and responding to the needs of our customers, members and community stakeholders across all markets.

Current Outreach Methods

Medica uses a variety of outreach methods to connect with our stakeholders. The details are highlighted below.

STAKEHOLDER	HOW WE IDENTIFY	OUTREACH METHODS
County staff – public health and social service	County staff directories State-based listings County collaboratives	In-person meetings at counties by Community Outreach Liaisons Direct mail – brochures introducing Medica Participation in county collaboratives Conferences
Providers	Medica network management Recommendations from counties	Regular e-mail communications Provider network website: medica.com/providers In-person meetings Trainings Direct mail Monthly newsletter for providers Conferences
Community organizations	Examples of organizations we would partner with include: Food shelves Mental health organizations Housing facilities Recommendations from counties	Conferences In-person meetings

Counties may contact their Community Programs Manager with questions about:

- Coding, billing, and reimbursement questions
- Specific member issues or concerns
- Requests for funding or invitations to participate in area health initiatives

We respond to all questions and issues in a timely manner. We meet with counties as often as requested, but at a minimum, we meet face-to-face annually with county public health, human services and social services staff. Media Behavioral Health staff also attends these annual meetings. We have received very positive feedback from Minnesota counties about this model, our annual meetings and about our Community Programs Managers.

Medica's County Outreach Model

In Minnesota, each county has a dedicated Community Programs Manager who is a single point of contact for all county staff. Our goal is to learn about the needs of a community to develop and deliver the highest quality programs and services. We intend to implement a similar model in Iowa.

OUTREACH IN IOWA

If selected as a health plan of choice to provide Medicaid services to Iowa residents, one of our first goals will be to build a presence throughout the State. We will leverage our experience in Minnesota to reach out to stakeholders in Iowa and begin establishing relationships. To accomplish this, we will work collaboratively with the state of Iowa.

To build these relationships, we will implement a model similar to what currently exists in Minnesota with our Community Programs Managers and build a team that covers specific geographic regions of the state. The roles in Iowa would be called Community Outreach Liaisons, and their primary role would be to identify and develop relationships with stakeholders in their assigned regions.

Our main goals will be to learn:

1. The county infrastructure and services the county provides to residents
2. The key providers that individuals go to for services
3. Suggestions for marketing and outreach opportunities throughout the state
4. What the barriers to care are for individuals
5. Public health priorities

We will also provide background of the work Medica has been doing for the past 30 years that has addressed the health and well-being of members receiving Medicaid, the types of community collaborations we participate in, and the programs and services we offer.

8.14 Implementation Support

1. Describe proposed strategies to support members during program implementation.

We will have multiple strategies to educate potential members on the new health plan options available to them, how these options impact them and how we can address their concerns and answer their questions about enrolling with a health plan. Changes, regardless of what they are, can be stressful. If challenges arise, we will assist members to overcome any confusion and barriers through education. In addition, we plan to:

- Hold public forums, which are geographically dispersed
- Extend our customer service hours so potential members can call to get questions addressed in a timely manner
- Provide written material in plain language about:
  - Why health plan changes are occurring
  - The benefits of choosing Medica
  - Where to call if they have questions
- Launch a media campaign to introduce Medica as a health plan of choice in Iowa

We will also have staff members who are fully trained on how to educate members on:

- Accessing health care services
- Resources Medica makes available to members
- Key phone numbers for members to have their questions and/or issues addressed
- The additional benefits available to them

Experienced staff from Minnesota will help with the implementation and training of newly hired staff in our Iowa headquarters. We have numerous years of proven success of onboarding new membership, successfully training and managing call center staff and working with key stakeholders such as providers, counties, the Minnesota Department of Human Services and community organizations.

We will hire staff that represents the ethnic and cultural backgrounds of our members. For example, according to Iowa Census data, the Hispanic/Latino population is the second largest population in the state of Iowa.

We will hire and assign up to three Community Outreach Liaisons to specific regions of Iowa. These individuals will be a single point of access to Medica and serve in a liaison role, working with the State Ombudsman to address county, provider and community partner questions and concerns. These staff will also provide trainings and informational sessions throughout the State leading up to the contract implementation date in January 2016.

Our vision is to become the community's health plan of choice, trusted for our integrity, respected for our service and admired for our commitment to innovation and efficiency.

8.15 Grievances, Appeals and State Hearings

1. Describe in detail your system for resolving inquiries, grievances and appeals, including how your system ensures all policy and processing requirements are met.

Medica has an established process and dedicated Consumer Affairs team whose main responsibility is accepting and resolving member grievances and appeals. We have a systematic process for our members or their appropriately authorized representative for resolving issues of dissatisfaction. Members are informed of their right to file grievances and appeals at enrollment, and are given fair and equitable treatment. All decisions will be made with integrity, consistency and within the contractual obligations of the health plan. Determinations will consider all applicable legal and accreditation requirements, including the requirements of Iowa DHS, the Balanced Budget Act (BBA), and NCQA. All grievances and appeals will be handled pursuant to 42 CFR 438.408.

HANDING VERBAL AND WRITTEN GRIEVANCES

Efficient, member-centered processes are in place for handling verbal and written grievances within Medica's call centers and Consumer Affairs Department. These departments work closely together to ensure that grievances are handled appropriately. We will ensure that individuals rendering decisions on grievance and appeals were not involved in previous levels of review or decision-making. In addition, health care professionals with appropriate clinical expertise in treating the member's condition or disease will be used if the decision is related to any of the following:

- An appeal of a denial based on lack of medical necessity
- A grievance regarding denial of expedited resolution of an appeal
- Any grievance or appeal involving clinical issues

PROCESS FOR GRIEVANCES ON PROVIDER QUALITY OF CARE

Members may report grievances at any time about the quality of care they received from providers. This process is described in more detail in the table below.

PROCESS	TIMELINE
Grievance form offered – accepted both verbally and in written form.	Upon notice from member
Receipt of acknowledgement of each grievance	3 business days
Decision on grievance	Within 30 calendar days (this timeframe may be extended up to 14 calendar days
Possible calendar extension (member provided written notice of the reason for delay, if not member requested)	14 calendar days

PROCESSES FOR LEVEL ONE AND LEVEL TWO APPEALS

The Consumer Affairs and Clinical Appeals Department has well-defined processes for handling level one and level two appeals. Oral and written appeals are accepted from providers, members and their authorized representatives. Verbal requests must be followed by a written request, unless the member or the provider requests an expedited resolution. Members, or authorized representatives acting on the member's behalf have thirty (30) calendar days from the date of action notice to file an appeal. Our processes are written to ensure appropriate handling of expedited appeals, appeals requiring medical necessity review and contractual appeals. Oral grievances regarding the denial of an expedited resolution of an appeal or one that involves clinical issues will be referred directly to the Consumer Affairs team. Once received we will acknowledge receipt of the appeal within three (3) business days

In accordance with 42 CFR 438.406, we will provide the member and their representative opportunity, before and during the appeals process, to examine their case file, including medical records and any other documents or records considered during the appeals process. In addition, the member and the member's representative shall have the opportunity to present evidence and allegations of fact or law in person as well as in writing. Upon determination of the appeal, we will ensure there is no delay in notification or mailing to the member and member representative the appeal decision. The *Appeal Decision Notice* describes the actions taken, the reasons for the action, the member's right to request a State fair hearing, process for filing a fair hearing and other information set forth in 42 CFR 438.408(e).

Decisions on standard appeals will be resolved within forty-five (45) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 CFR 438.408(c). If the timeframe is extended, for any extension not requested by the member, we will give the member written notice of the reason for the delay.

In the event a clinical case requires an expedited decision, the Clinical Appeals Department maintains an expedited clinical appeal process in compliance with *Iowa Administrative Code, Chapter 7 Appeals and Hearings*. This process is engaged when an appeal could seriously jeopardize the member's health or ability to maintain or regain maximum function. The disposition of expedited appeals will occur within three (3) business days after receiving notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c). In the event we deny the request for an expedited resolution of a member's appeal, the appeal will be transferred to the standard forty-five (45) calendar day timeframe and give the member written notice of the denial within two (2) business days of the expedited appeal request. We make all attempts to give the member prompt oral notice. We will provide general and targeted education to providers regarding expedited appeals including when an expedited appeal is appropriate and procedures for providing written certification thereof.

The member, or Medica on behalf of the member through appropriate consent, can request a State fair hearing within ninety (90) calendar days of the date of notice.

Member benefits may be continued during certain appeals. If benefits are continued or reinstated while the appeal is pending, the benefits will be continued until one of the following occurs: (i) the member withdraws the request; (ii) ten (10) days pass after we have mailed the notice of an adverse decision, unless a State fair hearing has resolved the matter; or (iii) the time period or service limits of a previously authorized service has been met. If the final resolution of the appeal is adverse to the member, that is, it upholds the original action, we may recover the cost of the services furnished to the member while the appeal is pending to the extent that they were furnished solely because of the requirements to maintain benefits in accordance with 42 CFR 431.230 and 42 CFR438.420. If Medica or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, we will authorize and provide the disputed services promptly and as expeditiously as the member's health condition requires. If Medica or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, we will pay for those services. We will comply with all requirements in accordance with 42 CFR 438.424.

Quarterly we track and trend data on grievance and appeals. This data will be reviewed on an on-going basis with operational areas in the Government Programs Oversight Committee (GPOC) meeting. Grievance and appeals records and their resolutions will be maintained for a minimum of ten years. Records will be retrievable either electronically (Q-Star/Micrographics) or paper file.

In order to ensure members are aware of these processes, we maintain all information regarding written internal process for resolution of appeals and the fair hearing process in the member handbook and other applicable enrollment materials. In addition, specific information regarding member grievance, appeal and State fair hearing procedures and timeframes will be available to members, providers and subcontractors on the member website.

2. Describe your proposed exception to Contractor policy process.

We will educate members on the exception to policy process for items or services not covered by DHS only when all other grievance and appeal options have been exhausted. There will be no fee for requesting an exception. We will direct members to the DHS website and provide assistance as necessary in completing the online Petition for Exception form and providing additional documentation at the member's request to help support their request.

SECTION 9: CARE COORDINATION

1. Describe proposed strategies to ensure the integration of LTSS care coordination and Contractor-developed care coordination strategies as described in Section 9.

Medica's State Public Programs (Medicaid) Department has a long standing history of serving members through a multi-channel approach including face-to-face Community-Based case management activities as well as telephonic case management programs. We have vast experience in the Minnesota market and work directly today serving 35,000 senior and adults with disabilities in fifty (50) counties throughout Minnesota. We engage to help members' access health and Community-Based services and improve quality outcomes. Our approach is to engage in regular and frequent communication to align goals in care plans, schedule and attend joint care plan review meetings, streamline service delivery and share information with treatment providers. The Community-Based case manager will serve as the primary point of contact for members receiving Long Term Services and Supports (LTSS) services, and will be responsible for the member-centered plan of care, which will incorporate activities provided by Medica's complex case management program. Program staff providing member related case management work to ensure open communication and active monitoring of care plans. The duties and activities of the LTSS Community-Based case manager are described in more detail in our response to Section 4.

Medica's complex case management program, for the purposes of this section, meets the requirements of the care coordination program, as described in the scope of work. Medica's Case Management program is a suite of multiple services tailored to meet the individual needs of the member. Our Case Management Program will comply with 42 CFR 438.208.

Our case management programs have a demonstrated record of:

- Improving quality outcomes
- Coordinating care across the healthcare delivery system
- Increasing member compliance with recommended treatment protocols
- Increasing members' understanding of their healthcare conditions and prescribed treatment
- Empowering members
- Providing flexible member-centered care.

9.1.1 INITIAL SCREENING

1. Describe your plan for conducting initial health risk screenings.

Medica will conduct initial health risk screenings within ninety (90) days of enrollment for all new members using a standardized screening tool. In our current Minnesota market we perform face to face health risk screening within 30 days for senior products and people with disabilities. In Iowa, we will conduct the initial health risk screening to assess a member's need for any special health care or case management services, using an NCQA accredited tool upon approval. During the initial health risk screening process, Medica will offer members assistance in arranging an initial visit with their PCP (Primary Care Provider) or if needed, assist in establishing with a PCP. The PCP will conduct a baseline medical assessment and other preventive services, including an assessment or screening of the member's potential risk, if any, for specific diseases or conditions.

2. Submit a proposed initial health risk screening tool. Exhibits and attachments may be included.

Medica will collect information to assess the member's physical, behavioral, social, functional and psychological status and needs. Our tool shall determine the need for case management, behavioral health services, or any other health or community services. Our tool complies with NCQA standards for health risk screenings and contains questions that can tie to social determinants of health.

We understand that currently DHS uses 3M'S Assess My Health tool, but that DHS intends to compare this tool with tools used by bid awardees. Medica has had great success in using our current tool, however we are open to collaborating with Iowa DHS on using a uniform tool. Medica has the capability to create custom assessments equivalent to the current DHS tool and can also import data from external assessment tools to automate case initiation and assignment to case managers. A third option is a self-assessment tool that offers members an option to perform their own health assessments and identify opportunities. A sample of the self-assessment tool is available in Tab 5.

3. Describe the methods that you will use to determine whether changes in member health status warrant subsequent screening.

Medica will conduct a subsequent health screening, using the tool reviewed and approved by Iowa DHS, if a member's health care status is determined to have changed since the original screening. Medica will rely on evidence of changes through methods such as claims review or provider notification. Medica uses the Johns Hopkins ACG predictive modeling software combined with other selected indicators, including evidence-based medicine gaps in care to identify the highest risk or most vulnerable members in need of additional screening. When a member in need of additional screening is identified, we will conduct a comprehensive health risk assessment. We will use the results from the comprehensive health risk assessment to determine the most appropriate case management program for the member taking into account the member's individualized assessed needs and claims experience.

In addition, Medica utilizes a daily admission report, which combines admission notification data received from hospitals and nursing homes with John's Hopkins ACG metrics (applied to claims) to identify members who have had high utilization and are anticipated to be high risk. The report, which is based, in part, on a prioritization algorithm, is a critical tool to identify those members at highest risk for re-admission and members in need of additional screening. Medica has a long standing history of successful collaboration with

hospital and nursing home providers receiving ninety-seven (97%) notification of all admissions in Minnesota. We will strive to establish similar relationships with providers in Iowa.

4. Describe methods that you will use to maximize contacts with members in order to complete the initial screening requirements.

Medica has a strong history of engaging the member to conduct health risk assessments in Minnesota including several unique ways such as:

Medica will conduct the initial health risk screening in a manner that is convenient to the member, which may include in person, by phone, electronically through a secure website, or by mail. Medica shall employ one or more of these methods in order to maximize contacts with members in order to complete the initial health screening in a timely manner. Medica strives to have a collaborative relationship with DHS to identify members preferred means of contact including, but not limited to telephone and email addresses. Medica utilizes self-management programs to focus on key areas such as tobacco cessation, healthy weight, exercise, stress management and at-risk alcohol use.

We will engage and activate members of all backgrounds and abilities to manage their health through a new online health risk assessment and a set of personalized self-management tools. We will provide information to members in new member packets, member newsletters, and through our website Medica.com. Medica welcomes DHS input on additional ways to engage members in Iowa.

9.1.2 Comprehensive Health Risk Assessment

Medica will conduct a comprehensive health risk assessment when a member is identified as having special health care needs or shows problem areas requiring follow-up care.

The HRA will assess the member's strengths, needs, choices and preferences in life domain areas. The HRA will include assessment of the physical, psychosocial, and functional needs of the member which may include the following:

PHYSICAL
Primary care relationships Clinical history High risk health conditions Medications Polypharmacy Visual and hearing needs Dental health; and Specialty medical needs including the need for durable medical equipment
PSYCHOSOCIAL
Social factors Cognitive functioning evaluation Developmental disability consideration Cultural and linguistic needs
FUNCTIONAL
Environmental factors ADLs, IADLs Factors affecting the ability to live independently Caregiver involvement and resources

Medica uses advanced analytics to identify members with special health care needs. We employ a special health care needs identification process when analyzing claims data for members, age 18 or > who meet at least one of the following criteria elements:

- ER visit ≥ 4 during the last 12 months.
- Inpatient stay within the last 60 days
- Re-admitted to the hospital within the last 60 days
- Total claims amount greater than or equal to $100,000.

1. **Submit a proposed validated comprehensive health risk assessment tool.**

Medica utilizes an extensive initial health risk screening tool for all new members as described above. Upon contract award we will work with Iowa DHS to ensure our tool meets Iowa DHS requirements. Medica supports a collaborative approach with Iowa DHS to implement a comprehensive health risk assessment. A sample Health Risk Assessment is included in Tab 5.

2. **Propose the timeframe in which all comprehensive health risk assessments shall be completed after initial member enrollment.**

All members, after initial member enrollment will be encouraged to complete an assessment within ninety (90) days. If the need for a more comprehensive assessment is indicated, Medica will conduct the assessment within thirty (30) days of the determination.

3. **Describe how the assessment process will incorporate contact with the member and his/her family, caregivers or representative, healthcare providers and claims history.**

INTEGRATED PROGRAM EVALUATING HEALTH INFORMATION EXCHANGE DEVELOPMENT

In 2009, a Minnesota partnership consisting of Dakota County, Medica Health Plan, and Medica Behavioral Health was formed to better meet the health, mental health, and social service needs of Medicaid-eligible adults with serious mental illness and children with serious emotional disturbance in Dakota County through a program of integrated care and services known as the Preferred Integrated Network (PIN).

However, the limited data sharing between navigators and health care providers resulted in the program not yet being a truly integrated health care system. To further enhance the work of the PIN and allow for future expansion, the development of a Health Information Exchange to enable electronic transmission of health-related information with the PIN partners was launched in early 2015.

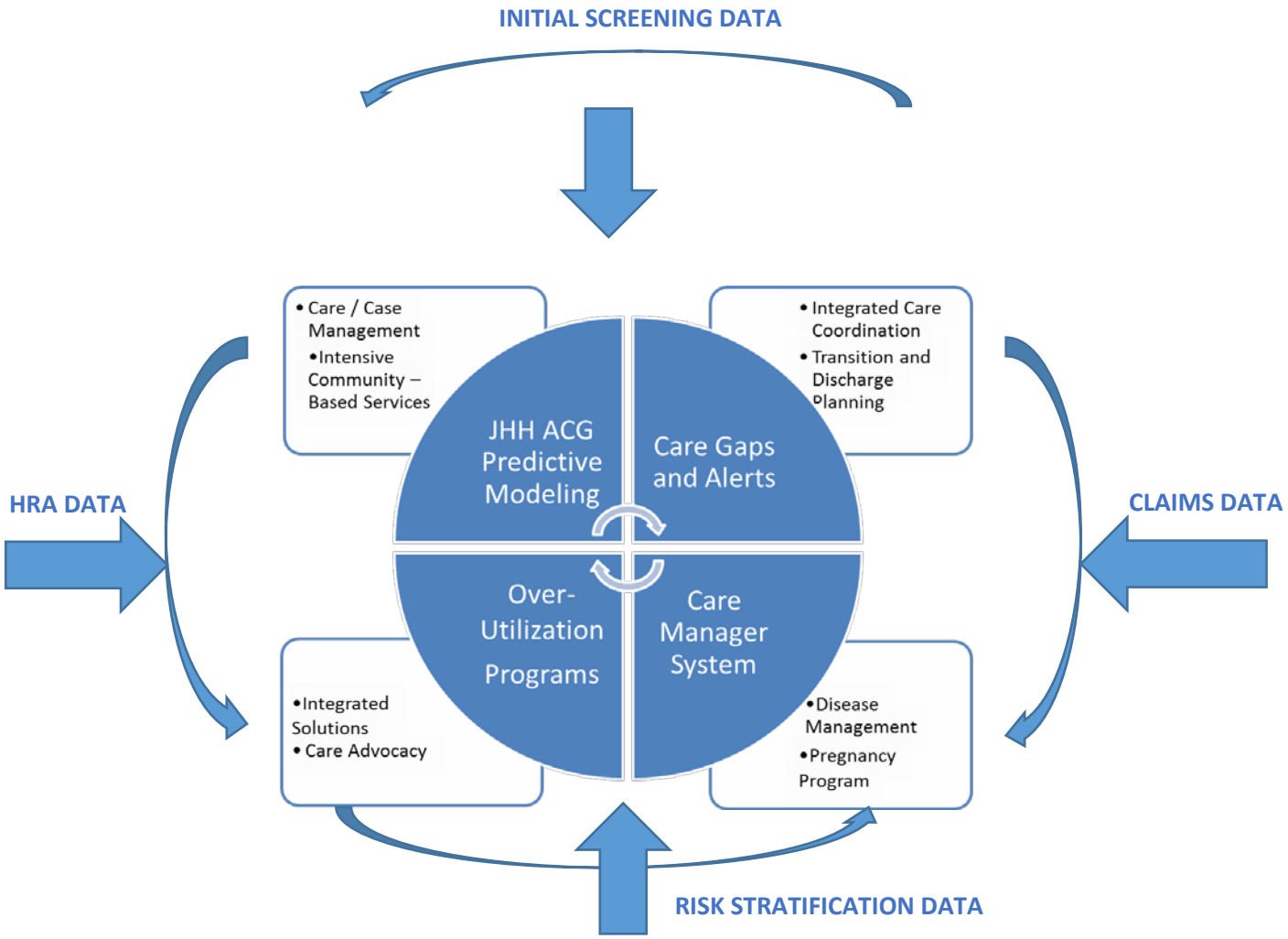
Medica will utilize the following methods:

- Obtain and record contact information in the member chart or the Medica information technology documentation systems at the time of the screening and/or comprehensive assessment.
- Ask the member for authorization to contact family members and significant others during the comprehensive assessment process. Verbal authorizations will be recorded.
- Directly speak to legal guardians and the member during comprehensive assessment. An example would be use of speaker phones when available and acceptable to the member and guardian.
- For outreach and coordination of care purposes, review of historical claims data to obtain names of current and past providers.
- Our member portal has the capability to create Integrated Care teams. The primary care provider can be set up as a member of the team and would have access to the care plans and other information. This is the preferred option.
- At the request of the member/guardian, we will print and mail, or send assessment information via secure email or fax.

9.1.3 Care Coordination

1. Describe in detail your proposed care coordination program including selection criteria and proposed strategies.

Medica is committed to member-focused, strengths-based processes, designed to best meet the needs of the individual member. Our comprehensive care coordination program consists of a variety of strategies including; care/case management, disease management, methods to target overutilization of services, and discharge and transition planning. Choosing the right care coordination strategy depends on the needs of the member as identified by the referral source, the initial screening data, the health risk assessment data, claims data and risk stratification findings from our proprietary algorithms. The following diagram provides an overview of our Care Coordination program.



The following is a description of our Care Coordination programs.

CARE/CASE MANAGEMENT

We utilize a collaborative case management approach to assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet an individual's health needs. We provide advocacy and collaborate with allied health professionals to supply creative resources to promote care at the right place, at the right time and at an affordable cost.

Determining the appropriate level of case management services starts with a comprehensive HRA with the member to address diagnostic, social, service coordination and benefit issues. The case management team will discuss with the member, his/her current situation and help identify any gaps in care or areas of unmet needs. The case manager will attempt to identify barriers to care that the member may be facing and assist in removing those barriers. Also, the Case Manager will help to identify appropriate services the member may need and make referrals as necessary.

In addition to findings from the HRA, members are identified for case management based on the level of complexity of their individual situation, including:

- History of utilization of higher levels of care
- Repeated uses of higher levels of care
- Multiple diagnoses
- Dual diagnoses
- Failure to comply with treatment plan leading to decompensation leading to more intensive interventions
- The presence of complicating social factors, such as homelessness

This identification occurs through automated processes via algorithms that identify members who are considered at-risk, or when staff members working with the case identify that a member meets a specific set of criteria. There are also algorithms that assign evidence-based gaps in care after identification of cases where expected activities prescribed in the member's treatment plan are absent, resulting in a gap in care.

Medica also uses an algorithm to identify members who could benefit from other available disease management or complex case management programs Examples of such programs include: the Integrated Care Coordination (ICC), Intensive Community-Based Service (ICBS) program, the I-Solutions program and Pregnancy Program.

We use an electronic clinical management system to track all member communication and activity. This system ensures that all behavioral health and the medical information is stored in one place. Information from this documentation system, including medical and behavioral claims detail, is used to identify members with special health care needs and complex medical-behavioral conditions for care coordination and case management programs. Medica also uses program-specific algorithms that run behind the scenes to identify gaps in care or situations where a certain course of treatment is indicated based upon diagnoses and treatment history.

INTEGRATED CARE COORDINATION PROGRAM

Medica's ICC program provides telephonic and face-to-face care coordination by mental health and medical clinicians who support members and their providers in improving the member's overall health. The goal is to stabilize the member's situation and reduce emergency room visits for non-emergency conditions. We work with these members to determine the cause of instability in their lives and factors that contribute to higher service utilization and then jointly develop individualized care plans with treatment goals and services designed to stabilize the situation, regardless of whether the issues are behavioral, physical or related to daily living needs. Our ICC program staff work to find and engage members who may be homeless, transient, shut-in or severely mentally or behaviorally disabled. Our team of community specialists will work with these members to stabilize social and environmental issues so that Medica's ICC staff can focus on clinical care. Utilizing this model we have been able to provide coordinated care to complex members through a trusted provider, one whose expertise is treating members with the most pressing needs. Our ICC program has yielded a savings of over $2,100 per member per month.

Intensive Community-Based Service Program

In a 2012 evaluation, ICBS was shown to have a significant impact (30% decrease) on member's overall behavioral health spend in the months after receiving ICBS.

Our Intensive Community-Based Service (ICBS) program pairs community mental health providers with members who have complex mental health, substance use, psychosocial, housing and medical issues to identify the member's unique needs, intensively coordinate complex health care and social service needs and provide support to the member over a period of one to six months.

Integrated Solutions Program and Care Advocacy

Our I-Solutions program engages members who frequently or repeatedly use higher levels of care, receive high cost care, and/or have chronically unstable conditions. This includes many members with Dual Diagnoses of mental illness and Substance Use Disorder and members with co-occurring behavioral and medical conditions. I-Solutions is a telephonic program that provides members with an assigned care advocate who engages and works with the member, as well as with the provider, to change service utilization patterns to receive optimal care.

Pregnancy Program

Medica's Pregnancy Program helps members and infants to achieve optimal wellness from pregnancy through the first six (6) weeks after delivery and reduces costs from pregnancy and newborn complications. Through the Pregnancy Program, we identify members who are pregnant, encourage early and ongoing prenatal care, and increase members' access to pregnancy-related educational information. The Pregnancy Program helps our members understand and better manage their pregnancies to promote healthy outcomes for mother and baby. If a pregnant member is identified with a high risk pregnancy, we will offer additional interventions which may include a face to face approach from clinical health professionals. In addition, Medica would seek to work with local public health to best streamline programs available for this population.

Disease Management

Medica clinicians offer education and self-management support for at-risk individuals with chronic health conditions such as diabetes, asthma and cardiac conditions. If the health care home or primary care provider has programming available, Medica will work collaboratively with this program and encourage member participation.

At-risk members are identified for outreach through a medical and pharmacy claims algorithm process. Members identified for intervention are distributed to appropriate disease management programs based on their level of risk. Low risk members will receive self-care information to gain access to educational resources and supports, which may include targeted mailings and/or access to on-line programs. We anticipate sixty percent (60%) of the population would be eligible for this level of programming. We will provide members found to be at moderate risk who have an established relationship with a health care home or primary care provider with support in accessing programming available through their provider. Medica staff will coordinate with providers to ensure members' needs are met. We anticipate that twenty percent (20%) of the population will be eligible for this level of programming. We will provide members identified as high risk, the remaining twenty percent (20%) of the population, with targeted disease management support from clinical staff based on the member's identified need.

We have embedded condition-specific care pathways—a framework to identify problems, interventions and actions—in our clinical management system to assess members' adherence to evidence-based standards of care. We use members' responses to the assessment to develop individualized care plans.

We endorse program interventions with an interdisciplinary holistic mind/body approach that considers member perceptions about their current health, chronic conditions, thoughts, emotions, and underlying health habits. When indicated, we will schedule consultations or make referrals among the interdisciplinary team to support identified member needs. Medica's interaction with program staff and care coordination with providers, public health and community resources will empower members to build upon strengths and increase their knowledge, motivation and confidence to take charge of and effectively manage their health conditions.

Programs to Target Overutilization of Services

We use claims data to identify high-cost members. We analyze this data to identify members who, based on their claims trajectory, missed an opportunity for an earlier intervention or treatment. This information of how and why this earlier opportunity was missed is input that goes into the evolving care plan for the member. Based on the identified member needs and geographic location, we may refer members to one of our ICC, I-Solutions, or ICBS programs. Through these programs, members with chronic conditions are able to get the health care they need to live healthier lives and get established with medical providers instead of using the emergency room (ER) for primary care.

Discharge and Transition Planning

Providers are encouraged to notify Medica when a member is admitted for inpatient treatment. Upon admission, a registered nurse follows the member's care and recovery, and if necessary, reviews progress/clinical information with a medical director. Following a hospitalization, these members are prioritized for targeted outreach. Once the nurse receives notification of discharge from the inpatient facility the registered nurse contacts the member and/or caregiver to help support discharge planning and ascertain the member's ability to care for themselves following discharge. This review includes medication review, review of discharge and personal health record, need for home services and follows up with provider(s) using our transitional care toolkit.

2. Provide data on outcomes achieved in your care coordination programs operated in other states, if applicable.

Medica's proven health and wellness program is for members who are at-risk for chronic diseases and multiple health conditions. The health and wellness program uses care coordination strategies along with education to help members develop the skills, knowledge and confidence to self-manage their health and well-being. **Evaluation of the program has found a $343 per participant per month cost savings in health care expenditures, and a 97% overall member satisfaction with the program.**

Our i-Solutions program showed significant cost savings and positive outcomes for members. Based on findings from two review cycles, members engaged in I-Solutions care coordination showed a significant decrease in medical and behavioral health ER visits and hospitalizations:

	SHORT-TERM (3 months)	LONG-TERM (6 months)
ER visits	Decrease of 36%	Decrease of 87%
Hospitalizations	Decrease of 44%	Decrease of 36%

A recent evaluation found that Medica members in the ICBS program experienced very positive outcomes including a 72 percent reduction in hospitalizations, 35 percent reduction in emergency room visits and 57 percent increase in prescription drug compliance. More than 90 percent of participants avoided jail, acute crisis services and detox centers while enrolled in the program and 82 percent took their psychiatric medications as prescribed.

Our ICBS program which offers care coordination to members with complex mental health, substance use, psychosocial, housing and medical issues began in 2002 in St. Louis County, Minnesota with support from the Medica Foundation. Since 2011, we have gradually expanded ICBS into 25 Minnesota counties, including the Twin Cities metro area. A recent evaluation found that Medica members in the ICBS program experienced very positive outcomes including a 72 percent reduction in hospitalizations, 35 percent reduction in emergency room visits and 57 percent increase in prescription drug compliance. More than 90 percent of participants avoided jail, acute crisis services and detox centers while enrolled in the program and 82 percent took their psychiatric medications as prescribed. Medica is the only health plan in Minnesota to offer such a program.

Medica welcomes the opportunity to discuss the implementation an Iowa-specific ICBS program with Iowa DHS so that members with complex medical and behavioral needs can be moved into the program at the start of the contract.

Our Integrated Care Coordination is a program that includes integrated behavioral health and medical care coordination teams that outreach and engage high utilization Medicaid members. A recent study completed on this program estimated $2,127 per participant per month (PPPM) lower costs when compared to a tightly matched cohort of controls. The program also demonstrates statically lower cost for prescriptions and for those members with surgical events in the period prior to program engagement. Analysis estimated a savings of $1309 PPPM in reduced prescription costs.

9.1.4 Risk Stratification

1. Describe your proposed risk stratification methodology.

Medica has a robust risk stratification strategy, which will be presented to Iowa DHS for review and approval. Our risk stratification levels help to determine the intensity and frequency of follow-up care that is required for each member participating in our care coordination program.

Medica employs proprietary algorithms including the Johns Hopkins ACG Case-Mix System Risk assessment software which is designed specifically for the stratification of Medicaid populations. The system processes medical, behavioral and pharmacy claims to produce a prospective risk score based on a combination of:

- Utilization of services or care
- Diagnosis
- Risk of hospitalization
- Medication/prescription adherence information
- Existence of co-morbidities
- Previous cost of care
- Demographic information
- Gaps in care.

We leverage a multi-dimensional approach to identify members with medical and behavioral health issues for outreach. Utilizing algorithms, HRA data, daily admission report, and claims data members are identified, evaluated and managed to address the member's physical and behavioral health issues. Members are referred to the appropriate case, care or disease management programs.

2. Describe your proposed risk stratification levels.

Medica treats each member as an individual and works with them to identify the best health management approach for them. The risk stratification process complements Medica's approach by placing members into one of three levels of care:

- Low risk – Low risk members have low utilization, low risk for adverse events and are established with a PCP. These low risk members have a record of self-management.
- Moderate risk – Moderate risk members have an established PCP relationship and have moderate health care utilization.
- High risk – High risk members have high utilization, high risk for adverse events, no established PCP relationship and needs assistance with self-advocacy.

3. Describe how care would be managed for members in each risk stratification level.

LOW RISK

We will provide low risk members with self-care information to gain access to educational resources and supports, which may include targeted mailings and/or access to on-line programs. Care Navigators are available, if needed, to offer members information about wellness and prevention, which may include Community-Based resources.

In addition, Medica will engage and activate members of all backgrounds and abilities to manage their health through a new online health risk assessment and set of personalized self-management tools. We will utilize self-management programs to focus on key areas such as tobacco cessation, healthy weight, exercise, stress management and at-risk alcohol use. We also have offline paper and telephonic options available. We will provide information to members in new member packets, member newsletters, and through our website Medica.com. Medica welcomes input from Iowa DHS on additional ways to engage members in Iowa.

MODERATE RISK

In addition to the services offered to low risk members, we will refer moderate risk members to programs available through their established health care home or PCP. Medica will provide the member with support in accessing programs available through their provider. If programs are not available through a provider, the member can participate in Medica's disease management programs described above.

HIGH RISK

In addition to the services offered to low risk and moderate risk members, we will offer members identified as high risk with support through Medica's targeted disease management program based on the members identified need. Based on the results of their risk findings, these members may also be identified for participation in more "hands on" intensive case management services provided through our comprehensive integrated programs, such as Integrated Care Coordination, Intensive Community-Based Services, Pregnancy Programs and Integrated-Solutions

9.1.5 MEMBER IDENTIFICATION

1. Describe how you will identify members eligible for care coordination programs, including how the following strategies will be utilized:

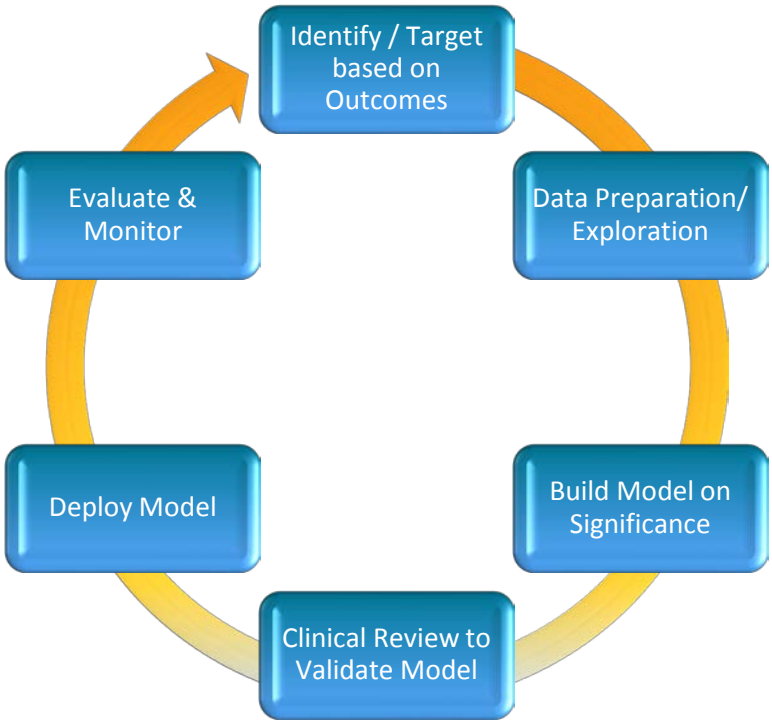
The primary way Medica identifies members is through the initial health risk screening and comprehensive health risk assessment. Medica will also utilize predictive modeling tools that provides critical data related to prior authorizations, notification of admissions, inpatient census, claims, member and caregiver requests and physician referrals.

a. Predictive Modeling

Medica deploys a multi-facetted rules engine, Coordinated Member Identification (CMI), to select or target members for specific Health Management programs and interventions. The identification process is supported through a combination of proprietary predictive models and rules (algorithms).

The potential cases identified are assessed to determine prior participation, current program participation, and eligibility based on program hierarchy or priority. Members are then prioritized for participation using a top down approach based on the algorithm results and the program.

The algorithms and models leverage a number of data sources including claims, pharmacy, member dimensions, provider dimensions, client data feeds, and vendor data feed, John Hopkins ACG, health assessments, and other content as needed. The following graphic depicts the predictive modeling cycle:



b. Claims Review

As noted in our response to 9.1.5-1(a) above, Medica's proprietary algorithms review medical, behavioral and pharmacy claims.

c. Member and Caregiver Requests

Medica will accept member and caregiver requests for our care coordination programs. When a request is made, Medica will make a referral to the care coordination program to conduct the comprehensive health risk assessment, and make referrals to the appropriate disease management program or Community-Based resources. In addition, Medica would offer resources that the member might be eligible for within their geographic location.

d. Physician Referrals

Direct referrals can be from providers, Medica's nurse line, internal referrals, utilization management, contact managers, and/or customer service staff. Medica will educate physicians and other treatment providers in its network about its case management programs and the criteria for assessing a member for risk. Referrals for care coordination will follow the same process described in the response to 9.1.5-1.c. In addition, we will ask the member to authorize the physician to forward all relevant medical records to be used as part of its comprehensive health risk assessment process.

9.1.6 Care Plan Development

1. Describe in detail how person-centered care plans will be developed for each member.

Medica has extensive experience in developing person-centered care plans based on member strengths and needs as identified in the health risk assessment process. We will develop a care plan for all members eligible for our case management program in Iowa. The care plan will be individualized and person-centered based on the findings of the initial health risk screening, comprehensive health risk assessment, available medical records, and other sources needed to ensure that care for members is adequately coordinated and appropriately managed.

Case Managers will develop the member's care plan based on the HRA within thirty (30) days of HRA completion or screening tool completion. If the member refuses to participate in the HRA or screening tool process, a care plan may be completed utilizing available data analytics. The care plan will include the risks and needs identified through the HRA or screening tool, members, authorized family members, guardians, caregiver's, and the member's PCP.

Medica has the capability to import data from various sources to identify at-risk members and automate case initiation and assignment to case managers. The case manager will then review available clinical, medical, pharmacy and behavioral health data and determine the most appropriate care pathway to develop the member's care plan.

Care plans include interventions (for the case manager to execute) and actions (steps for the member to follow) to help members achieve specified outcomes. Below is a sample of a Medica Care Plan to guide the member to meet the goals established as a result of the HRA.

Member Summary | Benefits | UM | Case | CM Program

Actions Attach Create Request Send View Refresh

Care Plan: 006-10001445 Start Date: 4/18/14 Source: IFB High Risk Report Type: Complex Active Priority: CM: High Severity: CM: General Assessment Owner: Hesse

Member Barriers (0)

Care Plan

	Name	Status	Outcome	Start Date	Target D...	End ...
Opportunity	At Risk: Pain management	Closed	Met	4/18/14		7/30/...
Goal	Verbalizes effective pain control and decreased limitations due to pain	Identified				
Intervention	Facilitate: Discussion with care provider regarding pain level, pain screenin...	Identified				
Intervention	Assess: Pain characteristics, current treatment plan, and extent of disabilit...	Closed	Met	6/17/14		7/30/...
Action	Schedule and keep appointment with care provider to discuss pain level, a...	Closed	Met	5/22/14		7/30/...
Opportunity	At Risk: Anxiety / stress	Closed	Not Met Membe...	4/18/14		7/30/...
Goal: Long Term	Verbalizes little or no anxiety / stress	Closed	Met	4/18/14	7/30/14	7/30/...
Intervention	Educate: Development of coping mechanisms	Closed	Not Met Clinical ...	6/17/14		7/30/...
Intervention	Facilitate: Plan for development of stress reduction and/ or counseling	Closed	Met	6/2/14		7/30/...
Action	Identify / initiate strategies for coping with anxiety / stress.	Closed	Met	5/21/14		7/30/...
Intervention	Assess: Anxiety / stress potential causes and need for support	Closed	Not Met Clinical ...	4/18/14		7/30/...

Detailed Case Data

Case Tasks: 006-10001445

Medica is committed to supporting our members' access to services that meet their needs, including facilitating access to and use of primary care providers and medical specialists. We view the care plan as a key tool in establishing the individualized goals and actions, facilitating seamless care, transitions, creating communication paths and plans with providers and monitoring the receipt of recommended care.

2. Describe how the care plan development process will be individualized and person-centered.

Medica will ensure that all care plans will be individualized, person-centered and specifically designed with the member's input at the forefront. As noted in the diagram in 9.1.3.1 above, we use initial screening information, HRA data, claims information and risk stratification data to identify the risks and needs of our members. These data sources also serve as a foundation in building a member's personalized care plan however, it is our hands-on approach of interaction and engagement with the member that drives the member-centered care plan. The following story, based on Medica's experience, illustrates our commitment to individualized care plan development.

> ***A telephonic case manager began working with a 50-year-old male. He had been homeless for 20 years, but had recently been housed. The member reported that he "didn't like people and people didn't like him." During an initial phone call, the member said he didn't need any help, but did agree to complete the assessment. The member let the case manager know he had an appointment to have multiple teeth pulled. Even though transportation assistance through our Provide-a-Ride service was offered, the member declined as he felt he couldn't rely on other people.***
>
> ***The case manager was respectful of his wishes and assured him that he should use Provide-a-Ride only if he was comfortable doing so. Two days later, he called and said he would try it. He stated that this was the first time in 20 years that he had asked for assistance. About a week later, he called asking about how to get glasses. A few weeks later, he called again about where to get a flu shot. He also agreed that the case manager could call him to follow up. When the care coordinator called to make a follow-up, he asked for assistance to quit smoking and to find a primary care doctor to get a physical. This is an example of how important it is to individualize each service for each member. For this member, it's not just that he is keeping medical appointments; it's that he is asking for and receiving help to meet his goals, on his time while taking charge of his health.***

3. Describe how the care plan development process will incorporate findings of the initial health risk screening, comprehensive health risk assessment, medical records and other sources.

Prior to meeting with member and/or caregiver, the Medica care coordinator will synthesize the findings of the initial health risk screening, comprehensive health risk assessment, medical records and other sources in order to create a complete picture of the member's physical and behavioral health status. This information will become the basis for discussion when meeting with the member and/or caregiver to develop the actual care plan. Treatment goals and recommended services will directly correlate to and address the issues identified from this information.

In addition, we will use pharmacy and medical claims data to stratify the population based on pre-identified risk categories. Medica's risk stratification capability automatically creates a case type with member-specific diagnostic information, risk scores and recommended interventions. We use this information to execute the interventions, which in turn, helps members achieve better health outcomes and lowers risk for chronic health conditions.

5. **Submit a sample care plan for each proposed risk stratification level.**

LOW RISK SAMPLE CARE PLAN

The following references potential actions the member can take based on the results of a self-assessment

Well Being Programs and Content

Members can select one goal:

- Nutrition:
  - Daily small step recommendations with supportive messaging, activity and assets.
  - 36 Total Programs.
- Fitness:
  - Cardio, Workouts With Weight, Workouts Without Weights, and Sit & Be Fit (Chair Exercises)
  - 4 levels of strength training; 2 levels of Sit & Be Fit.
  - Supportive messaging, written and video instructions
- Stress:
  - 2 overall paths, one focused on Sources of Sources, the second on Tools to Manage Stress.
  - 14 overall plans with over 40 two-week programs.
  - Audio, video, and written content along with supportive messaging.
- Purpose:
  - Workshop-style programs, with 5 progressive plans and over 30 modules.
  - Interactive exercises, multi-media content and supportive messaging.

Supportive Services

Rewards for activity and engaging:

- Healthy Goods: Members use their points to receive discounts on merchandise
- Raffles: Points to enter raffles to win prizes
- Local Deals: Points for coupons on merchandize, dining, travel, and services
- Charities: Social giving of points that results in cash donation

History: A page with details on member interactions

Local: Discount membership and special deals for members at national gyms and trainers.

Mobile: iPad & Android Tablet Compatible

Online Community for support:

- Buddies: One on one support to lead a healthy life.
- Groups: Formed to promote healthy and fun activities.
- Events: Scheduled for groups to engage at a deeper level.

MODERATE RISK SAMPLE CARE PLAN:

Comprehensive General Adult Care Plan Example:

Identified Opportunity: Self-Management - Inadequate care provider follow-up

→ **Associated Goal**: Verbalizes adherence to care provider(s) recommended appointment schedule

- **Intervention-**Educate: On the importance of recommended follow-up care provider appointments
- **Intervention**-Assess: For potential barriers to adherence with care provider appointments
- **Action**-Make and keep scheduled appointments with care provider(s) as recommended.

Identified Opportunity: At Risk - Pain Management

→ **Associated Goal**: Verbalizes effective pain control and decreased limitations due to pain

- **Intervention**-Assess: Pain characteristics, current treatment plan, and extent of disability due to pain (Attached: Pain screening tool)
- **Intervention**-Facilitate: Discussion with care provider regarding pain level, pain screening results and recommended treatment options
- **Action**-Schedule and keep appointment with care provider to discuss pain level, any limitations, and pain control options.

HIGH RISK SAMPLE CARE PLAN:

Asthma Care Plan Example:

Identified Opportunity: At Risk - Asthma control
→ **Associated Goal**: Improved asthma control

- **Intervention**-Assess: Actions taken with first symptoms of asthma, and adherence to treatment plan
- **Intervention**-Facilitate: Care provider discussion regarding asthma symptoms and current treatment plan
- **Action-** Keep a daily journal of symptoms to share with care provider at appointments**.**
- **Action**- Make appointment with care provider to discuss asthma symptoms.

Identified Opportunity: Self-Management - Asthma triggers
→ **Associated Goal:** Verbalizes strategies to reduce and manage impact of known asthma triggers

- **Intervention-**Educate: Strategies to avoid and/or manage impact of asthma triggers
- **Action-**Verbalize methods to stay away from or minimize impact of known asthma triggers.

Identified Barriers:

- Lifestyle behavioral issues
- Transportation issues

6. Describe how you will ensure that there is a mechanism for members, their families and/or advocates and caregivers, or others chosen by the member, to be actively involved in the care plan development process.

Medica will ensure that there is a mechanism for members, their families and/or advocates and caregivers, to be actively involved in the care plan development. This development will occur with a multidisciplinary team of qualified health professionals.

Medica's requires that every care plan includes the member and his or her designee they choose as the central participant. If that is not possible, Medica will require care coordinators to seek alternative representation authorized by the member such as an advocate or relative.

7. Describe how you will identify other caseworkers to be included in the care plan process and how services will be coordinated to avoid duplication and/or fragmentation of services.

Medica's care coordinators will collaborate with other health care professionals who conduct risk assessment functions and other screenings to identify special needs. If a member is receiving home and Community-Based waiver services, Community-Based case managers are responsible for coordinating and communicating with these waiver providers. They must also complete the care plan for these members, which should include any care coordination activities provided by Medica. Medica care coordinators will share with other providers the results of its identification and assessment of that member's needs to prevent duplication of those activities, as authorized by the member.

The care coordinator will invite other caseworkers or treating professionals to include feedback and information that will be a part of the care plan development process. In addition, the care coordinator will

encourage members to grant permission to directly include other treating professionals, including caseworkers, to participate in the care planning sessions in order to jointly develop care plans for members who are accessing multiple services concurrently or consecutively to produce an integrated care plan which avoids duplication and/or fragmentation of services.

8. Indicate how you will ensure that clinical information and the care plan is shared with the member's PCP (if applicable) or other significant providers.

Medica will ensure that the care plan, or a summary of the care plan is provided to the member's PCP (if applicable) or other significant providers. Our provider files will contain PCP contact information including phone number, fax number and secure email address.

Within thirty (30) days of completion the care plan, a summary of the care plan will be shared with the PCP or significant providers identified through claims review and/or care plan development with the member. Medica's tool for care coordination includes a member portal that provides the member with access to his or her care plan and also the capability to designate individuals who can access the member's care plan. The member portal can also be used to create a care team. The authorized care team will have access to the assessment, care plan and other clinical information within the member's record. Care teams support better-coordinated healthcare, benefits information, and care plan activities. Participants in a care team share an interest or some responsibility in the member's care management, and health and wellness. Participants in a care team always include the case manager, member, and whenever possible, service providers.

9. Describe how cultural considerations of the member would be accounted for in the care planning process and how the process will be conducted in plain language and accessible to members with disabilities or limited English proficiency.

The increasing diversity of Iowa residents requires stakeholders in the health care world be culturally competent because an individual's cultural beliefs and behaviors affect health outcomes. It's important for us to pay attention to the social and cultural factors in managing medical encounters with patients from very different social and cultural backgrounds.

Medica has been an active collaborator with the State of Minnesota, with the community and with other MCOs in measuring our ability to provide culturally-responsive services to Minnesota Health Care Program (MHCP) members. This collaborative approach has been a key to improving culturally responsive services. We would look to build a similar collaborative approach with DHS, providers and stakeholders to build off of the current efforts in Iowa.

Medica recognizes that our members come from diverse cultural backgrounds and may speak languages other than English. When needed, our case managers and care coordinators use the TransPerfect Translations Language Line to talk with members whose native language is not English. All materials sent to members include a language block providing instructions to the members on how to get the information interpreted into a language other than English. Educational materials are available in several different languages, including priority languages of Spanish, Somali, Hmong and Russian. We will add translation for additional languages based on the needs of Iowa members. Medica also continually seeks to hire bilingual case managers and customer service staff.

Each care plan will reflect cultural considerations of the member. We will conduct care plan development using plain language, and provide access to members who have disabilities and/or have

limited English proficiency. We will provide the member the opportunity to review the care plan as requested.

10. Describe how the proposed care plan process will include a system to monitor whether the member is receiving the recommended care.

Medica will utilize our evidenced based medicine algorithm to identify a gap in care, for example, if a member has not received recommended services such as preventive health visits. In addition, Medica will utilize claims to identify if recommended services were implemented and received by the member. If the member is receiving home and Community-Based services, the monitoring of the care plan is completed by the Community-Based case manager. This includes checking in with members to verify that services are being delivered that meet the needs of the member. In addition, Community-Based case managers develop back up plans with the member for coverage when a provider is unavailable.

9.1.7 Tracking and Reporting

1. **Describe how you propose to track and report on care coordination programs and share care coordination information with the member, authorized representative and treatment providers.**

Medica has systems in place to track member level reporting that focuses on individual member goals, gaps in care and outcomes. Medica care coordinators share this information with individual members and treatment providers as applicable. In addition, Medica is able to provide programmatic outcome data about the effectiveness of care coordination programs to the state. Medica will comply with all required reports as prescribed in the Reporting Manual.

2. **Describe the system that you will use to integrate and share information about members in order to facilitate effective care coordination.**

Medica's tool for care coordination includes a portal that provides the member with access to his or her care plan and also the capability to designate individuals who can access the member's care plan. The portal can also be used to create a care team. The authorized care team will have access to the assessment, care plan and other clinical information within the member's record. Care teams support better-coordinated healthcare, benefits information, and care plan activities. Participants in a care team share an interest or some responsibility in the member's care management, and health and wellness. Participants in a care team always include the case manager, member, and whenever possible, service providers.

9.1.8 Monitoring

1. Describe your care coordination monitoring strategies.

Medica uses medical trend, cost and utilization data to monitor the effectiveness of our care coordination programs. Care coordination managers review data on health risk assessment completion rates, engagement rates, and member satisfaction with the care coordination program for identification of poor performance, and areas for improvement. In addition, we analyze utilization data to identify systemic issues, such as ER usage/reduction, inpatient rates and readmission rates. When systemic performance issues are identified, we develop specific performance improvement projects to improve system performance. For example, Medica has an extensive improvement project team working on reducing readmission rates. The project includes provider education, care coordinator training, and outreach to members experiencing a hospitalization. Members' engagement and success in achieving health goals, reducing gaps in care and completing care plans will be reported and analyzed to determine program effectiveness.

2. Describe how case specific findings will be remediated.

Medica will implement strategies to address findings of poor performance or non-compliance. Case specific findings found during the program monitoring process will be referred to Care Coordination staff. Care Coordination staff will work with the member to ensure that all appropriate services and supports are in place for that member.

9.1.9 Reassessments

1. **Describe in detail your process for reviewing and updating care plans.**

   Medica offers members an opportunity to complete health risk screenings on an annual basis. Through the health risk assessment, Medica will review the results of updated screenings and update the care plans, as necessary. In addition, Medica will utilize data analytics to routinely monitor gaps in care, integrate this information into the case management application which will drive necessary changes to the member's care plan. For those members engaged with care coordination staff, the care coordinator will review and update care plans with changes in condition, and as member goals are accomplished.

2. **Describe the protocol that you will use for re-evaluating members to determine if their present care levels are adequate.**

   Medica's written policies and procedures direct our processes for conducting a re-evaluation of members in our care coordination program. Two (2) separate processes are used; they are as follows:

   - Re-evaluation will occur at regularly spaced intervals based on the member's level of care coordination.
   - We will also re-evaluate members enrolled in the program when major changes in condition, health care spend or types of services occur.

   Medica care coordinators, will conduct re-evaluations by contacting the member/guardian; persons on the member's healthcare team, reviewing most recent risk-stratification data from the John Hopkins tool, reviewing prior authorization and or/admission data, and reviewing the most current claims. Based on the result of the review, the care plan will be updated and when indicated, the member is moved to the appropriate care level. In addition, care coordinators will offer to conduct a comprehensive health risk assessment on all members who have experienced a hospitalization or transition of care. This comprehensive HRA will be used to create an updated care plan that reflects the members increased needs.

3. **Indicate the triggers which would immediately move the member to a more assistive level of service.**

   Multiple triggers, including daily admission reports as described in our response to question 9.1.1, number 3, review of gaps in care, and Care Coordinator input will indicate the immediate need to move the member to a more assistive level of care.

   Examples are as follows:

   - Low-level to mid-level care coordination:
     - Move from inhalers to home oxygen for member with COPD,
     - New onset Cardio-Vascular Accident in person with care coordination due to a head injury,
   - Mid-level to high-level:
     - Organ failure to transplant list,
     - Diagnosis of metastatic cancer in member with history of neurologic impairment,

   In all these examples, the member's health status has become significantly compromised and the number of treatment team members has expanded causing the need for increased coordination.

SECTION 10: QUALITY MANAGEMENT AND IMPROVEMENT STRATEGIES

1. Please explain how you propose to execute Section 10 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Medica will leverage our existing Quality Management and Improvement Program (QM/QI) in Iowa. This program monitors, evaluates and takes action on any identified improvements needed through careful planning, dedicating the right resources, collection and analysis of key data components, policy statements, and communication.

The Medica QM/QI program is designed to provide excellent quality healthcare services by utilizing effective resources to meet the needs of the Iowa population. The goals of the QM/QI program are to promote effective and timely care for all members and to demonstrate that methods and systems that are efficient and effective.

Medica's QM/QI processes and projects are integrative, collaborative and comprehensive. The vision of the QM/QI program is to optimize physical and behavioral health outcomes by providing and monitoring safe, high quality healthcare services. The QM/QI program will be responsible for measuring, tracking, trending and analyzing data correlating with improvement performance initiatives for the Iowa program. The QM/QI Program is also responsible for establishing guidelines, protocols and procedural operations with producing a positive impact on health services.

Through our QM/QI Program, we identify and implement activities that:

- Improve member care, service, access and/or safety
- Improve service to practitioners, providers, employers, brokers and other customers and partners
- Improve Medica's internal operations related to care, service, access and patient safety

Section 10.1 includes more detail on Medica's specific approach to implementing QM/QI activities

The QM/QI program is centered on a robust, dedicated QM/QI Committee. The QM/QI Committee includes a comprehensive infrastructure that clearly defines participations, roles and responsibilities and holds representatives accountable. The QM/QI Committee drives the implementation of the process improvement projects while providing high level comprehensive oversight of the QM/QI program. The committee is responsible for analyzing and evaluating the results of the QI initiatives and recommends policy decisions that align with evidence based practice guidelines. Medica will create an Iowa specific QM/QI Committee.

We update our QM plans on a yearly basis based on strategies and recommendations by the quality committee. We have taken the lead on managing quality committee(s) based on the components of the QM plan.

Communication of Program Activity

Medica communicates the results of its QI activities to internal and external audiences. Internal communication occurs through committees, work groups and management meetings. External communication vehicles include member, provider, and employer/broker newsletters and the Medica Web site. Medica's providers also receive program information through practitioner guidelines and quality study results.

The background of our current team members includes over fifty (50) years of experience developing and implementing quality management plans, each specific to organizational goals and objectives.

Regulatory and Accreditation Compliance

Medica's QI program is designed and administered according to applicable state and federal regulatory standards. Medica is currently accountable to state-level regulatory agencies in each state in which it operates. These include:

- Minnesota: Department of Health, Department of Human Services, Department of Commerce
- Wisconsin: Office of the Commissioner of Insurance
- North Dakota: Insurance Department
- South Dakota: Division of Insurance

Upon award, we look forward to creating a QI program that is aligned with Iowa's regulatory standards and consistent with Federal agency requirements. We will work collegially and collaboratively with DHS to create a fully compliant QI program.

Federal agencies that regulate Medica's business include the Center for Medicare and Medicaid Services, the Department of Health and Human Services and the Department of Labor. Medica participates in the Minnesota DHS Comprehensive Quality Strategy Advisory Committee to provide input to MN DHS as they develop their quality initiatives.

Medica's quality program may be audited by any of these regulators on a scheduled or ad hoc basis. If any quality program audit results in the need for corrective action, a project lead will be designated to convene a cross-functional work team, which will develop and execute a corrective action plan. The project lead will monitor and document all corrective actions, communicate with the appropriate regulators, and report progress to Medica leaders.

Medica provides timely reporting on quality and outcome measures to regulators on a scheduled and ad hoc basis.

Medica is accredited for selected health plan products by the National Committee for Quality Assurance (NCQA). Medica applies NCQA standards and guidelines to its entire book of business where appropriate. The Health Management Quality Improvement department coordinates preparation for NCQA accreditation surveys and monitors ongoing compliance with standards. Upon Award, Medica will move forward with obtaining Medicaid Accreditation for Iowa.

When regulatory and NCQA requirements differ for any element, Medica adopts the most stringent standard applicable. The accomplishment that speaks to Medica's overall success in managing care for vulnerable populations is our consistently excellent performance in NCQA reviews. NCQA measures the health outcomes, process standards and member satisfaction rates of individual health plans to create an overall quality rating that is used by government, employers and individuals to make health care purchasing decisions. Outcomes and satisfaction are measured annually; process standards are reviewed every three years. Since 2005, NCQA has consistently ranked Medica in the Top 20 of all Medicaid plans nationwide. More significantly, we have outranked our closest Minnesota competitor in every year since 2008.

10.1 Contractor Quality Management/ Quality Improvement Program

1. **Describe your Quality Management and Improvement Program, addressing all elements outlined in Section 10.1.2. Include how you will monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to members.**

Medica's Quality Management and Improvement Program (QM/QI) monitors, evaluates and takes action on any identified improvements needed through careful planning, dedicating the right resources, collection and analysis of key data components, policy statements, and communication.

The Medica QM/QI program is designed to provide excellent quality healthcare services by utilizing effective resources to meet the needs of the Iowa population. The goals of the QM/QI program are to promote effective and timely care for all members and to demonstrate that methods and systems that are efficient and effective.

Medica's QM/QI processes and projects are integrative, collaborative and comprehensive. The vision of the QM/QI program is to optimize physical and behavior health outcomes by providing and monitoring safe, high quality healthcare services. The QM/QI program will be responsible for measuring, tracking, trending and analyzing data correlating with improvement performance initiatives for the Iowa program. The QM/QI Program is also responsible for establishing guidelines, protocols and procedural operations with producing a positive impact on health services.

Through our QM/QI Program, we identify and implement activities that:

- Improve member care, service, access and/or safety; and/or
- Improve service to practitioners, providers, employers, brokers and other customers and partners; and/or
- Improve Medica's internal operations related to care, service, access and patient safety.

Plan-Do-Study-Act

In order to meet the above goals, the QM/QI program identifies challenges and implements innovative interventions and solutions utilizing the Plan-Do-Study-Act (PDSA) cycle for process improvement. The PDSA model is a tool used for continuous process improvement and is essential for effective planning, oversight and taking action to remedy issues and emerging issues found. The methodology used with the PDSA model incorporates qualitative and quantitative data to identify trends and drive process improvement.

- **Plan**: Evaluate data, identify opportunities to prevent/improve health problems or occurrences, and identify appropriate intervention strategies based on best practices and known barriers.
- **Do**: Implement program(s) to address identified needs and barriers.
- **Study**: Measure the effects of the improvement and assess its effectiveness.
- **Act**: Continue intervention if effective. Adjust as necessary to achieve goal targets. Repeat cycle if intervention doesn't achieve desired result.

The PDSA process continues until Medica meets its goals, or until improvement cycle results show a need to focus resources in another way.

Teams at Medica also use the "Four Disciplines of Execution" (4dX) model for quality improvement projects. Teams establish "Wildly Important Goals" (WIGs) that specify the baseline, the desired measure and the deadline for reaching the goal. Each WIG has "lead measures" that predict goal achievement and "lag measures" that measure goal achievement. Teams create scoreboards to track measures and meet weekly to review progress and commit to specific performance improvements.

IDENTIFYING OPPORTUNITIES FOR IMPROVEMENT

In identifying opportunities for clinical and service improvements, Medica focuses on high-risk, high-volume, and problem-prone areas that may expose members to potentially adverse clinical or service outcomes. Medica integrates clinical quality priority setting, Health Management priority setting, and business planning into the identification process. Medica evaluates the full spectrum of clinical care: inpatient, outpatient, ambulatory, ancillary, pharmacy, emergency services, home health, and skilled nursing care.

Medica routinely monitors and analyzes data from a variety of sources, including:

- Claims (showing utilization rates, disease prevalence by population, potential over- and underutilization)
- Clinical studies/disease management self-reported data
- Clinical medical record data
- Customer Service Center performance statistics
- Health Assessment (for select populations)
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Internal audits of Medica's utilization review, case management and grievance and appeals processes
- Member complaints and appeals
- Member demographic data
- Member and practitioner satisfaction surveys
- Regulatory audit results
- Utilization data from care management software applications

When a potential improvement opportunity emerges, Medica evaluates it to determine:

- The improvement's relevance to Medica's population
- Medica's ability to make an impact
- Integration potential with other programs
- Applicable laws and regulations
- Program costs and resource needs
- Availability of regional or national benchmarks for goal-setting

Measurable goals are set against current baseline measures. Periodic re-measurements assess the improvement's effectiveness.

Using Member-Driven Quality Strategy

An understanding of member perceptions and expectations is critical to integrated strategic and quality planning. Medica learns about its members and other important stakeholders through monitoring and analysis of:

Satisfaction surveys and related data

- Member survey data, which will include the Iowa Participant Experience Survey
- Provider satisfaction surveys
- Physician advisory groups

- Aggregate complaint, grievance and appeal data (members and providers)
- Market research data (e.g. J. D. Power survey)
- Member enrollment and disenrollment surveys
- Member forums and advisory groups
- Member satisfaction surveys: care coordination, case management, Customer Service, Health and Wellness Coaching, utilization management

Health outcome data

- Health outcomes from utilization management, case management and health coaching programs
- HEDIS (Healthcare Effectiveness Data Information Set)
- Clinical studies
- Medical record data
- Medicare Health Outcomes Survey

Utilization management data

- Over and underutilization measures

Progress toward QI work plan goals

- Quarterly work plan updates

The QM/QI program described above is centered on a robust, dedicated QM/QI Committee. The QM/QI Committee includes a comprehensive infrastructure that clearly defines participations, roles and responsibilities and holds representatives accountable. The QM/QI Committee drives the implementation of the process improvement projects while providing high level comprehensive oversight of the QM/QI program. The committee is responsible for analyzing and evaluating the results of the QI initiatives and recommends policy decisions that align with evidence based practice guidelines.

Our team members have written multiple quality management plans specific to organizational goals and objectives. We have experience updating the QM plans on a yearly basis based on strategies and recommendations by the quality committee. We have taken the lead on managing quality committee(s) based on the components of the QM plan.

Communication of Program Activity

Medica communicates the results of its QI activities to internal and external audiences. Internal communication occurs through committees, work groups and management meetings. External communication vehicles include member, provider, and employer/broker newsletters and the Medica Web site. Medica's providers also receive program information through practitioner guidelines and quality study results.

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Medica provides timely reporting on quality and outcome measures to regulators on a scheduled and ad hoc basis.

Medica is accredited for selected health plan products by the National Committee for Quality Assurance (NCQA). Medica applies NCQA standards and guidelines to its entire book of business where appropriate. The Health Management Quality Improvement department coordinates preparation for NCQA accreditation surveys and monitors ongoing compliance with standards. Upon award, we will move forward with NCQA accreditation for Iowa Medicaid.

When regulatory and NCQA requirements differ for any element, Medica adopts the most stringent standard applicable. The accomplishment that speaks to Medica's overall success in managing care for vulnerable populations is our consistently excellent performance in NCQA reviews. NCQA measures the health outcomes, process standards and member satisfaction rates of individual health plans to create an overall quality score that is used by government, employers and individuals to make health care purchasing decisions. Outcomes and satisfaction are measured annually; process standards are reviewed every three years. Since 2005, NCQA has consistently ranked Medica in the Top 20 of all Medicaid plans nationwide. More significantly, we have outranked our closest Minnesota competitor in every year since 2008.

2. Describe how you will utilize program data to support the development of the Quality Management and Improvement Work Plan.

Medica collects, manages and integrates data from a variety of sources and systems for its quality improvement programs. Medica uses an integrated approach and set of tools to meet its quality goals. Examples include, but are not limited to:

- CCMS: Used for utilization management, complex case management, Health and Wellness Coaching, and appeal and complaint/grievance management.
- Compliance360: Supports regulatory and accreditation compliance.
- COR: Internally-developed software application for documenting and analyzing data collected through medical record review.
- EBM Gaps in Care: Claims analysis algorithm built into CCMS that identifies potential gaps in members' disease management, medication adherence, care patterns and safety.
- Health Rules Care Manager: Used for utilization management, complex case management, Health and Wellness Coaching, and appeal and complaint management.
- Johns Hopkins ACG Case-Mix System: Risk assessment software that processes medical, behavioral and pharmacy claims to identify potential Health and Wellness Coaching and case management participants, as well as Special Needs Plans (SNP) members at high risk for hospitalization.
- QCS: Internally-developed secure software application for managing quality of care investigations.
- Verisk Quality Compass: Supports HEDIS data processing and analysis.
- Visual CACTUS: Used to manage credentialing and re-credentialing data.

Medica's data systems have standard and customized reporting capability. Medica can generate reports on medical record and claims data sorted by multiple variables, including patient, provider, diagnosis and procedure. Other report types include program activity, history and performance trends.

Medica has mechanisms to ensure that information received from service providers is accurate, complete and readily available to the health plan or to regulators when needed. Data accuracy is monitored through activities including claim and coding audits, quality studies and fraud/abuse investigations.

Additionally, several Medica committees and work groups, comprising subject matter experts from business units throughout the organization, report to QM/QI. Medica will create similar oversight functions for Iowa membership.

- **Account Management Meetings**: The Account Management teams, with members from Health Management and the Medicare, Medicaid and Commercial business segments, are structured to provide alignment and shared communication of the work related to quality improvement, STARS/HEDIS, member interventions, new vendor opportunities, and helping members lead healthier lives. The teams meet monthly to discuss strategy and program specifics for their members.
- **Delegation Committee:** Chair, Supervisor, Health Management Compliance. Provides ongoing oversight of clinics and vendors delegated to perform specified health plan functions. The committee evaluates delegates' performance, reviews requests for new delegation, and recommends remedies or sanctions when delegates do not meet performance expectations. Subgroups reporting to Delegation Committee:
    - Care Coordination Oversight Team
    - Credentialing Oversight Team
    - Dental Oversight Team
    - MBH/UBH Oversight Team
    - Medical/Behavioral QI Work Group
    - OHPH Oversight Team
    - Pharmacy Oversight Team
- **Health Management Audit Committee**: Chair, Supervisor, Health Management Compliance. Reviews and monitors Health Management internal audit results. Serves as internal advisory and oversight body for the clinical audit program, ensuring compliance with regulatory and accreditation requirements.
- **HEDIS/Stars Clinical Improvement Committee**: Chair, Senior Manager, Health Management Quality Improvement. Responsible for identifying, prioritizing and implementing clinical quality interventions to positively influence HEDIS/Stars rates.
- **Inter-Rater Reliability Committee**: Chair, Supervisor, Health Management Compliance. Reviews and monitors results of physician and non-physician inter-rater reliability audits. Recommends action if staff fall below performance thresholds.
- **NCQA Readiness Team**: Chair, Quality Improvement Program Manager. Coordinates and monitors preparations for health plan accreditation surveys.
- **Quality Indicators Review Committee (QIRC):** Chair, Quality Improvement Program Manager. Monitors, analyzes and recommends action on member service quality indicators, including member satisfaction, member complaints and appeals, customer service performance, network quality and adequacy, and cultural and linguistic competency. Subgroups reporting to QIRC:

- Access and Availability Committee
- Commercial Complaints and Appeals Work Group
- Quality and Accuracy Work Group
- Quality of Care Complaint Oversight Committee
- State Public Programs Grievances and Appeals Work Group
- State Public Programs Member Forum

Also reported to QM/QI are reports on clinical and service quality programs such as medical record review and claims validation, as well as reports on quality audits of care providers, including skilled nursing facilities, personal care attendant agencies and interpreter service agencies.

Process improvement initiatives include collection and analysis of these qualitative and quantitative data related to key performance measures for Iowa members. Due to different types of data collected, assessment methodologies will vary and be targeted appropriately. All data collected will coincide with the Adult and Children Performance Measures recognized by the Iowa Department of Human Services.

3. **Detail your experience in and strategies for improving quality indicators, including HEDIS measures, CAHPS measures and satisfaction surveys. Describe how you will apply that experience in Iowa.**

Establishing a QM Plan and QM Committee are essential components to improving quality indicators. A QM Plan establishes a guide to oversee the provisions of quality health care services provided to members, and outlines key methods for performance and process improvement initiatives. It also delineates roles and responsibilities and defines the programs leadership for developing, implementing, evaluating and coordinating quality improvement strategies based on specific quality measures.

Medica is accredited by the NCQA and works diligently to provide top quality care to its members. Medica has over 15 years' experience collecting, tracking and implementing improvement efforts for HEDIS and CAHPS. HEDIS and CAHPS scores are among priorities for the organization. As a result, Medica has the top Medicaid HEDIS scores in the state of Minnesota and are consistently in the top 15-20th ranking nationally. The most recent HEDIS report published by the NCQA for 2014-2015, Medica was ranked #18 with an overall score of 82.8. Consumer Satisfaction and Satisfaction with health plan services scored a 4 and Consumer Services and Treatment scored a 5. In 2013-2014, Medica was ranked #11 in the Top 15 Medicaid Health Insurance Plans.

The following 2015 HEDIS measures are tracked:

- General Guidelines for Data Collection and Reporting
- Guidelines for Calculations and Sampling
- Adult BMI Assessment
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Childhood Immunization Status
- Immunizations for Adolescents
- Human Papillomavirus Vaccine for Female Adolescents
- Lead Screening in Children
- Breast Cancer Screening
- Cervical Cancer Screening
- Non-Recommended Cervical Cancer Screening in Adolescent Females
- Colorectal Cancer Screening
- Chlamydia Screening in Women
- Non-Recommended PSA-Based Screening in Older Men
- Care for Older Adults
- Appropriate Testing for Children With Pharyngitis
- Appropriate Treatment for Children With Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation
- Use of Appropriate Medications for People With Asthma
- Medication Management for People With Asthma
- Asthma Medication Ratio
- Controlling High Blood Pressure
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Comprehensive Diabetes Care
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

- Osteoporosis Management in Women Who Had a Fracture
- Use of Imaging Studies for Low Back Pain
- Antidepressant Medication Management
- Follow-Up Care for Children Prescribed ADHD Medication
- Follow-Up After Hospitalization for Mental Illness
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Diabetes Monitoring for People With Diabetes and Schizophrenia
- Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Annual Monitoring for Patients on Persistent Medications
- Medication Reconciliation Post-Discharge
- Potentially Harmful Drug-Disease Interactions in the Elderly
- Use of High-Risk Medications in the Elderly
- Medicare Health Outcomes Survey
- Fall Risk Management
- Management of Urinary Incontinence in Older Adults
- Osteoporosis Testing in Older Women
- Physical Activity in Older Adults
- Aspirin Use and Discussion
- Flu Vaccinations for Adults Ages 18-64
- Flu Vaccinations for Adults Ages 65 and Older
- Medical Assistance With Smoking and Tobacco Use Cessation
- Pneumococcal Vaccination Status for Older Adults
- Adults' Access to Preventive/ Ambulatory Health Services
- Children's and Adolescents' Access to Primary Care Practitioners
- Annual Dental Visit
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Prenatal and Postpartum Care
- Call Answer Timeliness
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- CAHPS Health Plan Survey 5.0H, Adult Version
- CAHPS Health Plan Survey 5.0H, Child Version
- Children With Chronic Conditions
- Frequency of Ongoing Prenatal Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Adolescent Well-Care Visits
- Frequency of Selected Procedures
- Ambulatory Care
- Inpatient Utilization—General Hospital/ Acute Care
- Identification of Alcohol and Other Drug Services

- Mental Health Utilization
- Antibiotic Utilization
- Plan All-Cause Readmissions
- Relative Resource Use for People With Diabetes
- Relative Resource Use for People With Cardiovascular Conditions
- Relative Resource Use for People With Hypertension
- Relative Resource Use for People With COPD
- Relative Resource Use for People With Asthma
- Board Certification
- Enrollment by Product Line
- Enrollment by State
- Language Diversity of Membership
- Race/Ethnicity Diversity of Membership
- Weeks of Pregnancy at Time of Enrollment
- Total Membership

Medica will utilize CAHPS in Iowa to capture accurate and reliable information from consumers relating to their health care experience. The survey includes a set of core questions that associate key areas of care and services. Medica uses CAHPS and HEDIS survey results to make informed decisions to meet regulatory standards. Medica also uses survey results for internal quality improvement purposes. The results from HEDIS and CAHPS help drive quality initiatives and assist in decision making.

Our experience in establishing strategies for improving quality indicators spans across many years. Our team members have formed Quality Committees from the ground up by recruiting members from all levels of staff. We have experience in educating committee members on quality management, continuous process improvement tools and quality initiatives. Our experience includes team members that have served as Co-Chair(s) on QM Committees and have memberships to national quality associations such as AHRQ (Agency for Healthcare Research and Quality), NAHQ (National Association for Healthcare Quality) and AzAHQ (Association for Healthcare Quality of Arizona). Our experience ranges from ambulatory settings to in-patient care to behavioral health. Through this experience we have worked with CMS quality indicators, core measures, meaningful use and patient safety indicators (PSI), along with HRSA and HAB. We have managed and lead monthly and quarterly QM meetings and evaluated quality processes and system standards to ensure compliance with organizational standards and government regulatory requirements.

For 2015, after thorough analysis, Medica has identified the following measures to focus quality improvement efforts:

1. Antidepressant Medication Management - 6 month continuation
2. Avoidance of Antibiotics in Adults with Bronchitis
3. Breast Cancer Screening
4. Chlamydia Screening in Women
5. Colorectal Cancer Screening
6. Diabetes – HgbA1c Control (<8.0%)
7. Diabetes - Nephropathy Screening
8. Emergency Room Utilization
9. High Risk Medication
10. Hospital Admission Rate
11. Hospital Readmission Rate

12. Osteoporosis Management in Women with a Fracture
13. Postpartum Care
14. Well Child Visits in the First 15 Months of Life (*6+ visits*)
15. Care for Older Adults
    a. Advanced Directive (AD)
    b. Medication Review (MR)
    c. Functional Status (FS)
    d. Pain Screening (PS)
16. Follow-up for Children Prescribed ADHD Medication – Cont. & Maint.
17. Getting Needed Care – Composite
18. Medication Therapy Management
19. Reducing the Risk of Falling

4. Describe your experience and strategies in working with network providers to improve outcomes.

Our team members have a wide range of experience working with network providers across all areas of healthcare including behavioral health and LTSS. They have worked in both physical and behavioral outpatient and inpatient settings. We have team members that work with network providers on a daily basis and also work very closely with medical directors, nursing directors, and chief nursing officers to implement process improvement and achieve better-quality outcomes. We believe network provider buy-in is crucial for implementing successful innovative strategies. The trusting relationships we build with providers across all areas of healthcare have been key to our successful outcomes. Our goal is to not make more work for providers but to identify areas of improvement and implement a model that is sustainable.

Medica collaborates with its provider network in several ways to support improved quality at the care delivery site: for example, by working directly with providers on targeted projects to improve clinical outcomes. Other examples that can be leveraged within Iowa include, but are not limited to:

- **Provider College**: Operated by Medica's Provider Commerce department, Provider College offers continuing education for practitioners and office staff. For example, Provider College offers all network providers a comprehensive "train-the-trainer" kit on health literacy and cultural competency. Other educational opportunities, on topics ranging from coding and billing to Medica health plan products, are offered on an ongoing basis.
- **Clinical Review**: Clinical reviewers from the Quality Improvement team gather data from clinics that achieve the best results in certain areas, including patient compliance with treatment recommendations. The team co**Network Partnerles this information and shares it with the provider network through the "Connections" provider newsletter.
    - **Pay-For-Performance Program:** Medica offers its providers a pay-for-performance program that provides financial rewards to providers driving care improvements and achieving evidence-based outcomes. The incentives correspond to clinical priorities for the health plan that have reliable measures within providers' control.
- **Institute for Clinical Systems Improvement (ICSI):** Medica has been a principal ICSI sponsor since 2001.
- **Medical Home/Clinic-Based Chronic Care Management:** Medica works closely with its network providers to support the "medical home" model, in which-patients' care is coordinated through a primary care site and chronic conditions are monitored and managed. Medica supports medical homes

in ACO contractual relationships by supplying information regarding member utilization inside and outside the ACO to promote care continuity and chronic condition management.

- **Total Cost of Care Contracts**: Medica works with providers to better manage quality and cost through risk-based contracts whereby providers are measured on their performance to specific quality metrics and their overall PMPM cost trends.
- **Accountable Care Organizations**: Medica contracts with providers to create accountable care organizations (ACOs). Medica and the ACOs share risk for member claims expense and work to remove duplicate care management services across the continuum of care.

5. Outline the proposed composition of your Quality Management and Improvement Committee, and demonstrate how the composition is interdisciplinary and appropriately represented to support the goals and objectives of the Quality Management and Improvement Committee.

Medica is committed to using an interdisciplinary team to support the goals and objectives of the QM Committee. Medica understands the need for quality improvement initiatives to expand over many departments and the importance of quality being cross-functional. The infrastructure is established to serve as an interface with the overall quality management process and aligns with the goals of the quality management program. The involvement of the QI Committee is to pursue efforts that result in the provisions of professionally acceptable services through timely access to care, facilitation of best practices, appropriate resource utilization and improved patient and community health outcomes.

Membership of the QM/QI committee is interdisciplinary and represents multiple key areas of the Medica infrastructure capable of fulfilling the vision. Other key stakeholders deemed necessary are also involved as indicated.

The QM/QI members allow the committee to provide leadership to establish quality management processes that include effective systems to reviews, evaluate and monitor the quality of member services and care. It also provides a forum for interdisciplinary communication and problem solving as part of the quality process. The success of the QM/QI program requires active involvement of all levels of leaderships: administrative, clinical and programmatic. Organizational leaders have the authority and vision to create a culture ready to accept change and spearhead improvements. Active involvement of members includes participation on quality initiatives and project teams, contributing ideas for quality improvement projects and allocating sufficient resources to ensure the success of the QM program.

Our current QM/QI Committee Structure is shown below. The Committee is comprised of high-level staff and leadership across the organization. We will leverage our current structure and cross-functional oversight model to build a robust quality program in Iowa

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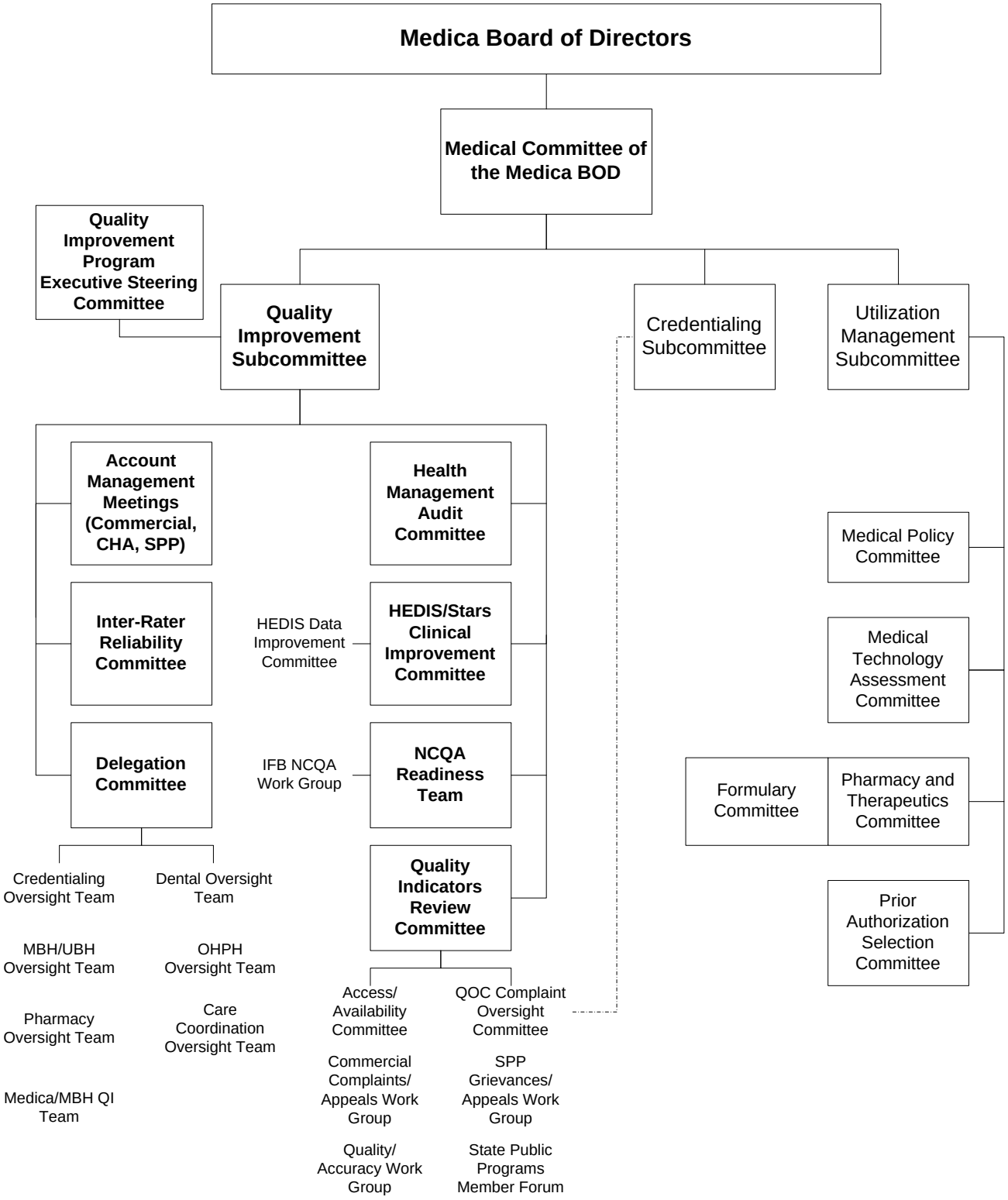
QUALITY COMMITTEE REPORTING STRUCTURE



Medical Committee/Medica Board of Directors

The Medica Board of Directors has designated its Medical Committee as the company's "quality assurance entity". The Medical Committee reports quality improvement activities to the full Medica Board of Directors on a quarterly basis. Reporting to the Medical Committee are the Quality Improvement Subcommittee (QIS), Credentialing Subcommittee and the Utilization Management Subcommittee.

Both the Medical Committee and the Board of Directors review Medica's quality improvement program, with the Board of Directors retaining final approval authority. The Medical Committee and the Board of Directors review and approve the Quality Improvement Program Description, Work Plan and Program Evaluation on an annual basis.

Quality Improvement Program Executive Steering Committee

The Quality Program Executive Steering Committee (QUEST) is the overall management committee for quality improvement at Medica. The Iowa Medical Director will be included in this Committee. QUEST has responsibility to develop an enterprise-wide definition of, and strategy for, quality improvement. Oversight and strategy direction includes, but is not limited to: clinical quality; quality standards and measures in network management contracting; risk adjustment strategies; HEDIS/Stars; and NCQA accreditation. QUEST communicates Medica's overall quality strategy through the Quality Improvement Subcommittee (QIS), which oversees and monitors execution through the various subcommittees that report into QIS. QUEST also approves Medica's annual quality priorities.

Quality Improvement Subcommittee

The Quality Improvement Subcommittee directs, oversees and evaluates the Medica quality improvement program, with the goal of promoting and continually improving clinical quality, service quality, provider quality and patient safety. The Subcommittee's role is to:

- Evaluate and recommend action on program and committee reports, performance data and other inputs.
- Review subgroups' analysis of clinical quality, service quality, provider quality and patient safety activities and results.
- Recommend policy decisions targeted toward highest-quality clinical care and service delivery; identify priorities for action; follow up on progress.
- Review and approve program reports and documents, including annual Quality Improvement Program Description, Program Evaluation and Work Plan.
- Review and approve quality improvement program policies.
- Send a designated Subcommittee officer member to the Medical Committee of the Medica Health Plans Board of Directors at least quarterly to report on subcommittee activities and to secure approval of the subcommittee's reports and actions.
- Send a designated Subcommittee officer member to the Medical Committee, and to the Medica Health Plans Board of Directors, annually to present Quality Improvement Program Description, Program Evaluation and Work Plan for review and approval.

QIS is scheduled to meet bimonthly, but must meet not less than four times per year. Voting members include:

- Senior Manager, Health Management Quality Improvement (chair)

- Vice President, Population Health (physician member, BOD and Medical Committee designee)
- Senior Medical Director (physician member)
- Medical Director (physician member)
- Senior Director, Finance, Government Programs/IFB (ad hoc)
- Senior Director, Healthcare Economics
- Director, Care Coordination/Dual Eligible Programs
- Director, Care Management Development, IFB
- Director, Case Management Integration
- Director, Community Health Initiatives, State Public Programs
- Director, Health Management Innovation and Design
- Director, Marketing and Strategy
- Director, Pharmacy
- Manager, Regulatory Quality, Government Programs
- Program Manager, Medicare Quality
- Program Manager, Quality Improvement, Operations

Representatives from the Medica Board of Directors, including an employer representative, if designated as a consumer director of the Medica Board, may also be included. The committee chair is designated by the Medical Committee of the Board of Directors to advise, oversee and actively participate in the implementation of QI plan functions. QIS is constituted as a peer review body, receiving and reviewing aggregate data on all aspects of clinical and service quality. QIS maintains signed and dated contemporaneous meeting minutes.

Credentialing Subcommittee

The Credentialing Subcommittee reports directly to the Medical Committee of the Medica Board of Directors. Chaired by the Senior Medical Director, the Subcommittee reviews Medica network providers' credentialing and recredentialing applications. It also reviews and approves oversight of delegated credentialing. As a peer review body, the Credentialing Subcommittee performs individual case reviews in response to quality of care concerns. The Credentialing Subcommittee retains final authority to suspend or revoke the network participation status of any provider, credentialed by Medica or its delegates, who does not meet Medica's performance standards. The Credentialing Subcommittee is described in greater detail in Medica's annual Credentialing Plan.

Utilization Management Subcommittee

The Utilization Management Subcommittee also reports directly to the Medical Committee of the Medica Board of Directors. Chaired by the Director of Utilization Management and Policy, the Subcommittee provides strategic clinical direction to and oversight of the care management program and is responsible for assuring that the care management program meets all necessary quality, regulatory and organizational requirements. The Subcommittee also addresses the potential for waste in the health care system by monitoring utilization patterns for inappropriate, unnecessary or duplicative services. Committees and work groups reporting to the Utilization Management Subcommittee include:

- Medical Policy Committee
- Medical Technology Assessment Committee
- Pharmacy and Therapeutics Committee/Formulary Committee

- Prior Authorization Selection Committee

Institute for Clinical Systems Improvement (ICSI)

The quality improvement program is further supported by Medica's partnership with the Institute for Clinical Systems Improvement (ICSI). ICSI's mission is to serve as "an objective voice dedicated to cha**Network Partneroning health care quality and to helping its members identify and accelerate the implementation of best clinical practices for their patients." Medica became a principal ICSI sponsor in March 2001. Medica Health Management staff participates in ICSI committees and task forces. Medica network physicians participate on ICSI guideline development work groups.

ICSI's evidence-based clinical guidelines, supported by health plans, hospitals and clinic systems, have become the standard set of practice guidelines across Minnesota and adjoining states.

In September 2002, Medica began using 56 ICSI-developed clinical guidelines as part of its care management program. Medica conducts consistency reviews to ensure that utilization management policies, coverage policies and clinical initiatives are consistent with the guidelines.

Staff from departments throughout Medica participates in various ICSI activities dedicated to improving the health of all Minnesotans and could be leveraged for Iowa. Focus areas include, but are not limited to: diabetes and heart failure registries; high-tech radiologic imaging; and depression screening and treatment.

10.2 State Quality Initiatives

1. Describe how you propose to work with the Healthiest State Initiative.

Medica stands ready to support Iowa's quest to improve its status as 16th in the nation when it comes to physical, mental and emotional health according to the 2014 Gallup-Healthways Well-Being index®.

We will promote the Healthiest State initiative by posting the activity calendar on our external and internal websites; encouraging our employees, members and provider network to participate in Healthiest State activities; and, by facilitating access to healthy eating at our offices and sites. In addition, Medica offers members who express a desire to quit smoking with a tobacco cessation program designed to help them reach their goals. This program aligns with one of the five focus areas of the Healthiest State Initiative.

Also, Medica will endorse and sponsor events that promote Healthiest State initiatives, such as the Healthiest State Walk. As a company that promotes the health of its employees, members and providers we will also send key staff to the Healthiest State conference.

2. Describe how you propose to work with the Mental Health and Disability Services Redesign.

Medica understands that all 15 regions under the state's Mental Health and Disability Services Redesign Plan began operating as of July 1, 2014. We applaud the state's accomplishment in having legislators, stakeholders and citizens working together to offer locally-administered services which meet the statewide standards of care. Medica agrees with the System Values and Guiding Principles of the Division of Mental Health and Disability Services and will promote consumer and family driven participation in the service delivery model. We will also provide a network of community based, high quality and results oriented services that are both accessible and effective.

We are aware Mental Health and Disability Services Redesign means that Services for Iowans under Redesign must be offered in the least restrictive setting possible. This aligns with the U.S. Supreme Court's landmark Olmstead decision in 1999 which said people of any age with disabilities should receive supports in the most integrated setting consistent with their needs. However, we also understand that this means transition for a vulnerable population. Therefore, we will draw upon our experience in working with local and regional entities that are responsible to ensure physical, behavioral and specialty services for their members. Key to our successful programs in MN, ND, SD and WI is our commitment to collaboration and collegial problem-solving at the local and regional level.

Jane Welter-Nolan, the Clinical Liaison at Medica in MN, has served as a consistent and active member of the state's 7 county Metro Children's' Crisis Services workgroup for approximately 7 years. Jane also, recently joined the Chisago County, MN Children's Mental Health Council Meetings.

In Iowa, we will partake in workgroups, taskforces and committees across the state. We look forward to participating in and contributing to state, regional and local meetings regarding Mental Health and Disability Services Design. During the preparation of this response, we have met with the Iowa Consortium for Mental Health to garner an understanding of the regional strategies necessary to afford successful redesign of Mental Health and Disability Services. Prior to award, not only will we continue to work with the Consortium, we will extend our outreach efforts, meeting with key Iowa stakeholders such as Kristie Oliver, the Executive Director of the Coalition for Family & Children's Services in Iowa and David Van Ningen, CEO of Hope Haven which is the largest provider of Intellectual Disability services in the state. Through meetings with local and regional

providers and collaboration with DHS' Division of Mental Health and Disability Services we will develop essential strategies, such as local care coordination and regionally assigned Provider Network Liaisons that are necessary to work with and support the Mental Health and Disability Services Redesign.

3. Propose strategies to incorporate the Value Index Score (VIS) as a tool to drive system transformation, and other strategies to support the State Innovation Model (SIM).

Medica is interested in collaborating with the state in identifying opportunities for using the VIS data in our efforts to improve the quality of care provided to our members, and would welcome the opportunity to collectively evaluate the quality of care provided to members in Iowa. Medica has experience working with ACO's and Care Systems in Minnesota to improve quality outcomes. For example, Medica supports medical homes in ACO contractual relationships by supplying information regarding member utilization inside and outside the ACO to promote care continuity and chronic condition management. This includes Provider Quality Metrics Reports, which gives the provider information on how they are performing on several priority quality areas. In addition, Medica offers its providers a pay-for-performance program that provides financial rewards to providers driving care improvements and achieving evidence-based outcomes. Medica will explore implementation of similar provider quality reporting with our network providers in Iowa.

Medica is interested in collaborating with the state to ensure that our alternative payment arrangements align with the State Innovation Model work already underway in Iowa. In addition, Medica will utilize the Value Index Score data in our work evaluating the quality of care being provided to our members.

At the request of Iowa DHS, Medica will participate in the State Innovation Model (SIM) testing grant phase that will enable the state to determine whether new payment and service delivery models will produce superior results when implemented in the context of a state-sponsored State Health Care Innovation Plan. We will also actively participate in SIM learning sessions and collaborate with other participating plans. Our goals will be to improve the health of Iowans enrolled in our plan and Iowan citizens in general. Through our participation in the SIM, Medica is committed to improve health care and lower the cost of care through a sustainable model of multi-payer payment and delivery reform. Medica's experience and dedication to delivering the right care at the right time in the right setting will enhance our success.

CURRENT SIM PARTICIPATION

In February 2013 the Center for Medicare and Medicaid Innovation (CMMI) awarded Minnesota a State Innovation Model (SIM) testing grant of over $45 million to use across a three-year period ending October 2016 to test new ways of delivering and paying for health care using the Minnesota Accountable Health Model framework. The goal of this model is to improve health in communities, provide better care, and lower health care costs.

Christine Reiten, the Product Administration and Compliance Director for State Public Programs at Medica, was appoint to the Minnesota Accountable Health Model Multi-Payer Alignment Task Force to assist in the development and implementation of strategies to build alignment across payers. The goal of the Multi-Payer Alignment Task Force as follows:

- Identification of barriers to alignment of Accountable Care Organization (ACO) payment methods and integration of services across the continuum of care, and strategies to address barriers
- Development of common performance measures on cost, quality and patient experience for ACOs

- Standardization of content and format of data analytics feeds and support to providers
- Alignment of approaches to risk adjustment, attribution or assignment, financial models and ACO contract requirements

COMPREHENSIVE QUALITY STRATEGY ADVISORY COMMITTEE

Christine Reiten, the Product Administration and Compliance Director for State Public Programs at Medica, was selected to the Comprehensive Quality Strategy Advisory Committee by the Minnesota Department of Human Services. The Committee provides input to the ongoing developments of the state's ongoing developments of the State's continuous quality improvement strategy that integrates all aspects of quality improvement programs, processes, and requirements across the state's Medicaid program, including by not limited to: fee-for-service populations, Reform 2020, Prepaid Medical Assistance Plus (PMAP+), and managed long term services and supports, and managed care and 1915(c) HCBS waivers.

4. Describe your experience in supporting a State authority in meeting the requirements of the Department of Health and Human Services Substance Abuse and Mental Health Services Administration Substance Abuse Prevention and Treatment Block Grant.

Medica team members have extensive experience working with behavioral and mental health services. Our team members have worked on substance abuse prevention and treatment services expansion projects and grants sponsored by SAMHSA. Through this experience, we have worked on initiatives to promote prevention and treatment of substance abuse and promote public health by planning, implementing and evaluating activities and improvement projects relating to substance abuse and mental health.

We have also worked on initiatives that measure the effectiveness of Substance Abuse and Mental Health Service projects through ongoing data analysis and collaborative efforts among state authorities.

5. Submit a project plan describing your specific approach and timetable for addressing this section.

INTRODUCTION

Medica will approach these quality initiatives using Plan-Do-Study-Act (PDSA) and Project Management Institute (PMI) principles. As stated earlier in Section 10.1, our Quality Management and Improvement Programs utilizes the Plan-Do-Study-Act cycle for continuous process improvement and for effective planning, oversight and taking action to remedy issues and emerging issues found during implementation and monitoring of our initiative/efforts.

APPROACH

Medica uses its Business Project Management Process to organize projects that use the PDSA process during implementation and monitoring. Our project management method includes five phases (Initiation, Plan, Implement the Plan, Monitor the Plan and Close) and includes tools for each phase. We base our project method on the best practices from the Project Management Institute (PMI), the leading global association for the project management professional. The more complex the project, the more structured and formal the use of our project management process.

The brief descriptions of the five phases are stated below:

1. Initiation – Determine feasibility, scope, objectives; assign project owner and manager; create project charter
2. Plan – Develop plan to accomplish need; define activities, milestone, detailed tasks and required resources; initiate project plan; and gain commitment and support for plan
3. Implement the Plan – Coordinate people and resources to care out the plan; establish and work with project team to build detailed task; and share planning documentation
4. Monitor the Plan – Ensure objectives are met by monitoring progress; take corrective action as needed, track progress; and communicate with stakeholders
5. Close – Bring project to an orderly end; hand off to business owner; conduct lessons learned interviews; and archive files

Medica will embrace Iowa's quality initiatives. We understand each initiative (Healthiest State, Mental Health & Disability Redesign, etc.) are at various stages of project management and implementation. Medica will quickly assess the current phase of each initiative and establish its leadership and/or participant role as directed by Iowa. For well-established initiatives, Medica will use the PDSA process to continuously evaluate, monitor and improve current implementation activities. For less established initiatives, Medica will follow the five phases of project management.

Medica has a wealth of knowledge and experience in successfully completing quality initiatives. During the initiation phase, we will utilize our available studies, outcomes, and achievements addressing the socio-economic factors influencing the health and wellbeing of members enrolled in governmental/state programs. Several examples of our expertise and knowledge include:

- Medica Pharmacy Services recognized members, especially those age 65 and older, can experience adverse drug effects and drug interaction when taking prescribed medications. Medica implemented a High Risk Medications initiative to have members use safer alternatives and successful reduced by 33% the rate of HRM prescription per 100 members between 2012 and 2013.
- Medica established a three-year initiative to increase colorectal cancer screening in race and ethnic minority populations in collaboration with several MN health plans. The objective of the study was to increase the CRC screening rate of disparate populations in targeted clinics through clinic specific interventions and "close the gap." By the end of two years, disparate populations screening rate increase from 43% to 59%, moving closer to the 68% MN statewide screening rate.
- The Medica Research Institute recently completed a study on "Implementation of Care Management in Primary Care: Care Managers and Program Structure Make a Difference." The study concluded that Care management in primary care can be effective in helping patients with chronic disease improve their health status, however, primary care practices are often challenged with implementation. Further, there are different ways to structure care management that may make implementation more or less successful.

Medica continues to collaborate with other health plans, governments, and health organizations to identify best practices to improve a specific population's health and overcome barriers such as language, ethnicity, culture, income, education, housing, and family/community support. Medica believes addressing barriers can improve member health and outcomes, especially in the socio-economic disparate populations. We look forward to collaborating in similar ways with our partners in Iowa.

Timetable

Medica established a high-level timetable for the state's major Quality Initiatives for 6 quarters, the 18 months from July 2015 through December 2016. Medica developed this initial timetable based on our preliminary discussions with Iowa leaders and stakeholders during the preparation of this RFP.

HIGH-LEVEL PROJECT MANAGEMENT TIMETABLE

State Quality Initiatives

July 2015 through December 2016

Initiative	July –Sept 2015	Oct – Dec 2015	Jan – Mar 2016	Apr – June 2016	July – Sept 2016	Oct – Dec 2016
Healthiest State Initiative - 5 Priorities	• Identify key Iowa stakeholders • Identify our role in current activities with leadership and project stakeholders • Explore new opportunities to align with state's implementation, leveraging our best practices • Identify existing Medica benefits and programs that align with the initiative	• Participate in State Walk • Meet with Iowa stakeholders to identify collaborative opportunities • Explore opportunities for Member outreach to support the 5 priorities	• Begin development of member outreach materials • Obtain appropriate approval of finalized materials • Develop plan for implementation • Review Healthiest State Activities and explore possible collaborative opportunities in 2016	• Continue implementation member outreach • Monitor effectiveness and adjust priorities as needed • Check-in with leadership and project stakeholders • Explore role in 2016 Healthiest State Walk • Continue implementation of new projects	• Continue implementation of current and new projects • Monitor effectiveness and adjust priorities as needed • Close each activity and document as needed	• Continue implementation of current and new • Monitor effectiveness and adjust • Close each activity and document as needed
Mental Health & Disability Services Redesign	• Follow-up on initial discussions with stakeholders • Continue review of state's accomplishments with stakeholders • Continue development of Medica's understanding of the redesigned Iowa service delivery model and • Review national and regional best practices including Medica's successes with vulnerable populations, transition, and integrated care	• Participate in workgroups, taskforces and committees across the state, and met again with Iowa Consortium for Metal Health • Identify possible strategies to support Iowa's service delivery model	• Meet with local and regional providers to analyze identified strategies • Establish measurable goals (lead and lag) • Establish quarterly meeting to facilitate collaboration	• Monitor progress towards goal • Maintain quarterly meetings	• Monitor progress towards goal and adjust • Maintain quarterly meetings	• Monitor progress towards goal and adjust • Maintain quarterly meetings

Initiative	July –Sept 2015	Oct – Dec 2015	Jan – Mar 2016	Apr – June 2016	July – Sept 2016	Oct – Dec 2016
Strategies for VIS and SIM	• Initiate our continued understanding of the SIM Model and VIS tool, including data elements and methodologies • Review national and regional best practices plus leverage our ACO and pay-for -performance experiences • Identify and meet with existing Iowa ACO's	• Plan for and create new or modified methodologies , systems, and reports • Identify and reach out to existing IOWA ACOs regarding quality metrics and performance • Establish workflow to complete, analyze, distribute, and submit timely data/report • Participate in SIM learning sessions	• Test methodologies and reports with provider stakeholders • Obtain Iowa leadership's approval and support of methodologies, systems, and reports • Refine workflow and product reports	• Implement plan • Utilize existing QI structure to review VIS score and interaction with stakeholders • Meet with to share reports with providers, leaders, and stakeholders	• Monitor progress of plan • Participate and share learning	• Meet with providers to share reports with leaders and stakeholders • Monitor progress and measure quality improvement and document • Evaluate and discuss results of alternative payment arrangements (models) with Iowa leadership
DHHS Substance Abuse Block Grant	• Schedule follow-up meetings and align work with existing activities and stakeholders • Further investigate current funding sources, payment methods, eligibility criteria, and processes	• Evaluate existing funding, payment methods, criteria and processes and • Identify alternatives, modifications, and/or improvement opportunities • Conduct conversations with stakeholders	• Recommend additional improvement opportunities • Obtain Iowa leadership and stakeholder insight	• Obtain Iowa leadership approval and stakeholder support • Implement additional initiatives	• Promote public health initiative	• Monitor progress and adjust • Measure quality improvement and document

CLOSING

Upon award, Medica will amend this high-level project timetable and develop detailed project plans for the initiatives to address the membership's needs, ensure compliance with Iowa requirements and to obtain approval from Iowa leadership. In addition, Medica will comply fully with the State of Iowa External Quality Review Organization (EQRO) process, and will present findings to the Medica Quality Improvement Subcommittee, identify improvements and implement performance improvement projects as indicated in the EQRO process.

10.3 Incentive Programs

1. Describe your proposed provider incentive programs.

Medica incents provider to improve Quality through a Pay for Performance program and through Total Cost of Care Contracts. Medica's Quality Executive Steering Committee, Quality Improvement Subcommittee and Medical Committee of the Board approve the Quality Priorities on a yearly basis. Targets are set based on NCQA's 90th percentile and/or CMS's 5 Star cut points.

Medica's Pay for Performance (P4P) initiative is for primary care clinics that see the majority of our members on Medical Assistance. Clinics that meet certain thresholds for services billed in a given year qualify to participate in that year. P4P supports the clinics with improvements in quality metrics; they earn financial rewards above and beyond their billable revenue by attaining their goals for the metrics. In 2014, our P4P metrics were improved rates for EPSDT screenings, emergency department utilization, hospital admissions, and 30-day readmissions. Each year, depending on Medica's financial performance in State Public Programs, a quality pool is established. This is divided among the qualifying clinics commensurate with the number of metrics for which they achieved their goals.

The table below provides an example of Medica's provider incentive model for Birth – 20 years screening completion:

PROVIDER INCENTIVES FOR SCREENINGS		
AGE	**DESCRIPTION**	**INCENTIVE**
Birth – 14 months	Six recommended visits	10 per visit $15 additional if all 6 visits completed
15 months – 20 years	Annual C & TC Screening	$25

2. Describe your proposed member incentive programs.

My Health Rewards by MedicaSM is an incentive program that encourages members receiving Medical Assistance to obtain recommended pregnancy care, cancer screenings and EPSDT visits. We will review statewide health metrics to determine which incentives are appropriate for Iowa members and providers.

Medica prides itself in working with key stakeholders: providers, public health, members, community agencies, schools and the state health department to solicit input and feedback. Feedback from counties led to an increase in the incentive amount for children ages 15 months to 20 years who receive EPSDT services from $10 to $25. Medica also expanded the age range for member to be eligible for a car safety seat, from up to 2 years to up to 8 years of age. In 2014, members earned nearly $175,000 in gift card incentives through this program. For over 14 years, this comprehensive incentive program has encouraged over 30,000 unique/individual members to receive well- child visits (Child and Teen Checkups) for ages 0-20 years.

In 2014, Medica staff met with more than 30 counties throughout Medica's Minnesota service area to garner feedback on what is working well, areas for improvement and our member incentive program

10.4 Critical Incidents

1. Describe your critical incident reporting and management system.

Medica has a posted "Adverse Health Care Events" reimbursement policy on Medica.com. This policy, which is based upon MN Statute, addresses adverse health care events, (also known as never events) and is applicable to hospitals, outpatient surgical centers and freestanding ambulatory surgery centers.

According to the policy, "Facilities are prohibited from billing members for services associated with an Adverse Health Care Event and Medica will not reimburse Facilities for services associated with an Adverse Health Care Event. If an Adverse Health Care Event involving a Medica member occurs, Facilities are required to submit an Adverse Health Care Event Identification Form to Medica."

The form is an attachment within the posted policy, and it instructs providers to either fax or mail the completed form to Medica's Payment Intent department, where an Auditor will review the member's claim history to ensure that Medica has not paid for an adverse health care event. Once the Auditor has completed the claim review, the form is then forwarded to the Quality Improvement Department to initiate a quality case review.

The Payment Intent department also runs quarterly reports based upon the policy criteria to identify potential unreported adverse events.

2. Describe strategies for training staff and network providers on critical incident policies and procedures.

Internal Staff: The Payment Intent department has a written standard operating procedure describing the quarterly audit process. The Adverse Health Care Events reimbursement policy is also reviewed annually by an internal reimbursement policy review committee.

Network Providers: The policy is maintained on Medica.com and has been communicated to providers through the provider newsletter, Connections.

3. Describe processes for implementing corrective action when a provider is out of compliance with critical incident reporting.

The Payment Intent department runs quarterly reports based upon the policy criteria to identify potential unreported adverse events. The report is analyzed and if a potential adverse event is identified the auditor requests and reviews medical records to determine if an adverse event actually occurred. If an adverse event appears to have occurred the auditor contacts the facility to request a copy of the itemized bill and then meets with a Medical Director to review the case and determine next steps. If the Medical Director determines that the criteria of the policy have been met and charges are re-coverable, a claim adjustment is requested. The case is then forwarded to the Quality Improvement Department by filling out a Quality of Care Case Identification Form.

4. **Describe how critical incidents will be identified, tracked and reviewed and how data gathered will be used to reduce the occurrence of critical incidents and improve the quality of care delivered to members.**

A well-structure internal critical incident form and review plan is essential in managing critical incidents and the organizations quality management system(s). The plan provides direction in communicating and monitoring critical incidents. Through internal audits, relevant information and data will be gathered through utilization of the corrective action plans.

Once an incident has been identified as meeting the criteria for a Major Incident, assure that the health and safety of all individuals (member, staff and visitors) is addressed immediately.

The Critical Incident Report, Form 470-4698 consists of four distinct parts. Part 1, Initial Report, must be completed and submitted by the end of the next calendar day following the incident.

Best practices recommend that an incident report be completed and submitted up to seven calendar days following an incident. If sections 2, 3 and 4 cannot be completed because necessary investigative activities are not yet complete and / or resolution activities have not been implemented, then the incident resolution should be updated and completed within 30 calendar days following the incident.

The Critical Incident Report, Form 470-4698 can be used to record multiple incident types if they relate to the same overall incident. If there are two distinctly separate incidents, two forms must be completed. The observer of the incident (or the staff involved) completes the Critical Incident Report, Form 470-4698 for any situation that meets the definition for a Major Incident. If the incident was not observed, the first person to become aware of the incident (or the first staff to become aware) completes the report. When there is more than one member involved in the incident, a report will be completed for each member. The report for each member will focus on the actions of that person and the steps taken by the provider on behalf of that person.

INCIDENT REPORTING

These incident reporting standards apply only to providers who have direct contact with members. The standards define “major” and “minor” incidents, and set procedures and prescribe the content of incident reports.

MINOR INCIDENTS

Means an occurrence involving a member during service provision that is not a major incident and that:

- Results in the application of basic first aid;
- Results in bruising;
- Results in seizure activity;
  Results in injury to self, to others, or to property; or
- Constitutes a prescription medication error.

Reporting Procedure for Minor Incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member’s file.

MAJOR INCIDENTS

Means an occurrence involving a member during service provision that:

- Results in a physical injury to or by the member that requires a physician’s treatment or admission to a hospital;

- Results in the death of any person;
- Requires emergency mental health treatment for the member;
- Requires the intervention of law enforcement;
- Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
- Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in numbered paragraph "1," "2," or "3"; or
- Involves a member's location being unknown by provider staff who are assigned responsibility for oversight.

Reporting Procedure for Major Incidents
When a major incident occurs or a staff member becomes aware of a major incident:

- The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
- The staff member's supervisor.
- The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
- The member's case manager.
- By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall report as much information as is known about the incident. The provider will report to the department's bureau of long-term care either:
- By direct data entry into the Iowa Medicaid Provider Access System, or
- By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.
- The following information shall be reported:
- The name of the member involved.
- The date and time the incident occurred.
- A description of the incident.

Also included in the process are opportunities for improvement. Opportunities for improvement determine the potential causes and root cause of the incident. This information will be reviewed with key stakeholders and a preventable action plan will be developed. The action plan will then be reviewed for its effectiveness.

10.5 Provider Preventable Conditions

1. Describe how you will ensure payment is not made for provider preventable conditions.

Medica will implement a policy for nonpayment for provider preventable conditions and health care-acquired conditions in accordance with Section 2702 of the Patient Protection and Affordable Care Act of 2010. The policy will incorporate a systematic and continuous approach based on epidemiologic principles, evidence-based research, guidelines and recommendations from nationally recognized organizations and pertinent federal, state, and local regulations. An assessment of the risk for infection, contamination, and exposure will be conducted annually through a systematic process that evaluates the probability of occurrence, impact of risk, and preparedness.

Medica and the State of Iowa will work collaboratively to promote a healthy and safe environment by identifying and reducing the risk of infection among patients, staff and visitors. Collaborative responsibilities include (but are not limited to): policy and procedure development with department managers, monitoring of processes, performance improvement activities and continuing education to providers and other staff members. The policy will correspond with CMS regulatory requirements and guidelines.

The Preventable Conditions and Health-Care Acquired Conditions comprise of infections and events that include the following:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III & IV Pressure Ulcers
- Falls and Trauma; including fractures, dislocations, intracranial injuries, crushing injuries, burn and electric shock
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Vascular Catheter-Associated Infection
- Manifestations of Poor Glycemic Control: Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity.
- Coronary Artery Bypass Graft (CABG)
- Bariatric Surgery-Laparoscopic Gastric Bypass, Gastroenterostomy, laparoscopic Gastric Restrictive Surgery
- Orthopedic Procedures – Spine, Neck, Shoulder, Elbow
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following a hip or knee replacement (with pediatric and obstetric exceptions)
- Wrong Surgical or other invasive procedure performed on patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

SECTION 11: UTILIZATION MANAGEMENT

Please explain how you propose to execute Section 11 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Medica, a non-profit health plan, has the highest accreditation status, Excellent, from the National Committee for Quality Assurance (NCQA) for its Minnesota Medicaid HMO Plans and commercial fully-insured health plans in Minnesota, Wisconsin, North Dakota and South Dakota. As such, our Medica Utilization Management (UM) program will adhere to NCQA UM standards and will meet the goals, objectives and requirements of the Iowa High Quality Healthcare Initiative.

11.1: Utilization Management Programs

1. **Describe in detail your utilization management program, including how you will operate and maintain the program.**

GOVERNANCE, OVERSIGHT AND MANAGEMENT

Medica's Health Management Department is responsible for our Utilization Management (UM) Program. The Health Management Department receives its authority for Utilization Management from the Medica Board of Directors. Governance oversight of utilization management functions is the responsibility of the Utilization Management Subcommittee, a committee reporting to the Medical Committee of the Board of Directors.

The Medical Committee will delegate overall accountability for the administration of the utilization management programs to the Senior Medical Director who will be an Iowa-licensed physician in good standing with the Iowa Board of Medicine and experienced in the administration of utilization management programs and clinical management. Our health management programs are contiguous; therefore our Senior Medical Director is responsible for all our clinical functions, including disease management, care coordination, clinical guideline development and oversight.

The Senior Medical Director is a physician with an unrestricted license who, in partnership with the Senior Vice President and Chief Clinical and Innovation Officer, is accountable for administration of the utilization management programs described in this document. Day-to-day operations for utilization management are administered by leaders and individual contributors, many who are licensed clinicians in director, manager, supervisor, and member support roles.

GOALS AND OBJECTIVES

Medica's Utilization Management (UM) Program applies a holistic approach to the delivery of our program. The program is structured to assure adherence with NCQA and DHS' goals of reducing inappropriate health care expenditures and maintaining a competitive level of overall medical trends. Our UM Program objectives are noted in more detail in the table below.

REDUCING
Inappropriate inpatient admissions
Readmissions in three (3), seven (7) and 30 days
Inappropriate Emergency Room utilization
Gaps in care

MONITORING AND EVALUATING
Trends in utilization and the appropriateness of care and services delivered to members.
The outcomes of Utilization Management programs and services with the intent of improving the programs and services for the subsequent year.
The effectiveness of the annual Utilization Management Work Plan and the outcomes of Utilization Management interventions
The effectiveness of training programs, the currency of staff licenses and credentials.

DESIGNING, DEVELOPING AND/OR MAINTAINING
Reporting templates to ensure that all Utilization Management staff members are appropriately trained, qualified and licensed, as applicable.
Confidentiality of member, practitioner, facility and customer information.

REVIEW PROGRAM

To maintain optimal services and structure, Medica established a Utilization Review Program that provides robust evaluation of medical necessity, appropriateness and efficiency of the use of specific health care services.

Prior authorization is required to align with State and Medica requirements and includes medications, technologies, services and procedures. Medica will regularly evaluate its prior authorization process to determine its impact on service delivery and access to care. Based on findings, non-state required prior authorization requirements may be revised.

A Utilization Management (UM) Policy is a document containing clinical criteria used when evaluating the necessity and appropriateness of health care services, procedures, and hospital services. UM policies are also coverage polices. The Medical Policy Committee (MPC) will be responsible to review and endorse all clinical criteria found in utilization management policies and the use of national evidence based guidelines.

Medica utilizes the following policies and guidelines to assist in making care authorization decisions:

- Utilization Management policies
- Coverage policies
- Medical Technology Assessment Position Statements
- Medica Clinical Guidelines
- Institute for Clinical Systems Improvement (ICSI) Health Care Guidelines
- MCG (formerly Milliman Care Guidelines)
- Medica Utilization Management (Operations) policies and procedures
- Medica Pharmacy policies
- The ASAM Criteria as published by the American Society of Addiction Medicine; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition
- LOCUS and CALOCUS for adult and child / adolescent Behavioral Health admissions Policies and Clinical Guidelines

Medica utilizes a comprehensive set of policies and clinical guidelines to best support optimal care for our members.

UM POLICIES

In Iowa, Medica will leverage the experience and background of the appropriate medical specialists from Medica's Corporate Physician Advisory Panel (PAP), a group of approximately one hundred and fifty (150) appointed, actively practicing network physicians to develop new policies based on current research. The criteria that are developed are reviewed by PAP, revised if needed, and then endorsed by the Medical Policy Committee. These policies are reviewed with input from practicing physicians and updated on an annual basis, or sooner if a clinical issue warrants. Medica's Utilization Management (Operations) policies and procedures are created by leadership and subject matter experts. Both clinical and operational policies are submitted for review or revision on an annual basis.

Medical Technology Assessment

A Medical Technology Assessment Position Statement communicates whether a particular medical technology is investigative as defined in Medica's coverage documents. Medical technologies include devices, diagnostic or screening procedures, medical or behavioral treatments or procedures, and surgical procedures. Pharmaceuticals included in the medical benefit are addressed by the Medica Pharmacy and Therapeutics (P & T) Committee. Medical Technology Assessment Position Statements are developed by one of two internal committees: the Medical Technology Assessment Committee (MTAC), or the Medical Technology Assessment Subcommittee (MTA Subcommittee). Both committees are charged with determining whether new and emerging medical technologies are investigative as defined in Medica's coverage documents. Each technology is evaluated for its safety, effectiveness, and effect on health outcomes. Determinations are made following a thorough analysis and consideration of clinical and scientific evidence, applicable laws and regulations, and community practice standards.

Clinical and ICSI Guidelines

ICSI Health Care Guidelines represent community-based best practice for prevention and treatment of health conditions. Medica adopted ICSI health care guidelines in 2002. ICSI is an independent, non-profit organization that facilitates collaboration on health care quality improvement by medical groups, hospitals, and health plans. Use of ICSI guidelines are intended to improve the effectiveness, efficiency and consistency of patient care, and provide a common foundation for clinical improvement initiatives. These guidelines assist clinicians by providing an analytical framework for the evaluation and treatment of patients. ICSI guidelines are reviewed and updated every twelve (12) to thirty-six (36) months.

ICSI Health Care Guidelines and Medica Clinical Guidelines are accessed and referenced by the Utilization Management and Clinical Appeals staff and Medical Directors. They may also be used as a reference when providing case management services to members. These clinical guidelines are used internally at Medica to develop member education materials, disease management recommendations, and conduct various quality studies. Clinical guidelines are sent to Medica practitioners upon request, and monthly updates are published in the provider publication "Connections." They are also available on Medica's website: www.medica.com.

MCG Guidelines

MCG Care Guidelines supplement ICSI and Medica Guidelines and are evidence based designed to span the continuum of care to support clinical decision and care planning, ease transitions between care settings and facilitate conversations between providers and payers. Our use of MCG is intended to identify gaps in care, improve quality, and enhance operational efficiency. MCG Care Guidelines are updated on an annual basis or more frequently if needed. Utilization of MCG is not intended without the independent clinical judgment of a qualified health care provider taking into account the individual circumstances of each member's case. Rather, MCG is a resource to help drive effective care resulting in better outcomes.

UM OPERATIONS POLICIES

Medica Utilization Management (Operations) policies and procedures provide guidelines for utilization management staff to assure consistency in administering programs and work processes. These policies and procedures provide for compliance with federal and state law, contractual obligations required by the Iowa Department of Human Services (DHS) and Centers for Medicare and Medicaid Services (CMS), as well as accreditation standards.

Pharmacy

Medica is responsible for formulary development and management, in addition to development and implementation of clinical programs designed to manage cost and utilization. We are also accountable for specialty pharmacy management, pharmacy network administration, and integration of pharmacy claims within Medica's overall Health Management program. In addition, Pharmacy Services oversees our pharmacy benefit management vendor and provides support for many functional areas within Medica on pharmacy-related issues.

ASAM

The American Society of Addiction Medicine (ASAM) is a professional society representing over thirty-two hundred (3,200) physicians and associated professionals dedicated to increasing access and improving the quality of addiction treatment; educating physicians, other medical professionals and the public; supporting research and prevention; and promoting the appropriate role of physicians in the care of patients with addiction.

LOCUS / CALOCUS

The Level of Care Utilization System (LOCUS) for those eighteen (18) years and older and CALOCUS Child & Adolescent Level of Care Utilization System (CALOCUS) for ages five (5) to seventeen (17) are assessments and placement instruments developed by the American Association of Community Psychiatrists and the American Academy of Child & Adolescent Psychiatry.

Appeals

Medica will follow all Code of Federal Record and Iowa state requirements relating to appeals processes and will be dedicated to monitoring the timeliness of standards according to state and/or federal or NCQA guidelines, based on prevailing rule.

The following appeals processes are available to the member, member representative and/or the requesting physician:

First-Level Pre- & Post-Service Appeal

Medica offers a first-level appeal to any member, member representative or requesting provider on behalf of the member disagreeing with the initial determination decision. The appeal is reviewed by a physician in the same or similar specialty as the treating provider who has not previously reviewed the case. Rights are communicated to the member in writing with each denial of service.

External Review

In compliance with health care reform regulations, an external review of disputed coverage determinations, when requested, is available. Clinical case denial letters to members instruct the member to contact the appropriate entity to initiate the external review process. The entity then forwards the request to Medica. An appeals staff member prepares the case summary and all supporting and case related documentation for submission to the external agency. The external review agency will issue its written determination to each party within the time frame required by the Agency.

Medica monitors its timeliness in decision-making and appeal language in letters by conducting audits where these criteria are evaluated. The audits are based on the Agency requirements and NCQA standards for clinical appeal management. Oversight of audits is the responsibility of the supervisors of Utilization Management and Clinical Appeals, and their Manager. If warranted through audit results, we will implement corrective actions plans.

Medica is committed to providing continuity of care to members as stipulated by the Agency and as contractually required. Medica will authorize continuity of care when a member is a new enrollee to our plan or transitions from another MCO to Medica and their provider is not in the network. To promote quality of care and provider monitoring, we will make effort to obtain the provider's agreement to join our network.

Current Course of Treatment

If a member is experiencing an acute episode of care that requires ongoing medical services and the provider who initially delivered the care is no longer in the network due to the change in health plans or termination of the provider contract, Medica will align continuity of care with the Agency's requirements.

Medical criteria include:

- An acute condition
- A life-threatening mental or physical illness
- Pregnancy beyond the first trimester
- A physical or mental disability defined as an inability to engage in one or more life activities, provided that the disability has lasted or can be expected to last one year, or can be expected to result in death
- A disabling or chronic condition that is in an acute phase
- The member receives culturally-appropriate services, and a provider is not available in Medica's network within time and distance requirements to deliver such services
- The member does not speak English, and a provider is not available in Medica's network within time and distance requirements who can communicate with the member directly or through an interpreter.

2. Describe your policies, procedures and systems to:

a. Assist utilization management staff to identify instances of over- and under-utilization of emergency room services and other health care services

Medica views our role in assisting utilization management staff to identify over and under- utilization of emergency services and other health care services as pivotal to the success of our UM Program. We use several strategies to assist UM staff to identify utilization management patterns, they include; appropriate professional, use of evidence-based guidelines, training, inter-rater reliability testing, random medical director reviews, and rules engine triggers.

APPROPRIATE PROFESSIONALS

Appropriately licensed health professionals supervise all review decisions and licensed clinical staff performs clinical review, prior authorization, and clinical appeals activities. The utilization staff, care coordinators, and appeals staff are all registered nurses and licensed practical nurses, many with national case manager certification. Clinical professional staff is licensed professionals in good standing in the state or jurisdiction of

licensure. The nurses receive extensive orientation and training in the principles of care and utilization management, criteria and discharge planning. Staff managing Utilization Managers and Appeals Analysts review appropriateness of requested services in utilization management. Under no circumstances may they independently deny a service determined to not meet medical necessity criteria. All potential denials require review and oversight by a licensed physician (referred to as a Physician Advisor or Medical Director).

Utilization management decisions for medications are reviewed and managed by licensed Pharmacists in good standing in the state or jurisdiction of licensure. Under no circumstances may they independently deny a service determined not to meet medical necessity criteria. All potential denials require review and oversight by a licensed physician (referred to as a Physician advisor or Medical Director). Utilization management decisions are based only on the appropriateness of service and existence of coverage. Utilization management decision-makers do not receive financial incentives from Medica as a means of encouraging them to make decisions that result in the under-utilization of services.

Non-clinical staff with managed care experience provide intake and support services.

USE OF EVIDENCE-BASED UM GUIDELINES

The UM guidelines that will be used by Medica of Iowa are described in our response to the question above. Our selection crosses the services that will be reviewed by our professional staff and facilitate the identification of over and under-utilization.

Training

Upon hire, our UM staff receive didactic training on our utilization management program which includes review of the goals, objectives and requirements of the Iowa High Quality Healthcare Initiative. Pre-tests are given to assess base knowledge, these are followed by training modules which review all elements of the UM Program. Staff are taught and tested on the use of the clinical criteria and guidelines including prudent layperson expectations.

Inter-Rater Reliability Testing

Medica is responsible for the ongoing monitoring and evaluation of its staff responsible for utilization management decisions concerning the consistent use and application of all utilization management criteria.

Medical Director Reviews

Medica's Senior Medical Director will regularly evaluate the consistency with which clinical staff and medical directors involved in utilization review and clinical appeals apply criteria, regulatory directives, and benefits outlined in the benefit documents in their decision-making.

When inconsistencies are identified, corrective actions are put into place to promote consistency.

Rules Engines and Resulting Data Triggers

Medica's UM staff will have access to information generated from three (3) types of rules engines that are housed within our enterprise-wide integrated information technology platform. The data outputs from these applications will serve to inform our UM staff of over and under- utilization by providers and members. This data will be used by UM staff to make target UM review activity and make referrals to our Care Coordination Team.

- Claims analysis is used to flag potential gaps (under-utilization) in members' disease management, medication adherence, care patterns and safety.
- Our technology platform is used for utilization management, complex case management, care coordination, Health and Wellness and appeal and complaint management. This module supports clinical documentation and provides a vehicle to inform department staff of over and under-utilization of services and allows the Integrated Care Team to see all clinical and utilization activity for a member.
- Medica's UM staff will have access to data from the Johns Hopkins ACG Case-Mix System assessment software which will serve to inform them of the utilization patterns of members and identify underutilization of evidence based standards of care.

b. Analyze emergency department utilization and diversion efforts

Medica routinely monitors and analyzes system-wide and member-specific emergency room data by reviewing the following information in our Utilization Management Committee:

- Provider Claims to determine utilization by assigned PCP
- Utilization by facility and geographical location
- Utilization by member demographic (age, enrolled program)
- Utilization by diagnosis
- Members with more than three emergency room visits in a rolling twelve (12) month period

We support this information by reviewing Medica's access to care and geo-mapping reports.

The co**Network Partnerlation of information from all the data sources above enables us to create the appropriate diversion strategies which are performed at three levels: network, community and member.

NETWORK STRATEGIES

Medica's network strategies include incentivizing local PCP groups to increase week-day and week-end hours and/or to offer open access appointing or contracting with additional urgent care facilities. In cases where specific emergency rooms not only have high utilization, but also may have high inappropriate admissions – an emergency department case management program may be an option.

COMMUNITY STRATEGIES

Medica's Community Health team will work through many community partners and events to educate our members about appropriate use of the emergency room and ways to access help in making that decision.

- Targeted mailings and member newsletters highlight appropriate emergency room use and emphasize preventive services and use of Medica CallLink for questions regarding illnesses and where to get care.
- A new print resource, *When and Where to Get Care*, is a simple educational tool outlining when it is appropriate to use the emergency room, primary care, urgent care and convenience care. This handout, offered in several languages, is brought to community fairs and events, member input forums, county meetings, blood lead testing events and clinic training programs. It is also distributed by our health coaches, customer service representatives and care coordinators.
- Automated phone calls are made to members during flu season referring members to Medica nurse line for help with home remedies or determining when they should see their primary care physician.

- Videos, sponsored by Medica, and produced in English and Spanish on the topics of Understanding the Emergency Room and Navigating the Healthcare System.

MEMBER-SPECIFIC STRATEGIES

- Community-Based Case Managers may also attend member visits with providers or community resources as an advocate to support the member's individual needs.
- Medica's Community-Based Case Managers will work with members who have been seen multiple times in the emergency room, along with members who have just been discharged from the hospital. Case Management staff members will educate members about appropriateness of ER use and provide education around using urgent care and other community clinic options.

Medica will offer our Medica nurse line service as a diversion technique for emergency services. Nurse line will notify Medica's UM Department regarding members who have been referred by a nurse to access care from the emergency room. Medica staff makes outbound calls to these members to ensure they understand their discharge orders, and provides education and referrals to Health and wellness programs or Case Management/Care Coordination services as appropriate.

MINNESOTA EXPERIENCE

Medica is committed to helping our members receive the most appropriate care possible - whether through a primary care physician or through appropriate use of the emergency room, and regardless of whether they live in a metropolitan or rural area. We educate our members on the benefits of receiving ongoing care from their primary physician in an effort to help them avoid overuse of the emergency room. The following programs have been successful in reducing ER overuse in Minnesota, and will be considered for use in Iowa.

- Since 2002, Medica has been a member of the **Mental Health Crisis Alliance**, a public/private partnership which provides crisis stabilization services to adults living in Washington, Dakota and Ramsey counties, Minnesota. More recently, this Alliance has been evaluating the impact of community-based crisis stabilization services on utilization of emergency rooms. Emergency department utilization decreased significantly post-crisis stabilization for all patients, even "high-frequency" patients who had five (5) or more ER visits in the six (6) months prior to crisis stabilization services. Medica has also been exploring the use of tele-health services.

> The Medica Foundation has focused funding on reducing inappropriate ER utilization, hospitalization and readmissions. Since 2011, 11 grants totaling $318,000 were awarded in this focus area.

- Another program that has had significant impact on reduction of ER use is **Integrated Care Coordination (ICC)**. In November 2011, Medica launched a pilot program to evaluate the needs of the Medicaid Expansion population and have been tailoring services to address these needs. The claims information showed significant use of the ER for non-emergency conditions. ICC includes in-person assessments, consultation and development of person-centered plans for care. Assessments and care plans focus on both the individual member's perspective on their personal goals as well as prevention of emergency department and inpatient stays.
- The purpose of the **Medica Research Institute ER Research Project** was to gain insight into the factors leading to non-emergent Emergency Room use. We interviewed patients in an urban ER over a

continuous twenty-four (24) hour period to learn their reasons for going to the ER. In addition, the hospital provided us with demographic information, insurance status, diagnostic codes and charges. We analyze this data to determine if there are predictive factors for non-emergent ER use. Medica uses this analysis to help us find unique and effective ways to educate our members about appropriate use of the emergency room.

- Medica created a policy for our **Provide-a-Ride** services which states that if a member calls to request a ride to the emergency room and does not have a doctor recommendation to go to the emergency room, they must first speak with a nurse to determine if this level of care is appropriate. If the emergency room is the most appropriate place for care, the nurse may invite the member to call back if they have questions once they are discharged. If needed, the nurse can also help the member find a primary care physician for follow-up and on-going care. Outside of business hours, all calls are triaged to the Medica Nurse Line to ensure our members get appropriate care.

c. Identify aberrant provider practice patterns

The coordinated member identification (CMI) process will be used to scan medical, physician and pharmacy claims for 100% of Medica members on a monthly basis. Through the use of this internal scanning tool and through our robust data reporting systems Medica is dedicated to identifying aberrant provider patterns. The use of this internal data monitoring and reporting systems will assist in tracking and trending significant patterns that are appropriate for utilization and quality review. In addition to CMI, we use several other strategies to identify aberrant provider practice programs. They are detailed below:

- Providers with statistically significant gaps in care will be identified through the claims analysis algorithm that is built into our documentation system within our enterprise information technology platform. The rules engine within the system will review for potential gaps in members' disease management, medication adherence, care patterns and safety.
- Our Johns Hopkins ACG Case-Mix System will enable us to stratify provider's utilization patterns. Admission diagnoses will be reviewed along with three (3) day, seven (7) day and 30 day readmissions. Preventable admission rates, hospital infection rates and others will be tracked. Our Medical Directors will intervene to educate providers when appropriate, progressive discipline will follow if indicated.
- Medica's UM staff will be trained to use Quality of Care Review tools that outline conditions directly associated with aberrant practice patterns such as nursing home falls, hospital-acquired conditions, ambulatory-sensitive admissions, and medication errors. Quality of Care referrals and peer review activities are conducted through engagement with our Quality Improvement (QI) Department.
- Review of daily prior authorization and inpatient census data.

Also, Medica supports patient safety through a variety of programs and projects. Efforts vary in scope, focus and method, but all are designed to:

- Promote and ensure safe clinical practices;
- Reduce or eliminate errors;
- Protect and assist vulnerable patients; and/or
- Provide members with quality and safety information.

Ongoing programs that contribute to patient safety include, but are not limited to:

- Clinical Review (Clinical and Service Quality Review site surveys, medical record review)

- Credentialing and re-credentialing activities
- Quality of care case investigations
- Performance-based incentives that reward providers for implementing safe clinical practices

Medication therapy management (MTM) is a significant patient safety initiative for members. Specially trained pharmacists are contracted to work one-on-one with members to help them achieve safe and effective results from their drug regimens. The MTM program includes an annual medication checkup during which the pharmacist reviews the member's medication profile to detect any potential conflicts or duplications. Also included in MTM are compliance monitoring, patient education, drug therapy problem resolution and assistance with over-the-counter medications.

In addition to investigating quality of care complaints, Medica also conducts targeted quality of care investigations to assure safe clinical practices. Investigations may focus on a single practitioner or group, or on multiple providers with similar practice patterns. Recent investigations in Minnesota have addressed opioid prescribing patterns and patterns of treatment outside the community standard of practice. We also recommend such a review in Iowa.

Medica makes patient safety information available to members via Web links on www.medica.com that connect to consumer safety tools and to hospital safety data.

d. Monitor patient data related to length of stay and re-admissions related to hospitalizations and surgeries

Length of stay and re-admissions are important in identifying trends that indicate the need for process improvement activities. In order to appropriately measure length of stay and re-admission rates, Medica uses the coordinated member identification (CMI) which scans the medical, physician and pharmacy claims of 100% of Medica members on a monthly basis. Claims identification and referral to case management/care coordination occurs routinely and may include the following criteria:

All enrollees with:

- Claims of $50,000 per year or more
- Frequent Emergency Room Utilization, Inpatient utilization, and high probability of cost in the future
- Hospital admissions for Medicaid enrollees who have had an admission for an AHRQ Ambulatory Care Sensitive Conditions including bacterial pneumonia, dehydration, urinary tract infection, adult asthma, congestive heart failure, hypertension and chronic pulmonary disease (identified through claims data are reviewed.
- Any individual with four (4) or more visits to the emergency room during the prior six (6) months. All diagnoses are included and identified through claims data.
- An inpatient admission for key diagnoses including; Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), pneumonia, adult asthma and diabetes (identified through claims data).
- A hospital readmission for members with two admissions in the last twelve (12) months for the same or similar diagnosis including; CHF, COPD, pneumonia, adult asthma and diabetes (identified through hospital notification).

- Home care services limited to all Personal Care Attendant (PCA) services (identified through prior authorization data)
- Any individual with ER-3, Cost Risk Index>=4.5 (weighted>11) in last rolling twelve (12) calendar months. Members with conditions associated with behavioral health indicators are integrated into Medica Behavioral Health programs.

Medica will provide this information to Community-Based Case Managers working with our members, as applicable, to provide the member with education and support. For members not receiving Community-Based case manager, Members will be identified and receive follow-up from Medica Care Coordination staff.

e. Assure the appropriateness of inpatient care

Medica monitors the appropriateness of inpatient care through a formal concurrent review program, discharge planning and transition of care planning. Medica utilizes MCG clinical guidelines to establish goal length of stay and evaluate member's individual clinical information against evidence based standards of care. Inpatient nurse reviewers also leverage MCG guidelines to determine appropriate level of care post discharge.

The inpatient case manager works collaboratively with the facility discharge planners, physicians, and Medica members to improve transitions in care and enhance discharge planning. This program also identifies members at risk for re-admission and conducts discharge follow-up calls to assure members understand discharge instructions, are compliant with the instructions and are scheduled for appropriate follow-up appointments

Cases are also reviewed with the Medica physician advisors at determined intervals if lengths of stay targets are not met; if readmissions occur; if non-compliance issues occur; or if adverse health care events are identified.

Measurement/Evaluation

Comprehensive measures and reporting are available for the Concurrent Review Program, including:

- **Operations Reporting:** Provides counts and metrics on how many members are participating in the program, and the extent to which program components are being utilized.
- **Evaluation Reporting:** Measures medical cost savings and clinical improvements.

Formal program evaluations are conducted every twelve (12) - twenty-four (24) months. All lessons learned are continually fed back into the program to enhance identification and interventions.

f. Ensure active participation of a utilization review committee

The UM Committee/Subcommittee is designed to provide excellent support quality healthcare services by utilizing effective resources to meet the needs of the Iowa population. The goals of the UM Committee are to promote effective and timely care for all members and to demonstrate that methods and systems that are efficient and effective.

The Utilization Management Subcommittee reports directly to the Medical Committee of the Medica Board of Directors, chaired by the Senior Medical Director. The Subcommittee provides strategic clinical direction to and oversight of the program activities and is responsible for assuring that the program meets all necessary quality, regulatory and organizational requirements. The Subcommittee also addresses the potential for waste

in the health care system by monitoring utilization patterns for inappropriate, unnecessary or duplicative services.

The committee:

- Evaluates the effectiveness of the utilization management program annually.
- Reviews and analyzes utilization reports and studies.
- Monitors under and over-utilization and other key indicators.
- Monitors and modifies the utilization management program based on data analysis

Membership includes representation from Health Management, Pharmacy Services, Medicaid, Health Management Analysis, Network Management, Medicare, Medical Affairs, and Finance.

Program staff monitors member participation as often as daily, weekly or monthly. Staff monitors participant satisfaction through member surveys and complaint monitoring. Using a pre- and post-program matched control study design, staff can compare results to previous performance. Effectiveness measures vary by program and may include, but are not limited to:

- Clinical outcome statistics
- Cost and utilization statistics
- Participant goal achievement
- Participant work history and productivity
- Participant readiness, activation, motivation and confidence levels

The following Committees are subsets of the Utilization Management Subcommittee:

- Medical Policy Committee
- Medical Technology Assessment Committee
- Pharmacy and Therapeutics Committee/Formulary Committee
- Prior Authorization Selection Committee

Members of the utilization review committee are responsible for implementing policies, plans and projects aimed at improving performance and achieving positive outcomes. Membership in the utilization review committee is multidisciplinary and will include key stakeholders from the following areas: medical, behavior health, long term care staff and network providers. One member of the committee will be appointed as the Chair, in which this person will be responsible for the overall implementation of the UM plan and quality activities herein discussed. Member participation will be documented through the meeting minutes, sign in sheet and agendas.

The infrastructure is established to serve as an interface with the overall UM process and aligns with the goals of the quality management program. The involvement of the UM Committee is to pursue efforts that result in the provisions of professionally acceptable services through timely access to care, facilitation of best practices, appropriate resource utilization and improved patient and community health outcomes.

Membership of the committee is interdisciplinary and represents multiple key areas of the Medica infrastructure capable of fulfilling the vision. Committee members include but are not limited to: network providers, program managers, quality analysts, and behavioral health providers from the following areas: care coordination, respiratory, cardiology areas.

Members allow the committee to provide leadership to establish quality and utilization management processes that include effective systems to reviews, evaluate and monitor the quality of member services and care. It also provides a forum for interdisciplinary communication and problem solving as part of the process. The success of the program requires active involvement of all levels of leaderships.

g. Evaluate efficiency and appropriateness of service delivery

Medica's Utilization Management program is designed to target services with variation in treatment patterns and utilization of services. Evidence based clinical guidelines provide standards of care to measure services and procedures. Services that do not meet evidence based guidelines are not covered. Quality of care concerns are reported to Medica's Quality Improvement team who conducts a formal investigation on all complaints.

h. Incorporate subcontractor's performance data

Medica collects, manages and integrates data from a variety of sources and systems for its quality improvement programs, this includes sub-contractor data. Medica uses both purchased and internally-developed software products to meet the objectives of its UM Program. Examples include, but are not limited to:

- CareManager: Used for utilization management, complex case management, Health and Wellness Coaching, and appeal and complaint management (select products)
- COR: Internally-developed software application for documenting and analyzing data collected through medical record review.
- EBM Gaps in Care: Claims analysis algorithm built into CareManager that identifies potential gaps in members' disease management, medication adherence, care patterns and safety.
- Johns Hopkins ACG Case-Mix System: Risk assessment software that processes medical, behavioral and pharmacy claims to identify potential Health and Wellness Coaching and case management participants, as well as Special Needs Plans (SNP) members at high risk for hospitalization.

Performance data will also be collected from HEDIS and CAHPS. Medica is accredited by the NCQA and works diligently to provide top quality care to its members. HEDIS and CAHPS scores are priorities for the organization. Medica will utilize CAHPS to capture accurate and reliable information from consumers relating to their health care experience. The survey includes a set of core questions that associate key areas of care and services. Medica uses CAHPS and HEDIS survey results to make informed decisions to meet regulatory standards. Medica also uses survey results for internal quality improvement purposes. The results from HEDIS and CAHPS help drive quality initiatives and assist in decision making.

The collection of sub-contractor performance data is crucial in determining areas of improvement and opportunities to reevaluate processes. The data will assist with decision making and effective system reviews. Data will be collected and reviewed on a reoccurring basis which allows Medica to make decisions concurrently.

i. Facilitate program management and long-term quality

Medica strives to be successful by providing quality healthcare services with effective and efficient utilization of resources to meet the needs of the community and population the program serves. Upon award in Iowa, Medica's UM program will continue to work closely with the Quality Management (QM) program. Medica will hold monthly meetings to properly manage programs, identify key issues, and implement improvement process deemed as necessary to ensure long term quality care and services.

The robust infrastructure of the UM and QM programs was designed to allow feasibility and program management. With the establishment of multiple committees, the ability to manage each program and its responsibilities is sustainable. Each committee is responsible for specific duties and requirements in correlation with the programs goals and expectations. Frequent meetings allow for constant communication and systems that are essential for the success of the program. Frequent data analysis and discussions are the segue way for implementing innovative process that increase collaborative efforts to ensure proper delivery of health care services and care.

The committees are comprised of members that have a unique combination of skills and ideas and have the ability to work well as a team to effectively lead program initiatives. Program management is a result of leadership structure throughout the path of quality that enables the ability to provide high quality services. The infrastructure of the committees provides continuous cross functional and departmental monitoring in the evaluation of patient care activities. To provide long term quality care and services, Medica will utilize pre analytic, analytic and post analytic processes. To ensure program management, each committee is responsible for scheduling and holding informational meetings in order to review quality improvement activities, patient safety activities, documentation quality methods and other matters deemed necessary.

Committee involvement demonstrates integration and collaboration of efforts to solve problems improve systems and fulfill strategic initiatives.

j. Identify critical quality of care issues

Medica recognizes that quality issues are important aspects in providing quality services and care to its members. All quality issues will be handled with integrity, care and respect. Medica is devoted to handling quality issues on an individual basis and will provide necessary follow up. All Medica staff will be responsible for the identification and communication of potential quality of care concerns. We will train staff that has contact with members and providers during orientation and at least annually thereafter on the types of occurrences and events that constitute a quality of care concern.

Medica looks at all quality of care complaints on an individual basis. At any time, either verbally or in writing, members are able to file grievances regarding quality of care concerns they have about providers or their staff. All quality of care complaints are forwarded to our Quality Improvement department for investigation and tracking. Due to confidentiality laws, a response on the results of the completed investigation is not sent to the member; however, each case would be reported to the Iowa Department of Human Services for oversight and auditing purposes. See member grievance, appeal and member rights section for forms and flowcharts.

The Quality Improvement team investigates quality of care complaints for all products. Medica investigates all quality of care complaints it receives according to established policies and procedures. Allegations may involve clinical or service quality performance. Quality Improvement staff review all reported complaints for trends and patterns that might indicate poor practitioner or provider quality, as well as for sentinel events that resulted in actual or potential patient harm. Staff also review clinical or service quality issues discovered through sources such as referrals by other Medica departments, the Credentialing Subcommittee, publicly-reported state regulatory findings, or media reports. The Quality of Care Complaint Oversight Committee reviews the cases in progress to ensure effective case handling and appropriate follow-up. The committee also identifies clinical care and patient safety implications and recommends action when needed. Such action may include a referral to the Credentialing Subcommittee, which retains final authority to recommend suspending or revoking the network participation status of any provider not meeting Medica's performance standards. Quality of care investigations are protected under state peer review laws; as a result, investigations and outcomes cannot be shared with members or with any internal or external stakeholders not covered under peer protection.

3. Provide a sample UM Work Plan.

Please see Tab 5 for Sample UM Work Plan. Medica will annually submit a UM work plan to the Agency for State review and approval.

4. Describe if any UM functions will be delegated. If any functions will be delegated, describe proposed ongoing monitoring strategies of the delegated entity.

Medica delegates UM functions to the following entities for Medicaid membership:

- MedImpact (Pharmacy Benefit Manager)
- Medica Behavioral Health (mental health and chemical dependency)
- Optum Physical Health (chiropractic services)

Medica delegates utilization management only to vendors and care systems with the infrastructure and capacity to meet regulatory and accreditation standards. Medica and the vendor mutually agree upon a formal delegation contract. The agreement stipulates the services delegated; the delegate's and health plan's responsibilities; reporting and oversight requirements; and consequences of non-performance.

Medica monitors delegate UM activities in compliance with NCQA standards (UM 15) by conducting an annual audit of all UM policies and reviewing files using NCQA 8/30 methodology. Any findings require a corrective action plan. Medica requires all delegates to provide us with quarterly UM reports, which permit us to monitor utilization trends and complaints. We also conduct annual letter review workshops to ensure UM decision notifications sent by delegates are consistent with Medicaid requirements and Medica member letters.

MEDICA'S SUBCONTRACTOR DELEGATION OVERSIGHT PLAN

UM delegation oversight includes review of the delegate's quarterly UM reports and annual UM program documents, as well as an annual site visit that includes audits of UM denial and appeal files. Medica staff may conduct more frequent visits or audits as needed to ensure continued compliance with regulatory and accreditation standards. Medica's Health Management department is responsible for managing delegation oversight across Medica. The Medical Director of Care Management and Reimbursement serves as the medical director for delegation. The Director of Quality & HM Compliance chairs the Delegation Committee. Dedicated Quality Improvement & Health Management Compliance Department staff coordinates oversight subcommittees, facilitate the Delegation Committee meetings and document oversight activity.

Medica's Health Management Department coordinates oversight of performance as part of its delegation oversight program. Oversight includes regular review of performance and utilization reports, periodic meetings with the delegate's representatives, and on-site reviews, at least annually, of the delegate's performance.

Medica actively collaborates with sub-contractors on efforts to improve care for members with co-existing medical and behavioral needs. Collaboration activities include:

- Coordination of care between care advocates and Medica Case Managers/Care Coordinators, including improving communication for members with co-existing medical and behavioral conditions.
- Provision of lists of members with certain mental health and substance abuse risk factors who may be appropriate for outreach by subcontracted care advocates.
- Determination of Appropriateness of psychopharmacological medications.
- Implementation of primary or secondary preventive behavioral health programs.

Data is collected and reviewed annually to identify opportunities for improvement and address gaps in performance. The delegation oversight process is managed by Health Management Compliance through oversight workgroups comprised of subject matter experts with clinical and regulatory backgrounds. The oversight workgroups report their activities monthly to Delegation Committee, who reports to Medica's Quality Improvement subcommittee, who in turn, reports to the Medical subcommittee of the Board.

5. Describe the process for developing and updating practice guidelines.

Medica will leverage the experience and background of the appropriate medical specialists from Medica's Corporate Physician Advisory Panel (PAP), a group of approximately one-hundred and fifty (150) appointed, actively practicing network physicians to develop new Policies based on current research. In addition, Medica proposes to create an Iowa Physician Advisory Panel. The criteria that are developed are reviewed by PAP, revised if needed, and then endorsed by the Medical Policy Committee. These policies are reviewed with input from practicing physicians and updated on an annual basis, or sooner if a clinical issue warrants. Once developed, these policies are reviewed annually by our UM Committee.

Medica also utilizes MCG Clinical Guidelines. These Guidelines are updated on an annual basis; the latest edition of the care guidelines is published in February, based upon systematic evidence review completed the previous December. Throughout the annual production cycle, the clinical editorial staff of MCG monitors the medical literature for new evidence (including published research studies, practice guidelines, and new editions of textbooks) that may be relevant to current guideline content.

In addition, to develop guidelines supporting optimal care, our clinical staff applies the principles of evidence-based medicine, defined as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients." (Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS. Evidence-based medicine: what it is and what it isn't. BMJ 1996;312:71-2. Reproduced with permission from BMJ Publishing Group.) All content is reviewed annually and updated by clinicians who cite more than twenty-five thousand (25,000) unique references in the current guidelines edition. Our epidemiologists examine databases that cover a significant portion of the U.S. population to validate that these published research results are achievable in real-life situations.

Medica will develop and adopt UM guidelines to interpret the psychosocial necessity of mental health services and supports. In the context of this requirement, psychosocial necessity is an expansion of the concept of medical necessity and shall mean clinical, rehabilitative or supportive mental health services which meet all the following conditions: (i) are appropriate and necessary to the symptoms, diagnoses or treatment of a mental health diagnosis; (ii) are provided for the diagnosis or direct care and treatment of a mental disorder; (iii) are within standards of good practice for mental health treatment; (iv) are required to meet the mental health needs of the member and not primarily for the convenience of the member, the provider, or the Contractor; and (v) are the most appropriate type of service which would reasonably meet the need of the member in the least costly manner. The guidelines for interpreting psychosocial necessity will meet the requirements of all Contractor practice guidelines.

6. **Describe how your UM program will integrate with other functional units as appropriate and support the Quality Management and Improvement Program.**

The structure and goals of our quality management and utilization review programs are aligned to improve the quality of services and members' whole health and wellness outcomes. To achieve our goal that all members receive high quality, appropriate care, the QM and UM programs will conduct internal quality reviews to assess the performance of providers and organizational entities. The goal of both programs includes:

- Improving health outcomes
- Increasing consumer satisfaction
- Delivering care that is accessible, coordinated and high quality

Medica uses several strategies to integrate with other functional units including, but not limited to, case management, care coordination, pharmacy management, behavioral health management and to support the Quality Management and Improvement Program. They are as follows:

- Our Enterprise-wide Integrated Technology Platform includes a work flow engine that will enable both auto and manual routing of information between functional units and staff.
- Extensive information will be exchanged through our robust Governance and Committee structure.
- Our training programs outline inter and intra- departmental communication pathways.

7. **Describe how the UM program will encourage health literacy and informed healthcare decision-making.**

Medica is committed to encouraging health literacy to assist members to make independent informed healthcare decisions. Case managers and Care Coordinators will provide members with educational materials to improve health literacy, which in turn, is likely to lead to better health outcomes.

Another strategy to promote health literacy is providing members with credible, evidence-based online health and wellness information through access to our member web portal, liveandworkwell.com. The liveandworkwell.com portal contains information and tools developed by internal professional staff, doctors, clinicians, industry experts and external content experts from respected healthcare organizations, for example, Johns Hopkins University and Thomson Micromedex. The liveandworkwell.com portal focuses on mind-body integration for a practical, low-cost approach to wellness and well-being. The portal provides member access to care and benefit self-management tools, prevention programs, searchable directories, educational materials, calculators, videos and more. There are specific tools developed for members with dual diagnosis including member self-screening and management tools. In addition, evidence based CarePathways are imbedded in Medica's care management technology platform. These pathways are designed to identify gaps in members' knowledge and adherence of health care services. Care plans are built within these pathways to guide the conversation between case managers and members to close knowledge and care gaps.

8. **Describe strategies to monitor member access to preventive care and strategies to increase member compliance with preventive care standards. Describe how you will identify and address barriers which may inhibit a member's ability to obtain preventive care.**

Medica's UM program works closely with our QM program to monitor member access to preventive care and to increase member compliance with preventive care standards. This is accomplished through collecting, tracking and analyzing performance data on HEDIS measures many of which are preventive in nature and through the work of our Community-Based case managers. Community-Based case managers, as a part of their care planning process with members, provide education about the importance of preventive care and help identify preventive screenings that may benefit the member. If barriers to accessing care exist, the Community-Based case manager assists the member in access resources to eliminate the barriers.

Medica works to educate members on the importance of preventive care though member mailings for missed services, in member newsletters and the annual member handbook. Medica's Network Services Department reviews appointment access through use of geo-mapping reports and review of complaint data related to preventive care access issues. We use provider outreach strategies to expand network access when gaps are noted, we intervene when geo-access indicates network adequacy but provider issues are identified. Medica also uses contracting strategies to encourage our Primary Care providers to provide open access appointments and to extend office hours.

Medica also has an incentive program—My Health Rewards by Medica that encourages members receiving Medical Assistance to obtain recommended pregnancy care, cancer screenings and EPSDT visits. We will review statewide health metrics to determine which incentives are appropriate for members and providers.

Medica has a history of working with Medicaid recipients to reduce/eliminate perceived and actual barriers to receiving preventive care. Some of the barriers we are aware of include:

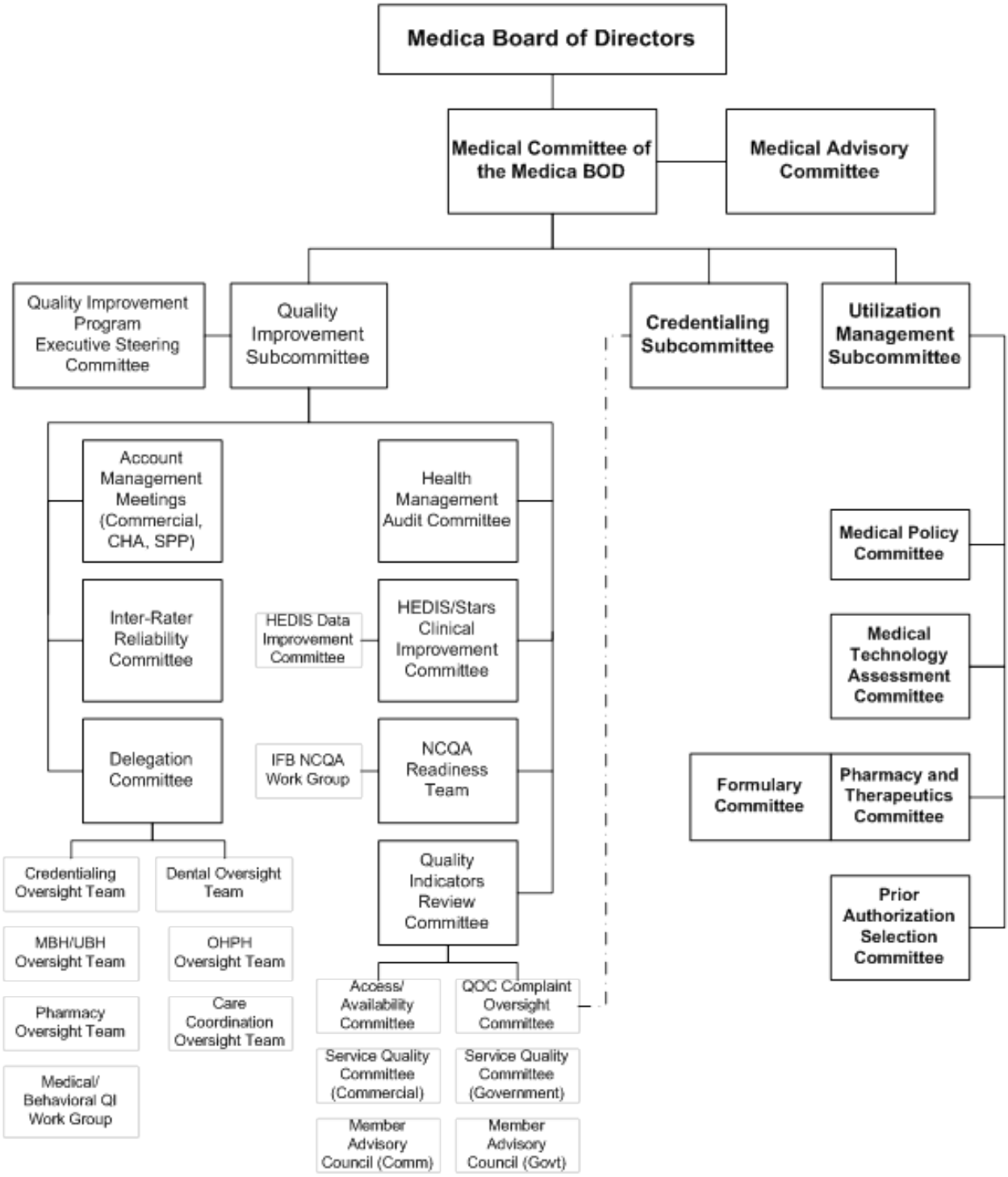
- Transportation
- Language
- Lack of understanding about the need
- Not sure what tests to get
- Fear
- Lack of provider or not sure where to go
- Not part of what they have done growing up, just seek care when something is wrong vs prevention

We offer non-emergency transportation services and will help members understand how to access it. We also provide health educational information for members in various formats including written (in English, Spanish, and other prevalent languages) and alternative formats. We provide interpreter services for non-prevalent languages free of charge.

Medica provides member education and outreach activities to address preventative health barriers and will establish appropriate incentives. Additionally, Medica will monitor the barriers of those members with special needs, mental illness diagnoses, and substance abuse disorders. Medica will also work to identify and address barriers to the successful participation in a behavioral health drug maintenance program, such as stigma.

9. Describe your UM Committee, including proposed committee composition and tasks

Medica's Medical Committee's Utilization Management Sub-committee and its subcommittees and workgroups are responsible for the governance of UM functions. The diagram below illustrates the UM organizational committee structure.



Key committee and subcommittee functions and composition are described on the next page.

UM Subcommittee

The UM Subcommittee reports directly to the Medical Committee of the Medica Board of Directors and is chaired by the Director of Utilization Management and Policy. The UM Subcommittee provides strategic clinical direction to and oversight of Medica's UM programs and is responsible for assuring that UM programs meet all quality, regulatory and organizational requirements. The UM Subcommittee also addresses the potential for waste in the health care system by monitoring utilization patterns for inappropriate, unnecessary or duplicative services. Medica's UM subcommittee goals and objectives include the following:

- Annually evaluate the outcomes of UM programs and services to improve programs and services for the subsequent year.
- Annually review and update UM programs and services.
- Develop and implement policies and procedures for health improvement functions.
- Monitor and evaluate the outcomes of Utilization Management interventions through the collection and analysis of cost, utilization, clinical and member self-reported data.
- Report findings from monitoring and evaluation activities to the appropriate committees to ensure that action is taken to continuously improve care and services to members.
- Advise senior management and the medical director in the development, implementation, and monitoring of UM activities.
- Verify that all UM staff is trained, qualified and licensed.
- Maintain confidentiality of member, practitioner, facility and customer information.

Committees and work groups reporting to the UM Subcommittee includes:

- Medical Policy Committee
- Medical Technology Assessment Committee
- Pharmacy and Therapeutics Committee/Formulary Committee
- Prior Authorization Selection Committee

Medical Policy Committee (MPC)

The Medical Policy Committee (MPC), chaired by Medica's Senior Medical Director, advises Medica leadership on issues relating to medical appropriateness, clinical criteria, and community standards of care for new and existing UM policies and clinical guidelines. The MPC is comprised of Medica network physicians who are members of Medica's Physician Advisory Panel and practicing in the disciplines of Family Practice, Internal Medicine, Obstetrics and Gynecology, and Pediatrics. Physician Advisory Panel members advise Medica on issues of community standards, medical appropriateness, utilization review and management, utilization management policy, clinical criteria/guidelines, the technology assessment process and Medica's quality improvement activities.

Medical Technology Assessment Committee (MTAC)

The Medical Technology Assessment Committee (MTAC), chaired by Medica's Senior Medical Director, and the Medical Technology Assessment Subcommittee (MTA Subcommittee) determines whether new and emerging

medical technologies are investigative as defined in Medica's coverage documents. Each technology is evaluated for its safety, effectiveness, and effect on health outcomes. Determinations are made following a thorough analysis and consideration of clinical and scientific evidence, applicable laws and regulations, and community practice standards. The MTAC is comprised of representatives from: Medical Directors, Medical Affairs, Utilization Management and Clinical Appeals, Pharmacy.

Pharmacy and Therapeutics Committee/Formulary and Drug Review Committee

The Pharmacy and Therapeutics (P&T) Committee, chaired by Medica's Senior Medical Director, advises Medica's leadership on issues related to prescription medication therapy. The P&T Committee is comprised of network practicing pharmacists and practicing physicians from varying disciplines. Expert opinion and clinical information may be solicited from various physician specialists who are on Medica's Physician Advisory Panel. The P&T Committee also oversees the Formulary and Drug Review Committee, which is responsible for decisions relating to the positioning of prescription drug products on Medica's drug formulary that result after deliberations, the receipt of the advice, and the clinical decisions of the Medica Pharmacy and Therapeutics Committee and for oversight of any formulary delegated to a third party for development.

Prior Authorization Selection Committee

The Prior Authorization Selection Committee (PASC) determines the appropriateness of the items placed on and removed from Medica's Prior Authorization List (PA List). The PASC uses a systematic process applying identified criteria, to make informed decisions to determine the items and services included or excluded from Medica's PA List. Business and Operational impacts are also taken into consideration in this process. The PASC is comprised of representatives from our Medical Affairs Department, the Utilization Management and Clinical Appeals Department (UM & CA), the Pharmacy Department, the Network Management Department, Medica's Claims Operations Department, Communications, and Medica's medical directors.

10. Describe any benefits which are proposed to require PCP referral and what services would be available on a self-referral process.

As part of our UM program, Medica facilitates provider requests for authorization for primary and preventive care services and offers assistance to help locate specialty providers when a referral is appropriate.

Medica also requires PCPs to make referrals to specialty providers when a member has a condition that requires the expertise of a specialist or needs specialty treatment. However, under certain circumstances, members are free to self-refer and do not need authorization from a PCP. The services that do not require prior authorization or a PCP referral are as follows:

- Members with special needs determined to need a course of treatment or regular care monitoring can access a specialty provider either through a standing referral from a PCP or a prior authorization of an approved number of visits.
- Female members will have direct access to a Medica network women's health specialist to provide women's routine and preventive health care services through a standing referral from a PCP, if the PCP is not a woman's health specialist, or a prior authorization of an approved number of visits. In addition, Medica will explore modifications to its claims processing procedures to pay providers that bill for certain women's health codes without prior authorization or referral.
- Members can access emergency services without prior authorization or PCP referral, regardless of whether these services are provided by a contract or non-contract provider. For members receiving

emergency services, Medica may consult with the member's treating physician and pre-approve post post-stabilization care when medically necessary.

- Medica can administer a plan that does not require prior authorization or referral for behavior health services
- Medica does not require prior authorization or referral for new members in transition for the continuation of medically necessary covered services.

When a referral is required, the following guidelines apply:

- A referral request must originate from and be authorized in advance by the member's PCP.
- Approved referrals are valid for the date(s) of service specified on the referral request form.
- Referrals are subject to the member's Medica eligibility status and covered services for the date(s) of service specified on the referral.
- A referral request is valid for a period not to exceed six months unless an extended time is required by regulation.

11.2 Prior Authorization

1. Describe policies and procedures for processing authorization requests including when consultation with the requesting provider will be utilized.

Medica's annually updated, written policies and procedures detail the processes our Health Management team follows for processing prior authorization requests. We oversee the prior authorization processes of our Behavioral Health and Pharmacy programs through our robust delegation oversight processes and written sub-contractor oversight plan.

Each therapy, condition or procedure requiring a PA is published on Medica's web site. Medica has a distinct policy for each that describes the criteria for a PA request.

Our policies and procedures provide guidance to providers on how to submit a PA request and the types of procedures or conditions that require PA. Providers can initiate a PA request by submitting a form by fax, email or U.S. mail. In cases where the request is for a non-urgent pre-service procedure, Medica completes the review taking into account the clinical needs of the member and notifies the provider of the decision as expeditiously as possible, but no later than fourteen (14) calendar days of receipt of the request.

The timeframe to process an urgent PA request is much shorter. Medica completes the review and notifies the provider as expeditiously as the member's condition requires but no later than seventy-two (72) hours of receipt of the request. Urgent PA requests are those that meet one or more of the following criteria:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function based on a prudent layperson's judgment
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request
- The attending provider is making the request or believes an expedited determination is warranted
- The service involves coverage of a concurrent hospital stay for medical care or mental health/substance abuse or the service involves the continuation of care in progress, such as pre-service home health therapy, or Skilled Nursing Facility (SNF) stay.

Medica employs licensed health professionals including registered nurses and licensed practical nurses, many with national case manager certification to make Prior Authorization (PA) decisions. Staff receive extensive orientation and training in the principles of care and utilization management, criteria and discharge planning. Prior to making a decision, Medica collects and reviews a minimum data set, which includes the following:

- Outpatient and inpatient medical records;
- Results of diagnostic studies;
- Consultant reports;
- Discharge reports/summaries and clinical notes;
- Covered benefits, clinical criteria, and regulatory directives; and
- If necessary, a literature search and/or other relevant clinical or scientific information from the Medical Affairs Department.

Medica has a team of licensed physicians available when there is the potential to deny the PA request based on medical necessity. A physician must make the final determination for medical necessity reasons. When specialized judgment is needed, Medica consults with board-certified physicians from appropriate specialties to assist in making determinations of medical necessity. Consultation with the medical professional that submitted the request is encouraged whenever it would aid in making a decision and is always appropriate prior to a decision to deny a PA request based on medical necessity. A physician to physician conference is also made available to the submitting physician upon request. Additionally, Medica will develop and implement written procedures, subject to Agency and IDPH approval, documenting access to board certified consultants to assist in making medical necessity determinations.

2. Describe mechanisms to ensure consistent application of review criteria for prior authorization decisions.

Inter-Rater Reliability Testing

Medica is responsible for the ongoing monitoring and evaluation of its staff responsible for utilization management decisions concerning the consistent use and application of all utilization management criteria.

Medica regularly evaluates the consistency with which clinical staff and medical directors involved in utilization review and clinical appeals apply criteria, regulatory directives, and benefits outlined in the benefit documents in their decision-making.

When inconsistencies are identified, corrective actions are put into place to promote consistency.

3. Describe processes for retrospective utilization monitoring for IDPH population services.

Medica monitors and analyzes its utilization data to detect potential under, over and mis-utilization of services. Data are sorted according to Medica's product lines, such as Medicaid and Medicare. Within each product line, demographics, utilization and cost data are sorted in various ways to monitor the various utilization indicators. Benchmark targets and thresholds are used to identify areas of variation. Thresholds for the various product lines are determined annually and reviewed quarterly to determine if utilization variance warrants further analysis and/or program implementation. Areas of variation are analyzed to identify areas of opportunity.

Medica's Measurement Work Group provides detailed data analysis on the areas identified by the Health Management department, the Utilization Management Subcommittee and the Trend Work Group. These committees then provide input into the data monitored for quality and utilization. The analysis conducted by these committees provides an opportunity to validate the effectiveness of current interventions programs and identify potential areas for additional opportunities for intervention as well as process and quality improvement.

4. Describe required staff qualifications for UM staff.

Appropriately licensed health professionals supervise all review decisions and licensed clinical staff performs clinical review, prior authorization, and clinical appeals activities. The utilization staff, care coordinators, and appeals staff are all registered nurses and licensed practical nurses, many with national case manager certification. Clinical professional staff are licensed professionals in good standing in the state or jurisdiction of licensure. The nurses receive extensive orientation and training in the principles of care and utilization management, criteria and discharge planning. Staff managing utilization managers and appeals analysts review appropriateness of requested services in utilization management. Under no circumstances may they independently deny a service determined to not meet medical necessity criteria. All potential denials require review and oversight by a licensed physician (referred to as a physician advisor or medical director).

Utilization management decisions for medications are reviewed and managed by licensed pharmacists in good standing in the state or jurisdiction of licensure. Under no circumstances may they independently deny a service determined not to meet medical necessity criteria. All potential denials require review and oversight by a licensed physician (referred to as a physician advisor or medical director). Utilization management decisions are based only on the appropriateness of service and existence of coverage. Utilization management decision-makers do not receive financial incentives from Medica as a means of encouraging them to make decisions that result in the under-utilization of services.

Non-clinical staff with managed care experience provide intake, support, and review of non-clinical and referral services. Non-clinical staff is supervised by clinical professionals. Under no circumstances may non-clinical staff deny a service determined to not meet medical necessity criteria.

The physician advisors and the Senior Medical Director oversee the Utilization Management Program and are board-certified physicians who hold unrestricted licenses. They are responsible for:

- Utilization management review decisions.
- Determination for all authorization requests that cannot be approved based on the established utilization management criteria.
- Interaction with network physicians and/or facilities regarding utilization management concerns.
- Peer review and review of unresolved clinical quality of care issues, and recommendations for actions and follow-up monitoring.

In addition, the Senior Medical Director is responsible for:

- Chairing the Medical Policy Committee, Pharmacy and Therapeutics Committee, and Medical Technology Assessment Committee.
- Facilitation of policy and guideline development and endorsement.
- Co-chairing the Utilization Management Subcommittee.

A licensed physician reviews all potential denials based on medical necessity. Only a licensed physician can make a denial determination for medical necessity reasons.

When specialized judgment is needed, board-certified physicians from appropriate specialties are consulted to assist in making determinations of medical necessity.

5. **Describe proposed utilization management clinical standards, including the use of any nationally recognized evidence-based practices.**

Medica leverages MCG Clinical guidelines and Milliman Benchmarks to evaluate service utilization against national standards of care. MCG modules include standards related to the following:

- Chronic Care
- Ambulatory Care
- Inpatient Medical
- Surgical Care
- Recovery Services
- Home Care
- Procedure and Services
- Neonate Intensive Care
- Long Term and Acute Rehab

In addition, Medica has adopted Institute for Clinical Systems Improvement (ICSI) guidelines, which represent best practice for prevention and treatment of health conditions. The ICSI guidelines are designed to improve the effectiveness, efficiency and consistency of member care, and provide a common foundation for clinical improvement initiatives. ICSI guidelines assist clinicians by providing an analytical framework for the evaluation and treatment of members and are not intended to replace a clinician's judgment or to establish a protocol for all members with a particular condition. The list below describes the topics for ICSI guidelines on Medica's web site:

- Acute Pain Assessment and Opioid Prescribing Protocol
- Adult Acute and Sub-acute Low Back Pain
- Adult Depression in Primary Care
- ADHD, Attention Deficit Hyperactivity Disorder in Primary Care for School-Age Children and Adolescents
- Antithrombotic Therapy Supplement
- Assessment and Management of Chronic Pain
- Colorectal Cancer Screening
- Diagnosis and Initial Treatment of Ischemic Stroke
- Diagnosis and Management of Asthma
- Diagnosis and Management of Chronic Obstructive Pulmonary Disease (COPD)
- Diagnosis and Management of Type 2 Diabetes Mellitus in Adults
- Diagnosis and Treatment of Chest Pain and Acute Coronary Syndrome (ACS)
- Diagnosis and Treatment of Headache
- Diagnosis and Treatment of Osteoporosis
- Diagnosis and Treatment of Respiratory Illness in Children and Adults
- Diagnosis of Breast Disease
- Healthy Lifestyles
- Heart Failure in Adults
- Hypertension Diagnosis and Treatment
- Immunizations
- Initial Management of Abnormal Cervical Cytology (Pap Test) and HPV Test in Adult and Adolescent Females

- Lipid Management in Adults
- Management of Labor
- Palliative Care
- Preoperative Evaluation
- Prevention and Management of Obesity for Adults
- Prevention and Management of Obesity for Children and Adolescents (Released July 2013)
- Preventive Services for Adults
- Preventive Services for Children and Adolescents
- Routine Prenatal Care
- Stable Coronary Artery Disease
- Venous Thromboembolism Diagnosis and Treatment
- Venous Thromboembolism Prophylaxis

In addition to the ICSI guidelines, Medica developed clinical guidelines using an evidence-based approach analyzing scientific literature and input from practicing physicians, Care Management staff and Medica Medical Directors. These Medica clinical guidelines, adapted from regional or national credible sources, are used by physicians in the network as a reference guide to encourage quality care. Clinical guidelines are also used internally at Medica to develop member education materials, disease management recommendations, and various quality improvement documents.

6. Describe how you will identify those services that will be reviewed for medical necessity determination. Provide a list of services for which prior authorization would be required.

The Medical Policy Committee (MPC) is responsible for advising Medica on matters of medical appropriateness, clinical criteria, and community standards of care for new and existing utilization management (UM) policies, Medica clinical guidelines and other program documents as requested. The MPC's recommendations are advisory in nature. The MPC is comprised of Medica network physicians who are members of Medica's Physician Advisory Panel and practicing in the disciplines of Family Practice, Internal Medicine, Obstetrics and Gynecology, and Pediatrics. Additional input is solicited from other specialists on the Medica Physician Advisory Panel, as applicable to designated UM policies, clinical guidelines or other program documents. Physician Advisory Panel members advise Medica on issues of community standards, medical appropriateness, utilization review and management, utilization management policy, clinical criteria/guidelines, the technology assessment process and Medica's quality improvement activities. The MPC is chaired by the Senior Medical Director. The Medical Committee of the Medica Board of Directors governs MPC.

The Prior Authorization Selection Committee is responsible for determining the appropriateness of the items placed on and removed from Medica's Prior Authorization List (PA List). The committee receives recommendations primarily from the Medical Technology Assessment Committee (MTAC), the Benefit Interpretation Committee (BIC), the Medical Affairs Department, the Utilization Management and Clinical Appeals Department (UM & CA), the Pharmacy Department, and Medica's medical directors. Current Home and Community-Based Waiver services requiring prior authorization are listed below. Medica will explore the addition of services home and Community-Based services to the list of services requiring prior authorization as deemed necessary.

This committee uses a systematic process, utilizing identified criteria, to make informed decisions regarding which items and services are included on and excluded from the PA List. Business and Operational impacts are also taken into consideration in this process. Items approved for inclusion are given to the Prior Authorization Implementation Workgroup for appropriate set-up within Medica's systems and processes. Members of this group include representatives from the Medical Affairs Department, the Utilization Management and Clinical Appeals Department (UM & CA), the Pharmacy Department, the Network Management Department, Medica's Claims Operations Department, Communications, and Medica's medical directors. Other department representatives may be added on an ad hoc basis as the subject matter demands. Items that are approved for removal from the PA List are placed in a monitoring status, and reviewed quarterly for utilization trends, changes in approved usage as indicated by community standard guidelines and/or scholarly

Each therapy, condition or procedure on the list below, which is published on Medica's web site, corresponds to a policy that describes the criteria for a PA request.

DEVICES/EQUIPMENT	DIAGNOSTICS
• Bone Growth Stimulators • Microprocessor Controlled Knee Prostheses, with or without Polycentric, Three-Dimensional Endo-skeletal Hip Joint System • Humanitarian Device Exemption • Implantable Deep Brain Stimulation • High Frequency Chest Wall Compression (HFCWC) Devices • Vacuum-Assisted Negative Pressure Wound Therapy • Sacral Nerve Stimulation (SNS) • Spinal Cord Stimulation of the Dorsal Column for Treatment of Pain • Vagus Nerve Stimulation	• Coronary Artery Calcium Scoring (CACS) • Genetic Testing for Hereditary Breast and/or Ovarian Cancer (BRCA 1 and BRCA 2 Genes and BRACAnalysis® Rearrangement Test [BART]) • Genetic Testing for Cardiac Channelopathies • Genetic Testing for Susceptibility to Colorectal Cancer (CRC) Syndromes • Genetic Testing for Cardiomyopathies • Real-Time Mobile Cardiac Outpatient Telemetry (RT-MCOT) • Comparative Genomic Hybridization (CGH) Microarray Testing • Human Leukocyte Antigen-DQ (HLA-DQ) Genetic Testing for Diagnosis of Celiac Disease) • Maternal Plasma Testing for Detection of Cell-Free Fetal DNA for Analysis of Chromosomal Aneuploidies • Positron Emission Tomography (PET) Scan
DRUGS	**INPATIENT**
• Drug Management Policies	• Inpatient (Hospital) Level of Care • Skilled Nursing Facility
HOME CARE	**MEDICAL/SURGICAL TREATMENTS**
• Extended Hours Home Care for Patients with Medically Complex or Medically Fragile Conditions • Home Health Aide • Personal Care Assistance • Medicaid Home Health Aide • Medicaid Private Duty Nursing (PDN) Services	• Outpatient Enteral Nutrition Therapy • Proton Beam Radiation Therapy • Posterior Tibial Nerve Stimulation for Overactive Bladder

SURGICAL PROCEDURES	TRANSPLANTS - ORGAN & BONE MARROW
• Rhinoplasty Procedure With or Without Septoplasty • Uvulopalatopharyngoplasty (UPPP or U3P) for Obstructive Sleep Apnea/Hypopnea Syndrome • Breast Implant Removal, Revision, or Reimplantation • Abdominoplasty/Panniculectomy • Adult Gender Reassignment Surgery • Thoracic Sympathectomy for Primary Hyperhidrosis • Varicose Vein and Venous Insufficiency Treatments • Female Breast Reduction Surgery - Reduction Mammoplasty • Reconstructive Blepharoplasty (Upper or Lower Eyelid), Blepharoptosis Repair (Upper Eyelid) and Brow Lift • Gastrointestinal Surgery for Morbid Obesity • Male Gynecomastia Surgery • Orthognathic Surgery • Otoplasty • Lumbar Spine Surgeries • Autologous Cultured Chondrocyte (Carticel™) Transplantation for the Knee • Transcatheter Heart Valve Replacement and Repair Procedures • Cervical Spine Surgeries • Mechanical Circulatory Support Devices • Hip Arthroplasty/Replacement and Hip Resurfacing • Knee Arthroplasty/Replacement	• Bone Marrow or Stem Cell (Peripheral or Umbilical Cord Blood) Transplantation • Liver Transplantation • Kidney Transplantation • Pancreas Transplantation (Pancreas Alone) • Pancreas-Kidney (SPK, PAK) Transplantation • Heart/Lung Transplantation • Lung Transplantation (Single or Double) • Heart Transplantation (Adult and Pediatric) • Intestinal Transplantation **WAIVER SERVICES** • Assisted Living • Homemaker • Adult Day Care • Environmental Modifications • Home and Vehicle Authorization • Consumer Choice Options • Chore Services

7. Describe your prior authorization request tracking system.

Our CareManager technology platform is used for utilization management, complex case management, care coordination, health and wellness and appeal and complaint management. This module supports clinical documentation and provides a vehicle to inform department staff of over and under-utilization of services and allows the Medica staff to see all clinical and utilization activity for a member. Clinical guidelines are embedded into CareManager which improves the efficiency of the review process and allows easy access to clinical information and guidelines to our physician reviews. All activities are tracked within the application including physician determinations. The system tracks turn-around-time and provides the nurses with alerts to assure compliance. The CareManager system is fully integrated in the claims payment system to assure claims are paid timely, efficiently and in accordance with the utilization management decision. Medica's Prior Authorization Tracking Tool will be incorporated into CareManager to include prior authorization data on a reliable, ongoing basis, with analysis and reporting designed to be actionable across the organization, which will help:

- Determine the specific prior authorization criteria that represent the biggest barrier to access
- Determine if the highest restricted services have increased or decreased over the last year
- Plan for future changes
- Formulate messaging and strategy for the purpose of improving patient access
- Quantify prior authorization access

8. Provide sample notices of action as described in Section 11.2.7.

In accordance with 42 CFR 438.210, Medica will provide written notice to the member and the provider who initiated the request for any service authorization denial, or authorization of a service in an amount, duration or scope that is less than requested. The notice will adhere to the requirements of 42 CFR 438.404 and all requirements on member communication materials for accessibility and readability.

Medica understands and agrees that our notification letters must be approved by the Agency prior to use and clearly explain the following:

- The action Medica or our subcontractor has taken or intends to take
- The reasons for the action
- The member's right to file an appeal with the Medica and the process for doing so
- After the member has exhausted the our appeal process, our notice will contain the member's right to request an external review or State Fair Hearing and the process for doing so
- Circumstances under which expedited resolution is available and how to request it
- The member's right to have benefits continue pending the resolution of the appeal, how to request continued benefits and the circumstances under which the member may have to pay the costs of these services.

Medica's sample Notices of Action is included in Tab 5.

9. Indicate if your organization elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds.

Our organization does not limit coverage or reimbursement because of an objection on moral or religious grounds.

10. Describe your program for ongoing training regarding interpretation and application of the utilization management guidelines.

The nurses receive extensive orientation and training in the principles of care and utilization management, criteria and discharge planning. Staff managing utilization managers and appeals analysts review appropriateness of requested services in utilization management. Under no circumstances may they independently deny a service determined to not meet medical necessity criteria. All potential denials require review and oversight by a licensed physician (referred to as a physician advisor or medical director). Medica monitors the application of the utilization management guidelines through a formal Inter-rater Reliability (IRR) Program.

Additionally, training is provided by the MCG CareGuidelines vendor via various methods such as individual training, vendor onsite training, online self-learning and peer to peer mentoring. MCG CareGuidelines offers certification training for Utilization and Case Management in use of their guidelines. MCG CareGuidelines are a nationally recognized evidence based medicine tool set.

SECTION 12: PROGRAM INTEGRITY

Describe your procedures for avoiding, detecting, and reporting suspected fraud and abuse to the State.

Medica has extensive experience and procedures for avoiding, detecting and reporting suspected fraud and abuse. Medica has a dedicated Special Investigative Unit (SIU) that takes a multi-pronged approach in avoiding, detecting and reporting suspected fraud and abuse by providers and members. Major program components of the SIU include:

- Internal monitoring and auditing, including prepayment monitoring and auditing of subcontracted services to detect Fraud, Abuse and Improper payments
- The development of detailed policies and procedures
- Comprehensive training to all staff
- Provision for prompt response to detected offenses, and for development of corrective action initiatives;

  Policies and procedures that safeguard against unnecessary or inappropriate use of services and against excess payments for services;
- Provision for post-payment edits and audit, including profiling provider services and member utilization that identifies aberrant behavior and/or outliers;
- Policies and procedures that safeguard against failure by subcontractors or participating providers to render medically necessary items or services that are required to be provided to a member
- Provision for identifying, investigating, and taking corrective action against fraudulent and abusive practices by providers, subcontractors, and members, or MCO employees, officers and agents
- Methods to verify whether services under this Contract, paid for by Medic were actually furnished to members

AVOIDING FRAUD, WASTE AND ABUSE (FWA)

We have found that a strong FWA awareness and compliance training plan for staff at all levels of the organization are the most effective deterrent to FWA. Additionally, we employ robust data analytic systems that run algorithms on claims to identify improper coding and providers submitting claims for services beyond what is normal for similar providers in the same geographic area. Our data system maps edits in line with the Correct Coding Initiative. Medica uses findings identified through our fraud and abuse data tools and dashboards to provide timely feedback, and identify provider training and education opportunities to prevent FWA. We work to identify fraud and abuse before it happens, and correct issues promptly when identified.

DETECTING FWA

Medica will employ an Iowa based Program Integrity Manager who will be responsible for Special Investigations Unit (SIU) activities, and will have continual oversight of FWA issues. Medica's local Corporate Compliance Officer and Program Integrity Manager will work with an Iowa based investigative team who are well- versed in State and Federal requirements, and are familiar with the local health care community. This team will prepare an annual Program Integrity Plan with quarterly updates, and provide any reports or investigations related to fraud and abuse that are required by the State. They will conduct FWA audits, investigations and monitoring and training activities. Supported by Medica's Special Investigation Unit (SIU),

additional resources, such as nurses, certified coders, and pharmacy technicians will be available to assist them in preventing, detecting and investigating FWA.

INCORPORATING SUBCONTRACTOR DATA INTO OUR FRAUD AND ABUSE PROGRAM

In addition to the robust tools for analyzing data to prevent and detect fraud and abuse, we incorporate the compliance efforts of our contracted Pharmacy Benefits Manager (PBM), specialty pharmacy partner, and other subcontractors into our FWA program. Our subcontractors follow evidence-based medicine, and practice patient-specific clinically appropriate treatment to minimize the cost of inappropriate, duplicative, or over-utilized therapies. Medica requires that all subcontractors maintain and submit a detailed log of all reports of provider fraud and abuse investigated on a quarterly basis.

Our subcontractors will also provide fraud and abuse data-mining decision-support tools and services. The PBM evaluates claims data utilizing prospective and retrospective processes to detect patterns of deviant or abnormal dispensing behavior for both Medicaid and Medicare populations, areas of high incidence of fraud, and other potential areas of abuse. The PBM will report suspicious activities to Medica's SIU department. These types of analyses will increase proactive interventions such as pharmacist education. The PBM will provide quarterly and annual reports that identify any prevented overpayments.

REPORTING FWA

Medica will develop, maintain and publicize a multimodal, confidential, and anonymous reporting process for the public, employees, contractors and members to report suspected fraud and abuse. The process will include immediate reporting of all credible allegations of fraud to the proper authorities within two (2) days.

On a monthly basis, Medica will monitor suspension or debarment of individuals, by the State of Iowa, other state, political subdivision, or the federal government. Additionally, we will utilize various databases to identify excluded providers and subcontractors. Medica will coordinate and communicate all Program Integrity efforts with the Agency, Iowa Medicaid Enterprise (IME), Department of Public Health (DPH) and Iowa's Medicaid Fraud Control (MFCU) staff as required.

Today, Medica submits numerous reports to the Minnesota Department of Humans Service on investigative activities and fraud and abuse prevention efforts. For example, we have developed a monthly report of adverse actions and a violation reporting process. We report in writing to the state any fraud that we know, or has reason to believe, has been committed by a provider or member within twenty-four (24) hours. Medica will collaborate with the Iowa Department of Human Services to develop reporting that meets the needs of the department.

1. Provide examples of outcomes achieved in other states regarding program integrity efforts.

Various forms of communication assist in our program integrity efforts. In 2014, a Minnesota based claims team developed provider correct coding tip sheets housed on Medica.com. To assist in correct coding, they also developed a special memo for the Minnesota Podiatric Association members about the correct interpretation of National Correct Coding Initiative (NCCI) edits. In addition, our provider Connections newsletter regularly contains provider education on correct coding topics such as the use of 59 and 25 modifiers. Our Provider Service Center agents are trained to direct providers to the appropriate educational materials.

These communications aid our providers in both proactively averting and in addressing unsophisticated and/or incorrect billing practices. Through our Provider College education program, we direct providers and staff, including the biller, front office and clinical staff to Medica resources on appropriately billing practices.

In 2014, Medica systematically inspected all claims activity through the development of a detailed claims algorithm. Through this inspection, over 15,000,000 claims were flagged for potential FWA and were actively investigated resulting in an overall recoupment from providers of $46,000,000.

2. Describe methods for educating employees, network providers and members on fraud and abuse identification and reporting.

Medica has an established comprehensive, readily accessible web-enabled training program that provides FWA education to employees, subcontracted vendors and providers that includes training on Medica's Standards of Conduct. This training describes federal requirements for Medicare and Medicaid programs, identifies federal database resources, such as the Excluded Providers database, System for Award Management (SAM), and the Medicare Exclusion Database (The MED) to assist network providers and employees identify excluded providers/subcontractors and report suspected fraud and program abuse.

Training will also include the Federal False Claims Act whose provisions include administrative remedies for false claims and statements, any state laws relating to civil or criminal penalties for false claims and statements, and the whistleblower protections under such laws.

The training component is the foundation of our compliance program. Staff at all levels of the organization will be trained at identifying fraud and abuse at the start of the contract, and annually thereafter. They will be educated regarding the methods to report suspected FWA and their protections upon notification.

Members will be offered information about FWA, awareness signs, and reporting methods on our website and in our handbook.

3. Describe internal controls to ensure claims are submitted and payments are made properly.

Medica's information management system is a vital part of our internal control process. Making our data meaningful is an important activity that drives our compliance. Our software systems, HealthRules and iCES, check incoming claims to verify that the member demographics on the claim match the member demographics on file. The software verifies provider demographics, credentials such as National Provider Identifier (NPI) match, and checks the claim for proper billing and coding irregularities. Large dollar claims, and claims with demographic or coding issues are flagged and stopped for manual review before payment or denial. Our high compliance rates and outcomes are due in part to our efforts to make our data meaningful.

Medica also incorporates a daily audit of manually processed and auto-adjudicated claims to ensure proper claims processing and claims payment. This daily audit is conducted by the Quality Team which is separate from the Claims Processing Unit. Audit results are tracked and reported on a monthly basis. In addition to the daily audit, a corporate function selects a random data set of processed claims for a quarterly quality review to continuously monitor overall quality.

Medica supports a portal to give providers information about many subjects including claim submission and policies and procedures. Provider reimbursement policies are closely monitored and governed by Medica's Reimbursement Policy Committee.

Medica will develop an Iowa specific data analytics tool that is compatible with Iowa's 1115 Waiver service requirements. We support the evaluation of encounters/claims and/or other administrative data to identify trends or behaviors at all system levels that indicate fraud and abuse.

4. Describe methods for verifying whether services reimbursed were actually furnished to members as billed by providers.

On-site audits are a critical component in detecting potential FWA. On-site audits verify whether services reimbursed were actually provided to members as billed by the providers. Prior to conducting these audits, Medica investigators employ data mining techniques to identify providers with high claim error rates, and claims for services without an expected corresponding claim from another provider. Investigators verify that claims are paid correctly and timely, and review medical records and associated documentation to ensure that the services were provided and appropriate.

Auditors look for potential up-coding, misuse of modifier codes, service splitting, etc. Claims may be corrected or denied based upon audit findings. Auditor's document the results generate follow-up letters, and track required actions. Technical assistance and provider education are integral parts of this process because we know that every red flag may not signal an instance of FWA. Often times these are the result of incorrect and/or unsophisticated billing practices. Medica is responsible for ensuring its providers receive ongoing education on proper billing practices and current trends.

In addition, Medica employs direct and indirect methods to verify whether services paid for by Medica were actually furnished to the members. Direct methods include:

- Confirming clinic visits or linking authorization and payment of transportation and interpreter services to clinic visits;
- Expansion of HEDIS and PIP chart review contracts to require notification to the MCO of any discrepancy in charts against paid claims;
- Individual notices to members of the payment of claims in the form of an Explanation of Benefits (EOB),
- Care manager or care coordinator follow up with members to confirm services and notification to MCO when services were not delivered,
- Post-payment review of provider documentation of services for a sample of claims.

Indirect methods to verify whether paid services were furnished to the members include billing monitoring and customer service surveys.

SECTION 13: INFORMATION TECHNOLOGY

Please explain how you propose to execute Section 13 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Medica has a state-of-the-art health information system constructed over time through a proven model and best practices. We operate an enterprise, mission-critical health information technology organization using innovative technology solutions with a continued commitment to develop and deliver best-in-class IT services. We provide integrated, flexible, high quality, and cost effective technology solutions while addressing the unique needs of our members and providers.

We pride ourselves in a mature, best-practice IT governance model and operation. From the experience in managing other state Medicaid plans, our governance model has shown to be responsive to our partner health plans and our business partners.

Our approach for operating information systems and data exchange capabilities is based on industry best practices for delivery of health care information technology within the Medicaid space. Our controls, processes, and procedures enable high levels of security and redundancy to meet our member and provider needs.

Medica IT has a track record of successfully implementing complex and time aggressive projects. Here are a few recent examples:

- **Claims and Health Management platform implementation** – Medica implemented a new member management and claims system in 2013. The new system went live in January of 2014 with more than 40,000 members. The new solution was integrated with multiple insurance exchanges, including the Federally Facilitated Marketplace (FFM); the Minnesota state based marketplace (MNSure) as well as a private exchange.
- **Online Health & Wellness solution** – Within Medica's Commercial business we recently changed vendor solutions for health tracking and incentive management. Medica successfully migrated 250,000 members from our legacy solution to the new vendor.
- **Government member portal** – Medica delivered a Medicare/Medicaid member portal recently allowing potential membership the ability to view their health plan, benefits, claim activity, and statements online.
- Medica has recently implemented a stronger **concurrent review process** with hospital admissions and discharge processes. We have successfully integrated Prior Authorizations (278) along with Admits/Discharges/Transfers (ADT) via a 278 format, into our care and case management systems.
- Medica completed a major **Data Center move** in the fall of 2012. Changing vendors and locations, as well as making substantial investments in new infrastructure. Over 450 applications and approximately 1000 data feeds were migrated without major issues or customer/member impacts.
- Medica is on-track to successfully implement **ICD-10 changes**, effective October 2015.

The architecture and design goal of Medica Information Technology is to provide best-in-class enterprise services delivered via robust, reliable, and secure infrastructure platforms and operations. The foundation of our infrastructure is a fault tolerant and secure high speed Local Area (LAN) and Wide Area (WAN) Network which connects to multiple data center locations. Internet, WAN, and network circuits are delivered through

multiple carriers for redundancy. Storage consists of enterprise class high performance arrays with multiple controllers and extensive redundancy for 'always on' availability for critical databases and applications. Critical business application services are delivered on servers with redundant processors, power supplies, network cards, storage interfaces, and disk storage. This physical infrastructure runs Medica's virtualized computing environment which is used to deliver application services. Virtualization technologies along with our tiered and modular architectures allow for growth while providing flexibility and minimizing the impact of maintenance activities and incidents.

13.1 Information Services and Systems

1. Provide a general systems description and a systems diagram that describes how each component of your information system will support and interface to support program requirements.

Medica's Enterprise System Platform operates on a technology infrastructure that is proven secure and scalable, and has at its core, key mission-critical enterprise business systems to support Iowa business functions including eligibility, enrollment, authorizations, clinical/care management and claims processing. Today, our system collects, stores, integrates, analyzes, validates, and reports data on members, which is used in a variety of programs and contexts to provide the best possible care to our members

Medica will manage Iowa operations on the Medica Enterprise System Platform that addresses system requirements in 42 CFR 438.242(b)(2) to establish and maintain a health information system that integrates the following processes and functions:

- Care coordination and care management
- Utilization management
- Quality Management
- Claims and encounter submission and payment
- Service authorization
- Network management
- Credentialing
- Grievance and appeals
- Data collection and storage
- Data analytics and reporting

Medica has the capability to transform information into actionable knowledge through an established Business Intelligence program. Reporting, dashboards and key metrics are all components of our program that enable data to transform into powerful information.

Medica has a governance structure that serves as a foundation for IT business systems and functions and aligns with health industry standards. We are able to support key business functions using enterprise health data across multiple integrated service-oriented modules including:

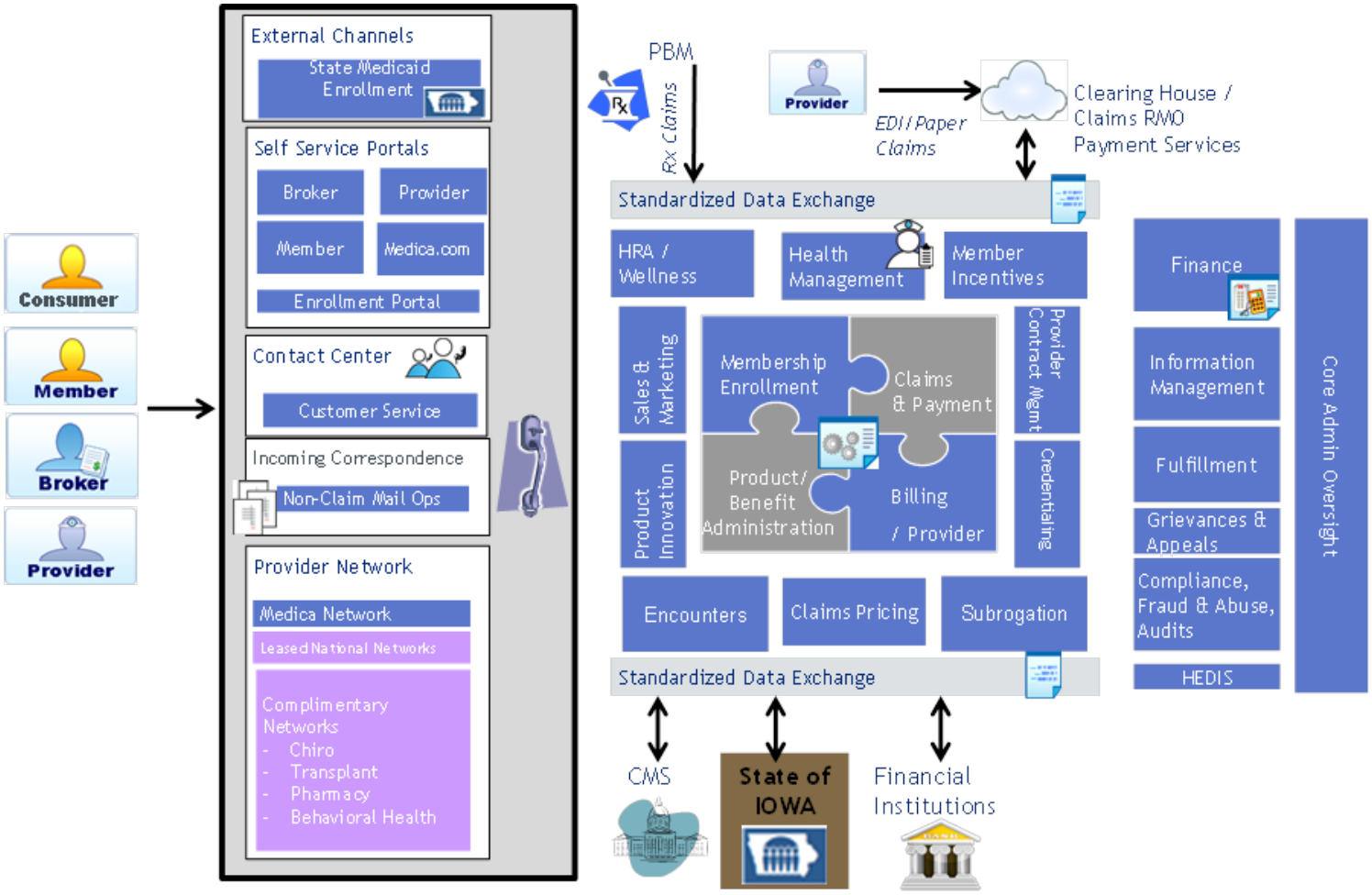
- **Member services**
  - Eligibility and enrollment
  - Member Portal
  - Demographic information
  - Call tracking / IVR
- **Utilization management**
  - Prior authorizations
  - Concurrent review
  - HEDIS measures
- **Provider relations**
  - Contract management
  - Billing and payment

- **Clinical Information**
  - Diagnosis and functional assessment score
  - Level of functioning
  - Service referrals
  - Medication
  - Appointments
  - PCP Assignment

- **Claims Adjudication and Payment**
  - Benefit Configuration and Management
  - Coordination of Benefits – the system offers a range of edits to help identify and manage the coordination of benefits, including cost avoidance and recovery.

Medica has been supporting our claims processing functions in Minnesota since 1975; each year, Medica processes over 50 million transactions.

The following diagram on the below illustrates the depth and breadth of our Enterprise System Platform capabilities.



The following paragraphs summarize additional functionality available in our Enterprise System Platform.

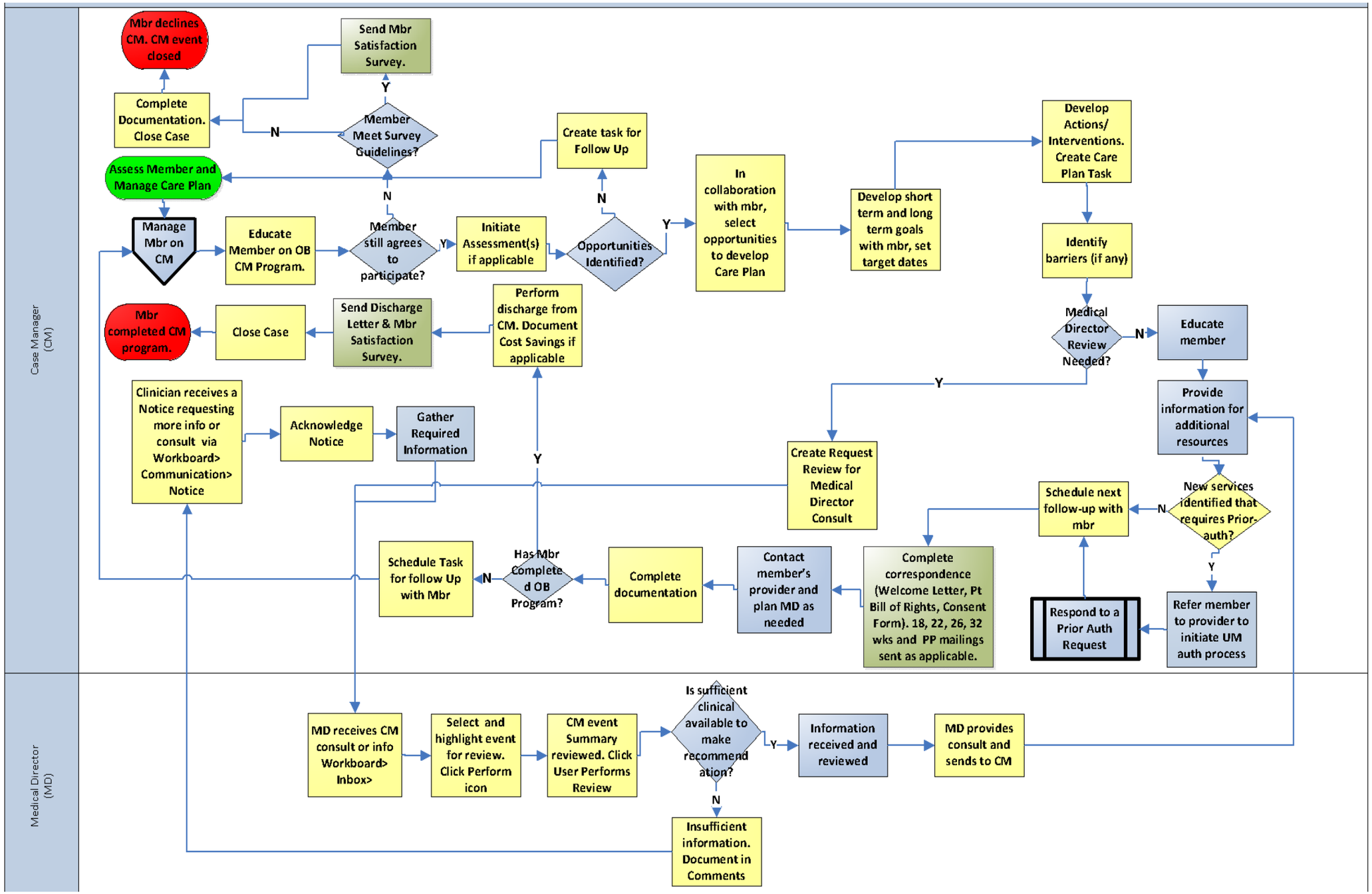
DETECTING WASTE, FRAUD AND ABUSE-CLAIMS MANAGEMENT

Medica's Enterprise System Platform, Integrated Claims Management Editing Platform (ICEP) enhances claims edit intelligence through the industry's most comprehensive correct coding and medical policy content libraries. We utilize the intelligence of ICEP coupled with historical claims information to further detect possible cases of fraud. We have programmed ICEP to execute a variety of algorithms, which detect potential claims coding and billing errors. By using data from the ICEP system, we will target providers for follow-up interventions such as chart audits. Our claims management process includes a best-in-class industry software for claims editing. We use this application to define and combine specific claims data criteria, such as provider or diagnosis, and the ability to create custom edits for refined auditing power.

CARE MANAGEMENT/CARE COORDINATION

Our Enterprise System Platform supports a variety of integrated case and care management activities including but not limited to case assignment, assessment, care planning, service coordination and document management. We have the capability to preconfigure workflow rules to prompt case and care managers of predefined event-driven actions, such as upcoming appointments or medication refills, which in turn results in more effective member care. We also leverage branched logic to display context sensitive information, such as assessment deadlines, service coordination notes and service accessibility data. Upon login, a summary screen presents case managers with an overview of their assigned caseload, assessment due dates and associated tasks. We use an automated escalation process to alert case managers and supervisors of upcoming and overdue assessments, and generate audit reports to further drive compliance with standards. Medica has the capability to automate and customize care management functions specific to Iowa members.

Medica has an advantage in ensuring integrated care coordination for Iowa members through our Health Management System – a clinical support system that includes messaging capabilities. We use the system to integrate key clinical information such as inpatient and pharmacy claims data and lab results within member-centered records that are then compared to over 1,000 evidence-based clinical rules and related algorithms developed by board certified physicians and pharmacists. Findings from our data analysis and informatics identify member- specific opportunities for providers to optimize care using evidence-based treatment recommendations – "Care Considerations." At the same time, we use a similar data analysis and informatics approach for "Wellness Considerations"—for communication with members on prevention and wellness issues such as childhood immunizations, breast cancer screening, and disease appropriate screening and vaccinations. The process flow is depicted in the diagram below.


Case Manager (CM)
Medical Director (MD)
Mbr declines CM. CM event closed
Send Mbr Satisfaction Survey.
Complete Documentation. Close Case
Member Meet Survey Guidelines?
Y
N
Create task for Follow Up
Assess Member and Manage Care Plan
Manage Mbr on CM
Educate Member on OB CM Program.
Member still agrees to participate?
Initiate Assessment(s) if applicable
Opportunities Identified?
In collaboration with mbr, select opportunities to develop Care Plan
Develop short term and long term goals with mbr, set target dates
Develop Actions/ Interventions. Create Care Plan Task
Identify barriers (if any)
Medical Director Review Needed?
Educate member
Provide information for additional resources
New services identified that requires Prior-auth?
Refer member to provider to initiate UM auth process
Respond to a Prior Auth Request
Schedule next follow-up with mbr
Complete correspondence (Welcome Letter, Pt Bill of Rights, Consent Form). 18, 22, 26, 32 wks and PP mailings sent as applicable.
Contact member's provider and plan MD as needed
Complete documentation
Has Mbr Completed OB Program?
Schedule Task for follow Up with Mbr
Create Request Review for Medical Director Consult
Perform discharge from CM. Document Cost Savings if applicable
Send Discharge Letter & Mbr Satisfaction Survey.
Close Case
Mbr completed CM program.
Clinician receives a Notice requesting more info or consult via Workboard> Communication> Notice
Acknowledge Notice
Gather Required Information
MD receives CM consult or info Workboard> Inbox>
Select and highlight event for review. Click Perform icon
CM event Summary reviewed. Click User Performs Review
Is sufficient clinical available to make recommendation?
Information received and reviewed
MD provides consult and sends to CM
Insufficient information. Document in Comments

We also have a Predictive Analytics tool, which assimilates information from a variety of sources, including a data warehouse that transforms it into a series of markers measuring both risk and opportunity. We use this tool to score these markers and assign a risk stratification level to members, reflecting both the level of risk and potential opportunity for improvement, thereby helping case managers provide the appropriate level of care coordination.

GRIEVANCE SYSTEM TRACKING AND TRENDING

Medica maintains an application that supports the Grievance and Appeals process by tracking member and provider issues from inception to resolution. Our system addresses issues affecting individual member and provider satisfaction in addition to potential system delivery trends. When deficiencies are identified, we use this information to take prompt, corrective action. Our internal application will be configured to integrate requirements of the Grievance and Appeals process in Iowa.

DOCUMENT MANAGEMENT

Medica's document management solution supports the capture, management, and archiving of scanned documents, such as paper claims and other electronic image files through their entire lifecycle.

ONLINE DRUG FORMULARY

Our Pharmacy Benefit Manager partner provides a web-based online drug formulary available to providers for use at the time of treatment and prescription. The tool assists providers in reducing errors by displaying up-to-date references for drug dosage, potential drug interactions and clinical alerts from the Federal Drug Administration and Centers for Disease Control.

DATA ACCESSIBILITY

Medica employs protection strategies consistent with HIPAA Security Rule recommendations for encryption of data at rest and in transit. Furthermore, Medica will provide attestation at the time of submission that any data transmitted is accurate, complete and truthful, to the best of the Medica's Chief Executive Officer (CEO), Chief Financial Officer (CFO) or designee's knowledge in conformance with the Iowa Medicaid Enterprise (IME) (42 CFR 438.606). Medica has the capability to produce standard reports at any requested frequency—including ad hoc reports—with daily, weekly, monthly, quarterly or annual production schedules available.

CONTRACTOR COMPLIANCE

Medica's enterprise contractor compliance program will comply with Iowa requirements. We will implement the following Supplier Management and Development controls for contracted vendors:

- **Privacy and Security program** – Designed to obligate new and existing stratified suppliers to attest to their compliance on a series of information privacy and security requirements via Medica's Supplier Information Privacy & Security Attestation (IP&S) process; suppliers must attest to compliance before a contract is signed and then annually thereafter.
- **Annual Independent Third Party Onsite Audit Assessment** – Additional due diligence, which enables a risk-stratified suppliers' compliance to Medica's Vendor Privacy & Security Attestation. Approximately 20-25 suppliers are selected annually for an independent onsite audit assessment. Medica Internal Audit leverages third party attestation for audits. Internal audit identifies in-scope vendors for review based on their criticality to the organization and its financials.

Medica requires vendors to adhere to industry best practices for data Privacy and Security standards. Where applicable, vendors are required to provide documentation of third-party audits, including an attestation of SSAE-16 SOC I/Type II review. Medica's Corporate Compliance and Information Security programs are compliant with applicable laws and regulations, including HIPAA and HITECH. In addition, Medica incorporates other industry guidelines, such as ISO 27001 and NIST, to ensure policies, standards and processes have a consistent, repeatable theme.

ELECTRONIC MAIL ENCRYPTION

Medica's top priority is to secure and maintain the confidentiality of each member's personal health information (PHI) by securing all outbound email. Our information technology systems that collect and store member PHI are consistent with HIPAA Security Rule recommendations for encryption of data at rest and in transit. To meet the in-flight requirements, Medica has deployed a company-wide outbound email encryption technology and requires via policy that any emails containing sensitive information be sent utilizing this technology. The technology scans all outgoing emails and determines whether sensitive data is contained in the subject line, body text of the message or unprotected attachments. If an identifier is met, the technology sends a notification to the recipient that a secure email was sent to them and to prompt the recipient to login in to a secure website and retrieve the message. If the message has not been retrieved by the recipient within ninety (90) days, the email will expire and be deleted from the secure web portal.

Additionally, all email, whether containing sensitive or otherwise confidential data, attempts to be transmitted in an encrypted manner regardless of the encryption technology deployed. This is done natively with the solution Medica utilizes for email communications.

ELECTRONIC REMITTANCE ADVICE (ERA) AND PAYMENT

Medica's electronic remittance advice and payment solution contains the following capabilities:

- Customer service support for provider registration and logins
- Role-based user management and security (need-to-know access management)
- Auditing functionality
- Duplicate file and transaction safeguards
- Secure, easy-to-user interface for providers.

Medica leverages an interactive web portal to allow providers to opt into Electronic Payment and Statements (EPS). The secure portal allows providers to set up electronic transfers so Medica can direct deposit funds into a provider's bank account. Providers can see payment records online, such as a provider Explanation of Benefits (EOB) statement, with claims payments information grouped by tax ID number, or electronic provider remittance advices (EPRAs) for industry standard, HIPAA compliant X12 835 transactions.

CERTIFICATION

Medica will submit encounters in accordance with the State's prescribed format.

CLAIMS AND ENCOUNTERS

Reporting

Medica's policies and procedures will comply with IMHP requirements regarding reports, content and frequency of submission, providing for IMHP receipt of any deliverable (for example, Corrected Pended Encounter Data, New Day Encounters or Medical Records for Data Validation).

Reinsurance Eligibility/Aging Reports

Medica will manage a separate, closely coordinated process, using data from the claims platform to identify, through predetermined thresholds, claims eligible for reinsurance. They will then compare these claims to EMS to isolate pended or denied encounters less than three (3) months from their respective adjudication deadlines, allowing them to prioritize and handle them accordingly. Staff will void encounters for any claims recouped in full, with replacement encounters submitted when any recoupment/adjustment results in reduced/increased claim value.

Encounter Error and Acceptance Reports

Medica will generate Encounter Error and Acceptance Reports upon receipt of response files (277, 277U, NCPDP / PAH - post adjudicated history). The reports will include the age and description of submission errors and provide necessary information for encounter management staff to promptly identify, track and resolve encounter errors. Should a claim require re-adjudication as the result of an encounter error, we will resubmit it to the claims platform for processing, and import it to the EMS for resubmission in accordance with encounter correction protocol. We will generate from EMS the appropriate void, replacement and/or corrected records. If re-adjudication is unnecessary, the encounter management unit will perform the corrections necessary to allow resubmission of the associated encounter per protocol.

Remediation Strategies

Medica’s Claims Operations team will research each pend or denial edit. The team will employ diverse strategies to track related issues to their point of origin, and utilize continuous improvement methods to identify, assess, remediate and control sources of error.

Manual Adjudication

Medica will monitor and address Claims Analyst errors related to procedural, payment or financial accuracy. We will initiate coaching, performance improvement plans and, if necessary, further corrective action. If a manual adjudication error is traced to an existing claims policy and procedure, a Claims Training Update (CTU) will be distributed to Claims Analysts to prevent further errors. We will update policies and procedures, along with training materials, as necessary.

Auto Adjudication

The Claims Operations team will review encounter edits, pends and denials to validate correct application for submitted claims processing in the claims platform for member enrollment, benefits, edits, provider set-up and reference files. The Claims Operations team will pend and adjust impacted claims in process, if necessary, and adopt manual workarounds as needed until the issue is resolved.

Provider Education

The Claims Operations department will identify opportunities for targeted provider education regarding specific errors related to unacceptable claim and billing practices. Based upon specific identified errors, Claims Operations will work with Provider Services personnel to complete outreach, education and training for providers. Medica will concentrate on those providers with a history of submitting incomplete, inaccurate or untimely claims for additional training and support.

Encounter Workgroup

The Quality & Training department will lead a cross-functional group comprised of System Configuration Specialists, a Provider Claim Educator, and personnel representing our IT; claims and claims audit departments; compliance; encounters; provider data management and services and the Medicaid Provider Solutions Team. This workgroup will meet regularly to address issues with resolving pends and denials, improving workflows, and any open encounter system concerns

Collaboration

Medica personnel will attend a monthly meeting where encounter management, claims, compliance, finance, and configuration personnel meet and collaborate with Iowa staff to resolve pended encounter issues.

Medica will model the meetings based on the success of Medica Minnesota where we have achieved several cost and time saving elements.

Medica will monitor claim audit findings and claim dashboard results, and will approve and validate system changes, such as reference file and fee schedule updates, as well as benefit changes. This team will also be responsible for post-production validation of claim processing-related projects and system change activities.

Encounter Submission Initial and Global Acceptance Rates

Medica has a proven track record of superior encounter claim submission acceptance rates as evidenced in Table on the following page. We will employ the same or similar processes and methods to replicate this success in Iowa.

Medica's clean claims rate for State Public Programs is ninety-five percent (95%). We work to ensure that claims processing is as smooth as possible and we monitor this very closely. Our ability to turn around reimbursement quickly and accurately is essential to retaining and recruiting quality providers to our network.

We have stringent claims operational goals and excellent outcomes as evidenced by the following 2014 results:

MEDICA OR SUBCONTRACTOR	% CLAIMS PAID	% DENIED	% "CLEAN CLAIMS"	PAID WITHIN 30 DAYS	PAID WITHIN 90 DAYS
MEDICA	89.80%	10.20%	95.00%	99.90%	100.00%
BEHAVIORAL HEALTH	91.55%	8.45%	92.00%	99.94	100.00
DENTAL	94.50%	5.50%	96.90%	99.96%	99.98%
PHARMACY	52.66%	26.83%	80.00%	44.50%	99.98%

Medica's system will provide for the accurate, timely, and complete submission of encounter data, and will be used for encounter reporting activities. Through our system, Medica will be able to submit reports for tracking, trending, reporting process improvement, and monitoring submissions of encounters and encounter revisions in conformance with the Billing Manual, or as directed by State (42 CFR 438.242(b)(3)).

Medica's experience in claims and encounter processing demonstrates expertise to effect change in the way we will deliver health care to our members and enhance our ability to serve diverse populations.

2. Describe data back-up processing plans including how data is stored at an off-site location.

Medica is committed to data protection through a comprehensive set of best practices for data back-up and storage. Our systems are designed to secure and store data off site on a daily basis. Medica performs regularly scheduled comprehensive backup of member data in accordance with HIPAA requirements. Backed up data is stored locally on disk and then replicated to disk at a secondary site to provide a simplified and timely recovery process in the event the primary site becomes unavailable. In addition, a third copy of production data is written to tape and taken off site daily and stored in a secure vaulting facility. Medica performs regularly scheduled, comprehensive back-ups of member data in a way that is consistent with HIPAA guidelines for access and encryption of data at rest and in flight.

3. Describe how clinical data received will be used to manage providers, assess care being provided to members, identify new services and implement evidence-based practices.

Medica Enterprise System Platform supports a variety of integrated case and care management activities including but not limited to case assignment, assessment, care planning, service coordination and document management. We will implement a mechanism to harvest and transform clinical data available to Medica into effective formats that can influence care decisions and optimize members' clinical outcomes.

We use Medica's Enterprise System Platform to analyze extensive medical and pharmacy claims data to generate a single integrated member record and to continuously monitor for opportunities to avoid risk and optimize member care. We analyze member-specific data in the care engine system, which houses a suite of approximately 1,000 evidence-based algorithms that span the health care service delivery continuum—from wellness and prevention to managing chronic conditions. A team of board certified physicians and pharmacists, utilizing the most current clinical practice guidelines, peer reviewed studies, trade journals and

standards of care will develop, routinely review and update algorithms. When scanning the available claims data reveals an opportunity to avoid drug interaction or contraindications or to recommend an appropriate testing or treatment additions a targeted provider communication will be generated.

These communications are stratified according to the severity of the situation. Medica will communicate those that represent a potential life-threatening situation (Level One) to providers via phone with fax follow-up, while those that are serious, but not life threatening (Level Two) will be communicated via phone or letter. Level Three Care Considerations are based on generally recognized standards of care and are typically be communicated by letter. This places time sensitive and critical information directly into the provider's hands for immediate intervention and engagement of the members to avoid adverse events and improve outcomes.

MONITORING

To assess adherence and adoption of the American Society Addiction Medicine guidelines, Medica monitors the use of selected recommended services by practitioners along with related member outcomes. We direct the resulting information to medical committees, where it will be used to evaluate overall performance and assess the efficacy of a new program. We also link the information to individual physician profiles, to evaluate over- and under-utilization, and determine the need for provider education to improve practice patterns. We will provide feedback to practitioners on their individual performance and emphasize the importance of using the guidelines in the development and monitoring of members with co-occurring disorders. Medica will assess the continued appropriateness, medical necessity and cost effectiveness of services through the concurrent review process. If Medica determines that the member would benefit from an alternative level of care or service, Medica works with the clinical team to identify and secure the appropriate services to meet the member's needs.

Medica analyzes data to link services while reviewing information in an integrated context. We utilize our Enterprise System Platform for data analysis to identify and act on priorities with administrative, financial and clinical implications.

4. Submit a draft Information Systems Plan as described in Section 13.1.5.

Per the details provided in the Scope of Work (Attachment 1), this section contains a draft information systems plan that addresses receiving, creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 160, 162 and 164 and the HIPAA Security Rule at 45 CFR 164.308). Upon bid award, a final draft plan will be submitted to the State of Iowa for review and feedback.

13.1.5.1 Planning, developing, testing and implementing new operating rules, new or updated versions of electronic transaction standards, and new or updated national standard code sets

Medica plans to approach the implementation of the Iowa specific requirements in alignment with the high level timeline on the next page.

TASK NAME	START	FINISH
RFP Review & response	Mon 3/2/15	Tue 5/26/15
Project Planning & start-up	Mon 4/13/15	Fri 5/15/15
Analysis & Design	Mon 5/18/15	Fri 7/10/15
RFP Response Due	Tue 5/26/15	Tue 5/26/15
Build	Mon 7/13/15	Fri 9/11/15
RFP Bid winners announced	Fri 8/7/15	Fri 8/7/15
Test	Mon 9/14/15	Fri 12/18/15
Implementation	Mon 12/21/15	Fri 1/1/16
Go Live	Fri 1/1/16	Fri 1/1/16

Additionally, we have a pre-defined release schedule that accounts for updates of new or updated codes sets on a pre-defined frequency. Below is a sample of a high level schedule for code set updates.

JANUARY	APRIL	JULY	OCTOBER
CMS Professional Fee Schedule (Major Release)	CMS Professional Fee Schedule (Small)	CMS Professional Fee Schedule (Small)	CMS Professional Fee Schedule (Small)
Surgical Grouper (Small)	Surgical Grouper (Small)	Surgical Grouper (Major Release)	Surgical Grouper (Small)
APC (Small)	APC (Small)	APC (Small)	APC (Major Release)
DRG (Small)	DRG (Small)	DRG (Small)	DRG (Major Release)
CPT (Major Release)	CPT (Small)	CPT (Small)	CPT (Small)
Modifier (Major Release)	Modifier (Small)	Modifier (Small)	Modifier (Small)
HCPCs (Major Release)	ICD9 (Small)	HCPC (Small)	HCPC (Small)
Revenue Codes	HCPCs (Small)	CARC/RARC Updates	ICD9 (Major Release)

13.1.5.2 Concurrent use of multiple versions of electronic transaction standards and codes sets

Medica follows a change control process to ensure concurrent versions of electronic standards and code sets are maintained and tracked.

13.1.5.3 Registration and certification of new and existing trading partners

Medica has a well-defined process for registration and certification of new and existing trading partners. These processes include setup to move data, set-up for sending and receiving data from external organizations. To protect Medica and our member's data, we employ stringent measure to follow safe contractual, compliance and information security policies before transferring data.

Medica uses standard data content and data file transfer processes to gather important information to setup connectivity with external partners. Information collected enables Medica IT to schedule jobs to move data and monitor these jobs based on schedule and expectations.

13.1.5.4 Creation, maintenance and distribution of transaction companion guides for trading partners

Medica leverages an industry standard clearinghouse vendor that works with trading partners to provide standard transaction companion guides for our Medicaid business.

13.1.5.5 Staffing plan for electronic data interchange (EDI) help desk to monitor data exchange activities, coordinate corrective actions for failed records or transactions, and support trading partners and business associates

Medica monitors all the data transactions in and out of our organization. Alerts are automatically created when there is an issue with file transmissions and incident tickets are created at the appropriate priority given the specific data and timing of the transaction. These incidents tickets are then routed to the appropriate support team queue and resolved within predefine service level agreement timeframes based on priority.

13.1.5.6 Compliance with all aspects of HIPAA Privacy and Security rules

The list below represents current Medica activities and efforts regarding compliance with various aspects of HIPAA transactions:

a. Medica Compliance area monitors adherence to current HIPAA transaction requirements, National Operating rules, and Minnesota state requirements.

b. Medica is a member of the Minnesota Uniformity Committee (AUC). The AUC is a voluntary, broad-based group representing Minnesota health care public and private payers, hospitals, health care providers and state agencies, working to standardize, streamline, and simplify health care administrative processes and transactions. Medica has representation on AUC Operating committee level as well as on Transaction Advisory Groups (TAGs).

- Medica is a member of Workgroup for Electronic Data Interchange (WEDI) and currently participates in WEDI working groups and attends WEDI webinars and other national meetings and events.

13.1.5.7 Strategies for maintaining up-to-date knowledge of HIPAA related mandates with defined or expected future compliance deadlines

In addition to the activities listed in 13.1.5.6, Medica employs the following strategies to maintain the most current knowledge regarding HIPAA related mandates:

- Medica participates in CAQH/CORE webinars and events to keep current with latest national operating rules updates
- Medica participates in X12 webinars and events to keep current with latest HIPAA transaction updates/changes
- Medica also has an internal program in place, “Administrative Simplification” whose goal is to implement provisions under the Affordable Care Act [ACA] of 2010, including:
    - i. Implementation of Phase I and II Operating Rules for eligibility (270/271) and claims status (276/277) determination
    - ii. Implementation of Phase III Operating Rules for EFT payments and remittance advice (835)
    - iii. Health Plan Certification Phase I: Certify compliance with the standards and operating rules for eligibility (270/271), claim status (276/277), ERA (835), and EFT transactions.
    - Implementation of Phase IV Operating Rules for claims (837), enrollment (834), premium payments (820), referrals/ authorizations (278), and claims attachments (275)

Health Plan Certification Phase II: Certify compliance with standards and operating rules claims (837), enrollment (834), premium payments (820), referrals/ authorizations (278), and claims attachments (275)

Enumeration of a unique Health plan Identifier. Implementation of HPID in all electronic transactions

Overall, Medica's Information Systems implementation approach will be similar to plans we have implemented in other contracts. The various steps, or stages, of our systems migration plan are shown in section 2.14.a.

Medica's Enterprise System Platform stores and transmits data elements in specified formats, including HIPAA 834 and 837 transactions. Our platform is powered by an EDI Gateway that serves mission critical information sharing for the state of Minnesota today. The EDI Gateway is scalable, currently processing over 35 million real-time and batch-time transactions per day. Over 30 terabytes of data is exchanged monthly through the EDI Gateway in a multitude of formats compliant with HIPAA Transaction and Code Sets Standards.

5. Describe your proposed information systems staffing model.

Medica will leverage the existing shared services model that is already in place within our IT organization. We have structured our IT department for agility, flexibility and responsiveness. Medica's IT Department is staffed by over hundred-fifty (150) industry professionals. The following teams and roles exist within Medica's IT organization:

- Software Development
- Quality Assurance
- Business Intelligence – Enterprise Data Management
- Reporting and Analysis Services
- Data Center and Network Services
- Voice/Contact Center Engineering
- Incident and Problem Management
- Change and Release Management
- Contact Center Services Department
- Database Administration
- Production Support Team
- Incident Management
- Information Security
- IT Procurement and Vendor Management
- IT Finance
- IT Business Operations – Project Managers
- Enterprise Architecture Services

6. Describe your plan for creating, accessing, transmitting, and storing health information data files and records in accordance with the Health Insurance Portability and Accountability Act's mandates.

Medica will comply with all applicable laws and regulations including, but not limited to Health Insurance (HIPAA) and Iowa state laws pertaining to the use and disclosure of sensitive information. Medica will comply with applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) as well as the procedures, policies, rules and statutes in effect during the term of our contract. This will include but will not be limited to eligibility/enrollment (HIPAA compliant 270/271 and 834) and encounter data (HIPAA compliant 837.)

Medica Enterprise System Platform will include support for the electronic transactions listed below:

TRANSACTION	DESCRIPTION
Claims (Instructional/Professional)	HIPAA 837 i/p
Enrollment	HIPAA 834 or Proprietary if needed
Payments	HIPAA 820 v206, v306
Proprietary Support	Flat file / XML
Claims Status(Batch & Real-Time)	HIPAA 276/277 claims status (clearinghouse , provider portal)
Eligibility (Batch & Real-Time)	HIPPA 270/271 Eligibility
EOB	XML (explanation of benefits)
Provider Remittance	HIPAA 835 remittance
Provider Demographics	XML /Flat File interface supporting provider directory for Find-A-Doc
Referrals/ Authorizations/ Waivers/ Hospital Notifications	HIPAA 278 transaction
Accumulators (Pharmacy Claims) – Real-Time	TYPE 44 // Rx Claims

By leveraging existing expertise and successful techniques from Medica Minnesota, Medica will maintain the same seamless interoperability. Electronic communication and web-based technologies are leveraged to reduce cost, eliminate unnecessary administrative requirement, support increasing health literacy, and improve health care outcomes. Medica will develop the functionality and support to keep pace with the changes in HIPAA requirements and to support electronic connectivity.

7. Describe your proposed electronic case management system and all information which is tracked in such system.

Medica's Enterprise System Platform supports a variety of integrated case and care management activities including but not limited to case assignment, assessment, care planning, service coordination and document management. As part of our Enterprise Platform, we employ a care management software suite that streamlines health management day-to-day work activities while improving member health. The system uses state-of-the art technology that empowers Medica to focus on identified patients at the right time, with the interventions that are most appropriate.

Our care management suite includes advanced workflow capabilities and analytical tools to support health management processes and goals in the areas of:

- Case management
- Utilization management
- Disease management
- Referral management
- Patient analytics

By focusing data in a member centric approach, we are able to utilize the fourteen (14) Care Pathways leveraged by Case Management and Disease Management Programs Patient Health Questionnaire:

- Comprehensive General Adult (Female)
- Asthma (Adult and Pediatric)
- Chronic Obstructive Pulmonary Disease (Adult)
- Diabetes (Adult and Pediatric)
- Metabolic Syndrome (Adult and Pediatric)
- Pain Management
- High Risk Pregnancy
- Follow-Up
- Depression, Major (Adult)
- Tobacco Cessation
- Nutritional Screening
- Comprehensive General Adult (Male)
- Coronary Artery Disease (Adult)
- Heart Failure (Adult)
- Oncology
- Pain Screening
- Hypertension (Adult)
- Initial
- Pregnancy Postpartum
- Comprehensive General Pediatric
- Sleep Screening
- Care Transition Assessment

Our Analytics and Reporting allows for configurable reports based upon client specific needs:

- Operational Reporting
- Case load
- Case activity
- Case acuity
- Efficiency
- Timeliness
- Outcomes Reporting
- Tracking of goals progress
- Cost savings analysis
- Reduction in utilization of services

The process flow for care management/care coordination is described in our response to question 13.1.1, Care Management/Care Coordination.

9. Indicate if an Electronic Visit Verification (EVV) System is proposed and what methodologies will be utilized to monitor member receipt and utilization of HCBS.

Medica uses a hybrid approach and not a "one size fits all" model. Medica proposes a phased implementation that will best suit the State of Iowa as well as providers and stakeholders and that will involve feedback from impacted parties.

Medica will establish an EVV Standards Workgroup to help develop a solution that establishes technical and functional EVV standards.

We believe this approach enables providers to choose the EVV system which best meets their needs. It provides assurances to the state that any system selected will feature strong technical controls that promote visit verification, thereby minimizing fraud and abuse. More importantly, it relieves the state from having to incur the upfront costs and risks associated with selecting a single source EVV system and forcing all providers to use it, including providers that already have another EVV system in place.

10. Describe in detail how clinical records, as described in Section 13.1.13 will be maintained in your information system.

Medica's Enterprise System Platform aggregates data, which is often organized as a longitudinal member record. We have the technology, through the application of syntactic translation, to transform data into dynamic information with corresponding logical actions instead of traditional static representations of past events.

Medica will configure the Medica Enterprise System Platform to be the decision support and care coordination center, continuously cycling evidence-based care algorithms across the data environment. Through the Medica Enterprise System Platform, we will generate automatic messages that identify member-specific opportunities to optimize care. This includes sending and receiving data and information to and from the State related to member outcomes, patient records, individual service plans, service referrals, network capacity, initial assessment and updates to the assessment, annual administrative review, provider performance measures and dashboard performance reports.

Our Medica Enterprise System Platform incorporates an EDI Gateway, a hub architecture that facilitates data exchange and data sharing of the claims data file in the prescribed format.

Medica's approach to integrated health care and care coordination across populations and service categories is designed to achieve better health outcomes. It does not matter whether a person is receiving General Mental Health/Substance Abuse or Child/Adolescent services; our data systems enable providers to coordinate care across multiple entities by providing access to appropriate client information.

While we adopt this approach for clinical records, it can also be applied to data and data connectivity as a whole accelerating traditional care coordination into advanced health intelligence, analytics and quality measurement. This will result in two important byproducts:

- Minimal data collection burden: Medica's systems will provide access to structured electronic data that can be extracted for quality measurement without requiring time and resource-intensive data collection efforts.
- Rich clinical context: Information stored will be rich in content and detail. This information can provide a view of processes of care and clinical outcomes not possible from data sets based only on claims data

Ultimately, our systems will provide the State with a comprehensive look at a member's quality of care.

11. Submit system problem resolution plans and escalation procedures.

The information below represents a standard Medica Incident and Problem Management Process. System-specific plans can be made available upon request.

MEDICA INCIDENT MANAGEMENT PROCESS

Scope: The goal of the incident management is to restore normal service operation quickly and efficiently, to minimize the adverse impact on business, and to ensure that IT maintains the best possible level of service, quality, and availability. The desired result of the incident management process is to resolve and/or implement a work around for an incident. Incidents take precedents over all other work.

Definitions:

- **Incident –** An unplanned interruption to an IT Service or a reduction in the Quality of an IT Service. Failure of a Configuration Item that has not yet impacted service is also an incident.
- For example, Failure of one disk from a mirror set.
- **Incident Management –** The process responsible for managing the lifecycle of all Incidents. The primary objective of Incident Management is to return the IT Service to users as quickly as possible.
- **Problem -** A cause of one or more Incidents. The cause is not usually known at the time a Problem Record is created, and the Problem Management Process is responsible for further investigation.
- **War Room -** A War Room is assembled to help communicate information, tap into all sources for knowledge and get the full context, rationale and details around a specific problem. The War Room helps make effective, educated decisions rapidly using a predictable set of steps
- **Incident Response Team (IRT) -** An IRT is made-up of key IT resources and may require business participation depending on the type of incident. Its members can vary depending on the type and impact of the incident. During an incident the IRT reports to the Incident Manager and needs to be available as necessary to provide progress reports or attend a War Room to address the action plan or status of an incident.
- **Post Incident Review (PIR) –** The primary goal a PIR is to reduce the number of incidents and increase customer satisfaction. A PIR should provide action items that will reduce or eliminate the possibility of a repeat of the same incident. A PIR will be in the form of a Problem ticket for root cause identification and elimination and will be assigned within five (5) days of incident resolution.
- **Category (CTI) -** Incidents can be categorized according to the type of incident and the nature of the support services to be provided. The more precisely incidents are categorized within Service Now, the more useful and effective the Service Desk is in communicating and trending incidents.
- **Severity -** Severity represents the impact that the service disruption has on the customer. It may be sensitive to the number of systems or services disrupted, but volume is not the only criterion applied. The number of customers, sites, or systems affected may or may not have a significant business impact. The productivity impact of the service disruption and the business processes that are affected must be understood.

INCIDENT MANAGEMENT ROLES AND RESPONSIBILITIES

Incident Management Activities

- Detecting and recording incident details
- Matching incidents against known problems
- Resolving incidents as quickly as possible
- Prioritizing incidents in terms of impact and urgency
- Escalating incidents to other teams as appropriate to ensure timely resolution

An Incident Manager has responsibility for:

- Driving the efficiency and effectiveness of the incident management process
- Producing management information, including KPIs and reports
- Monitoring the effectiveness of incident management and making recommendations for improvement
- Developing and maintaining the incident management system
- Driving, developing, managing and maintaining the major incident process and associated procedures
- Reviewing and auditing the process
- Ensuring that all IT teams follow the incident management process for every incident

Incident Process

1. **Recording –** An incident is initiated when a customer reports an incident using the Knowledge Network (KN) or by placing a call to the Service Desk. If the ticket is generated through the KN, the Service Desk is notified by email, if the customer calls the Service Desk, the incident is created at the time of the phone call. Whichever way is used there are minimum requirements for information that the Service Desk needs for facilitating the process. The exact information required varies based on the type of incident. However, Below is a basic list on information that is required:
   - Name
   - Department
   - Location
   - Time Incident Occurred
   - System(s) Impacted
   - Description of Incident
   - Number of customers affected \ Business impact
   - Category, Type and Item
   - Priority Level

2. **Communication –** All responsible parties should ensure there is consistent and constant communication to our customers, incident management and support teams throughout the incident process.

   For Severity 1 and 2 incidents the Incident Management Team which includes the Service Desk should begin to draft a customer communication once the basic facts have been gathered, and use the appropriate templates.

Below is a matrix that outlines who should receive and send incident voice, text message and voice communication.

COMMUNICATION TYPE	COMMUNICATION JUSTIFICATION	DISTRIBUTION FOR CORE AND NON-CORE HOURS	REQUIRED APPROVALS FOR EMAIL COMMUNICATIONS	SENT TO/BY
Incident Management	Severity 1 or 2 incident	For all Severity 1 & 2 incidents Service Now will notify by text message all individuals in the Sev. 1 & 2 paging group DL for specific business group or individuals impacted (If impacted during core hours)	Service Desk or Incident Manager	Service Now Service Desk Mailbox
	Severity 1 incident	By changing Impact to 1- Critical Service Now will present option for War Room (If needed) This will page out required information	Incident Management Team \ Service Desk	Service Now
	Severity 3 or 4 incident	Communicate with ticket requestor	IT ticket owner	IT ticket owner
	Severity 1 – 2 incidents related to UHG Products	Short Description should start with UHG ISSUE: No War Room for Internal Medica Support teams.	Incident Management Team \ Service Desk	Service Desk Service Now

NOTE: for security-related incidents, the CSIRT Lead should be contacted prior to any additional communication due to security incidents being sensitive in nature.

3. **Investigation -** After an incident is recorded and the appropriate communication has been determined, the Service Desk or IT Support begins the investigation process through a series of qualifying questions or steps to accurately categorize and describe the basic details of the incident. The Service Desk or IT Support may need to contact the customer to gather more facts relating to the incident.

4. **Diagnosis –** Now that the facts of the incident are gathered, the Service Desk or IT support staff will actively attempt to identify the source and nature of the service disruption. As the diagnosis progresses it may become necessary to escalate the incident to a higher level of expertise to assess the cause of the incident more thoroughly.

5. **Escalation –** As the incident resolution process progresses the incident is may need to be escalated to another resource within the IT Support Team or the Incident Manager when the initial contact at the Service Desk lacks either the authority or the capability to resolve the incident. The Incident Manager can escalate to a higher authority if an incident is not being addressed appropriately. The below escalation workflow should be followed:

ELAPSED TIME	SEVERITY 1	SEVERITY 2	SEVERITY 3	SEVERITY 4
15 minutes	Incident Manager, Director IT Infrastructure, IT Vice Presidents, appropriate technical team manager	Incident Manager		
1 hour		Appropriate Technical Team Manager		
2 hours		IT Services Manager		
4 hours		Director Technology & Outsourcing		

NOTE: If the severity of an incident escalates in such a way that you are unsure of the global business impact to Medica contact the Crisis Manager to determine if the incident needs to be handed off to Crisis Management. See the Medica Crisis Management

6. **Resolution –** Solution needs to be implemented, and the affected application or system returned to normal operation or stability.
7. **Documentation –** Incident has been recorded, communicated, investigated, diagnosed and resolved it must be documented. Each IT support staff member involved with the incident must document their progress within the Service Now ticket. This reduces duplication of effort.
8. **Closure:** The incident is now ready to be closed. The Service Desk or the IT support staff working on the incident is responsible for incident closure. An incident is not considered closed until the customer agrees that the issue has been resolved and that they are satisfied with the resolution and that all documentation and further actions are implemented. Securing customer acceptance is critical for customer satisfaction. If the incident was a severity 1 or 2 the Incident Manager is required to facilitate a PIR.

ROLES AND RESPONSIBILITIES

Service Desk: Is the single point of contact between IT and customers relating to incident management. The Service Desk is a strategic part of the overall infrastructure support. The Service Desk is principally responsible for the facilitation and restoration of normal operational services with minimal business impact. This includes:

1. Managing, recording, and communicating throughout the life-cycle of all incidents that effect operational services delivered to the business.
2. Managing the delivery of IT services in the areas of customer service, incident and problem management, and service level management.
3. Managing the incident management process; this includes notifying the Incident Manager of all severity 1 and 2 incident and may include escalation to a business partner(s).

Incident Manager: The Incident Manager will become engaged in all major severity 1 and 2 incidents, and will engage members of the IRT as needed to quickly and efficiently resolve incidents. The role is also responsible for facilitating all War Rooms.

The Incident Manager will work with the other IT teams and facilitate assembling the IRT based on the necessary skill sets to resolve the incident. The Incident Manager will remain engaged throughout the incident and act as the single point of contact for the IRT and IT Management.

The Incident Manager is responsible for the completion of all incident related administrative activities. The Incident Manager will communicate to impacted business units and IT Management using the most efficient method regularly or periodically as appropriate to update those impacted by the incident. As always, when an

incident is resolved, the Incident Manager will ensure Service Now is updated to reflect the new status and explanation of the incident.

PROBLEM MANAGER

The Problem Manager will facilitate the Post Incident Review (PIR). The Incident or Problem Manager may convene a "Lessons Learned" session to improve how IT handles incidents in the future
PIR Requirements

- Incident Summary
- Related Incident tickets
- Vendor information
- Issue Details
- Work around
- Root Cause
- Permanent Corrective Action
- Ensure all the above is clearly documented

PIR Optional Items

- Lessons learned (process, communication, etc). Assign and follow up on Action Items (create service requests for each assigned task)

MAJOR INCIDENT TEAM

Members are:

- **Service Desk Manager**
- **Incident Manager**
- **Major Incident Manager**
- **ATOMIC**

Major Incident Manager has to be a liaison between all internal parties involved, also acquainted well to technical aspects of the outage. So he will often be recruited between people formerly engaged in a project, or those involved in service catalogue definition.

Problem Manager: remember him? He will be most helpful here in investigative phase, towards closure phase, and a life saver in post mortem reporting. Better keep him on our side. Mind you, Major Incident is still an incident, but usually has some underlying cause which will be recognized as a Problem. Hence Incident and Problem Manager have to work closely here, each with his own goal in mind (service restoration vs. underlying cause).

Other members of *Major Incident Team*: representatives of all people involved, impacted users, competent technical staff, vendors... Good practice would be to choose people here the same way you would choose ECAB (Emergency Change Advisory Board) members. There is always a chance that you will be implementing an Emergency Change during a Major Incident resolution process.

Computer Security Incident Response Team (CSIRT) Member: Participate in CSIRT resolution process, as part of the problem notification/evaluation/resolution process; maintaining emphasis on information communication and availability.

- Utilize professional expertise and software diagnostic tools to identify problem.
- Participate in incident impact assessment

- Identify and discuss incident solutions
- Document problem chronology (take appropriate notes)
- Participate in the PIR

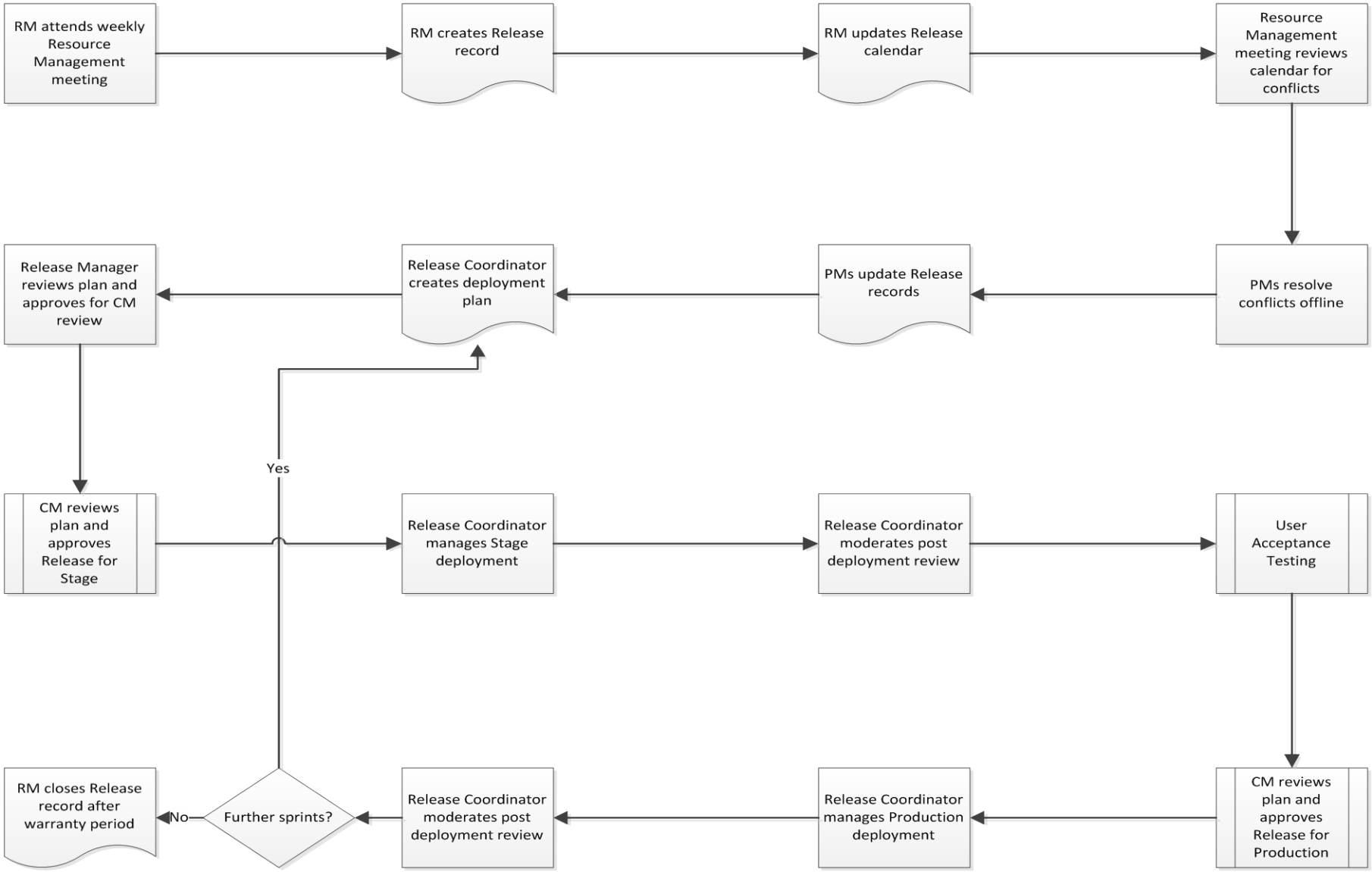
Computer Security Incident Response Team (CSIRT) Lead: Facilitate the implementation of solutions and communication consistent with common IT standards and procedures.

- Review reported Security Incident to validate information – gathers additional information and consults with IT Technical experts when needed
- Organization of the CSIRT if warranted by Security Incident – acquires additional resources as needed throughout the Incident Response process
- Management of the response process, including containment, eradication, and recovery with an emphasis on maintaining forensic evidence
- Iterative communication with the Incident Manager and IT Management, along with the CSIRT to maintain updated documentation and status
- Escalate to the Privacy Council for breach of personal data
- Act as liaison between key business partners and CSIRT
- Assist in conducting post-incident evaluations and documentation
- Support policy modifications resulting from Security Incidents

1. Submit sample release management plans.

The diagram below represents our standard release management process. Medica plans to incorporate releases specific to Iowa Medicaid business into the overall Medica Release Management planning process.

Release Management Process – High Level



13.2 Contingency and Continuity Planning

1. Provide a detailed disaster/recovery plan and contingency and continuity planning documents.

The information below depicts the breadth of our disaster recovery planning. Continuity planning occurs on an annual basis, a sample is available in Tab 5. Iowa specific business continuity and disaster recovery plans will be made available upon contract award.

MEDICA'S DISASTER RECOVERY OVERVIEW	
Facilities	Medica has primary and secondary sites with network, storage, and compute infrastructure in place to recover applications and databases in the event of a disaster. Medica's corporate offices and data centers have UPS and generator backup power in the case of an event.
Enterprise Backup and Recovery	Production servers, databases, file shares, and email stores are backed up daily at a minimum. Backup data is stored locally where backed up, and replicated to the alternate physical site for a second recovery copy. A third copy of production data is written to tape and taken off site daily to a tape vaulting facility. Standard retention and versioning policies are applied as minimum requirements to all production systems. Back-up restoration testing is performed monthly to validate the recovery process. A duplicate enterprise backup and recovery system can be brought online in the alternate site in the event it's needed for recovery purposes.
Software Replication	Business related virtual servers are replicated to standby server instances that can quickly be powered on and configured to run in the recovery location.
Databases	Critical databases are replicated between facilities.
Email	Email systems are located at both our primary and recovery sites with email databases replicated to the failover systems.

MEDICA'S DISASTER RECOVERY OVERVIEW	
File Shares	Business critical file shares are replicated multiple times per day from the primary site to the recovery site in addition to the enterprise backup process.
Core Services	Many enterprise core services are deployed in a multi-site highly available design and are always available from multiple locations.
Telephony	For telephony, if an outage was to occur Medica has equipment that automatically takes over and provides continuous service located at the remote data center.
Production Operations	The Production Support and Operations teams have detailed operations, support and installation/recovery documentation for the technologies and processes Medica maintains. Team members are cross trained to assure that we have multiple individuals available to respond in the event of an incident. Our on-call processes are designed so we can appropriately respond to production incidents 24 x 7. For awareness of process failures or other incidents, automated alerting and incident ticket creation in in place for many systems.

13.3 Data Exchange

1. Describe your process for verifying member eligibility data and reconciling capitation payments for each eligible member.

Medica's advanced systems and processes allow for a streamlined and accurate method for receiving HIPAA-compliant 834 and 820 files from the State.

RECONCILIATION PROCESS

Medica utilizes an automated approach to compare the 834 eligibility file to the 820 file to verify member eligibility and to reconcile the capitation payments for each member. Medica utilizes this process to effectively track and manage enrollment to ensure that the member is in the correct group and that claims are paid timely and accurately.

This process utilizes demographic data from the eligibility file and the payment file to identify if; 1) the rate expected was the rate received; 2) if the rate expected was not received based on eligibility; 3) the rate was received but member is not active and 4) the rate was received but is different than the rate expected. In each occurrence when full reconciliation is not matched, Medica does a comprehensive review of the members' eligibility to ensure full reconciliation. Medica also verifies the specific PMPM data in the 820 file and compares it to the rate sheets by product to reconcile to the rate cell.

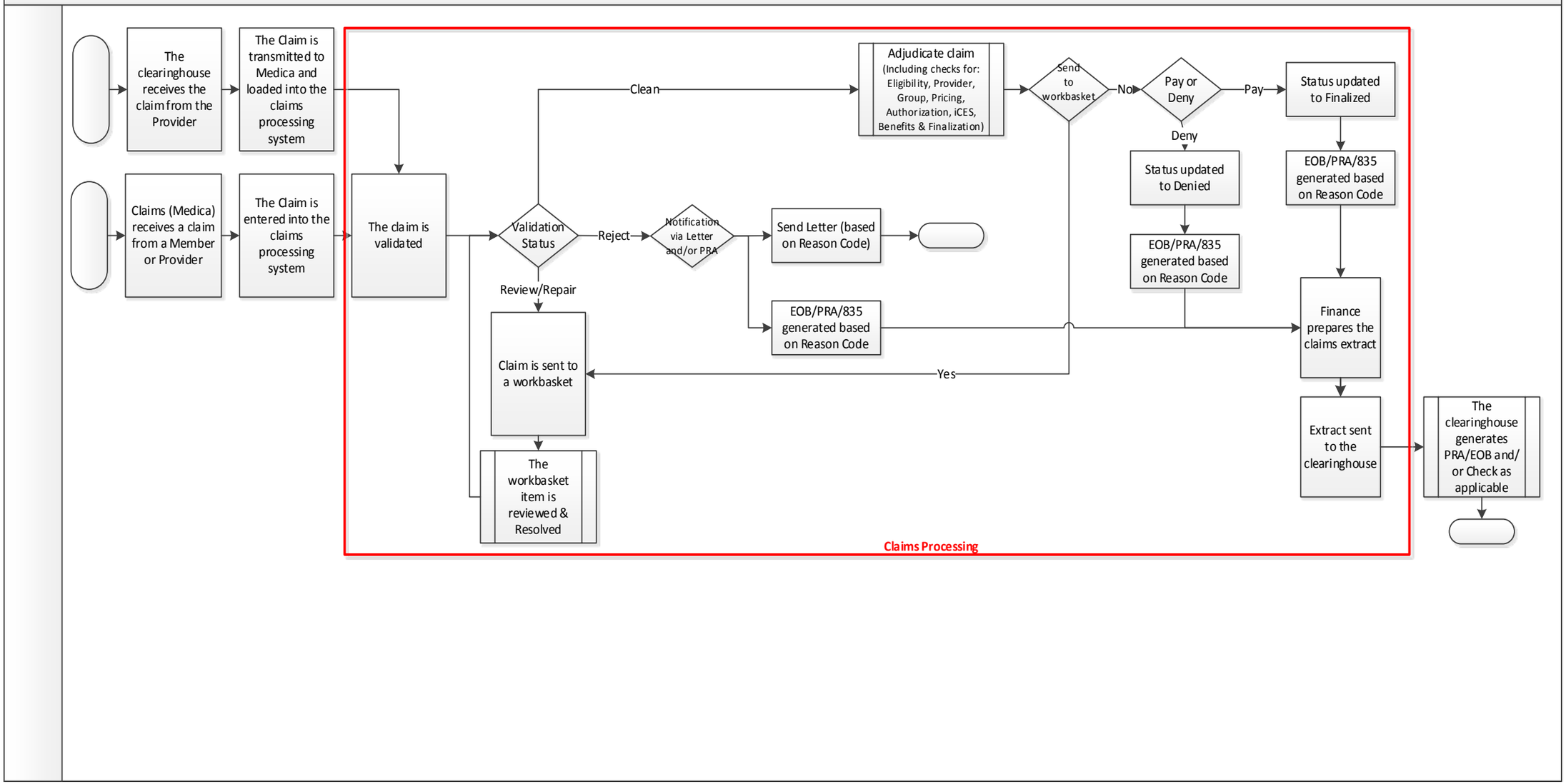
13.4 Claims Processing

1. **Describe your capability to process and pay provider claims as described in the RFP in compliance with State and Federal regulations.**

Medica will require providers to submit claims in conformance with the Iowa Billing Medicaid Manual, IV, Billing Iowa Medicaid to Medica, and Specifications Manual requirements, in accordance with HIPAA for each covered service delivered to a member.

The diagram on the next page depicts Medica's provider claims adjudication process.

Provider Adjudication Process



Medica scans claims received in a paper format and load them into our claims platform for adjudication. Once the electronic files are loaded, the IT department runs a daily batch process to auto adjudicate.

During that process, a series of CCI-compliant claims edits are applied based on our claims platform applications. We use these applications to consistently and uniformly apply comprehensive edits to automatically pay, pend or deny each claim.

Medica has configured the claims platform with claims adjudication logic to reimburse non-participating providers at no more than the established State Fee-For-Service rate at the time the service was rendered, based on the location of service. This is done by automatically applying the State's reimbursement schedules and reference files, authorization requirements, provider configuration and processing rules to the claim as part of the adjudication process. We will configure provider data by specialty and category of service, according to information from the State's reference files. This enables enforcement of categories of service and provider type on claims validation. Certain procedures can only be performed by select network provider types. For example, Medica will not permit the processing of a claim for in-office heart surgery by a podiatrist. We use an industry standard application for additional support to review any claim line set to "Pay" for billing appropriateness by specialty. Medica's claims platform checks other provider-specific items as well, verifying, for example, that each provider has obtained the requisite National Provider Identifier (NPI) or its equivalent, and has included it on claims submissions.

Medica automatically pends claims that fail to auto adjudicate, regardless of reason, for manual review. With the exception of those that pend for medical or clinical review, a Claims Analyst performs the manual review and adjudicates the claim. The Claims Analyst, using a comprehensive set of claim policies and procedures will analyze and resolve the edits in order to adjudicate the claim with the goal of resolving clean claims pended for manual review within 30 days.

Medica pends claims for medical review because of outliers, facility authorization mismatch and reconsiderations based on additional medical information and sent to a medical management team for further review. A Registered Nurse, with appropriate training and expertise, will review the claim, applying Medica's policies, procedures and clinical practice guidelines or similar medical criteria, to determine final adjudication status of the claim. Medica's goal is to resolve clean claims pended for manual review within thirty (30) calendar days.

Medica pends for HCBS review because of mismatched HCBS authorizations, member share of cost clarification and member room and board clarification and send them to a specialized HCBS unit further review. A Claims Analyst will apply policies and procedures to determine final status of the claim. The goal will be to resolve claims pended for manual review within 30 calendar days.

Medica will finalize claims if they are auto adjudicated, or have had a manual intervention that sets them to pay. Medica will then conduct a minimum of a weekly check run or make EFT payments to providers, and send a remittance advice for finalized claims. Medica monitors internal claims reports to make certain payment is within applicable timeliness standards.

COMPLIANCE WITH STATE AND FEDERAL CLAIMS PROCESSING REGULATIONS

Medica will comply with applicable federal and state claims processing laws and regulations, including HIPAA, for transaction and code sets as well as confidentiality and PHI. Medica will comply with requirements as set forth in Iowa Admin Code and will require providers include the NPI on submitted claims based on 45 CFR 162.410, or as directed by the state.

OUT-OF-NETWORK CLAIMS

Medica's claim processing system will not rely upon a unique to Medica specific provider number in order to process claims. Out-of Network providers will be able to submit claims to Medica for processing with the same effective and efficient processes as those for In-Network providers.

CLAIMS PAYMENT TIMELINESS

Medica's processing guidelines require providers to submit claims no later than 12 months from the date of service. When timely submissions are received:

- Medica will pay ninety percent (90%) of clean claims from providers in individual or group practice or who practice in shared health facilities within twenty (20) days of receipt.
- Medica will pay 99 percent (99%) of clean claims from providers in individual or group practice or who practice in shared health facilities within sixty (60) days of receipt.
- Medica will pay other claims within twelve (12) months of receipt, except in the following circumstances:
    - Retroactive adjustments paid to providers who are reimbursed under a retrospective payment system;
    - If a claim for payment under Medicare has been filed in a timely manner, Medica will pay a Medicaid claim relating to the same services within six months after the agency or the provider receives notice of the disposition of the Medicare claim; or
    - The time limitation does not apply to claims from providers under investigation for fraud or abuse.

Additionally, Medica conducts prepayment review for claims based on the following criteria:

- Verify that the recipient was included in the eligibility file and that the provider was authorized to furnish the service at the time.
- Check that the number of visits and services delivered are logically consistent with the recipient's characteristics and circumstances, such as type of illness, age, sex and service location
- Verify that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed
- Verify that a payment does not exceed any reimbursement rates or limits
- Check for third party liability within the requirements of § 433.137

Finally, Medica conducts post-payment claims review utilizing our state-of-the-art analytic software that meets the requirements of parts 455 and 456 of 42 CFR 447.45.

CLAIMS REPROCESSING AND ADJUSTMENTS

Medica's processing guidelines allow providers one-hundred eighty (180) days to submit initial claims and three-hundred sixty-five (365) days to request an adjustment. Processing guidelines will be re-evaluated based on the requirements specific to the State of Iowa.

These electronic transactions include eligibility verifications, claims submitted for processing, claims status verifications, prior authorizations and electronic remittance advice. Medica also offers providers a choice between receiving payment via Electronic Funds Transfer (EFT) or physical checks. We will encourage providers to receive payment via EFT using the current number of large provider systems that regularly use EFT services as an example to show the efficiencies and cost savings associated with this process.

Medica will establish the following basic functionality required for EFT and ERA through the use of online registration via a secure web portal:

- EFT – direct deposit payments to providers.
- ERAs – conversion services and distribution of 835 transactions and other formats.
- Printing and mailing of payments for those providers who don't want to receive their payments electronically.
- Printing and mailing of provider remittance advices for those providers that decline to receive data electronically with identity theft as a commonplace threat, it is critical to secure providers' registration information, preferences and banking information.

Medica's solution will have a secure and comprehensive registration process for these tasks by:

- Obtaining the information necessary to render services according to the providers' preferences, including any combination of electronic or paper payments and ERAs.
- Securing the banking information required to make electronic payments.
- Authenticating the individual supplying the provider banking information, which radically diminishes the potential for fraud.

To maximize long-term success, Medica will proactively work to transition providers from paper processes such as checks and remittance advices to electronic payments and remittance advices. We will develop and implement a marketing campaign to educate and support providers during the transition process. We will target providers through the Medica website, Medica email flyers, discussions at community engagements and face time.

Our system will allow providers to retrieve their remittance advice online in multiple electronic formats that can then be printed as reports or downloaded into a computer data file. Downloaded information can be imported into the provider's practice management, hospital information system (HIS), or other software application for automatic electronic reconciliation. Other features made available will include:

- Proactive Payment Notification; and
- Flexible Banking Options.

Medica's solution is designed to easily work with almost any financial institution for EFT origination, which has the added benefit for providers to maintain their current banking relationships.

2. Describe your plan to monitor claims adjudication accuracy.

Medica's current claim system is fully automated and incorporates a robust full cycle of claims adjudication reviews. This HIPAA- compliant, rules-based claims adjudication system has processed more than four million Medicaid claims in 2014 with an accuracy of 99.79% and a turnaround time of ten days. The claims system is continually enhanced to meet client's needs. Building on the Medica Enterprise System Platform experience in other states, Medica has the capacity to process large amounts of claims data. We conduct system audits as part of the comprehensive claims process review to measure claims for accuracy on a regular basis and initiate process improvement measures using Plan-Do-Study-Act (PDSA) protocols in order to promote financial and payment accuracy. In our most recent implementation we executed a 100% review of all claims initially and gradually decreased this number down as the results proved to be accurate. On-going, a 3% random daily audit is conducted by a claims quality auditor outside of the claims team for all system and all manually processed claims. Additionally, all new claims processors are subjected to a 100% claims processing audit and will remain at the 100% claim audit until they have successfully achieved quality standards.

Medica will use a variety of tools, from reports, audits and open channels of communication with the state, business partners, and providers to ensure adjudication accuracy.

3. Describe your provider claims submission process, including provider communications addressing the provider claims process.

Our claims submission process is described in detail in our response as part of section 13.4.1. We have also included a workflow depiction of this process. Medica works extensively with providers to communicate, educate and support them through the claims submission process. We use our website, email flyers, meetings and face-to-face sessions as a means to communicate.

4. Describe policies and procedures for monitoring and auditing provider claim submissions, including strategies for addressing provider noncompliance; include any internal checks and balances, edits or audits you will conduct to verify and improve the timeliness, accuracy, and completeness of data submitted by providers.

Many of Medica's internal checks and balances, edits and other strategies to improve the timeliness, accuracy, and completeness of data submitted by providers are contained in the responses to questions 13.4.1-3. Medica's comprehensive approach will include the development and distribution of technical guidance documents for providers to have up to date policies and procedures for claims submission. In addition, Medica will expand and apply an existing Provider Audit Program to proactively analyze claims data and confirm that claim submissions accurately represent the services delivered to members, and to ensure that billing is conducted in accordance with current guidelines and other applicable standards, rules, laws, regulations, contract provisions, policies and procedures.

Medica's objective for the Provider Audit Program is to work with providers and the State of Iowa to reduce or eliminate inadvertent or intentional provider actions or misrepresentations. The areas reviewed by the Provider Audit Program will include, but are not limited to, the following:

- Billing for services that were not provided
- Intentional misrepresentation

- Billing services at a higher level than which was rendered
- Failure to comply with the Contract/Health Services Agreement, Plan policies and procedures, and/or other relevant guidelines, regulations or laws
- Inadequate documentation to support the services billed
- The deliberate performance of unwarranted or medically unnecessary services for the purpose of financial gain

Depending on the outcome of the audit, Medica will take the necessary next steps in order to improve provider claim submission. Actions that could result from the audit include trainings and recertification of the provider, recoupments, sanctions, fines, corrective action plans, and/or have their contract terminated.

5. Describe your claims dispute procedures.

Medica has developed policies and procedures to establish the claims dispute process for both in and out of network providers. Prior to implementation, we will send the policies and procedures to the State of Iowa for review and approval.

We will have a well-defined process for addressing providers' rights to file claim disputes and requests for hearing. We also include claims dispute rights in each remittance advice following adjudication of the provider's claim.

Medica's Grievance and Appeals department will manage claims disputes and requests for hearing, including documenting individual disputes, coordinating resolutions, and tracking, trending and reporting data. Filing a claims dispute or requesting a State Fair Hearing will not negatively affect or impact members or their providers.

Claims disputes must be filed with Medica in writing no later than sixty (60) days after the date of the adverse action. Those challenging claim issues, including claim denials, must be filed with Medica in writing no later than twelve (12) months from the date of service or initial eligibility posting date, whichever is later, (for a hospital inpatient claim, the date of discharge) for which payment is claimed, or within sixty (60) days from the date of a timely claim submission. Medica will strive for timely acknowledgement and resolution of claim disputes. We will appoint specific individuals with the requisite experience to administer the claims dispute process and the authority to require corrective action.

6. Describe proposed processes for collaborating with other program contracts to simplify claims submission and ease administrative burdens for providers.

Medica is aware of the administrative burden that some providers experience when submitting claims. In addition to offering technical assistance, training, technical guidance documents and support to individual providers, Medica will form a workgroup that includes a cross section of providers throughout Iowa to better understand current processes and where hinge points in the system are located in the claims submission process. The goal of the workgroup is to work collaboratively with other program contracts and where it is applicable share data, decrease the number of steps to submit claims from a provider perspective, and increase accuracy and timeliness.

7. Propose ideas for handling Medicare crossover claims which reduce the administrative burden on providers.

Medica utilizes the Centers for Medicare and Medicaid Services (CMS) crossover process. The CMS crossover process routes Medicare Supplemental claims directly from Medicare to Medica so that providers do not need to also submit the claim to Medica. This Medicare crossover process will increase efficiency by requiring one claim submission, which in turn, reduces duplicate submissions while improving payment accuracy, and increasing member and provider satisfaction.

To improve the Medicare crossover administrative process, we will instruct providers to follow rules concerning Medicare secondary claim submission. CMS requires that when a Medicare claim has been crossed over, providers are to wait thirty (30) calendar days from the initial Medicare remittance date before submitting the claim to Medica.

Medica will reject provider submitted claims when Medicare is considered primary including those with Medicare exhausted-benefits that have crossed over if they are received within 30 calendar days of the initial remittance date or with no Medicare remittance date. We expect this process will decrease the number of duplicate claim submissions.

We will work with providers through education and communication as well as inclusion into the Medica Provider Manual for processes and procedures for Medicare submissions.

8. Describe processes for notifying providers of a member's financial participation or cost sharing requirements.

Medica will utilize provider education in order to facilitate the process of looking up and finding those members with financial participation or cost sharing requirements. Through the use of an interactive web portal or interactive phone system, providers will be able to:

- Look up member eligibility for the current date or past dates of service.
- Determine if the member has a primary insurance.
- Determine if the member is enrolled in another managed care plan.
- Discover any remaining spend down on file.

Medica will provide education and multiple pathways to ensure that the providers have the necessary tools to see a member's financial participation or cost sharing requirement. Medica will empower both the provider and member to be able to have access to this information in a timely manner. By allowing several different options and trainings around these options, Medica will help alleviate timing issues regarding the member records and requirements and will make sure this is a routine part of the providers check in process before services are rendered. Medica will process claims in accordance with the liability amount net of any financial participation amounts. Medica will build on existing and proven integrated care models that focus on dual eligible members and comply with Medicare Part A and B policies and procedures. Medica is committed to limiting cost-sharing responsibilities for the member whenever feasible, in accordance with the Contractor Operations Manual Medicare Cost Sharing Policy and the Provider Manual, 3.5 Third Party Liability and Coordination of Benefits.

COST SHARING

Medica utilizes measurable administrative and clinical policies, procedures, and processes to effectively coordinate benefits for dual eligible members. Understanding that the dual eligible population often faces financial burdens, we will take care to coordinate care and payment in a way that results in seamless service delivery for the member.

Medica has vast knowledge of Medicare cost-sharing, and will implement streamlined processes that eliminate burdens for members and the providers. We will be prepared to assume the administrative burden associated with cost-sharing.

MEDICARE PAYMENTS

Our program promotes delivery of fully integrated Medicare and Medicaid benefits so that Medicare primary and Medicaid secondary coverage is coordinated to result in minimal out-of-pocket costs for the member and/or the member's family. We will coordinate the benefits and pay claims appropriately for the funding source and make the process seamless for the member. Medica understands that we have no obligation to share costs if the Medicare payment exceeds what we would have paid for the same service provided to a non-Medicare member. We will implement specific "lesser of" claims adjudication logic into our systems and payment policies to protect state funds from the risk of overpayment.

9. Describe processes for providing monthly prospective reimbursement to providers of IDPH funded services.

Medica will provide prospective reimbursement each month to contracted IDPH-funded substance use disorder network providers. Medica, through the coordination of its corporate Compliance Officer, will fully cooperate in any review, audit, investigation, or request for information about Medica, subcontractors, or providers. We will have terms and conditions in our agreements with any subcontractors or providers that delineate their responsibilities with regard to any request of IMHP.

Medica will employ the following strategies to ensure IMHP funds are expended as required:

- **Encounter Value Reporting**: Medica will establish encounter reports that will be available, bi-monthly.
- **Adjustments**
  - Timing: Medica will regularly monitor and review provider encounter levels and make adjustments prospectively, based on the providers encounter values against funding
  - Notice: Prior to the imposition of prospective adjustments, Medica will make every effort to schedule and hold an in-person meeting with the provider to notify him/her of the decision, explain the basis for the decision
  - Withhold of Funds: The application of these prospective interim adjustments will continue until the provider has met the criteria established and communicated during the notice period. During the period in which a provider is having adjustments applied to his/her monthly prospective payments, further adjustments (upward or downward) can be applied based on the provider's progress in encounter values.

13.5 Encounter Claims Submissions – Trade Secret/Confidential

1. **Describe your policies and procedures for supporting the encounter data reporting process, including:**
    a. **A workflow of your encounter data submission process proposed, beginning with the delivery of services by the provider to the submission of encounter data to the State. If you will subcontract with multiple vendors or provider organizations for claims processing management, workflows should incorporate all such vendors, including vendor's names and the approximate volume of claims per vendor identified.**

    b. **Your operational plan to transmit encounter data to the State, indicating any internal checks and balances, edits or audits you will use to verify and improve the timeliness, completeness and accuracy of encounter data submitted to the State.**

2. **Describe your experience and outcomes in submitting encounter data in other states.**

Encounter Claims Submission information can be found in its entirety in the Original version of this proposal.

13.6 TPL Processing

1. Describe your plans for coordinating benefits in order to maximize cost avoidance through the utilization of third-party coverage

Medica's standard operating procedure will be to coordinate benefits with primary insurance or recover payments from other liable parties before applying Medicaid as a source of payment. If required, we will have a COB team hired or an outsourced COB service to review claims prior to processing. Currently, under our “pay and pursue” operation, once we are made aware that a member has other insurance we do update the member’s account with the other insurance information and pay in accordance of sequential order. We will apply claims-specific edits to maximize cost avoidance according to Iowa DHS, Medicaid TPL Action Plan.

2. Describe your process for identifying, collecting and reporting third-party liability coverage.

We will identify potential Coordination of Benefit (COB) opportunities with information received from the State; Health Management Systems (HMS); internal staff, including care managers; members; claims, and Explanation of Benefits (EOB). If we verify Other Insurance (OI), we will move to last payer position and adjudicate the claim in accordance with our COB protocols.

When we receive a claim without an EOB attached, and the member's eligibility record identifies OI, we will deny the claim. Our internal training department will provides training to staff with exposure to claims and encounters to identify and report COB and TPL opportunities.

When OI is confirmed, we will update the member's eligibility record. If OI is retroactive, a Claims Analyst will research the member's claims history, and any funds paid as primary will be subject to recoupment. We will auto-adjudicate claims for dual eligible members to first apply the Medicare benefit, and then apply the remainder to the Medicaid benefit.

We will report to the State, per its protocols, that OI is verified, but was not received in the State’s eligibility file no later than ten 10 calendar days from the date of discovery. In addition, we will notify the State of any known change in coverage, including Medicare, via the appropriate technical interface.

Our standard operating procedure for TPL is to "pay and chase". We will contract with a third party vendor to recover payment when applicable. We will route claims received with indication of potential TPL opportunities, based on diagnosis codes, to our contract partner for recovery. Our contract partner will investigate and pursue recoveries, and return to Medica any remuneration from other payers or insurers. We will recover payments Medica makes as primary when the member had OI for the dates of service. Recoveries that our contract partner pursues on our behalf will be for claims payments that are older than a year. Our contract partner will work directly with the identified insurance carrier, not the provider.

Medica will submit, on a quarterly basis, a summary of our cost avoidance/recovery activity as specified in the IMHP Program Integrity Reporting Guide. Medica will apply standard operating procedures.

3. **Describe your process to identify members with third party coverage who may be appropriate for enrollment in the Health Insurance Premium Payment (HIPP) program.**

We will encourage providers at the time of service to complete the Health Insurance Premium Payment (HIPP) Program Application and document it in the member record. We will review this information upon eligibility determination, update the member benefits profile as necessary and handle care coordination and payment responsibility accordingly. We will notify the State of any known change in coverage, including Medicare or HIPP, via the appropriate technical interface.

13.7 Health Information Technology

1. Describe your proposed healthcare information technology (HIT) and data sharing initiatives.

Medica employs state-of-the-art tools and methods to effectively engage with providers to actively disseminate share information. We will educate and support providers to adopt and expand their use of health information technology. The Medica Enterprise System Platform Collaboration Suite promotes the use of best-practice approaches, methods, processes and tools that will incent providers to "meaningfully use" health information technology as a standard of doing business in Iowa and the entire healthcare industry.

Medica will collaborate with the State to help providers adopt health information technology tools with the following strategies:

- Provide access to a comprehensive suite of provider functions and technologies for a "meet me where I am" approach to providers.
- Engage providers in appropriate levels of information for health information technology advancement opportunities.
- Provide clear actionable information and incentives to advance their health information technology.

PROVIDE ACCESS AND ENGAGE PROVIDERS

Medica's provider collaboration suite will include solutions for all levels of technology environments that are easy to adopt and implement. Medica Enterprise System Platform offers world-class opportunities for providers to collect, analyze, integrate and report data regardless of their current state of technology. Medica will work hand-in-hand with the State to help develop and implement the Iowa Health Information Network (IHIN) from its current status until it becomes fully operational and beyond.

While our collaboration suite is designed to help providers access the right kinds of data at the right time to effectively coordinate member care, there are clear advantages in moving to the more advanced end of the health information technology spectrum. Even so, the traditional channels of calling our provider services representatives, getting information through interactive voice response and/or using our online interactive service web portal, provides a multitude of options even for the most technology capable provider setting.

We envision the following as the focus for key advancements with respect to our provider community and health information technology.

ENHANCING CLINICAL DECISION-MAKING AND WORKFLOW

For low-tech and mid-tech providers, Medica will offer a single point, web-based access to a comprehensive community health record. Providers use this secure, web-based clinical application to view patient information aggregated from multiple systems throughout the community.

To complement the community longitudinal patient record at its core, Medica will deliver capabilities such as an ambulatory Medications history, clinical claims summary, discrete problems and allergies lists, and continuity of care document (CCD) exchange. These capabilities enhance clinical decision-making and workflow.

With online access to the community member health record providers spend less time searching for information and more time focusing on providing high quality and cost-effective care.

EMPOWERING HIGH-TECH PROVIDERS

Medica's goal is to promote the use of high-tech, meaningful use of health information technology for providers. Many providers are headed in that direction and are well down the path. We envision this as the target state, a standard of doing business in Iowa and in the entire health care industry. Medica will collaborate with providers to implement "meaningful use" health information technology, including offering a host of components to improve their systemic environment.

We will achieve this level of adoption through three steps:

- Understanding the provider's current health information technology capability/maturity.
- Offering solutions and implementation assistance to achieve certification / "meaningful use" levels.
- Connecting certified electronic health records (EHR) directly to the Medica Enterprise System Platform information sharing grid.

Medica will promote EHR adoption and e-prescribing as routine components of Medica's provider education and outreach programs by offering providers clear, actionable information and incentives to advance their health information technology. We will provide regular updates to providers to keep them apprised of the state's progress and available resources.

Our robust network of primary care providers currently provides access to 99.9% of Iowa Medicaid members has an exceptionally low PCP turnover rate. Medica will support highly functioning PCPs that incorporate our state-of-the art health information platform into their practice and in some cases fully integrate care into the practice.

Our strategy to achieve this goal is as follows:

- Medica will offer a monthly care management fee to providers who participate in our Integrated Health Home Network.
- We will offer an enhanced rate of Medica's fee schedule to PCPs if they are a National Committee for Quality Assurance (NCQA) Level III accredited Patient-Centered Medical Home or a Utilization Review Accreditation Commission (URAC) accredited Patient Centered Health Care Home (PCHCH), and a lower enhanced rate if they are not NCQA or URAC accredited.
- PCPs will receive a NQCA or URAC application fee to promote accreditation by our providers.

1. Describe how you propose to interface with the Iowa Health information Exchange.

The interface and ability to transmit data between IDPH and Medica is of the utmost importance when it comes to the IHIE. Medica Enterprise System Platform core systems adhere to service-oriented principles and best practices in both design and operation. We will deliver information and key functions for the business model in a clear and concise fashion to stakeholders through appropriately secured communication channels. For electronic data interchange (EDI), Medica's Enterprise System Platform incorporates a hub architecture that facilitates data exchange and data sharing while allowing each trading partner unique control and ownership of its own data subject to privacy and security policy and confidentiality agreements. Medica's Enterprise System Platform will support the required technical interfaces and will comply with applicable HIPAA requirements, as well as the procedures, policies, rules and statutes in effect during the term of our contract.

In addition, we believe that an open channel of development is a best approach to mature the IHIN. Through our experience, we know effective governance is critical to multi-stakeholder collaboration and data sharing. We bring proven leadership in this area and will actively seek membership on the Iowa e-Health Board of Directors. Medica will be well-represented at various levels within Iowa e-Health collaboration. This leadership will accelerate our efforts as we work with the state in realizing the next generation of collaboration and information sharing.

Medica will focus to advance HIE maturity to include appropriate behavioral health information in collaboration with relevant HIE's, providers, and community partners. The result will be the furthering of the state's health information exchange system where authorized health care providers can safely access the right information at the right time. We are committed to enrolling our local and national HIE subject matter and technical expertise to support continual optimization, effective utilization, and extensibility of the exchange across stakeholders. This will improve the access, quality, and safety of health care while enabling providers to make appropriate, safe decisions about care, even if they have never seen that patient before. This, in turn, will result in lower costs and improved health outcomes.

2. Describe HIT initiatives you have implemented in other states.

Medica has had a strong history of partnering with providers and state based agencies in working towards mutual success. A couple of recent examples of that include:

- **Minnesota HIE** – Minnesota Health Information Exchange. Medica was one of the initial sponsoring organizations in the establishing of a state based information exchange model between large Care System Providers and Payers within the State. Medica worked to help build the solution, as well as provide real-time services for eligibility and pharmaceutical (Rx) history inquiries.
- **Dakota County PIN Grant** - The Preferred Integrated Network (PIN) program is offered in Dakota County only. It is for adults who have a serious and persistent mental illness. Medica is working to solidify an implementation grant that will help improve care coordination and data exchange between county based contracted vendors, providers, and our behavior health solution.
- Medica is also partnering with providers, mental health providers, county public health and human services and facilities, as well as other payers, on a **Northwest Minnesota eHealth Initiative** for a Health Information Exchange solution.

Medica is willing to work with the IOWA eHIX (aka Iowa Health Information Network) as we move forward to promote an integrated model with providers.

SECTION 14: PERFORMANCE TARGET AND REPORTING REQUIREMENTS

1. Describe your plan to provide the reports described in the RFP, in the format required, and using templates that may be specified in the Reporting Manual and updated from time to time.

Given our extensive background in the Medicaid Managed Care Market, Medica has a vast amount of experience with State and Federal regulatory reporting requirements. Medica has a comprehensive process for monitoring and auditing overall reporting requirements to ensure the timely and accurate submission of all required contractual performance reports. Medica will comply with all reporting requirements required by Iowa DHS and will work with DHS to ensure that appropriate templates are utilized for reporting

Medica will establish performance targets in collaboration with the Iowa DHS, and in accordance with industry standards and national benchmarks. We will use program-specific standards and procedures to monitor and track our performance and outcomes. We understand that once sufficient baseline data is available, DHS intends to utilize performance outcomes as a factor for auto-assignments and development of materials to facilitate member choice of contractor enrollment. We also recognize that failure to meet performance targets may result in corrective action as outlined in Exhibit E of the RFP.

The Medica Compliance Officer dedicated to the Iowa Medicaid Health Plan has the ultimate responsibility for submitting complete and accurate data and reports. In accordance with 42 CFR 438.604 and 42 CFR 438.606, Medica will ensure that data is certified by an individual that has delegated authority to complete the certification. The certification will attest, based on best knowledge, information and belief the accuracy, completeness and truthfulness of the data and documents submitted to the State. We will employ data verification and validation techniques and adhere to Generally Accepted Accounting Principles (GAAP) to facilitate accuracy in our financial and non-financial performance data. This certification statement will be submitted concurrently with the certified data.

2. Describe additional data/reports you are capable of providing that can help the State evaluate the success of the program.

REPORTING NETWORK ADEQUACY AT THE LOCAL LEVEL

Medica has significant experience collaborating with counties and regions throughout Minnesota and will make the most of that experience in collaborating with Iowa stakeholders. Through our work, we have learned the importance of tracking and reporting access to care standards at the county and regional level. We have found this detailed level of tracking and trending enables us to effectively and expeditiously identify and respond to local access to care issues with creative strategies. For example, we were the first health plan in Minnesota to develop provider incentives that facilitated the development of a robust, engaged and invested provider network throughout all the areas we serve – both rural and urban. We believe that access to care reporting across disciplines by all contracted providers at the regional and/or county level will be helpful to DHS to evaluate the status of local provider network. This will be important as the State transitions from its current Medicaid payment model to a Medicaid Managed Care model. We recommend quarterly reporting.

INTEGRATION OF MEDICAID MANAGED CARE WITH OTHER PUBLICALLY SUPPORTED SERVICES

Medica has extensive experience with integrating Medicaid managed care programs with other publically supported services and community resources. As a result of this experience, we recognize the importance of shared-visioning so these stakeholders can work collaboratively to achieve common goals. Medica welcomes the opportunity to work with the State, other Medicaid Managed Care Organizations, provider coalitions, and other stakeholders to develop system tracking and reports of members receiving services from the Iowa MCOs and through publically supported services. Medica has developed a variety of performance monitoring reports to ensure that we continually meet the access and availability standards including geographic access reports, provider credentialing reports and provider availability. We also monitor the performance of the provider call center and monitor the volume and type of calls. Medica views these reports as an important tool to track and ultimately enhance the coordination of services for members receiving services from multiple funding streams.

ASSESSMENT AND CARE PLAN AUDIT REPORTS

For members receiving Community-Based case management services through the 1915(i) waiver programs, Medica will conduct annual assessment and care plan audits of all contracted waiver case management providers to measure compliance with state requirements. Medica will produce an annual report to the state with audit results.

QUALITY AND TRANSPARENCY REPORTS

Medica can provide the state with information about our quality activities centered on the Medicaid population, highlighting our efforts to improve the quality of care provided to the Iowa Medicaid population. Linking back to Medica identified quality priorities; the reports would include information about project goals, interventions, and will include an evaluation of program outcomes.

HEDIS ANALYSIS/IMPROVEMENT

Initial HEDIS analysis is completed by the Medica Health Analytic staff; this analysis includes rates over time, the HEDIS percentile, and competitor results. These reports are shared through internal Medica meetings which include Health Management and Medicaid programs staff. The HEDIS/Stars Committee reviews the data to identify potential underlying issues such as data collection problems, regional variation, cultural mores, or other types of problems. Improvement activities are identified based on identified barriers. Projects are prioritized based upon corporate strategies and divisional targets.

COMMUNITY-BASED CASE MANAGEMENT PROGRAM EVALUATION

The Regulatory Quality Manager uses inputs from throughout the organization, including CAHPS results, HEDIS Results as well as case management program specific data to develop an annual evaluation of the Medica community-based case management programs. The program goals set annually are used to determine effectiveness. The report, which includes recommendations for action, is presented to the Program Leadership and the Quality Improvement Subcommittee of the Board.

OPERATIONAL PERFORMANCE REPORTS

Medica had developed and monitors overall operational reports on a regular basis. Medica is able to customize reporting to meet the needs of Iowa DHS. Medica can provide numerous performance reports for claims, including summary and lag reporting, denials, timeliness and accuracy. Medica can also provide performance reports on the member helpline and enrollment and disenrollment reports. We also track grievance, appeals and state fair hearings by volume, type, timeliness and resolution.

CHRONIC CONDITIONS ANALYSIS AND REPORTING

Internal analysis of member's chronic conditions is completed by Medica Finance and Health Analytic staff. The analysis includes member risk summaries, a chronic condition summary, member coordination, medication adherence, and using John Hopkins ACG methodology, includes the probability of inpatient stay in the next six (6) – twelve (12) months. This analysis is shared with provider groups on a regular basis. Hospital and Emergency Room readmission rates are monitored quarterly and shared between the State and Medica.

ENCOUNTER DATA PERFORMANCE REPORTING

Medica closely monitors all encounter submissions to ensure accuracy and timeliness. We have developed detailed reporting to track the claims submitted/reported and reconciled. Extensive work has gone in to develop back-end reporting upon receipt of the 835 to ensure full reconciliation and correction. Examples of available reporting include

- Error reporting on all edits (denials, warning and failed voids) from 835 response files
- Turnaround time monitoring and reporting of submission and correction deadlines
- Reporting (and processes) for managing encounter submissions on adjusted claims
- Reporting on the quality of NPI values submitted for Billing, Treating, and PCA providers
- Reconciliation reporting of submitted encounters relative to encounters in subsequent 835 response files
- Quantitative reporting to reconcile claim volume to downstream encounter volume
- Qualitative reporting on encounter data elements relative to claims data elements

FINANCIAL REPORTS

Medica generates a number of financial statements to report, monitor and analyze the financial performance of the program and all products and services administered within the program. These reports serve a number constituents, internal and external, as well as administrative, regulatory and compliance. Our annual financial estimates are actuarially certified and financial results are audited by independent CPAs.

Medica monitors its financial progress against budgets and forecasts to ensure performance is on track or that any variance is noted and understood. Data is tracked and analyzed at the product and program level to generate information by health care cost categories and administrative expense categories to further allow detailed reporting and analytics of trends and variations, to monitor and improve benefit administration and overall financial performance.

3. Describe your internal operational structure that will support the co Network Partnerlation of the performance data and reporting processes of the programs, including:**

Medica's performance data and reporting processes are supported by an internal organizational structure that links responsible departments through strong inter and intra-departmental communication pathways. The departments work directly with the Medica Iowa Compliance Officer who is responsible for coordinating and submitting in a timely and accurate manner all required reports to the State of Iowa.

For quality reporting, the Quality Improvement Subcommittee (QIS), as described in section 10.1.5 of this RFP is the Quality Management committee for Medica. The QIS along with its workgroups and additional sub-level committees is responsible for the accuracy and reliability of our quality performance data and reporting processes.

INTERNAL ORGANIZATIONAL STRUCTURE

The table below describes our current internal organizational departmental structure, the type of reports generated, the associated activity and the responsible person, credentials and years of experience. This model will be replicated to support Iowa based on the proposed staffing model outlined in section 2.8 and 2.9. Medica will also leverage the tenured Medicaid experience of existing staff resources, as outlined below, to facilitate reporting.

Medica Department	Report Type	Activity	Responsible Person; Title	Credentials; Years of Experience
Medica's State Public Programs Finance Department	Financial Reports and Performance Targets	• TPL collections • Iowa Financial reporting • Annual Independent Audit • Physician Incentive Plan Disclosure • Insurance Premium Notice • Reinsurance • Medical Loss Ratio	Tim Rude, Sr. Director, Government Programs Finance	MBA, 25 years health care experience
Government Program Compliance, in conjunction with Health Management and Operations	Member Services Reports and Performance Targets	• HRAs • Care Plan Development • Member Helpline Performance Reporting • Enrollment and Disenrollment • Member Grievance Reporting • Program Integrity Plan	Christine Reiten	BBA, 25 years , health care experience in government programs compliance and operations
Network Management	Provider Network Reports and Performance Targets	• Network Geographic Access Reports • Twenty-four (24) hour Availability Audit • Provider Credentialing • Subcontractor Compliance Summary Report • Provider Helpline Performance Report	Steve Prosser, Director of Alternative Contracting and Network Initiatives at Medica	BHCA, 16 years of health care experience
Quality Improvement	Quality Management Reports &	• Quality Management and Improvement Work Plan • Quality Management	Cara Broich, Senior Manager Quality	RN, CPHQ; 21 years health care and quality

Medica Department	Report Type	Activity	Responsible Person; Title	Credentials; Years of Experience
	Performance Targets	Committee meeting minutes • Care Coordination Reports • HEDIS Report • Quarterly Health Outcomes and Clinical Reports	Management	management experience
SPP Regulatory Quality	LTSS Reports and Performance Targets	• Nursing Facilities Admission Rates • Nursing Facility Days of Care • Return to Community • ICF/ID and PMIC Reports • Fall Risk Management • Hospital Admission after Nursing Facility Discharge • Self-Direction • Timeliness of Level of Care • Timeliness of Needs Assessment and Reassessments • Care Plan and Case Notes Audits • Critical Incident Reporting • Out of State Placements	Kathleen Albrecht, Manager of Regulatory Quality	MSW, LISW, 15 years health care and compliance experience
SPP Regulatory Quality	Quality of Life Reports and Performance Targets	Develop and Analyze Quality of Life reports	Kathleen Albrecht, Manager of Regulatory Quality	MSW, LISW, 15 years healthcare experience
Health Management and Pharmacy	Utilization of Reports and Performance Targets	• Prior Authorization report • Pharmacy reporting	Julia Beckstrom, Director, Utilization Management and Policy Kerri Hoernemann. Director of Clinical Pharmacy	MBA, 30 years health care experience RPh, 20 years health care experience
SPP Operations	Claims Reports and Performance Targets	• Claims Summary and Lag reports • Claim denial reports	Christine Reiten	BBA, 25 years , health care experience in government programs compliance and operations

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4. The qualifications and experience of the staff responsible for the production and delivery of performance data to the State.

The Internal Organizational Table provided in our response to Question 14.3 provides the credentials, qualifications and experience of existing Medica staff responsible for the production and delivery of regulatory and performance date to DHS. As previously mentioned, Medica will also leverage the tenured experience of existing staff resources in addition to the staffing model proposed in sections 2.8 and 2.8 to facilitate reporting.

Additional data is provided below for those individuals key to the production and delivery of reports.

TIM RUDE, SENIOR DIRECTOR, GOVERNMENT PROGRAMS FINANCE

Timothy Rude brings twenty (20) plus years of finance and leadership experience in government programs and managed healthcare. Joining Medica in 2010, he provides financial and operational services for the Medicare and Medicaid products in the Government Programs business segments.

Previously Mr. Rude provided financial and operational leadership to Blue Cross Blue Shield of Minnesota, Blue Cross Blue Shield Northern Plains Alliance, and to UnitedHealth Group. His experience encompasses Medicare (Cost, MAPD and SNP plans), Medicaid, and fee-based related businesses, with an emphasis on programs serving the aging, vulnerable and chronically ill populations.

Starting in Share Development Corporation and Share Health Plan of Minnesota, his tenure with UnitedHealth Group included service in multiple financial capacities in Accounting, Treasury, Business Development, Mergers & Acquisition, and Business Planning. In addition, he has served as CFO and Regional Vice President of Evercare Operations.

Mr. Rude holds a Bachelor of Science Degree in Accounting from the University of Minnesota, and is an Inactive Certified Public Accountant in the State of Minnesota.

CHRISTINE REITEN – DIRECTOR OF COMPLIANCE AND PRODUCT ADMINISTRATION

Christine Reiten, Director of State Public Programs (SPP) Compliance and Product Administration is responsible for oversight of compliance, claims, enrollment and encounter operations for SPP product lines, and product administration including contract management of the MN DHS contract for the Families and Children product. In addition, Christine has matrix compliance and operations oversight with core operational partners/vendors.

Christine has over twenty-five (25) years of experience working with Medicaid and Medicare Programs which include compliance and operations. Chris received a Bachelor degree in business from the University of Saint Mary's.

STEVE PROSSER - DIRECTOR OF ALTERNATIVE CONTRACTING AND NETWORK INITIATIVES

Steve Prosser is our Director of Alternative Contracting and Network Initiatives. In this role Steve manages a $1 billion annual budget for risk-based reimbursement arrangements for provider negotiations to hospitals, physicians and clinics in Medica's Medicaid and Medicare programs. In addition, he has led the development and deployment of a new business module for total cost of care contracts. He has over sixteen (16) years of health care experience including payer and provider management, business development, market penetration and network production development. Steve received his Bachelor's degree in Health Care Administration from Concordia College.

CARA BROICH, RN, CPHQ - SENIOR MANAGER, QUALITY IMPROVEMENT

Cara Broich is our Senior Manager, Quality Improvement and chairs Medica's QIS. She is an RN, a Certified Professional in Healthcare Quality (CPHQ) and has over twenty-one (21) years of experience working to improve healthcare quality. Cara is responsible for providing strategic leadership and oversight of directing Medica's Quality Improvement program across all lines of business, including developing the strategic plan and, implementation and evaluation of Medica's quality improvement activities including; NCQA accreditation, Star and HEDIS rate improvements, regulatory quality requirements, quality of care concerns, and Medica's quality programs. Cara obtained her Bachelors of Arts in Nursing from Gustavus Adolphus College in St. Peter Minnesota and has been a CPHQ since 2002. Prior to focusing on quality improvement, Cara worked as a RN in the Cardiovascular ICU.

KATHY ALBRECHT, MSW, LISW- MANAGER OF REGULATORY QUALITY

Kathy is responsible for LTSS and Quality of Life Reporting. She has over fifteen (15) years of experience working with Medicaid home and Community-Based waivers in both Iowa and Minnesota. Kathy has experience as a case manager, Director of Case Management, auditor and in her current role as Manager of Regulatory Quality. As Manager of Regulatory Quality, Kathy is responsible for quality improvement initiatives, audits, and other regulatory compliance activities developed either internally or by outside regulatory agencies to comply with overall quality requirements. Kathy obtained her Bachelor's Degree in Social Work from Wartburg College in Waverly, Iowa and her Master's Degree in Social Work from the University of Minnesota.

JULIA BECKSTROM, MBA - DIRECTOR OF UTILIZATION MANAGEMENT AND POLICY

Julia Beckstrom is our Director of Utilization Management and Policy. During her tenure at Medica Julia has overseen the development of medical and reimbursement policies that promote safe, evidence-based, effective and necessary health care for our members. Prior to her start at Medica in 2012, Julia led several global projects for Cargill, including policy development. She also served as Director of Benefits, managing health and welfare benefits for over 45,000 employees. Julia brings a unique mix of leadership and experience to Medica with her background in information technology, customer service and global human resources. She has a passion for leading teams to discover new and innovative ways to better serve our members and engage our employees. Julia received her Bachelor's degree in Business Administration from the University of Wisconsin-Eau Claire and her Master's degree in Business Administration from the University of St. Thomas.

KERRI HOERNEMANN, PHARMD - DIRECTOR OF PHARMACY SERVICES

Kerri Hoernemann is our Director of Pharmacy Services. Kerri leads a team of twelve (12) professionals that include clinical pharmacists and pharmacy operations personnel. Her team is responsible for clinical pharmacy initiatives such as; prior authorization, trend management, formulary development and maintenance, pharmacy benefit design, pharmacy benefit set-up, and administration of the pharmacy benefit.

Kerri brings expertise to her role at Medica from a variety of previous work settings. Kerri has over twenty (20) years of health care experience in managed care, hospital, retail and industry practice. She has been with Medica since May 2003 and prior to that, held positions as a clinical pharmacist at Fairview Southdale Hospital, Medical Liaison with a major pharmaceutical company, and as a clinical pharmacist with a Pharmacy Benefit Management (PBM) company. Kerri earned her Doctor of Pharmacy degree from the University of Minnesota and also completed a Pharmacy Practice Residency at the VA Medical Center in Iowa City, Iowa.

a. The process for internal review and validation of data prior to submission to the State.

Each business unit is responsible for the development and validation of reports required by the State. The required reports are submitted from the business area to the Compliance Department for an additional level of review and final submission to the State. Each business unit will be expected to develop a policy and procedure related to each reporting element, along with a standard operating procedure for the development and validation of the data. The Compliance Officer of the Iowa Medicaid Health Plan has the ultimate responsibility for the accuracy of all reports and data submitted. The Compliance Officer will annually review all reporting requirements, and will conduct an annual audit on a random sample of submitted reports.

In accordance with 42 CFR 438.604 and 42 CFR 438.606, Medica will ensure that data is certified by an individual that has delegated authority to complete the certification. In addition, the certification will attest, based on best knowledge, information and belief the accuracy, completeness and truthfulness of the data and documents submitted to the State. We will employ data verification and validation techniques and adhere to Generally Accepted Accounting Principles (GAAP) to facilitate accuracy in our financial and non-financial performance data. This certification will be submitted concurrently with the certified data.

b. Please provide any available Medicaid HEDIS scores in states in which you operate.

Medica has achieved the top Medicaid HEDIS scores in the state of Minnesota and is consistently in the top 15-20th national ranking. Medica was ranked number 18 with an overall score of 82.8 in the most recent NCQA HEDIS report (2014-2015). Medica also scored a rating of 4 in Consumer Satisfaction and Satisfaction with health plan services and a 5 in Consumer Services and Treatment. In 2013-2014, Medica was ranked number 11 in the Top 15 Medicaid Health Insurance Plans.

For over twenty (20) years, Medica has been using HEDIS scores to improve the integration of services and for quality improvement. The HEDIS/Stars Clinical Improvement Committee identifies, prioritizes and implements clinical quality interventions to positively influence HEDIS/Stars rates, thereby improving Medica's accreditation scores and/or Medica's Star Rankings. The HEDIS/Stars Clinical Improvement Committee will work with internal stakeholders to:

- Analyze HEDIS and other clinical quality data to identify trends and areas for concern;
- Analyze Star Ratings and other clinical quality data and initiatives to improve ratings;
- Identify financial risks to Medica, that would lessen risk due to improvement in HEDIS/Star ratings or DHS contract;
- Propose possible interventions and set implementations priorities;
- Implement and monitor interventions;
- Document interventions and results on the annual Quality Improvement Work Plan; and
- Report activities to Quality Improvement Subcommittee.

The following tables provide our 2013 scores across a portion of the HEDIS measures we track by Measure/Data Element and Rate. A listing of all the HEDIS measures can be found in Section 10.1.3 of this proposal.

EFFECTIVENESS OF CARE: PREVENTION AND SCREENING	
Adult BMI Assessment (aba)	92.70%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile	73.72%
Counseling for Nutrition	58.15%
Counseling for Physical Activity	52.31%
Childhood Immunization Status (cis)	
DTaP	81.02%
IPV	93.67%
MMR	89.78%
HiB	93.19%
Hepatitis B	92.46%
VZV	90.51%
Pneumococcal Conjugate	83.70%
Hepatitis A	77.86%
Rotavirus	71.29%
Influenza	56.20%
Combination #2	77.62%
Combination #3	76.40%
Combination #4	68.13%
Combination #5	64.23%
Combination #6	51.82%
Combination #7	59.12%
Combination #8	48.42%
Combination #9	46.96%
Combination #10	44.53%
Immunizations for Adolescents (ima)	
Meningococcal	67.64%
Tdap/Td	90.27%
Combination #1	66.42%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	17.52%
Lead Screening in Children (lsc)	88.52%
Breast Cancer Screening (bcs)	62.58%
Cervical Cancer Screening (ccs)	73.48%
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	2.23%
Chlamydia Screening in Women (chl)	
16-20 Years	54.00%
21-24 Years	66.67%
Total	59.29%

EFFECTIVENESS OF CARE: RESPIRATORY CONDITIONS	
Appropriate Testing for Children with Pharyngitis (cwp)	86.72%
Appropriate Treatment for Children With URI (uri)	92.97%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	26.09%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	42.03%
Pharmacotherapy Management of COPD Exacerbation (pce)	
Systemic Corticosteroid	89.90%
Bronchodilator	95.96%
Use of Appropriate Medications for People With Asthma (asm)	
5-11 Years	93.45%
12-18 Years	92.34%
19-50 Years	77.17%
51-64 Years	83.33%
Total	85.91%
Medication Management for People With Asthma (mma)	
5-11 Years - Medication Compliance 50%	52.14%
5-11 Years - Medication Compliance 75%	28.40%
12-18 Years - Medication Compliance 50%	46.29%
12-18 Years - Medication Compliance 75%	22.71%
19-50 Years - Medication Compliance 50%	60.88%
19-50 Years - Medication Compliance 75%	40.14%
51-64 Years - Medication Compliance 50%	68.18%
51-64 Years - Medication Compliance 75%	50.91%
Total - Medication Compliance 50%	55.51%
Total - Medication Compliance 75%	33.60%
Asthma Medication Ratio (amr)	
5-11 Years	83.76%
12-18 Years	72.98%
19-50 Years	54.11%
51-64 Years	68.94%
Total	68.39%

EFFECTIVENESS OF CARE: CARDIOVASCULAR	
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	
LDL-C Screening Performed	82.76%
LDL-C Control (<100 mg/dL)	56.90%
Controlling High Blood Pressure (cbp)	69.10%

EFFECTIVENESS OF CARE: DIABETES	
Comprehensive Diabetes Care (cdc)	
Hemoglobin A1c (HbA1c) Testing	93.80%
HbA1c Poor Control (>9.0%)	24.45%
HbA1c Control (<8.0%)	62.96%

EFFECTIVENESS OF CARE: DIABETES	
HbA1c Control (<7.0%)	43.40%
Eye Exam (Retinal) Performed	64.05%
LDL-C Screening Performed	85.40%
LDL-C Control (<100 mg/dL)	50.00%
Medical Attention for Nephropathy	84.67%
Blood Pressure Control (<140/80 mm Hg)	52.01%
Blood Pressure Control (<140/90 mm Hg)	78.47%

EFFECTIVENESS OF CARE: MUSCULOSKELETAL	
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	87.01%
Use of Imaging Studies for Low Back Pain (lbp)	78.60%

EFFECTIVENESS OF CARE: BEHAVIORAL HEALTH	
Antidepressant Medication Management (amm)	
Effective Acute Phase Treatment	47.61%
Effective Continuation Phase Treatment	34.04%
Follow-Up Care for Children Prescribed ADHD Medication (add)	
Initiation Phase	49.02%
Continuation and Maintenance (C&M) Phase	50.00%
Follow-Up After Hospitalization for Mental Illness (fuh)	
30-Day Follow-Up	80.34%
7-Day Follow-Up	63.16%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	72.73%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	NA
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	44.62%

EFFECTIVENESS OF CARE: MEDICATION MANAGEMENT	
Annual Monitoring for Patients on Persistent Medications (mpm)	
ACE Inhibitors or ARBs	86.06%
Digoxin	NA
Diuretics	85.82%
Anticonvulsants	67.55%
Total	85.07%

ACCESS/AVAILABILITY OF CARE	
Adults' Access to Preventive/Ambulatory Health Services (aap)	
20-44 Years	88.64%
45-64 Years	90.44%

ACCESS/AVAILABILITY OF CARE	
65+ Years	82.35%
Total	89.31%
Children and Adolescents' Access to Primary Care Practitioners	
12-24 Months	97.52%
25 Months - 6 Years	90.01%
7-11 Years	92.63%
12-19 Years	91.88%

INITIATION AND ENGAGEMENT OF AOD DEPENDENCE TREATMENT (IET)	
Initiation of AOD Treatment: 13-17 Years	36.91%
Engagement of AOD Treatment: 13-17 Years	21.03%
Initiation of AOD Treatment: 18+ Years	33.23%
Engagement of AOD Treatment: 18+ Years	13.86%
Initiation of AOD Treatment: Total	33.50%
Engagement of AOD Treatment: Total	14.39%
Prenatal and Postpartum Care (ppc)	
Timeliness of Prenatal Care	91.48%
Postpartum Care	71.78%
Call Answer Timeliness (cat)	58.46%

UTILIZATION	
Frequency of Ongoing Prenatal Care (fpc)	
<21 Percent	23.65%
21-40 Percent	23.35%
41-60 Percent	12.81%
61-80 Percent	11.26%
81+ Percent	28.93%
Well-Child Visits in the First 15 Months of Life (w15)	
0 Visits	1.46%
1 Visit	0.97%
2 Visits	2.43%
3 Visits	4.62%
4 Visits	8.52%
5 Visits	13.38%
6+ Visits	68.61%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	73.48%
Adolescent Well-Care Visits (AWC)	41.36%

5. **Provide a copy of your most recent external quality review report for the Medicaid contract that had the largest number of enrollees as of the RFP release date.**

Medica has provided the most recent external quality review report for review by Iowa DHS as requested in the RFP, please see Tab 6 for this document (Medica EQRO Report).

SECTION 15: TERMINATION

1. Describe your plan to complete the duties outlined in Section 15 in the event of contract termination or expiration.

Medica understands that termination or expiration of the Contract does not discharge Medica's obligations with respect to services or items furnished before termination or expiration of the Contract. Termination or expiration of the Contract does not discharge the State's payment obligations to Medica or Medica's payment obligations to its subcontractors and providers for member services received in accordance with the Contract.

Medica understands that in the event of Contract termination, the Agency may require Medica to continue to serve or arrange for the provision of services to members for up to forty-five (45) calendar days from the date of Contract termination, or until the members can be transferred to another program contractor, whichever is longer. During this transition period, the Agency will continue to make payments under the terms of the Contract.

Medica will cooperate in good faith with the Agency and its employees, agents, and independent contractors during the transition period between the notification of termination and the substitution of any replacement program contractor. Medica will take whatever actions are necessary in order to ensure the efficient and orderly transition of members from coverage under this Contract, to coverage under any new arrangement developed by the Agency.

Upon notice of termination or upon request of the Agency, Medica will designate a liaison with relevant contract implementation and termination experience that will interact closely with the Agency and staff from the successor program contractor to ensure a safe and orderly transition. This liaison will address post-transition concerns and will be responsible for ensuring that the appropriate claims, member services, care coordination and provider services staff are in place to facilitate a smooth transition.

In the event of a termination or closure, Medica will follow all closure policies prescribed by the Agency.

Medica will submit a detailed Transition Plan within sixty (60) days of Contract termination, 180 days upon contract expiration for Agency approval. Medica will execute, adhere to and provide services set forth in the Agency approved plan. Medica will revise the plan as necessary in order to obtain approval by the Agency within the established timeframes and will make updates to maintain a current version of the plan. To minimize the disruption of services to members and providers, the Transition Plan will include how Medica will:

- Provide the Agency, or its designated entity, all records related to Medica's activities undertaken pursuant to the Contract, in the format and within the timeframes set forth by the State, which shall be no later than thirty (30) calendar days of the request. Such records shall be provided at no expense to the Agency or its designated entity.
- Provide the Agency, or its designated entity, in the format and within the timeframes set forth by the State, information on all Iowa Health and Wellness Plan members' completion of Healthy Behaviors Program requirements as described in Section 5.2.21.1.
- Provide the Agency, or its designated entity, all performance data with a due date following the termination or expiration of the Contract, but covering a reporting period before termination or expiration of the Contract, including but not limited to CAHPS and HEDIS.

- Participate in the External Quality Review, as required by 42 CFR 438, Subpart E, for the final year of the Contract.
- Maintain the financial requirements, as described in the Contract as of Medica's date of termination notice, fidelity bonds and insurance set forth in the Contract until the Agency provides Medica written notice that all continuing obligations of the Contract have been fulfilled.
- Submit reports to the Agency every thirty (30) calendar days detailing Medica's progress in completing its continuing obligations under the Contract. Medica, upon completion of these continuing obligations, shall submit a final report to the Agency describing how Medica has completed its continuing obligations. The Agency shall advise in writing whether the Agency agrees that Medica has fulfilled its continuing obligations. If the Agency finds that the final report does not have evidence that Medica has fulfilled its continuing obligations, then Medica will submit upon the Agency's request a revised final report. Medica will continue to work with the Agency on the final report until the Agency notifies Medica in writing that Medica has submitted a revised final report evidencing to the satisfaction of the Agency that Medica has fulfilled its continuing obligations.
- Be responsible for resolving member grievances and appeals with respect to dates of service prior to the day of Contract expiration or termination, including grievances and appeals filed on or after the day of Contract termination or expiration but with dates of service prior to the day of Contract termination or expiration.
- Maintain claims processing functions as necessary for a minimum of twelve (12) months in order to complete adjudication of all claims for services delivered prior to the Contract termination or end date.
- Be financially responsible for all claims with dates of service through the day of termination or expiration of the Contract, including those submitted within established time limits after the day of termination or expiration of the Contract.
- Be financially responsible for services rendered through the day of termination or expiration of the Contract, for which payment is denied by Medica and subsequently approved upon appeal or State fair hearing. Medica will be financially responsible for inpatient services for patients hospitalized on or before the day of Contract termination or expiration through the date of discharge, including the diagnosis related group (DRG) payment and any outlier payments.
- Be responsible for submitting encounter data to the Agency for all claims incurred before the Contract expiration date according to established timelines and procedures and for a period of at least fifteen (15) months after termination or expiration of the Contract.
- Arrange for the orderly transfer of patient care and patient records to those providers who will assume care for the member. For those members in a course of treatment for which a change of providers could be harmful, Medica will continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged. Medica will transfer all applicable clinical information on file, including but not limited to approved and outstanding prior authorization requests and a list of members in case or care management, to the State and/or the successor program contractor in the timeframe and manner required by the Agency.
- In the event that the Agency assigns members or responsibility to another program contractor, Medica will work cooperatively with, and supply program information to, any successor program contractors.

Both the program information and the working relationship among Medica and successor program contractors will be defined by the State.

- Notify all members about the Contract termination and the process by which members will continue to receive care. Medica will be responsible for all expenses associated with member notification, and Medica understands that the Agency must approve all member notification materials in advance of distribution.
- Coordinate the continuation of care for members who are undergoing treatment for an acute condition.
- Notify all providers about the Contract termination and the process by which members will continue to receive medical care. Medica will be responsible for all expenses associated with provider notification, and Medica understands that the Agency must approve all provider notification materials in advance of distribution.
- Report any capitation or other overpayments made by the State to Medica within thirty (30) calendar days of discovery and cooperate with investigations by the State or its subcontractors into possible overpayments made during the Contract term. Medica will return any capitation or other overpayments, including those discovered after Contract expiration, to the State within fourteen (14) calendar days of reporting the overpayment to the State.

2. **Provide a general end-of-contract transition plan which addresses the key components outlined in Section 15.**

As noted above in 15.1, Medica will provide a detailed transition plan to the agency within sixty days of contract execution. A general outline of the plans contents is below.

Table 1.0 General End-of-Contract Transition Plan

ACTIVITY	DESCRIPTION	KEY ACTION ITEMS	APPROXIMATE START DATE	APPROXIMATE END DATE
Record Retention	Medica will provide all records related to Medica's activities undertaken pursuant to the Contract.	Medica practices highly mature record retention, data management, and data archival processes. Medica will create quality extracts for: • All subscribers and members • All group enrollment • All claims (paid, denied) • All utilization management records (prior authorizations / notifications) – open and closed • Provider data as requested by the Agency. • Any other applicable data request by the Agency • Ensure receipt and usefulness of all data	Upon notification of termination	No later than thirty (30) calendar days of the termination request
Healthy Behaviors Program	Medica will provide information on all Iowa Health and Wellness Plan members' completion of Healthy Behaviors Program requirements.	Key activities of Medica's Health Management data warehouse environment include: • Create a file extract as of specified date that lists all the IA members that have participated in Healthy Behaviors programs • Work with IA to determine what fields need to display on the extract • PGP (Pretty Good Privacy) Encrypt the data • Send extract via secure method (File Transfer Protocol) to the Agency (or other location specified) • Ensure receipt and usefulness of data	Within the timeframes set forth by the State	No later than thirty (30) calendar days of the termination request

ACTIVITY	DESCRIPTION	KEY ACTION ITEMS	APPROXIMATE START DATE	APPROXIMATE END DATE
HEDIS/CAHPS	Medica will provide all performance data including but not limited to CAHPS and HEDIS.	• Monitored by the Vice President and the Compliance Department, each relevant department lead will request and deliver performance data to Medica's compliance department. • Compliance will coordinate encrypted and secure transfers of the data through Medica IT to the Agency. • Medica will offer HEDIS data in a highly flexible fashion: ➢ Rates by measure ➢ Data by measure ➢ Member detail data, list of members in each measure, indicators if they are numerator compliant or not • Some flexibility in file format will also be offered.	Ongoing	HEDIS/CAHPS
External Quality Review Organization (EQRO)	Medica will participate in the External Quality Review for the final year of the Contract.	Medica's quality department will lead the execution to fulfill the requirement. Other participating areas will include: • Medica Compliance • All relevant Medica department leads (directors and managers) for Medicaid • Business system architecture & strategy resources • IT & procurement management	Ongoing	Through close of final contract year
Financial Records	Medica will maintain the financial requirements, fidelity bonds and insurance set forth in the Contract.	Medica will meet the timeframe requirement established in the Contract.	Following the Contract termination or end date.	Until the Agency provides Medica written notice that all continuing obligations of the Contract have been fulfilled.

ACTIVITY	DESCRIPTION	KEY ACTION ITEMS	APPROXIMATE START DATE	APPROXIMATE END DATE
Agency Reporting	Medica will submit reports to the Agency detailing Medica's progress in completing its continuing obligations under the Contract. Submit final report describing how Medica has completed its continuing obligations.	Medica compliance will lead the execution as follows: • Create an encompassing cross-functional team at Medica • Work with the Agency, Medica compliance to determine the breadth and depth of reporting required • Govern ongoing execution of the reporting activity	• Every thirty (30) calendar days. Upon completion of these continuing obligations.	Upon completion of these continuing obligations
Grievance and Appeals resolution	Medica will remain focused on member satisfaction and equitable outcomes in resolving member grievances and appeals.	• Medica will continue to resolve member grievances and appeals related to dates of service prior to the contract termination in accordance with the terms and conditions set forth in the contract.	Following the Contract termination or end date.	Upon completion of these continuing obligations
Claims run-out	Medica will maintain claims processing functions as necessary.	Medica's claim processing system is robust and highly configurable. Relevant resources are well-trained and experienced. • Claims operations will continue to process claims through the run-out period for members that were eligible on the date of service of the claim • Claims operations will provide any reports that are required to the Agency	Following the Contract termination or end date.	For a minimum of twelve (12) months.

ACTIVITY	DESCRIPTION	KEY ACTION ITEMS	APPROXIMATE START DATE	APPROXIMATE END DATE
Financial Obligation for Claims	Medica will remain financially responsible for all claims with dates of service through the day of termination or expiration of the Contract, including those submitted within established time limits after the day of termination or expiration of the Contract.	Medica will set an appropriate incurred but not reported (IBNR) (claims liability), at the end of the contract to recognize our member benefit/service liability. Medica will also maintain adequate reserves to ensure continued payment of claims with valid dates of service, at a minimum, within the established claim run out time limits.	Following the Contract termination or end date	Upon completion of these continuing obligations

3.2.4 Information to Include Behind Tab 3: Bidder's Approach to Meeting the Scope of Work.

3.2.7.1 RFP Forms

In accordance with the Statement of Work dated 4/22/15 and the Scope of Work Question #45, Medica is including the following three (3) documents in Tab 6:

- Release of Information Form
- Primary Bidder Detail and Certification Form
- Disclosure of Ownership Form (one for each proposed subcontractor)
- Subcontractor Disclosure Form (one for each proposed subcontractor)

MEDICA®

MEDICA POSITION PROFILE

Job Title: Behavioral Health Manager

Job Code:
Salary Grade:

Department: Health Management
FLSA Status: Exempt
Reports to:
Revision Date: 4/22/15

POSITION OVERVIEW:

The Behavioral Health Manager is responsible for ensuring that Medica's behavioral health operations, which include the operations of any behavioral health subcontractors, are in compliance with the terms of the Contract. The Behavioral Health Manager must coordinate with all functional areas, including quality management, utilization management, network development and management, provider relations, member outreach and education, member services, contract compliance and reporting.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility

Management of Behavioral Health program operations	• Implements all Behavioral health management programs and services for government business and effectively monitors, manages and allocates resources to achieve business initiatives. • Responsible for program implementation. • Tracks and evaluates productivity, program performance and the performance guarantees. Develops program recommendations. • Collaborates closely with Medica's Government business/clinical leadership to ensure seamless operations and service. • Develops and assures business processes/program workflows are implemented consistently, evaluated for effectiveness and efficiency and are improved. • Is responsible for performance management, supervision, and direction of staff. • Acts as a subject matter expert for Behavioral Health for Medica, our clients and in project teams. • Serves as key contact for government case management for representation of the program and problem resolution of operational issues and implementation of action plans. • Maintains communication between key stakeholders and departments such as Customer Service, Claims Operations, Provider Services, Medical Directors, Pharmacy, and Account Management. • Collaborates closely with other areas within Health Management; Utilization Management, Health Innovation, Pharmacy and HCE to ensure collaboration and alignment, as well as operational linkages and efficiencies, including vendors and MBH. • Develops and oversees process of customer and regulatory audits for the team. • Monitors case quality to ensure competence in case management and care support decision-making, documentation and compliance with regulatory, accreditation and policy/procedure changes. • Provides leadership to the team in the context of Medica's direction and goals as an organization.	**65%**

Regulatory and Accreditation Compliance: assessment, monitoring and implementation	• Assures reasonable compliance with regulatory/accreditation standards and implements departmental action plans as necessary. • Develops and implements compliance with department policies and procedures. • Monitors audit results, assesses business case recommendations • Participates in customer audits, and audits for accreditation and regulatory purposes. • Assesses and implements compliance obligations as required by government and accreditation entities. • Ensure adequate staff training	**15%**

Monitor, track and report trends to facilitate benefit design, medical policy decisions and improve operational efficiencies	• Develops and refines as needed data collection tools, systems and reports to support operational performance and improvements. • Develops and maintains measurement reporting tools and reports and provides representation of data. • Is responsible for open communication between team and senior management regarding reports and recommendations. • Responsible to work with departmental and cross-functional teams to implement above noted opportunities, insuring all regulatory requirements maintained.	**20%**
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

Education/Experience: (Include any required licensure/certifications)

1) Iowa licensed behavioral health professional such as a psychologist, psychiatrist, social worker, psychiatric nurse, marriage and family therapist or mental health counselor, with experience in both mental health and substance use disorder services**.** Minimum of 8 years clinical experience.
2) Minimum of 5 years managed care experience in Behavioral Health program management
3) Experience leading case management programs.
4) Experience with implementing regulations, legislation, rules and/or laws and accreditation standards.
5) Experience with utilization management and case management tools, procedures and programs.
6) Experience with data collection, assessment tools, reporting and analysis.
7) Past experience with complex project management required; proven track record of accomplishing strategic goals and projects.

Skills/Abilities:

1) Demonstrated leadership skills including: excellent interpersonal communication skills, creative and innovative problem-solving ability, critical thinking and independent decision-making ability, group facilitation, negotiation, change, conflict management and performance management skills.
2) Demonstrated process improvement and organizational skills.
3) Demonstrated ability to analyze data, conduct root cause analysis, understand and solve multi-dimensional problems, implement necessary improvement plans.
4) Presentation skills, success with managing a client and regulatory audience
5) Experienced with Microsoft Office Suite / Visio; case mgt. tools, related IT tools
6) Is a self-starter; can initiate project plans and actions once problem has been identified.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles:

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

MEDICA®

MEDICA POSITION PROFILE

Job Title: **Chief Financial Officer**

Job Code:

Salary Grade:

Department:

FLSA Status: Exempt

Reports to:

Prepared By:
Date: **4/22/2015**
Revision Date:

POSITION OVERVIEW:

The CFO has overall responsibility and oversight for financial analysis and reporting, health cost and administrative budgeting and forecasting, pricing and rate development, rate filing, CMS Bid filing, and medical expense trend evaluation for the Iowa Medicaid program. The financial oversight has significant impact on the financial strategy, tactics, and results of Government business. The position will provide primary support to product development and evaluation.

The incumbent is responsible for managing a team of financial analysts and providing expert internal consulting to the Senior Vice President of Government Programs.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
• Monthly and annual analysis and reporting of segment's financial operating results.	• Assures accurate financial reporting by staff. • Directs analysis of results and advises segment senior management of implications. • Assures the timely delivery of financial reporting to support the decision-making of the management teams of the Government/IB Segments.	35%
• Annual budgeting of health care costs and administrative expenses. Quarterly and multi-year forecasting of financial projections.	• Works closely with segment leadership to produce operating budgets for health care costs/revenues and administrative expenses. • Oversees support for quarterly forecasting (Outlook) and multi-year forecasting working closely with the Finance department. • Supports development of strategic plan by segment leadership. • Provide consultation on development of administrative cost efficiencies.	15%
• Medical Cost trend analysis and reporting.	• Works closely with Finance Department team to analyze and report on medical cost trend for reporting and forecasting. Also, works with Finance team on IBNR levels, reserve levels, claims retro activity reporting, and restated financials. • Provides reporting and consultation to segment senior leadership on management of medical loss ratio and cost management strategies. Oversees reporting on medical costs for strategies and tactics for care management/coordination and provider management.	25%

• Supervise Finance and actuarial staff for Government/IFB segments	• Provide leadership, supervision, and coaching to finance and actuarial staff. • Assure that staff complete assigned responsibilities and meet deadlines. • Prioritize staff activities. • Assure that staff have adequate tools and resources to successfully complete responsibilities. • Assure staff (and career) development.	25%
	Total %	100%

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

Education/Experience: (Include any required licensure/certifications)
Bachelor's Degree in finance or related area.
Experience: 10 years including 5 years of management experience
Specific experience:

- Advanced degree (MA, MBA, MHA) or significant related experience preferred.
- Experience in financial analysis and reporting in health care, insurance, managed care, or financial services preferred.
- Oversight of actuarial and/or underwriting services a plus.
- Experience in Government finance a plus.

Skills/Abilities:

- Strong oral and written communication and presentation skills.
- Self directed and can develop and lead a technical team.
- Ability to analyze and interpret complex financial data.
- Skill in budgeting, forecasting, and development of financial modeling.
- Knowledge of medical cost trend drivers.
- Understanding of regulatory environment and requirements.
- Strong project management skills.

DIRECT/INDIRECT REPORTS *(if any)*:

- Number of direct reports and titles __
- Number of indirect reports (total number in department/area) ___

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

- Oversee development of Government health care cost budgets and department administrative budgets. Assist segment leadership in managing budgets. Develop and manage team administrative budget.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Community Outreach Coordinator

Job Code:
Salary Grade:

Department:

FLSA Status: Exempt

Reports to: Marketing Manager

Prepared By:
Revision Date: 5/1/2014

POSITION OVERVIEW:

The Community Engagement Coordinator is responsible for developing community-based relationships to enhance Medica's presence and relationships in the community. This position will work to build and sustain relationships with community organizations that serve members and potential members. The primary responsibility of the Community Engagement Coordinator is to partner with the Community Health team to identify, implement and evaluate community engagement activities.

This position assists the Director of Community Health in developing annual plans for general community outreach and member engagement including but not limited to: health fairs, professional conferences, community partner presentations, member advisory forums, fireside chats, and sponsorship opportunities.

Strong project management and relational skills are essential attributes for this position. In addition, this position must be flexible, provide timely responses, have strong listening skills and the ability to think big picture. Strong technical skills in the Microsoft Office suite are also required.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Events coordination	Manage and maintain events database Research opportunities for new health fairs, professional conferences and community events Create a calendar of events for the year Coordinate SPP's participation in health fairs and professional conferences including registration, working with Accounts Payable, sponsorships, collateral, and staff training and attendance Serve as the point person for events	40%
Community partnerships	Work with Directory of Community Health to identify, initiate and deepen relationships with various community stakeholders Create and implement annual outreach plan Schedule and personally conduct at least 8 presentations quarterly throughout Medica's service area Develop and conduct an annual stakeholder feedback survey	40%
Member/ stakeholder feedback	Organize MSHO member stakeholder forum and annual member input forums Identify, organize and attend community fireside chats with Medica members Assist with the Community Advisory Council and Advisory meetings	20%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree or equivalent experience required
Major: Communications, social work or a health-related field
Years of experience required: 3 years

Specific types of experience required:
Minimum 3 years of health plan experience or similar industry
Project management experience preferred
Experience building relationships in the community

REQUIRED CERTIFICATIONS/LICENSURE:
None

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

- ✓ Excellent written and verbal communication, facilitation, and presentation skills
- ✓ Demonstrated ability to communicate and work effectively with all levels of management
- ✓ Strong project management skills, including the ability to concurrently manage multiple projects and deliver results on schedule
- ✓ Flexible and adaptable
- ✓ Strong computer skills

DIRECT/INDIRECT REPORTS *(if any)***:**

Number of direct reports and titles: None

Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:**

Manage to departmental budget

MEDICA®

MEDICA POSITION PROFILE

Job Title: Compliance Officer

Job Code:
Salary Grade:
FLSA Status: Exempt

Department:

Reports to: Vice President, Iowa Medicaid

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

The Compliance Officer is responsible for planning, directing and managing all aspects of Medica's compliance program and compliance function including maintaining an effective Compliance Program, Implementation of new laws and regulations across the organization, oversight of Medica's HIPAA Privacy program. This position reports to the Vice President, IA Operations and will work closely with Medica's Legal Department, all Medica business units and compliance leads to build and maintain a legally and practically effective compliance program.

This position will be responsible for the daily operations of all aspects of Medica's Compliance functions in the IA location. In brief, the position must understand effective compliance, industry standards and practices, HIPAA Privacy requirements, HIPAA Security requirements, Medica's Implementation process and standards, and Medica's Vendor Management function. The position will be responsible for providing direction and leadership to all Compliance Operations staff, compliance lead staff and business unit staff for implementation and compliance support.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
Maintain an effective compliance program	• Develop and manage an annual strategic plan for ensuring effective compliance program elements across the organization. Program elements will address the following: 1. Procedures and standards of conduct 2. Compliance oversight 3. Training and education 4. Reporting and investigating 5. Enforcement and discipline 6. Monitoring and auditing 7. Response and prevention	25%
	• Work closely with the Vice President, Compliance and Privacy to develop, document and complete the Compliance Operations annual business plan.	
	• Develop, review, ensure and document systems and structures to ensure the effectiveness of Medica's compliance program.	
	• Direct the assessment of key compliance risks and direct the development and documentation of an annual compliance auditing plan	
	• Serve as oversight to Corporate Compliance Regulatory Manager and compliance leads concerning all aspects of Medica's compliance program, including issue identification and resolution, project management strategy, training and risk management.	

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
	• Work with the Corporate Compliance and Privacy Manager and contract leads as necessary to enhance, update and document structures and processes to resolve identified issues to minimize risk for the organization.	
	• Prepare reports for Medica's Board and officers on the status of Medica's compliance program activities.	
	• Maintain a solid understanding of business unit operations, department interaction and the impact of each program element in the business in order to implement an effective overall compliance program	
	• Oversee management of Medica's Integrity Line and Internal Compliance reporting processes to ensure all reports are investigated and resolved based on Medica's policy, standards and procedures for compliance reporting.	
Provide leadership and direction to all compliance lead and business unit staff so that the Compliance Process Management approach is consistently executed across Medica.	• Provide leadership and direction to Corporate Compliance Regulatory Manager, compliance lead staff, and business unit staff to support comprehensive understanding and execution of CPM standards.	25%
	• Provide Oversight to ensure consistent use of Compliance Process Management by designated compliance business unit staff to ensure implementation standards are met for new laws, regulations and regulator audit findings.	
	• Direct development and documentation for annual auditing and monitoring plans for all key organizational risks.	
	• Provide oversight and direction as necessary to ensure any identified corrective actions are completed and documented.	
	• Provide direction and compliance support as necessary to implementation teams to help project leads consistently deliver measurable results. Identify and resolve barriers for implementation teams as necessary.	
	• Work with business unit Vice Presidents to ensure appropriate compliance representation and accountability across the organization.	
Provide leadership and direction to Medica's Compliance Privacy Program to meet legal and business requirements	• Work with Medica's Vice President, Compliance and Privacy, to maintain a legally and practically effective Compliance Privacy program based on the seven core elements of effective compliance and that is incorporated into the overall business structure to meet business and legal requirements.	30%
	• Direct implementation and ensure the effectiveness of Medica-wide Privacy policies that address legal requirements and are consistent with Medica's business operations. Provide direction and support to compliance lead staff to develop appropriate department level procedures to support the organization's Privacy policies.	
	• Manage reporting and complaint process, annual training, monitoring and auditing plan, written standards and procedures, etc.	
	• Serve as oversight for Medica's business unit staff and compliance leads concerning all aspects of Medica's Privacy program, including issue identification and resolution, project management strategy, training and risk management.	
	• Manage comprehensive implementation plans to ensure effective compliance with the requirements.	

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
	• Provide oversight to Compliance and Privacy Manager as necessary to enhance, update and document structures and processes to resolve identified vendor compliance and privacy issues.	
	• Provide direction and strategy to develop and implement effective auditing and monitoring protocols to ensure Medica's privacy practices meet legal and business requirements.	
	• Direct development and administration of annual compliance and privacy training as required by the Privacy regulations.	
Oversee daily operations of Compliance department to meet administrative and department requirements.	• Provide oversight and direction to all compliance staff for daily work and to meet department goals and objectives.	10%
	• Represent Corporate Compliance on committees and workgroups as requested by Vice President, Compliance and Privacy.	
	• Work closely with the Vice President, Compliance and Privacy to maintain the Compliance Operations budget in compliance with Medica's business expense management procedures and requirements.	
	• Meet with staff at regular 1/1s to address work and professional development needs.	
Achieve full compliance with Medica's policies and procedures	• Review, update, and create policies annually or as needed for the Corporate Compliance department.	10%
	Total %	100%

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

Education/Experience:

- Bachelors or equivalent of seven to ten years supervisory/management experience
- Five to seven years compliance related experience required
- Understanding of Medica's Compliance Process Management standards and the GoldMine for Compliance software application.
- Solid understanding of health care/managed care industry including knowledge of managed care operations, customer needs and cost trends.
- Solid understanding of regulatory environments and compliance program guidelines, including state and federal laws.
- Solid understanding of HIPAA Privacy and Security requirements and implementation standards
- Solid Understanding of "fraud and abuse," "consumer protection" laws, and "managed care" laws preferred.

Skills/Abilities:

- Demonstrated success leading teams and managing/executing complex projects across organizations.
- Must be able to appropriately challenge "conventional wisdom."
- Must be able to develop innovative solutions that balance legal and business needs.
- Must demonstrate exceptional analytical, planning, issue identification and resolution skills.
- Ability to analyze situations and make appropriate decisions.
- Proven ability to communicate effectively with all levels of an organization.
- Demonstrated ability to organize complex information and to effectively report information to senior management.

- Ability to develop and deliver training to staff.
- Ability to operate independently and handle multiple, complex projects with a high degree of initiative required.

DIRECT/INDIRECT REPORTS *(if any)***:**

- Number of direct reports and titles:

1 Product Administration Manager
2 Compliance Analysts
1 Program Integrity Manager
1 Grievance and Appeals Manager

- Number of indirect reports (total number in department/area):

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:**

- Support development of Compliance Operations annual budget
- Meet all business expense requirements as directed by Medica policies and procedures.

ESSENTIAL COMPETENCIES:

5=Master, 3=Skilled, 1=Novice	1	2	3	4	5
Dealing with Ambiguity Can effectively cope with change, and is able to shift gears comfortably. Can decide and act without having the total picture. Can comfortably handle risk and uncertainty.				x	
Customer Focus Is dedicated to meeting the expectations and requirements of internal and external customers. Acts with customers in mind. Establishes and maintains effective relationships with customers and gains their trust and respect. Uses data/information for improvements in products/services.					x
Effective Team Player Blends people into teams when needed; a team player; creates strong morale and spirit; creates a feeling of belonging in the team and fosters open dialogue; lets people finish and be responsible for their work; defines success in terms of the whole team and shares wins and successes.					x
Interpersonal Savvy Relates well to all kinds of people—up, down, and sideways, inside and outside the organization. Builds appropriate rapport, and constructive and effective relationships. Uses diplomacy and tact. Can communicate effectively in written and verbal formats.				x	
Problem Solving Uses rigorous logic and methods to solve difficult problems with effective solutions. Looks beyond the obvious and doesn't stop at the first answers. Probes all fruitful sources for answers.					x
Drive for Results Can be counted on to exceed goals successfully. Constantly and consistently takes initiative. Is quality focused and bottom-line oriented. Steadfastly pushes self and others for results.					x

ADDITIONAL COMPETENCIES RELATED TO POSITION:

▪

Medica is committed to compliance with all laws and regulations that govern our work. It is every Medica employee's responsibility to follow the laws and regulations that govern our work and to abide by the Medica Standards of Business Conduct, as demonstrated by...

1. *Consistently conducting your work in accordance with the laws, regulations and policies that govern that work;*
2. *Attending Medica's Compliance Program Training;*
3. *Participating in Compliance Program activities, as appropriate for your job duties; and*
4. *Supporting all elements of the Compliance Program and the Allina Employee Standards of Business Conduct, including but not limited to, reporting good faith compliance concerns.*

APPROVALS:

_____ _____

Manager (print) Date

_____ _____

Medica Human Resources Date

MEDICA®

MEDICA POSITION PROFILE

Job Title: Director, Pharmacy

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to:

Prepared By:
Revision Date: 04/20/2015

POSITION OVERVIEW:

This position is responsible for programs and services provided by the Pharmacy Management area. The position performs administrative functions as needed to ensure pharmacy programs are compliant with all company policies, state, and federal regulations.

The Director of Pharmacy is a key member of the Pharmacy Management team and a key contributor to strategy and process planning. Projects vary from program design and implementation at the operational level to strategic planning efforts that span every department within Medica.

This position manages a complex set of interrelated activities involving internal and external stakeholders to meet strategic goals. This person has a strong understanding of managed care and PBM business practice and processes with the ability to effectively navigate a large health care organization. This person understands the unique needs of customers including members, providers, employers/brokers and fellow employees.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Direct, Develop and Implement Medica's Clinical Pharmacy Programs	Development and coordination of operational processes relating to clinical programs Mail Order cost review and report Medicare Part D Pay for Performance Quantity Limit opportunities Oversee and provide strategic direction for miscellaneous clinical and strategic projects assigned to department Pharmacy Academic Detailing Medication Therapy Management Delegation Oversight Activities	20%
Formulary Development, Implementation and Maintenance	Oversight of Formulary including: determination of therapeutic drug classes presented to P&T; formulary exception and prior authorization processes; distribution of formulary Facilitation of P&T	20%
Pharmaceutical Manufacturer Relations	Develop profitable relations with pharmaceutical manufacturers representatives and management Asses opportunities and negotiate rebate contracts or grants in support of Medica's clinical initiatives Direct PBM regarding rebate contract administration Review PBM rebate contracts and assess opportunities for pursuing direct contracting with manufacturers	15%

PBM and Pharmacy Network Management	Oversee PBM's audit plan, reports and results. Ensure PBM performing to contract provisions. Evaluate network and revise contracts, as needed Address Pharmacy Provider requests in cooperation with PBM Manage PBM to create accurate and efficient pharmacy benefit plan administration that delivers client and member satisfaction	15%
Department Administration	Managing day-to-day team responsibilities Recruiting, hiring, training, and coaching team members Developing job descriptions and goals for team members Establishing priorities in conjunction with Senior Director Health Management, Medical Directors, Directors within Quality and Care Management, and other business units. Foster good communications with staff, customers and other company departments through interpersonal relationships and formal communication skills Represent Pharmacy Clinical Programs at management level during meetings or presentations Assist in Preparation of Pharmacy budget yearly	15%
Benefit design input, interpretation and development	Provide expertise to Product Management and MBS in the design and implementation of new prescription benefits Ensure benefits are supported in member and provider agreements Utilize PBM and HCE reporting and analytic tools to determine value of proposed benefit changes Establish PBM's ability to support benefit design	15%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Pharmacist
Years of experience required: 5 years

Specific types of experience required:
5+ years experience in pharmacy benefit management or managed care
Bachelors degree (required), Pharmacist (highly desired), MBA (desirable)
Excellent communication skills in both one-to-one and group settings
Ability to develop business relations with Pharmacy Providers and Pharmacy Benefit Management (PBM) vendor
Experience in contract negotiations, preferable in rebate contracting
Minimum of 3 years in management/leadership position
Knowledge of applicable state and federal laws

REQUIRED CERTIFICATIONS/LICENSURE:
Registered Pharmacist required, with a current pharmacy license that is in good standing (MN preferred)

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:
Demonstrated leadership abilities

Excellent communication skills in both one-to-one and group settings
Excellent communication skills (oral and written)
The ability to handle multiple, unrelated tasks in a high pressure environment
Strong service/marketing orientation in dealing with internal and external contacts
Ability to develop business relations with Pharmacy Providers and Pharmacy Benefit Management (PBM) vendor
Self directed, able to work with limited direct supervision

DIRECT/INDIRECT REPORTS *(if any)***:**

Number of direct reports and titles: 4

Manager, Clinical Pharmacy Programs
Manager, Pharmacy Operations
Government Pharmacy Services Manager
Manager, Client Service & Program Development

Number of indirect reports (total number in department/area):

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:**

Prepare and accountable for Budget #20001412

MEDICA®

MEDICA POSITION PROFILE

Job Title: **Director, Clinical Operations**

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to:

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

Health and Populations Management are at the cornerstone of improving Medica's members' health and life-long wellbeing. Through innovation and the creation of care system capabilities, Medica is complimenting the population health abilities of our partner health systems while advancing our members' self-management capabilities. Optimizing the core health management functions of case management, utilization review, pharmacy management, prior authorization and wellness coaching functions are equally essential. This role will be part of a dynamic and innovative team which has accountability for creating value in healthcare, addressing challenges of medical care spending and partnering with health systems around accountable care models.

The Director, Clinical Operations provides overall leadership of day-to-day clinical operations for the Iowa Medicaid program. This role is responsible for the performance and compliance of all functions related to the program including:

Health Improvement – Health and Wellness Coaching, Healthy Pregnancy, Treatment Decision Support, Program Development and Evaluation
Health Support –Case Management, Utilization Management
Quality and Affordability – Policy development, Compliance and Accreditation, Regulatory Analytics
Pharmacy Service
Long Term Care

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)

Lead Clinical Operations Activities	Effectively and efficiently manage various department activities including the following: Population health management including improvement in medical expense trend Enhanced member self-management Health Improvement – Health and Wellness Coaching, Healthy Pregnancy, Treatment Decision Support, Program Development and Evaluation Health Support – Case Management, Utilization Management Quality and Affordability – Policy Development, Compliance and Accreditation, Regulatory Analytics Pharmacy Services Long Term Care	70%
Manage and coach direct reports and staff. Provide leadership to supporting departments.	Role model and foster a culture of teamwork, collaboration, shared success, partnership and transparency. Motivate and lead a high performance management team. Attract, recruit, and retain highly talented staff. Provide supervision and coaching to management team. Foster a success-oriented, accountable environment and ensure that employees have clarity regarding what is expected of them. Mutually establish and evaluate annual direct reports goals.	30%
Total		100%

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree + experience; Master's Degree preferred and/or experience in clinical care or public health settings.
Major: Business Administration or Health Administration or similar field
Years of experience required: 5-10 years

Specific types of experience required:

Five to Ten years population health management or managed care with management experience
Leadership experience with large, organized delivery systems and personal experience working within an integrated delivery system
Knowledge of state and federal regulations
Knowledge of quality standards (NCQA, JCAHO, URAC) and how to apply/implement/interpret for managed care setting
Knowledge of data, data analysis, measurement systems, evaluation methods, preferably study designs
Demonstrated experience in building collaborative relationships both within and outside of a large health care organization
Experience in process improvement or process design with demonstrated results
Experience with managing/facilitating physician committees/work groups

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Naturally collaborative high trust style, with strong relationship building skills.
Ability to think and act in a strategic manner while executing to achieve desired results.
Executive who understands health plan and provider systems.
Able to function in a system with shared accountabilities and still hold reports and others accountable for coordinating across functions and achieving objectives.
Excellent communication and relationship development skills

Analytical, able to interpret data reports and translate into an action plan
Strong oral and written communication skills.
Strong strategic and business planning and financial management skills, accountable for results
Strong people management skills and experience
Ability to manage multiple projects and complex processes simultaneously
Prioritization skills
Strong interpersonal relationship skills including community relations experience
Ability to set strong performance goals and standards and then measure, monitor and take corrective actions as necessary

DIRECT/INDIRECT REPORTS *(if any)***:**
Number of direct reports and titles: 4
1 UM and Quality Manager
1 Care Coordination manager
1 Long Term Care Manager
1 Pharmacy Manager

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:**

MEDICA®

MEDICA POSITION PROFILE

Job Title: Facilities Manager

Job Code:
Salary Grade:

Department: HRLF Administration

FLSA Status: Exempt

Reports to: Director Facilities

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

The purpose of this position is to manage all services involved in facilities management, office services and real estate for Iowa Medicaid to ensure an effective and cost efficient operation.

This includes planning for space and real estate, the daily churn of space and staff, implementation of policies and processes to assure the operational effectiveness of the workplace. It includes all areas related to furniture inventory, landlord relationship, mail, document management, shipping & receiving, office supplies, food service, conference management, reception, switchboard, safety, security, facility emergency preparedness, housekeeping, life-safety, office equipment, and utility management.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Facilities Management & Real Estate	Ensure that the company has the appropriate amount of space required to meet its business and staffing plan. This is performed through strategic planning, management of employee churn, space planning and realignment, maintaining space standards and policies related to space. Use of CAD/CAFM products to maintain accurate and timely data. Oversee the Staff Action process to facilitate the On-Boarding, Move and Termination process with HR and IT. Provides construction management when necessary. Manage all assets related to the operation and furnishings of the building. Ensure inventory levels are intelligently managed, equipment is deployed and utilized, purchase product based on established standards and customer requirements. Ensure maintenance and housekeeping items are maintained to establish service levels. Operates the hot line to handle customer request, maintain job tickets to tract issues, escalates problems to the appropriate source. Coordinate landlord issues on behalf of Medica, manages sub lease agreements, negotiates leases and related issues and ensures that landlord live up to lease agreements.	45%

Office Services and Security and Safety	Direct the management of the Mail and Document Management operation. Provides mail and document services that meet the company's business requirements, are cost effective and customer focused. Direct the management of the Security Operation to ensure a safe and secured work environment for the staff. Protect the assets of the company, control building access and develop safety and security policies that complement the business. Oversee the collection and destruction of confidential waste. Manage the vending and coffee services to provide a quality and reasonable product Ensures that AV, room set up, catering and support activities are provided based on customer expectations.	30%
Other	Oversee HRLF's compliance to the 3rd party contracting process, coordinates activity with Compliance, maintain files and database. Manage out sourced vendors to perform major service functions for the company. Manages Facilities Management expense budgets ensure policy and procedures are followed and that the operation comes in on target on an annual basis. Oversee the development of a facility BCP/DR plan and annually update and test data to ensure reliability.	25%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Business admin, architecture, finance or engineering services
Years of experience required: 10+ years

Specific types of experience required:
Position requires college degree in business administration, architecture, or engineering services.
10 + years experience in corporate real estate, facilities, interior design. CFM, FM or FMA designation helpful.
Demonstrated project and construction management experience.
Multi site operational experience highly desirable
Experience with real estate leases and negotiation process
Experienced with 3rd party contractors and purchasing process and procedures.
Purchasing experience and extensive management of 3rd party contractors required.
IFMA or BOMA membership helpful.

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Ability to manage multiple projects
Must be detailed orientated
PC skilled, CAD and CAFM knowledgeable
Must be politically sensitive and able to operate in an changing environment

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles:

Number of indirect reports (total number in department/area):

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

MEDICA®

MEDICA POSITION PROFILE

Job Title: Grievance and Appeals Manager

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to: Compliance Officer

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

The Grievance and Appeals Manager is responsible for the administration of the member appeals, grievance and organization determination processes for Medicare and Medicaid members.

This role is responsible for ensuring that all processes and procedures related to the handling of grievances, organization determinations and appeals are in accordance with regulatory requirements and that staff receive regular and on-going communication/training. The Manager must ensure that the staff has current and accurate procedures, and the Manager must ensure grievances, organization determinations and appeals are audited on a regular and consistent basis. The Manager is responsible for implementing quality improvement processes as appropriate.

The incumbent serves as the compliance expert for critical functions including appeals, grievances, organization determinations and call center operations. They are responsible for intake and assessment of regulatory guidance related to these functions. They work collaboratively with functional area staff within Medica and Medica's vendors to interpret and implement the requirements in a timely and compliant manner. This role also maintains compliance monitoring metrics and reporting mechanisms to evaluate and ensure compliance with Medicare requirements. This position conducts ongoing oversight of the Medicare functions and performs validation of auditing and monitoring results that are reported by functional areas within Medica and Medica's vendors. They recommend and oversee interventions based on their assessment of the results. They work collaboratively with the functional areas to implement effective interventions, process improvements and corrective actions.

This position actively participates in regulatory audits and audit readiness activities. They serve as the compliance lead for the functional areas described above to ensure a continuous state of audit readiness and they ensure effective execution of corrective action plans in response to any deficiencies.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)

Serve as compliance lead for the guidance intake, assessment and implementation process	• Serve as the lead compliance expert for functional areas including appeals, grievances, organization determinations and call center operations, and as assigned, by providing compliance leadership and subject matter expertise. • Serve as the primary compliance contact for Medica staff and vendors that perform these functions. • Manage the intake, assessment and interpretation of regulations and guidance related to the assigned functional areas. • Coordinate training and communication of requirements to functional areas within Medica and vendors . • Project manage and oversee the implementation of requirements in a timely and effective manner. • Develop policies, procedures, training, auditing tools and monitoring protocols to ensure compliance with the requirements. • Develop and conduct training for functional areas within Medica and vendors. • Ensure complete and timely documentation of compliance with Medicare requirements.	20
Oversee functional auditing and monitoring activities; analyze and validate results	• Actively participate in an annual risk analysis to identify risk areas and prioritize areas of focus for compliance auditing and monitoring activities. • Develop, implement and maintain compliance monitoring metrics and reporting mechanisms to evaluate compliance with Medicare requirements. • Analyze and validate auditing and monitoring results from functional areas within Medica and vendors • Identify service and operational problems and improvement opportunities, and ensure appropriate reporting of issues to management. • Provide recommendations for improvements or corrections and oversee their implementation.	20
Actively participate in regulatory audits and audit readiness activities	• Actively participate in audit readiness activities to ensure proper preparation by Medica functional areas and vendors . • Lead audit readiness activities for the functional areas described above, and as assigned. • Develop and conduct training for functional areas on regulatory audit topics, including file preparation and interviewing. • Conduct thorough quality review and analysis of audit documents, sample files and universes. • Actively participate in regulatory audits conducted by external auditors. • Ensure complete and timely documentation of audit activities.	20
Coordinate and ensure effective execution of corrective actions	• Develop and implement corrective action plans for identified compliance matters and in response to audits. • Provide compliance expertise in the development and implementation of solutions to address compliance matters.	10

Managerial Oversight- Consumer Affairs	• Manage all member appeals, organization determinations and grievances. • Manage and oversee audits of appeals, organization determinations and grievances to ensure all requirements are met, including compliance with regulations, quality standards and customer satisfaction. • Oversee external review process. • Oversee CTM complaint and ensure they are resolved within appropriate timelines. • Manage DHS and CMS complaint and appeal reports and ensure submission is accurate and timely. • Monitor standards for quality, turnaround time, effectiveness and productivity. Provide leadership and coaching to direct reports through consistent 1:1's and team meetings, manage and measure team workload, performance and administer incentive program. • Work with direct reports to develop yearly goals, measure progress against the goals and performs the annual performance reviews. • Creates a positive climate among the team and rewards goal achievement. • Research, recommend and approve training and development opportunities for direct reports.	30%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: College degree, or equivalent experience
Years of experience required: 5 years

Specific types of experience required:
Minimum 5 years insurance or managed care experience
Minimum 2 years experience in a supervisory/management position

SKILLS/ABILITIES:

Strong customer focus and ability to quickly identify and resolve problems.
Knowledge of specific Medicare functional areas, including organization determinations, appeals, grievances, and call center
Ability to manage multiple responsibilities/priorities simultaneously
Proven ability to communicate effectively including strong written and verbal skills.
Must be able to develop innovative solutions that balance legal and business needs.
Strong drive for results and accountability
Must demonstrate strong analytical and problem identification and resolution skills.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: 4 Consumer Affairs Advisors
Number of indirect reports (total number in department/area): 0

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

- Limited administrative budget responsibilities.

MEDICA®

MEDICA POSITION PROFILE

Job Title: HR Generalist

Job Code:
Salary Grade:
FLSA Status: Exempt

Department:

Reports to:

Prepared By:
Revision Date: 4/21/2015

POSITION OVERVIEW:

The human resource generalist is responsible for performing HR-related duties on a professional level and works closely with senior HR management in supporting designated geographic regions. This position carries out responsibilities in the following functional areas: employee relations, training, performance management, onboarding, policy implementation, recruitment/employment, affirmative action and employment law compliance.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Human Resources Capacity	Administers various human resource plans and procedures for all company personnel; assists in the development and implementation of personnel policies and procedures.. Participates in developing department goals, objectives and systems. Provides policy and procedure interpretation to employees and leaders to ensure compliance with State and Federal laws and mandates. Conducts recruitment for exempt and nonexempt personnel, students and temporary employees; writes and places advertisements and conducts new-employee orientations. Handles employee relations counseling, outplacement counseling and exit interviewing. Participates in administrative staff meetings and attends other meetings and seminars. Performs other related duties as required and assigned.	60%
Problem Solving/Consulting	Assists in evaluation of reports, decisions and results of business department in relation to established goals. Recommends new approaches, policies and procedures to effect continual improvements in efficiency of business areas/departments and offers people solutions when appropriate.	30%

Project Management.	Creates project plans for execution of HR initiatives or solutions at the local/geographic location as required. Provides status updates to HR and business leaders to ensure continued focus and buy-in for projects.	10%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:
Education Level: Bachelor's Degree
Major: Human Resources or related field
Years of experience required: 2 years
Specific types of experience required:
Thorough understanding of State and Federal employment laws and HR capabilities.

REQUIRED CERTIFICATIONS/LICENSURE:
PHR certification preferred.

ADA STATEMENT:
Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.
Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:
Excellent oral communication skills
Excellent writing skills
Ability to present company position persuasively
Strong relationship building skills
Effective project management abilities
Solid presentation skills
Strong organizational skills
Ability to assimilate information from various sources and recommend courses of action
Ability to work in a rapidly changing environment and adjust priorities quickly

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: None
Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Long Term Care Manager

Job Code:
Salary Grade:
FLSA Status:

Department:

Reports to: Director of Clinical Operations

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

The position is responsible for the oversight of implementation, coordination, and day-to-day management of the state's community based and facility programs. Additionally, this position oversees the long-term care provider reviews, utilization reviews, member satisfaction surveys, and member health and welfare.

Role includes:

- Comprehensive understanding of CMS rules and regulations.
- Stay current with institutional practices, policies, legislation and provide training as needed
- Liaison to the State, external vendors, clinicians, Operations staff

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)

Implement, coordinate and manage community and facility based programs	Implements case management programs, chronic condition coaching programs and treatment decision support program and effectively monitors, manages and allocates resources to achieve business initiatives. Responsible for oversight and maintenance of operations related to new business implementation, reporting of care coordination performance guarantees, communication with care coordination client sites to insure seamless customer service. Responsible for project management activities Maintains communication between key stakeholders and departments Conducts assessment, monitoring, analysis and communication of community and facility program utilization data and identifies opportunities for improvement. Provides operations management to the unit while maintaining teamwork and collaboration Has a good understanding of member benefits (such as familiarity with Certificate of Coverage, Elderly Waiver, Medicare, and Medicaid benefits Stays current on Medicare, Medicaid and state policy program changes and attends pertinent DHS trainings Partners with external vendors to ensure the member's needs are followed through.	50%
Utilization and Facilitation	Management oversight of the following activities: • Understanding of health plan benefits and coordinate discharge/referral plan as necessary. • The process for verbal and written communication of review outcomes to facilities, physicians and members. • Early identification and assessment of members for potential inclusion in a comprehensive case management program. Refers members for ongoing complex case management accordingly • Assists Member Services, Claims and Provider Services with issues that require medical interpretation or definition. • Assures adherence to all regulatory and compliance requirements. • Assures the protection of confidentiality of utilization review, quality management information and beneficiary identification	40%
Stay current with community and facility based programs policies, legislation and provide training as needed	Attend internal/external meetings in regards to community based and facility programs Develop and modify training materials and collaborate with other team members to provide training to partners	10%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major:
Years of experience required: 5 years Long Term Care policy

Specific types of experience required:

Bachelor's degree preferred.
Minimum of 5 years of clinical experience. Some experience in working directly or with programs that serve frail members is preferred.
Past experience working with Skilled Nursing Facilities
Current RN licensure
Experience in training adult learners a plus.
Experience in implementing regulations, contract provisions and best practice standards
Strong project management experience, including organizing, planning, and executing projects from vision through implementation

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: 5-10 %
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Demonstrated success in managing and developing relationships with diverse stakeholders
Comprehensive knowledge of CMS rules and regulations
Knowledge of health plan operations
Demonstrated interpersonal communication skills, creative and innovative problem-solving ability, process improvement and organizational skills, critical thinking and independent decision making ability.
Knowledge of the Medicare Part A Skilled Care Coverage Benefit
Ability to work with Skilled Nursing Home Providers
Knowledge and ability to work with DHS
Knowledge of Community and Long Term Care Programs
Excellent written and verbal communication skills
Willingness to travel
Proficient in the Microsoft Office Suite
Data management skills

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: None
Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Medical Director

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to:

Prepared By:
Revision Date: 0/20/2015

POSITION OVERVIEW:

The Medical Director is responsible for oversight of all Iowa Medicaid Program clinical activities. This includes program development, medical management, health policy development and risk management activities of Medica. The Medical Director will provide medical leadership and community visibility for the noted areas of responsibility. The incumbent is also responsible for Quality Management and Improvement across all medical programs.This position requires a solid medical and business mind, and an ability to develop and implement medical programs and policies that effectively balance provider, patient, and health plan interests. It is expected that the Medical Director effectively creates strong collaborative relationships with provider systems, governmental and community organizations, and Medica staff. The Medical Director must be comfortable working with multidisciplinary teams and diverse communities.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Clinical Leadership of Medica's Iowa Medicaid Programs Business	Provide the clinical leadership to Medica's Iowa Medicaid Program business. This includes program development, executing and coordinating clinical protocol and utilization management processes, leading interdisciplinary teams of direct care and management staff. Specific duties include but are not limited to: • Clinical program development and support of Care Coordination and Nurse Practitioner programs • Medical direction and development of clinical protocols and utilization management processes. • Leading clinical interdisciplinary teams with staff of diverse health care backgrounds. • Medical leadership in quality improvement, CMS star rating, risk adjustment, and health education outreach programs. • Medical direction on clinical aspects of government products. • Participate in escalated utilization management and benefit exception decisions and facility claims audits.	50%
Actively participate in meetings and committees	Actively participate in department meetings and activities that further Medica's goals related to Health Management and Government Programs. Attends and participates in scheduled quality committee meetings with IA DHS. Directs internal Utilization Management Committee meetings.	20%

Support Medica's provider relation strategy with adult living facilities, Medica Care System and contracted care system providers	Work in conjunction with Medica Government Programs, Health Management and Network management staff to develop and maintain productive relationships with adult living facilities and Medica's Care Systems and network providers. This includes developing visible relationships with these providers, working with these providers on quality improvement, utilization, care coordination activities, providing input into contracting strategies and co-leading contracted care system medical directors' meetings.	10%
Provide Health education programming to clinical staff, members and other stakeholders	• Develop and deliver health education training to clinical staff on a routine basis through large group trainings, interdisciplinary team meetings, etc. • Develop and provide health education programming to members at annual member meetings, newsletter articles, website pieces, etc. • Be available to speak to the community on health related topics.	10%
Participate in creating health care policy with government stakeholders and other health plans.	Keep current on CMS clinical policies and changes. Represent Medica on various community, government, and Council of Health Plan Committees.	10%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Doctorate
Major: Medical Degree
Years of experience required: 7+ years

Specific types of experience required:

Must be a licensed physician in Minnesota with current Board certification, preferably in a primary care specialty; current license to practice must be without restrictions.
7+ years' experience in health care, including:

- at least 4 years' experience in the clinical practice of medicine
- 3 or more years in medical management which must include leadership in delivery system/hospital or in health plan management.

Experience in Medicare and State Public Programs is strongly preferred.

REQUIRED CERTIFICATIONS/LICENSURE:

Licensed Physician

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _30__%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Required:
High integrity, morals, and mission driven focus
Outstanding written and verbal communications skills
Strong process management and strategic planning skills
Physician executive leadership experience with proven success in developing and implementing clinical programs
Knowledge in analyzing data to identify opportunities, develop clinical programs, and measure outcomes
Ability to influence and drive discussions toward resolution

Strongly Desired:
Previous program development for Medicare and/or State Public Programs in case management, utilization management, quality improvement, and population health are strongly desired.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: None

Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Manager, Care Coordination

Department: Health Management
Reports to: Director of Clinical Operations
Revision Date: 4/20/15

Job Code:
Salary Grade:
FLSA Status: Exempt

POSITION OVERVIEW:

This position is responsible for daily operations and the performance of the Clinical Care Coordination and Case Management teams. This includes:

- Relationship building within Medica and its vendor partners to prioritize, integrate and coordinate interventions for population segments based on medical, behavioral and social needs
- Relationship building with provider care teams as accountable partners facilitating member self-care management
- Adoption of transformational interventions and case management models for conditions and populations driving medical expense trend
- Population specific care coordination
- Population specific complex case management
- EOL management
- Transitional care management (post-discharge)
- Predictive modeling and proactive member identification
- Specialty medical condition management (i.e., transplant, HRP)

This position is responsible for providing overall direction to clinical staff and is responsible for the implementation, evaluation, intervention and improvement of programs delivered for the government lines of business. The case management activities in the team are engineered to deliver process oriented outcomes, through focus on a comprehensive established plan of care, collaborative interactions with the member and provider, and the Medica Case Manager assuming assertive, purposeful direction of the case.

This team manager will be required to monitor and prioritize significant regulatory and customer requirements, and accreditation standards to ensure reasonable compliance at all times. This role is critical to Medica, as the team directed will provide critical feedback to the member and the provider to intervene and influence decision-making regarding clinical plan and management of the member. This individual will identify areas for process improvement and work closely with monitoring data for trends, identifying opportunities for improvement and implementing improvement plans, as appropriate, and as directed by the Medical Directors and the HM leadership.

This position is responsible for analyzing and taking appropriate action on operational and program data to support staff/operations management, as well as multiple reports of program outcomes.

This individual must be capable of strategic thinking and mature social/business judgment in situations with Medica staff, members and providers involving risk and conflict. This position works directly with all managers and directors within the Health Management department, the medical directors, the Customer Call Center, and Provider Services areas in Medica. This individual must be comfortable working with senior management to support program deliverables and when cases with risk to Medica are identified. This position regularly interacts with Account Management and Government Markets divisions, and the segment clinical programs to address customer linkages and needs. Must have excellent presentation skills and ability to reflect confidence and clinical skills with consultants, regulators, and employers.

The manager partners with other leaders in Health Management and throughout Medica to develop strategy around case management interventions to manage utilization of health care services.

The manager understands, articulates and supports the organization's mission, vision, goals and strategies, and maintains confidentiality of all privileged information.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
Management of business/program operations	• Leads and manages the program and team as outlined under the Position Overview section. • Implements all case management programs and services for government business and effectively monitors, manages and allocates resources to achieve business initiatives. • Responsible program implementation. • Tracks and evaluates productivity, program performance and the performance guarantees. Develops program recommendations. • Collaborates closely with Medica's Government business/clinical leadership to ensure seamless operations and service. • Develops and assures business processes/program workflows are implemented consistently, evaluated for effectiveness and efficiency and are improved. • Is responsible for performance management, supervision, and direction of staff. • Acts as a subject matter expert for case management for Medica, our clients and in project teams. • Serves as key contact for government case management for representation of the program and problem resolution of operational issues and implementation of action plans. • Maintains communication between key stakeholders and departments such as Customer Service, Claims Operations, Provider Services, Medical Directors, Pharmacy, and Account Management. • Collaborates closely with other areas within Health Management; Utilization Management, Health Innovation, Pharmacy and HCE to ensure collaboration and alignment, as well as operational linkages and efficiencies, including vendors and MBH. • Develops and oversees process of customer and regulatory audits for the case management team. • Monitors case quality to ensure competence in case management and care support decision-making, documentation and compliance with regulatory, accreditation and policy/procedure changes. • Provides leadership to the case management team in the context of Medica's direction and goals as an organization.	**35%**

Maintain efficient departmental operational systems and processes	• Ensures conformance to processes, policies and procedures, quality improvement activities and customer requirements. • Provides oversight for policies and procedures used in decision making by case management staff for Medica government products. • Delivers reporting for departmental dashboard • Facilitates team meetings and team building activities. • Creates positive team climate by setting individual and team goals and achieving results, eliminating non-value added activities, and recognizing and rewarding good work. • Assesses business tools, processes and systems to aid in efficiencies and accuracy of decisions. Integrate team processes with those of Utilization Management, segment operations, pharmacy, MBH, and other departments (i.e., Provider Services, Claims Operations and Account Management departments). • Responsible for support in establishing unit budget and monitoring • Completes and ensures compliance with business policies/ procedures. • Assess staffing/structure impacts due to change, and implement plans as necessary. • Work with Supervisor to assess work distribution and staffing ratios.	**35%**
Regulatory and Accreditation Compliance: assessment, monitoring and implementation	• Assures reasonable compliance with regulatory/accreditation standards and implements departmental action plans as necessary. • Develops and implements compliance with department policies and procedures. • Monitors audit results, assesses business case recommendations • Participates in customer audits, and audits for accreditation and regulatory purposes. • Assesses and implements compliance obligations as required by government and accreditation entities. • Ensure adequate staff training	**15%**
Monitor, track and report trends to facilitate benefit design, medical policy decisions and improve operational efficiencies	• Develops and refines as needed data collection tools, systems and reports to support operational performance and improvements. • Develops and maintains measurement reporting tools and reports and provides representation of data. • Is responsible for open communication between team and senior management regarding reports and recommendations. • Responsible to work with departmental and cross-functional teams to implement above noted opportunities, insuring all regulatory requirements maintained.	**15%**
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

Education/Experience: (Include any required licensure/certifications)

1) RN with active state license required, Bachelors degree required (prefer post-graduate degree)
2) Minimum of 8 years clinical experience.
3) Minimum of 5 years managed care experience in health management (utilization, case, or disease management),
4) Experience leading case management programs.
5) Experience with implementing regulations, legislation, rules and/or laws and accreditation standards.
6) Experience with utilization management and case management tools, procedures and programs.
7) Experience with data collection, assessment tools, reporting and analysis.
8) Minimum of 5 years experience with management of professional staff.
9) Past experience with complex project management required; proven track record of accomplishing strategic goals and projects.

Skills/Abilities:

1) Demonstrated leadership skills including: excellent interpersonal communication skills, creative and innovative problem-solving ability, critical thinking and independent decision-making ability, group facilitation, negotiation, change, conflict management and performance management skills.
2) Demonstrated process improvement and organizational skills.
3) Demonstrated ability to analyze data, conduct root cause analysis, understand and solve multi-dimensional problems, implement necessary improvement plans.
4) Presentation skills, success with managing a client and regulatory audience
5) Experienced with Microsoft Office Suite / Visio; case mgt. tools, related IT tools
6) Is a self-starter; can initiate project plans and actions once problem has been identified.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: 1 Behavioral Health Manager

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

- Manages department budget with oversight from Director/VP. Monitors team expenditures. Supports the Director in planning and setting annual budget.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Manager Claims Administration

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to:

Prepared By:
Revision Date: 4/20/2015

POSITION OVERVIEW:

is responsible for policy and procedures in billing, and claims. This position forms, manages, and monitors these functions performed by Medica employees.

The Manager Claims Administration is responsible for the productivity and quality of the billing and claims functional areas. The position is responsible for implementing controls to ensure compliance standards are met, and for creating and implementing auditing/monitoring processes to ensure Health Plan performance standards are met or exceeded.

This position provides leadership, functional advice and is responsible for establishing and managing processes that ensure accurate implementation and interpretation of the customer benefits (including compliance with applicable federal and state laws). This position also manages interdepartmental relations and processes for accurate and efficient handoffs and tracking of progress within Medica and our vendors.

This manager will also be a key participant in Process Improvement projects such as enrollment portal enhancements, workflow improvements, new product roll-outs, renewal rates, program builds, team creation and implementation, platform implementations, etc. Under the leadership of the Director, this manager will be a team player in many of these projects.

This position is expected to build relationships with both internal and external customers.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Management	Manage billing and claims business policy & procedures. Recommend, approve and implement changes as appropriate (particularly in regard to Medica's compliance of federal and state laws). Work with other Operations manager to maximize overall productivity. Manage, coach and develop direct reports. Monitor key performance metrics, and take corrective action as necessary to ensure acceptable performance levels for accuracy and timeliness. This includes individual performance of direct reports. Key Responsibilities may include: - Work with direct reports dedicated to claims examination to manage the day to day inventory of their respective queues to ensure that turnaround time guarantees are consistently met. Develops and implements strategy for cost recovery.	60%
Communication and Direction	Collaborates with key teams (Corporate Shared Services, and Finance), to outline, drive, and execute the appropriate project plans and scorecards to monitor and manage the key projects. Meet with and educate appropriate parties regarding issues/trends to avoid repeated errors (e.g., sales, claim service staff, customers, may include providers.) Contacts appropriate business partners to correct systems errors as needed. Proactively communicates with and advise key leadership regarding process improvements and ongoing initiatives. Maintains adequate communication regarding project status, risks, issues and priorities with leadership business and project team. Direct and communicate training activities from needs assessment, material design, delivery and evaluation to ensure consistent application of all operational policies and procedures. Manages cross functional teams to expand the organization's view of these key initiatives.	20%
Project Management	Be a key contributor to projects. Identify and solve for service trends or issues that impact Medica's customers. Be a resource for other departments on impacts to the operational areas when corporate initiatives are being implemented. Create, develop, and implement teams when necessary for new business projects and programs.	20%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree or Equivalent Experience
Major: Business Administration or Healthcare Administration
Years of experience required: 5-8 years

Specific types of experience required:
Knowledge of health care industry/products/benefits is required
Knowledge of Medica's operational systems is a plus
In-depth knowledge of health plan enrollment and billing processes, contact center, health claim processing, health plan operations business processes, claims systems and linkages
Project management and/or business analysis experience
Previous experience supervising/managing a team of people for at least 5 years

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.
Travel: ____%
Lifting/Carrying Weight: ____
Other special Requirements: _____

SKILLS/ABILITIES:

Ability to effectively manage internal staff and exceed corporate goals
Strong interpersonal and relationship building skills
Drive and capability to create, implement, and oversee a new business function
Good understanding of basic operational and administrative processes (contact center, enrollment, billing, claims)
Decision-making and analytical skills
Strong written and verbal communication skills
The ability to work across the organization to influence individuals who don't have a direct report line to them, and achieve the required project deadlines and meet/exceed corporate goals
Individual must have strong business acumen, analytical abilities, and problem solving abilities to review data and trends and then manage/work with individuals to identify root causes and implement effective solutions
Good presentation skills are necessary and meeting facilitation skills are a plus
Strong business process/workflow knowledge

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: possibly 4 – 8 enrollment specialists; 3-4 Billing analysts, 9-14 service representatives, 3-4 claims examiners.
Number of indirect reports (total number in department/area):
This position indirectly guides the activities of cross organizational teams can include up to 20-40 people. Individuals represented are internal Medica staff, key points of contact representing our customers, Phoenix project members, and vendors.

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Contract and Vendor Management

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to:

Prepared By:
Date: 4/21/2015

POSITION OVERVIEW:

This position has major responsibility for vendor management issues as well as delegation oversight processes.

This position also leads a team of auditors and liaisons that perform duties in line with financial stewardship and compliance guidance.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Successfully manage the contractual relationships with vendors	Monitor the core elements of each contract and ensure compliance. Assure vendors meet performance standards as outlined in vendor agreements. Schedule and lead regular business meetings with each vendor to identify and resolve contractual and operational issues. Develop and maintain regular communications with each vendor. Identify and work with Medica Legal department to issue appropriate amendments to the master agreements. Negotiate vendor agreements. If needed, prepare and issue an RFP to accurately assess market value for vendor services and select vendor.	40%

Develop and maintain contact liaison relationship with each vendor and all relevant internal Medica departments.	Triage operational issues with each vendor. Triage operations issues from Medica departments. Determine appropriate resolution to operational issues. Develop and oversee joint project management groups for larger operational or implementation issues. Communicate resolution of operational issues to relevant Medica departments. Maintain a history of operational processes to respond to similar requests as they arise. Communicate vendor performance to relevant Medica departments. Maintain and manage overall perception of vendor effectiveness.	30%
Project Management	Provide project management for new or changing business activities as assigned.	10%
Mange the delegation oversight process	Co-chair a bi-weekly oversight team which monitors each vendor's performance on delegated activities. Issue corrective action plans if needed; review vendor responses and communicate resolution. Attend Medica delegation committee; communicate and report status of vendor performance on delegated activities. Make recommendations for continued delegation or removal of delegation status. Communicate vendor delegation performance to appropriate Medica departments including, compliance, legal, SIU and customer service.	10%

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Healthcare related field
Years of experience required: 5 years

Specific types of experience required:

BA/BS in healthcare related field
5 years of managed care/health plan experience required
Legal/regulatory/compliance experience preferred
Vendor Relations experience desirable

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____

Other special Requirements: _____

SKILLS/ABILITIES:

Excellent interpersonal/relationship skills
Proven ability to communicate effectively
Strong written communication skills
Strong organizational skill
Strong drive for results and accountability
Demonstrated success leading project teams and managing/executing complex projects across organizations.
Knowledge of 'managed care' laws preferred.
Must be able to develop innovative solutions that balance legal and business needs.
Must demonstrate strong analytical, and problem identification and resolution skills.
Ability to handle multiple, complex projects with a high degree of initiative.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: 3
Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: Fiduciary responsibility regarding transportation spend as it relates to transportation options and stewardship of federal monies in driving results.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Mgr Information Systems and Security

Job Code:
Salary Grade:

Department: Information Technology

FLSA Status: Exempt

Reports to:

Prepared By:
Revision Date: 04.20.2015

POSITION OVERVIEW:

The Manager of Data Integration will lead the team responsible for the development and implementation of data integration services solutions. This includes but is not limited to those solutions using Medica's Tibco integration engine (EAI/EDI), internal and external data feeds and data transformation efforts. The position will interface primarily with IT technical resources but is also exposed to business owners to insure that technical solutions will meet business requirements.

The incumbent will serve as a liaison between Medica and DHS or its designee, regarding claims submissions, capitation payment, member eligibility, enrollment and other data transmission interface issues. Responsible for ensuring all IT system security and controls, program data transaction, data exchanges and other information system requirements are in compliance and data submission requirements are met.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Management of the Data Integration Department	General management duties of EC team (coaching, 1:1 meetings, team meetings, issue escalation and problem solving, performance appraisals) Creation and maintenance of team policies and procedures, keeping in sync with IT departmental processes (software development life cycle, Quality Assurance, test strategies, etc) Ensure daily operations are functioning to health plan and business partner expectations, operating in a timely and efficient manner Strategic planning for future department and IT initiatives and opportunities Recruitment/Selection/Retention of team members, in partnership with Human Resources Development, monitoring and reporting of departmental goals and metrics Attend and participate in departmental, divisional and Medica management meetings Conduct and coordinate tactical and strategic resource planning for the DI team	45%

Promotion of Data Integration Capabilities within Medica	Internal Medica consultant and expert for Integration (new concepts/initiatives/transactions); identify opportunities for use of Medica's integration technology Education and training of Medica staff, including departmental presentations. Attend industry meetings and task forces, collaborative efforts Provide subject matter expertise to Medica resources regarding hub infrastructure	20%
Information security	This position will ensure appropriate security controls and policies are implemented and are effective in protecting the organization and programs. • Perform ongoing information security risk assessments and audits. Ensure appropriate corrective action • Monitor compliance with information security policies and procedures, ensuring appropriate corrective action • Monitor the access control systems to assure appropriate access levels are maintained	35%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Computer science, programming or related field
Years of experience required: 7 years

Specific types of experience required:

5+ years experience in the information technology field
3 or more years of experience in a staff leadership or personnel management role
3 or more years experience in application and business partner integration
2 or more years of experience using Tibco as an integration tool, preferred
3 or more years JAVA programming experience
Meaningful experience and demonstrated knowledge of the following:
Project Management
IT Resource Management
IT Infrastructure (hardware, network, security)
Database (Logical Design, Physical Design)
Production Support
Technical Architecture

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Excellent analytical and problem solving abilities
Ability to work in a team environment
Demonstrated strength in verbal and written communication
Collaborative style with the ability to work with staff at all levels of a complex organization.
Exceptional customer service skill set
Demonstrated competency in coordinating multiple projects/activities
Proven ability to organize and coordinate

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: None
Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Mgr Marketing Communications

Job Code:
Salary Grade:

Department: Corporate Communications

FLSA Status: Exempt

Reports to: Vice President, Iowa Medicaid

Prepared By:
Revision Date: 4/21/2015

POSITION OVERVIEW:

Responsible for strategic communications planning and ownership of all communications disciplines and tactics for specified audience(s). Ensures that the key communications needs of the Government and Health Management teams are met. Ensures that messages and related communications vehicles are well targeted and in sync with overall corporate objectives and messages. Directs the creative team and/or consultant/agency in the development of on-target, creative, cost-effective marketing communications materials. Selects and oversees external vendors and consultants. Often serves as primary concept developer and occasionally copywriter. Presents concepts and final creative to customers. Ensures communications meet legal and compliance standards.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Assessment and Planning	Works closely with Government and Health Management along with other internal clients to determine communications needs and then develops strategic communication project plans encompassing multiple communications elements to serve a business purpose. Maintains alignment of messaging and strategy across initiatives and departments. Represent communications function on cross-functional business teams	25%
Manages Communications Team and Resources	Oversees the work of Corporate Communications Specialist, who directly reports to Corporate Communications Manager. Evaluates resource requirements. Selects and oversees the work of external vendors and consultants, when needed, who provide such services as copywriting, photography, printing and graphic design services. Establishes time lines and accountabilities, ensuring projects are completed on time. Forges productive relationships with internal stakeholders and external partners. In conjunction with Director of Corporate Communications, develops communications budget and manages budget, ensuring that projects stay within budget.	50%
Creative direction	Serves as creative director on all projects. Contributes to creative process in concept development and occasionally copywriting. Oversees the development of creative, including overarching concepts, copy and final product. Edits materials to ensure they are on target in message and are accurate. Works closely with Sales, Product, Legal and other subject matter experts and stakeholders.	25%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Communications
Years of experience required: 5 years

Specific types of experience required:

This person must have a BA/BS in communications, journalism, public relations or a related communications field and 5+ years of related experience. Excellent strategic planning and project management skills, including budgeting are required. Experience in leading a team; excellent writing, editing, and proofreading skills; experience in print production and electronic production capabilities are also required. Communications experience in healthcare or the insurance industry is preferred, but not required.

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

The desired candidate must have the ability to turn verbal direction into written communications and be able to multi-task.
The candidate must have excellent listening skills, and needs to be resourceful and able to switch gears at any time.
S/he will receive direct communication from the communications director and needs to be able to execute and meet deadlines.
Must be able to demonstrate strategic thinking in dealing with key internal customers
The desired candidate will also have strong project management skills.
Must be able to prioritize, negotiate and juggle resources, and have the ability to work with budget management.
Microsoft Office skills also required.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles:
3 Community Outreach Coordinators

Number of indirect reports (total number in department/area):

Manages relationships with key outside vendors, including printers, designers, copywriters and photographers.

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

In conjunction with Director of Marketing Communications, responsible for developing marketing communications budget and ensuring that projects stay within budget.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Mgr, Member & Provider Service Call Center

Job Code:
Salary Grade:
FLSA Status: Exempt

Department:

Reports to: Sr. Director, Government Programs Call Center

Prepared By:
Revision Date: 04/20/2015

POSITION OVERVIEW:

This position is responsible for managing Member and Provider service call center and staff. The manager is accountable for achieving call center standards. This position is responsible for developing and managing relationships with internal and external customers, including interfacing with the leadership and CMS to ensure that needs are being identified and addressed and that call trends are reported to the organization. The Call Center Manager is responsible for the development and implementation of methods, systems and strategies that support customer and provider needs/requests. The manager works closely with the director to ensure the day to day operations of the call center are being met

This position is directly responsible for managing direct contact with Medica's membership and providers. It is imperative that customers receive the highest level of service possible in every interaction. The Call Center Manager provides the leadership necessary to meet our mission statement of "Exceeding our Customer's Expectation".

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)

Managerial Oversight/General Department Operations	Lead the department into achievement of the call center standards, as defined by senior management. Responsible for the identification and quick resolution of vendor errors or processes that impact calls volume. Facilitate the identification, resolution and communication of member service issues and inquiries. Escalate issues requiring further investigation to other appropriate areas within Medica. Evaluate and monitor call center performance metrics, work processes, and quality approach to ensure service needs are being met. Implement corrective actions as necessary. Report service metrics and standards as appropriate. Monitor staffing structure and associated ratios to regularly achieve Member Service performance targets. Develop forecasts, future staffing and resource requirements for the Customer Service unit. Ensure cross training among service staff to maintain proper service levels, to provide career advancement tracks to staff and to adjust quickly to any staff turn over. Ensure up-to-date policies, procedures and reference materials are available to all call center personnel. Conduct research and analysis of phone service technologies and benchmarks. Implement modifications or enhancements as necessary.	35%
Personnel Management	Manage the interviewing, hiring, training and staff development activities as needed. Provide direct supervision for the department supervisors and other key staff in the unit. Facilitate individual and team communication by conducting regular 1:1 and team meetings Perform annual performance reviews, set clear goals and objectives for each employee, team and the call center overall. Act as a mentor and guide on identifying, investigating and resolving department, personnel or administrative issues Promote a positive working climate that supports open and honest communication, integrity, service quality and customer focus. Provide opportunities for employee development, such as networking, external training and development programs.	35%
IA Service Representative	Represent Government Programs Service through active participation on standing and ad hoc internal committees. Share all pertinent information with department management and staff as necessary. Collaborate with other service areas within Medica to leverage collective knowledge and ensure clear delineation of service responsibilities. Promote Government Programs call centers internally to enhance understanding of interdependencies and the impact of organizational changes/initiatives on the call center. Make recommendations to Medica regarding operational improvements to prevent persistent service problems. Support Government Programs leadership in communicating issues and concerns and provide suggestions for improvement.	30%
	Total %	**100%**

<u>ESSENTIAL QUALIFICATIONS/REQUIREMENTS</u>:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Business, management, or healthcare field
Years of experience required: 5 years

Specific types of experience required:
Bachelor's degree in business, management or healthcare field is required
5 years experience working in a customer service environment in managed care.
2 years experience in a supervisory/management position in a call center.
Medicare knowledge/experience required

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Ability to manage multiple responsibilities/priorities simultaneously
Results-driven with a focus on performance management as it relates to both people and metrics
Strong negotiation and conflict management skills needed with the ability to effectively work through difficult situations
Customer focused
Strong written and verbal communications
Computer literate-specifically Microsoft Word, Power Point and Excel
Experience in working with various call center software (i.e., ACD, IVR, Workforce Management)
Strong ability to think creatively in multiple situations
Strong presentation and organizational skills

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles:

2 Customer Service Supervisors
2 Q/A Analysts

Number of indirect reports and titles:
30 Customer Service Representatives

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

Direct allocation of resources within budget guidelines
Assist Director and VP on annual budget planning and preparation

MEDICA®

MEDICA POSITION PROFILE

Job Title: Mgr, Member Svc Call Ctr

Job Code: MCS383
Salary Grade: 112

Department: Iowa Medicaid

FLSA Status: Exempt

Reports to: Director, Government Programs

Prepared By:
Revision Date: 4/222/15

POSITION OVERVIEW:

Medicaid is a fast paced call center that serves as the first point of contact for Medicaid members and their representatives, prospects, termed members and other stakeholders. The call center staff must have a broad range of knowledge regarding Medicaid products and services, benefits, enrollment, claims, billing, grievances and appeals.

This position is responsible for managing call center and staff. The manager is accountable for achieving call center standards. It is the manager's responsibility to support Medica's Market Business Segments by managing the operations of the call center. This position is responsible for developing and managing relationships with internal and external customers, including interfacing with the leadership and CMS to ensure that needs are being identified and addressed and that call trends are reported to the organization. The Call Center Manager is responsible for the development and implementation of methods, systems and strategies that support customer needs/requests. The manager works closely with the director to ensure the day to day operations of the call center are being met. The accountabilities of the manager includes working with Real Time Operations team to develop monthly forecasts, staffing requirements and development of staff schedules to ensure the call center is staffed appropriately during business hours. The manager communicates and supports call center supervisors to ensure alignment with team schedules. This position takes the lead on all new call center technology roll-outs and system enhancements for Customer Service. The manager is responsible for evaluating and monitoring Government Programs performance metrics, work processes and quality approaches to ensure service needs are being met.

As part of the Leadership team in member service and because of their knowledge, advancement opportunities should be high. This person could potentially move to a higher level of management such as Director or VP. This person would also have several opportunities in Sales and Marketing, Health Care Services, Provider Services, Product Administration, etc.

This position is directly responsible for managing direct contact with Medica's membership. It is imperative that customers receive the highest level of service possible in every interaction. The Call Center Manager provides the leadership necessary to meet our mission statement of "Exceeding our Customer's Expectation".

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Managerial Oversight/General Department Operations	Lead the department into achievement of the call center standards, as defined by senior management. Responsible for the identification and quick resolution of vendor errors or processes that impact calls volume. Facilitate the identification, resolution and communication of member service issues and inquiries. Escalate issues requiring further investigation to other appropriate areas within Medica. Evaluate and monitor Government Programs Call Center call response and performance metrics, work processes, and quality approach to ensure service needs are being met. Implement corrective actions as necessary. Report service metrics and standards as appropriate. Monitor staffing structure and associated ratios to regularly achieve Member Service performance targets. Develop forecasts, future staffing and resource requirements for the Customer Service unit. Ensure cross training among Government Programs Service staff to maintain proper service levels, to provide career advancement tracks to staff and to adjust quickly to any staff turn over. Ensure up-to-date policies, procedures and reference materials are available to all Government Programs Call Center personnel. Conduct research and analysis of phone service technologies and benchmarks. Implement modifications or enhancements as necessary.	35%
Personnel Management	Manage the interviewing, hiring, training and staff development activities as needed. Provide direct supervision for the department supervisors and other key staff in the unit. Facilitate individual and team communication by conducting regular 1:1 and team meetings Perform annual performance reviews, set clear goals and objectives for each employee, team and the call center overall. Act as a mentor and guide on identifying, investigating and resolving department, personnel or administrative issues Promote a positive working climate that supports open and honest communication, integrity, service quality and customer focus. Provide opportunities for employee development, such as networking, external training and development programs.	35%
IA Medicaid Service Representative	Represent Government Programs Service through active participation on standing and ad hoc internal committees. Share all pertinent information with department management and staff as necessary. Collaborate with other service areas within Medica to leverage collective knowledge and ensure clear delineation of service responsibilities. Promote Government Programs call centers internally to enhance understanding of interdependencies and the impact of organizational changes/initiatives on the call center. Make recommendations to Medica regarding operational improvements to prevent persistent service problems. Support Government Programs leadership in communicating issues and concerns and provide suggestions for improvement.	30%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Business, management, or healthcare field
Years of experience required: 5 years

Specific types of experience required:
Bachelor's degree in business, management or healthcare field is required
5 years experience working in a customer service environment in managed care.
2 years experience in a supervisory/management position in a call center.
Medicare knowledge/experience required

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Ability to manage multiple responsibilities/priorities simultaneously
Results-driven with a focus on performance management as it relates to both people and metrics
Strong negotiation and conflict management skills needed with the ability to effectively work through difficult situations
Customer focused
Strong written and verbal communications
Computer literate-specifically Microsoft Word, Power Point and Excel
Experience in working with various call center software (i.e., ACD, IVR, Workforce Management)
Strong ability to think creatively in multiple situations
Strong presentation and organizational skills

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: TBD

Number of indirect reports (total number in department/area): TBD

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

Direct allocation of resources within budget guidelines
Assist Director and VP on annual budget planning and preparation

MEDICA®

MEDICA POSITION PROFILE

Job Title: Mgr Provider Service Center

Job Code: MPS312
Salary Grade: 112
FLSA Status: Exempt

Department: IA Medicaid

Reports to: Director, Provider Service Center

Prepared By:
Revision Date: 4/21/15

POSITION OVERVIEW:

The Manager of the Provider Service Center is responsible for the operations and performance targets for one of Medica's call centers servicing contracted and non-contracted providers. This call center is accountable for responding to provider inquiries and complaints. It represents the first point of contact for providers to inquire or communicate regarding accuracy and timeliness of claims payments, referral procedures, product information, benefit verification and general plan information. This position is accountable for managing and reacting to staffing needs, technology shifts, conflict resolution and other organizational demands while continuously improving upon the service to the provider community.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Personnel Management	Conduct interviewing, hiring, training and staff development activities as needed. Facilitate individual and team communication by conducting regular 1:1 and team meetings Perform annual performance reviews Act as a mentor and guide on identifying, investigating and resolving provider service, personnel or administrative issues	25%
Provider Representative	Represent Provider Service through active participation on standing and ad hoc internal committees. Share all pertinent information with department management and staff as necessary. Collaborate with other service areas within Medica to leverage collective knowledge and ensure clear delineation of service responsibilities. Promote the PSC teams internally to enhance understanding of interdependencies and the impact of organizational changes/initiatives to the provider community. Make recommendations to Medica regarding operational improvements to prevent persistent provider service problems.	25%

Provider Service Center Operations	Facilitate the identification, resolution and communication of provider service issues and inquiries. Escalate issues requiring further investigation to other appropriate areas within Medica. Respond directly to providers regarding PSC complaints and issues requiring managerial attention. Evaluate and monitor Provider Service Center call response and performance metrics, work processes, and quality approach to ensure service needs are being met. Implement corrective actions as necessary. Report service metrics and standards as appropriate. Monitor staffing structure and associated ratios to regularly achieve Provider Service performance targets. Ensure cross training among Provider Service staff to maintain proper service levels, to provide career advancement tracks to staff and to adjust quickly to any staff turn over. Ensure up-to-date policies, procedures and reference materials are available to PSC personnel. Prepare and manage the Provider Service Center budget. Conduct research and analysis of phone service technologies and benchmarks. Implement modifications or enhancements as necessary.	50%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Business management, health services administration, or other relevant discipline
Years of experience required: 5 years

Specific types of experience required:

Minimum of five to eight years combined experience in customer service management, call center management or provider relations.
Previous experience in health care claim (CMS 1500 and UB-04) analysis and resolution

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Proven ability in conflict management and negotiation.
Ability to translate complex data into understandable, usable information and tools.
Knowledge of Call Center environments and terminology's
Working knowledge of standard management processes, controls, and tools, including budgeting, performance monitoring, and information systems.
Collaborative management style with the ability to work with staff at all levels of a complex organization.
Exceptional communication tools, both verbal and written.

Additional Competencies:
The Manager of the Provider Service Center must possess a tremendous amount of composure and ability to comprehend people and situations quickly.
Process management skills are imperative to evaluate and manage a call center environment.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles:
Provider Service Center Supervisor
Quality, PAA, Super Rep Supervisor (

Number of indirect reports (total number in department/area

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

Responsible for the Provider Service Center cost center budget (providing input on budget creation, monitoring of expenditures, etc.)
Responsible for approval of any Provider Service Center expense reports

MEDICA®

MEDICA POSITION PROFILE

Job Title: Manager, Quality Management

Job Code:
Salary Grade:

Department: IA Medicaid

FLSA Status: Exempt

Reports to: Clinical Operations Director

Prepared By:
Revision Date: 4/21/15

POSITION OVERVIEW:

The Manager, Quality Management is responsible for quality improvement initiatives, audits, and other regulatory compliance activities developed either internally or by outside regulatory agencies to comply with overall quality requirements. These requirements are established by state and national agencies. This position is responsible for designing, developing, and implementing quality initiatives for Medicaid in Iowa. The manager will link with needed resources throughout the organization or externally as necessary, as well as maintain reporting and professional relationships with involved regulatory agencies and provider clinics involved in ongoing initiatives or quality audits. This position manages delegation review and oversight of care coordination entities providing care coordination services.

This critical position ensures the right quality and compliance measures are proactively taken by Medica. This helps to ensure that the health plan successfully prepares for and passes regulatory audits, keeps ongoing contacts with public members and providers, and avoids any fines arising from being out of compliance. This position leads and manages audits required by CMS or DHS with minimal notice. The Manager must be flexible and creative in order to meet constantly emerging or revised requirements.

The success of this role will determine Medica's success in Medicaid programs in terms of meeting regulatory requirements related to quality. Additionally, valuable gains in quality improvement areas can reduce overall costs for the organization as well as identify new modes of care delivery that could benefit both Medica and its enrolled members. Several of the activities managed in the Regulatory Quality area have direct financial impact for Medica. This position represents Medica on both state and national groups which work to improve the measures used to evaluate metrics for government programs populations.

The Manager, Quality Management and related staff are required to work with a number of data sources and information resources to collect data and identify regulatory reporting needs. These needs must be met in a timely fashion and require work with regulatory agencies to review and evaluate Medica's compliance with requirements. This position will require creativity in terms of identifying t current research and reporting needs , monitoring potential new metrics, how they can best be met, and how to maintain regulatory relationships throughout the process. This individual must have the ability to manage and support staff with largely independent roles.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)

Lead the development and implementation of **Medicaid** regulatory reporting and quality initiatives.	Maintain compliance with appropriate sections of DHS contracts, in cooperation with Medicaid Compliance staff Ensure Medica staff from a variety of departments complete and submit reports timely per DHS specifications by educating them on requirements, supporting data collection, and reminders of timelines. Participate in external and internal committees which develop metrics to evaluate Medicaid products. Maintain compliance with all Medicaid HEDIS and CAHPS reporting requirements as they are developed. Maintain participation in ongoing projects in connection with PIP initiatives, communicate with key Medica staff to ensure corporate support and prevent duplication of efforts.. Work with Health Improvement to ensure the design and implementation of clinical focus studies meet Medicaid member needs. Manage delegation review and oversight of the Care System, County, and Agency Care Coordination entities providing services to the Care Coordination Products. Provide overall leadership of Medicaid quality initiatives. Oversee and identify areas for improvement relating to customer satisfaction surveys, evaluation and reporting. Provide principal quality assurance liaison with DHS, special advisory committees and work groups related to Medicaid activities. Maintain liaison with Health Management, Clinical Operations, and Health Management Analytics internally to ensure sufficient resources to meet Medicaid regulatory and quality requirements.	50%
Lead Quality improvement initiatives	Provide overall leadership for Medicaid quality initiatives. Ensure staff utilizes process improvement and project management strategies and tactics to achieve goals. Coordinate government programs QA activities with other health plan QA activities to ensure efficient cost management, for example work on the Collaborative Assessment and Care Plan and the Collaborative PIP/QIP efforts. Collect data in cooperation with Health Management Analytics and conduct trend analysis to identify opportunities for quality improvement initiatives based on current Medicaid program and claims experience. Identify and actively lobby for quality priorities for Medicaid products. Design, implement, evaluate and report specific quality initiatives related to Medicaid programs in cooperation with Health Management Analytics, the HEDIS Improvement Team, Delegation Oversight Committee, and others. Assist Medica's quality department as the Government Programs lead in meeting NCQA accreditation requirements and other external research objectives. Represent Medicaid QA activities on QIS committee, UM Committee, Delegation Committee, and other committees or boards as needed. Maintain relationship with utilization management to determine QA/UM standards. Monitor delegate Corrective Action Plans	30%
Provide supervision of direct reports	Conduct face to face meetings with the direct reports on a routine basis to discuss performance, development opportunities, etc. Communicate accurate and timely information to team members to enhance their effectiveness and the efficiency of the programs. Employ a coaching management style. Research, recommend and approve training and development opportunities for direct reports. Work with direct reports to develop yearly goals, measure progress against the goals and perform the annual performance reviews. Create a positive climate among the team and recognize and reward achievement.	20%

	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:
Education Level: Bachelor's Degree
Major:
Years of experience required: 5 years

Specific types of experience required:
At least 5 years of experience in designing, developing and implementing healthcare quality initiatives;

2+ years work with quality measures, for example collecting and/or analyzing IA Community Measurement measures, HEDIS, CAHPS, and/or member survey result

3+ years experience in a managed care environment with background knowledge of Medicaid/ and/or Medicare regulations and standards; and

2 years experience managing and coaching direct reports. Comfortable with direct reports who often work external to the office.

Past experience as a Care Coordinator preferred

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: __ 15___%
Lifting/Carrying Weight: ___20 lbs__
Other special Requirements: _____

SKILLS/ABILITIES:

Ability to operate independently and to handle multiple priorities with a high degree of initiative
Ability to develop strong partnerships with influencers at Medica, health plans, regulators, etc.
Strong analytic, issue identification and resolution skills
Demonstrated ability through previous experiences to interact with regulatory agencies
Strong project management skills required
Excellent verbal skills in telephonic interactions, small and large groups and in face-to-face communications
Excellent written communication skills
Demonstrated strong integration skills
Demonstrated learning ability
Computer experience and general understanding of data collection methods

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: TBD

Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

MEDICA®

MEDICA POSITION PROFILE

Job Title: Manager, Utilization Management and Quality

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt
Reports to: **Director of Clinical Operations**
Revision Date: 4/21/2015

POSITION OVERVIEW:

This position is responsible for daily operations of the following functions:

- Provider transaction intake and assignment
- Inpatient and outpatient service data entry
- Notification and authorization intake and processing
- Oversight of clinical review functions associated with service authorization, including pre-service, concurrent, retrospective review and regulatory compliance
- Clinical appeal processing
- National Accounts Utilization Management and Care Coordination
- Regulatory Compliance for Care Management programs and functions
- Care management program/intervention development, operations and evaluation

The clinical appeal, notification and utilization management functions have significant regulatory requirements and the manager must have a comprehensive knowledge of state and federal regulations and accreditation standards to ensure compliance at all times. This position is responsible for providing overall direction to staff. It is also responsible for the implementation, evaluation, intervention and improvement of utilization management, clinical appeals and notification programs. This role is critical to Medica, providing feedback to the organization to influence decision-making regarding clinical cases. This individual will identify areas for process improvement and work closely with monitoring data for trends, identifying opportunities for improvement and implementing improvement plans, as appropriate and as directed by the Director, Quality & Health Management Compliance.

This position is responsible for documenting regular program statistics for regular management reports, analyzing the data reports and acting upon them appropriately.

This individual must be capable of strategic thinking and functioning calmly in situations involving risk and conflict. This position works directly with all managers and directors within the Health Management department, the medical directors, and all customer and provider service areas in Medica. This individual must be comfortable working with senior management when cases with risk to Medica are identified.

The manager partners with other leaders in Health Management and throughout Medica to develop strategy around clinical appeals and utilization management interventions to manage utilization of health care services.

This position is responsible for achieving and maintaining compliance to key Minnesota and Federal rules and laws of managed care as well as maintaining Medica's accreditation status.

The manager understands, articulates and supports the organization’s mission, vision, goals and strategies, and maintains confidentiality of all privileged information.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
Management of business/program operations	• Implements all care management programs and services (e.g. notification, prior authorization, and clinical appeals, etc.) and effectively monitors, manages and allocates resources to achieve business initiatives. • Oversees the criteria and participates in the process of placing items on prior authorization, keeping items on and removing items. Works with appropriate workgroups and committees throughout the process. • Responsible for oversight and maintenance of operations related to national product line of business including new business implementation, reporting of care coordination performance guarantees, communication with Optum Care Coordination client sites to insure seamless customer service. • Manages, reviews and implements policies and procedures used in decision making by care management, clinical appeals and notification staff. • Is responsible for ongoing supervision and performance management of direct reports. • Acts as a subject matter expert for notification, prior authorization and clinical appeals in project teams. • Serves as key contact for problem resolution for operational issues and implementation of action plans. • Maintains communication between key stakeholders and departments such as Customer Service, Government Programs, Claims Operations, Provider Services, Medical Directors, and Pharmacy. • Collaborates closely with other areas within Health Improvement (e.g. Health & Wellness, Program Operations and Program Development and Evaluation) to ensure alignment and operational efficiencies. • Monitors staff training, to ensure competence in case decision-making, documentation and compliance with regulatory, accreditation and policy/procedure changes. • Provides management to the notification, prior authorization and clinical appeals units while maintaining teamwork and collaboration with the direction and needs of Medica • Collaborates closely with Director, Quality & Health Management Compliance and others as appropriate to determine member identification, intervention and program evaluation for the department.	**35%**

Maintain efficient departmental operational systems and processes	• Ensures conformance to processes, policies and procedures, quality improvement activities and customer requirements. • Provides oversight for notification, prior authorization and clinical appeals processes to insure timely and accurate transmission and distribution of information for prior authorization and appeal functions. • Provides oversight for technical policies used in decision making by staff for Medica regional and national products. • Is responsible for initiating team problem solving by managing change and diversity within the team and other departments. • Facilitates team meetings and team building activities. • Creates positive climate motivated by achievement, minimize non-productive and restrictive rules, set high standards and recognize and reward good work. • Assesses business tools, processes and systems to aid in efficiencies and accuracy of decisions. Integrate team processes with those of Health & Wellness and other departments as appropriate (e.g. Customer and Provider Services and Claims Operations departments). • Is responsible for establishing unit budget and monitoring throughout the year; completes and ensures accuracy of paperwork in compliance with business policies/procedures. • Responsible for continuous oversight of call flow and phone wait times for cost saving and process improvement opportunities. • Assess staffing/structure impacts due to change, and implement plans as necessary. • Work with Supervisors to assess work distribution and staffing ratios.	**35%**
Regulatory and Accreditation Compliance: assessment, monitoring and implementation	• Assures compliance with regulatory and accreditation standards and implements departmental action plans as necessary • Develops and implements compliance with department policies and procedures. • Monitors (audits) policy/procedure compliance and COC compliance, closes gaps with corrective action plans. • Participates in surveys and audits for accreditation and regulatory purposes. • Assess and implement compliance obligations for all states in which Medica is licensed to operate. • Ensure adequate staff training on regulatory, accreditation and policy/procedure changes. • Monitor (audit) policy/procedure compliance through inter-rater reliability testing and other means, close gaps with corrective action plans and improvement plans.	**15%**
Monitor, track and report trends to facilitate benefit design, Medical policy decisions and improve operational efficiencies	• Assesses adequacy of and refine as needed data collection tools, systems and reports to support continuous operational improvements • Develops and maintains measurement reporting tools and reports and provides representation of data as required by business unit. • Conducts continuous assessment, monitoring, analysis and communication of data and opportunities for improvement. • Is responsible for open communication between team and senior management regarding findings. • Responsible to work with departmental and cross-functional teams to implement above noted opportunities, insuring all regulatory requirements maintained.	**15%**
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

Education/Experience: (Include any required licensure/certifications)

1) RN with active Minnesota license required, Bachelors degree required (or equivalent work experience in a health-related) field
2) Minimum of 5 years clinical experience. Minimum of 5 years managed care experience in utilization, case management, benefit appeals and quality improvement.
3) Experience with implementing regulations, legislation, rules and/or laws and accreditation standards.
4) Experience with utilization management and case management tools, procedures and programs. Knowledge of utilization management criteria sets.
5) Experience with implementing regulations, legislation, rules and/or laws and accreditation standards
6) Experience with regulatory and accrediting agencies, legal departments and staff.
7) Experience with data collection, assessment tools, reporting and analysis.
8) Minimum of 2 years experience with management of professional staff.
9) Past experience with complex project management required; proven track record of accomplishing strategic goals and projects.

Skills/Abilities:

1) Demonstrated leadership skills including: excellent interpersonal communication skills, creative and innovative problem-solving ability, critical thinking and independent decision-making ability, group facilitation, negotiation, change, conflict management skills and coaching skills.
2) Demonstrated process improvement and organizational skills.
3) Demonstrated ability to analyze data, conduct root cause analysis, solve multi-dimensional problems, implement necessary improvement plans and achieve business excellence through these efforts.
4) Experienced with Microsoft Office Suite / Visio; can rapidly learn new IT systems
5) Is a self-starter; can initiate project plans and actions once problem has been identified. Can act independently.
6) Ability to use data to drive results

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles

- 4 UM Nurses
- 2 Review Coordinators
- 1 Quality Analyst

- Number of indirect reports (total number in department/area)

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

- Manages department budget with oversight from Director. Monitor department expenditures. Assists Director in setting annual budget needs.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Manager, Utilization Management

Job Code*:*
Salary Grade: 113
FLSA Status: Exempt

Department: IA Medicaid

Reports to: Director, Health Management

Prepared By:
Creation Date: 4/21/15

POSITION OVERVIEW:

The Utilization Management (UM) Manager is responsible for being the first line resource for concurrent review and prior authorization staff. This includes, training on policies and procedures to assure compliance with policies and regulatory requirements. The Manager provides oversight of the daily management of concurrent review staff, appeals and auditing functions, and assuring that all staff provides a level of customer service that meets or exceeds the organizations expectations.
The Manager is also responsible to understand, promote and audit the principles of Utilization Management to facilitate the right care at the right time in the right setting. Identify trends or issues in the UM process that require further evaluation for their quality or utilization implications and bring these items to the attention of the Director. Communicate effectively and interact with the Medical Directors, hospitals, provider offices, and staff daily or as indicated regarding UM issues. Possess care coordination skills including but not limited to, development and monitoring of care plans, post discharge call, Vital Care referrals, and hospital contracts. Organize and facilitate weekly UM meetings to disseminate new information.
Know Medica's policies and procedures and be prepared to address those staff members who do are not in compliance. Verify that patient confidentiality is maintained by the staff and that HIPAA compliance is observed at all times.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Identification and Utilization Management	• Oversight of hospital census monitoring and follows identified admission processes for case identification, utilization and management. • Monitoring of handoffs from notification associate to start clinical review in a timely manner according to policies. • Identifies trends and factors which contribute to delays in discharge and works to reduce those trends. • Prepares reports on utilization information, including admissions, discharges, authorization denials, use of covered services and other pertinent performance data, as directed	10%

Utilization & Facilitation	Management oversight of the following activities: • The Review and analysis of medical information either telephonically or onsite, in order to determine the medical necessity of continued stay according to review standards. Utilization management, transfer coordination, discharge planning and review of authorizations for covered services as needed for members. • Presents facility-patient status updates and addresses barriers to discharge/transition at regularly held concurrent review rounds. • Early identification and assessment of members for potential inclusion in a comprehensive case management program. Refers members for ongoing complex case management accordingly. • Understanding of health plan benefits and coordinate discharge/referral plan as necessary. • Post service review process. • Assures adherence to all regulatory and compliance requirements. • Assures the protection of confidentiality of utilization review, quality management information and beneficiary identification • Documentation of utilization reviews in Care Management software system. • The process for verbal and written communication of review outcomes to facilities, physicians and members. • Length of stay negotiations and discharge plans with facility. • Appeals related to the review determinations. • Assists Member Services, Claims and Provider Services with issues that require medical interpretation or definition.	65%
Evaluation	Management oversight of the following activities: • Scheduled MD Rounds at Medica to discuss cases with case managers, Medical Directors and leadership. • Participate in compliance audits and interrater reliability	15%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Nursing
Years of experience required: Requires 5+ years of nursing experience, 2 years in an acute care setting, and 1 year of Utilization Management or case management preferred. 2+ years Supervisory experience.

Specific types of experience required:

Professional RN license in state required.
BSN or BS/BA preferred with a minimum of five years clinical experience
Managed care experience preferred.
Hospital utilization management or case management experience a plus
Working knowledge of Milliman Care Guidelines or InterQual in review determination process.
Demonstrated experience in utilization management, facility concurrent review, discharge planning and transfer coordination.

REQUIRED CERTIFICATIONS/LICENSURE:

RN License in IA

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: Minimal – to onsite hospital and to Medica
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Experience with management of clinical and non-clinical staff
Experience working with multiple age groups, medical, surgical background and a generalized level of understanding across specialty care areas
Ability to assume responsibility and exercise good judgement in making decisions within the scope of authority of the position
Ability to think and work effectively under pressure and accurately complete tasks within established times
Strong customer service skills, strong decision making skills, active, listening skills, patience, independence and excellent organizational skills
Ability to think creatively, negotiate and access resources
Excellent verbal and written skills
Basic PC use and basic typing skills
Ability to work independently
Highly organized, time management skills, requires ability to make decisions under stress and manage multiple complex issues on a daily basis
Ability to demonstrate flexibility and adaptability in an ever changing health care environment

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: TBD
Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Product Administration Manager

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to: Compliance Officer

Prepared By:
Revision Date: 4/21/2015

POSITION OVERVIEW:

The Product Manager is responsible for developing, implementing and managing a portfolio of products/programs for the assigned market. This role is also responsible for developing and monitoring a multiyear strategy for product/program performance.

The incumbent develops and manages competitive offerings by overseeing market research, defining product requirements/features, designing the overall customer experience and managing the product performance life cycle. The PM works to ensure on-time delivery of new products to the market.

The role is a self directed position that collaborates with internal departments including the Sales, Account Management, Communications, Compliance, Legal, IT, Network, Operations, Brokers, Consultants and governmental agencies.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Product/Program Development	• Developing new products/program and features, enhancements, portfolio revisions and product/program discontinuation as needed to achieve market position, membership goals and profitability targets. • Leading cross-functional teams responsible for assessing/implementing new/revised or enhanced product/program designs. • Incorporate voice of the customer in product/program roadmap. • Assess requirements, design, develop and implement new process and tools to support products/programs.	20%

Product/Program Implementation	• Leads and manages cross-functional product/program implementation teams. • Mapping and managing the customer experience (point of sale, service and on-line). • Collaborating with Communications in the development of product collateral, marketing and communications initiatives. • Responsible for conducting internal training and serving as subject matter expert for external training.	25%
Product Performance	• Assessing market and competitive positioning in support of product/program strategies. • Providing product performance feedback to key stakeholders. • Monitoring and reporting on-going performance of product portfolio(s) including customer satisfaction, membership growth/retention and operational performance. • Develop course correction proposals, as needed, based on metrics. • Responsible for ensuring product/program meets regulatory and compliance requirements.	30%
Communication development	• Creates, approves and coordinates distribution of member materials	20%
Special Projects	• Support and assist in projects assigned by leadership.	5%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Healthcare, business administration or marketing
Years of experience required: 5 – 7 years

Specific types of experience required:

- 5 - 7 plus years experience in product/program development, design and implementation of healthcare products within a large healthcare/managed care company.
- At least 2-3 years experience leading and managing cross-functional teams
- Project management skills preferred

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Knowledge of health care and health care operations.
Ability to lead and motivate cross-functional/cross-organization teams
Excellent written and verbal communication skills, including conflict management
Experience with cross-organization leadership in planning and moving product plan objectives forward
Demonstrated history of strong project management and completion of projects with measurable results
Strong project management, health plan operations and product lifecycle management experience required
Detail oriented and results driven
Expertise in resolving complex issues with all levels of employees and leadership
Ability to multi-task and prioritize work with a variety of internal and external customers simultaneously
Proficient in the Microsoft Office Suite

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: None

Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

Responsible for input and monitoring of cost and expense associated with product/program development, implementation, and resources required to achieve Medica's profitability and membership goals.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Program Integrity Manager

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to:

Prepared By:
Revision Date: 04/21/2015

POSITION OVERVIEW:

The Program Integrity Manager is responsible for oversight of the Special Investigations Unit and Regulatory Investigations.

The Special Investigations Unit is responsible for protecting the Plan, it's membership, and the provider community from financial and health risks by identifying, investigating, and eliminating abusive and fraudulent billing practices. Consistent with Medica's mission, abuse and fraud management ensures a high quality, cost-effective health care experience for our customers across the continuum of care.

The Regulatory Investigations area responds to to complaints filed by state regulatory agencies such as the Attorney General's Office, Department of Commerce and Department of Health and complaint letters directed to Medica's Board of Directors and Senior Management.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Staff Leadership	Coaches and develops direct reports. Promotes and models appropriate communication skills and continuous improvement principles relative to team department and organizational issues. Communicates accurate and timely information to team members to maximize compliance and performance. Coordinates training and development opportunities for team members. Establish strong and effective relationships with customers.	15%
Other	Develop, maintain, and enhance collaborative relationships with the AG's office, FBI, DOH, DHS, OIG, local law enforcement and other external agencies to address abuse and fraud issues affecting Medica members and providers as well as the entire community. Information exchange coordination for sharing of information with law enforcement (HIPAA).	5%

Complex case identification and investigation. Investigation of provider, member, broker or employer fraud	1. Conduct investigation and analysis of pending, current and historical claim experience of a physician, clinic or facility identified. a) Conduct audit activities and produce reports by identifying abusive trends, setting criteria for appropriate sample size, and developing an action plan for review. b) Initiate an internal investigation of resources such as system reports, review of the provider contract and correspondence file, and interviews with respective Plan staff. c) Conduct medical record review and/or patient interviews to evaluate accuracy of billing practices. d) Conduct and/or assist investigations with the most complex patient, provider and related party interviews. e) Represent Medica in court when a case is litigated. Serve as the primary contact for all external law enforcement cases, as the point person to receive all requests for information and participate in the external case task forces when needed. Identification and investigation of member fraud and abuse. Enforce member compliance with Certificates of Coverage (COC) for enrollment eligibility, authentic claim submissions, and appropriate use of member identification cards. Work collaboratively with other Medica departments to develop improvements in abuse and fraud detection and to create and implement system-wide enhancements to achieve financial savings and minimize financial liability for the Plan.	30%
Management of day to day operation of Special Investigations	Review referrals for investigation and assign cases as appropriate for investigation. Monitor case management, in order to achieve department goals and complete unit initiatives. Ensure continued development and updating of departmental policies and procedures. Identify and facilitate cost savings opportunities, including policy and procedure development and implementation of prospective and retrospective investigations. Develop and implement Abuse and Fraud training programs and materials to educate internal staff and external customers. Develop, maintain and enhance abuse and fraud monitoring, tracking and detection tools to identify patterns and trends and assure accurate reflection of abuse and fraud incidents and financial savings. Establish proactive measures through prospective analysis and monitor deviations in coding and billing patterns to prevent financial loss. Recover overpayments identified through retrospective analysis. Serve as a consultant to credentialing and contracting staff during screening processes and contract negotiations to minimize financial liability for the Plan. Work in coordination with credentialing and contracting staff to develop disciplinary action when appropriate. These recommendations may include placement on administrative hold, a formal corrective action plan, or termination of participation status resulting in financial savings for the Plan. Develop and implement ongoing monitoring of abuse and fraud programs to assure the integrity of control systems. Ensure effective communication and coordination within Medica and between Medica and United Health Care. File annual Fraud and Abuse Plan with the Minnesota Department of Human Services (DHS) to ensure compliance with contract requirements.	40%

Regulatory Investigations	1. Manage investigations of complaints filed by state regulatory agencies and complaints directed to Medica's Board of Directors and Senior Management. 2. Prepare monthly reports for review by Senior Management identifying any trends/gaps and forward to the appropriate department for root cause analysis and fix.	10%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:
Education Level: Bachelor's Degree
Major:
Years of experience required: 10+years

Specific types of experience required:
A bachelor's degree in criminal justice, business management, health services, or related field or equivalent combination of education and experience.
The qualified candidate will have at least 10 years in the field, with at least five years of management experience.
Established working relationship with law enforcement agencies is preferred.

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

The desired candidate will have experience in criminal/civil insurance investigation and have a working knowledge of provider contracts, member certificates of coverage and claims processing procedures.
Demonstrated experience and skills in public speaking.
Excellent written and verbal communication skills.
Conflict management and negotiation skills are also important.
Experience testifying in criminal and/or civil litigation cases.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles:
7 (Manager, Sr. Investigator, Int. Investigator, Associate Investigator, Legal/Administrative Assistant)

Number of indirect reports (total number in department/area): 15

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

Oversee a total budget of approximately $1.7 million.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Provider Relationship Manager

Job Code:
Salary Grade:

Department: Network Management

FLSA Status: Exempt

Reports to: Network Management Director

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

The Provider Relationship Manager is responsible for the management of contracting negotiations, provider relationships and network development within the Iowa Medicaid program.

The processes performed in the Network Management department are fundamental to delivering cost-effective, accessible care to subscribers. It is critically important that the negotiating process be compliant with regulatory and accreditation requirements, company policies and procedures, as well as consistency with strategic objectives. Since unit cost is one of the principal drivers of organizational profitability, close collaboration with other departments is required. The incumbent is required to identify and cultivate key provider relationships for consideration of this financial model as well as a thorough understanding of the underpinnings of financial modeling.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Negotiations & Contracting	Successfully develop, negotiate & execute contracting arrangements with providers Maintain positive working relationships with Medica's key providers Coordinate negotiations and ongoing provider relationship activities with Provider Finance, Operations and Legal in understanding data analytics, operational compatibility and sound legal instruments Ensure contracts are completed in a timely and accurate fashion Identify contracting opportunities within program area, determine data needs and perform analyses	50%
Provider Relations	Maintain positive working relationships with Medica's key providers Manage provider networks in program area	30%

Department Activities	Comply with department and company-wide policies & procedures and training requirements Recommend P&P changes where gaps exist Participate in cross-functional department workgroups as assigned	20%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Business Administration or Finance
Years of experience required: 3 years

Specific types of experience required:

A proven track record as a successful contract negotiator for health care services, provider or health plan
A proven track record of cultivating and maintaining effective, collaborative external relationships where the parties trust information that's conveyed
Conceptual and operational understanding of claims payment and financial reporting systems and methods
The ability to communicate complex concepts in a simple, concise manner
Strong financial and quantitative skills
A working knowledge of contracts and interaction with legal staff
Strategic-thinking skills with the ability to conceptualize a wide range of outcomes and probabilities and to provide advice based on the most likely successful outcome
The ability to make decisions with confidence
An understanding and appreciation for standardizing processes to generate efficiencies and improve service levels

REQUIRED CERTIFICATIONS/LICENSURE: N/A

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Interact with provider economics in an iterative process that determines reimbursement terms throughout the negotiation process
Effectively communicate with operations to ensure appropriate claims adjudication

In addition, this individual must be of high integrity, diplomatic and persuasive in his/her negotiations with providers in order to maintain long-term contractual relationships

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: TBD

Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:** None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Public Policy Manager

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to: Vice President, Iowa Medicaid

Prepared By:
Revision Date: 4/21/2015

POSITION OVERVIEW:

This position supports the Vice President of Public Policy and Government Relations and is responsible for managing Medica's public policy agenda and interests. This position is responsible for tracking state and federal legislation and regulation, communicating policy issues within the organization, conducting health policy research and working with the Government Relations Director and the Vice President of Public Policy and Government Relations to achieve Medica's public policy agenda.

This person works at the direction of the Vice President of Public Policy and Government Relations and the Vice President of Public Policy and Government Relations or his/her delegates oversee this person's work.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Monitor state and federal legislative/regulatory activities and appropriately assess their impacts against Medica's business needs	Monitor legislation and regulations introduced at the state and federal levels, appropriately identify relevant legislation and regulations and track their outcome. Assist the Director of Legislative Affairs in monitoring relevant legislative floor sessions, committee meetings and conference committees Participate with Trade Association activities related to Medica's legislative agenda. Prepare comment letters and other communication in response to proposed state and federal regulations or requests for information Act as a resource to elected officials and their staff on matters of health care policy Assist the VP of Public Policy and Government Relations in working with interest groups to workout differences in legislative language	25%
Communicate all relevant state and federal legislation and regulation to appropriate staff and gain their input as dictated by business needs	Gather and catalogue internal input on specific legislative/regulatory proposals from impacted business units and legal staff Provided written and oral summaries of legislative proposals and activities as directed by the VP of Public Policy and Government Relations Respond to employee questions regarding specific public policy issues	20%

Research and make recommendations on current health care policy issues	Monitor trade organizations' activities including AHIP the Minnesota Council of Health Plans and others Conduct research as directed on all health policy issues and prepare white papers or summaries as needed Assist the VP of Public Policy and Government Relations and the Director of Government Relations in developing Medica's public policy position on relevant health care topics	15%
Provide public policy support to business segments	Work with identified Business Segments to understand their business needs and the impact of public policy changes on their business Serve as a resource to business segments on current and proposed legislation and regulations	15%
Represent Medica and its public policy interests in public forums such as Trade Associations and other committees and task forces as necessary	Attend the Minnesota Council of Health Plan committee meetings, including public policy, legal and regulatory and government programs. Attend the Minnesota Chamber of Commerce public policy committee meetings Participate and/or ensure appropriate staffing on task forces, working groups and other committees as dictated by business needs	20%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:
Education Level: Bachelor's Degree
Major:
Years of experience required: 2 years
Specific types of experience required:
Thorough understanding of legislative process
J.D. or Masters in health care or public policy preferred

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:
Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.
Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:
Excellent oral communication skills
Excellent writing skills
Ability to present company position persuasively
Strong relationship building skills
Effective project management abilities
Solid presentation skills
Strong organizational skills
Ability to assimilate information from various sources and recommend courses of action
Ability to work in a rapidly changing environment and adjust priorities quickly

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: None
Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:** None

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MEDICA POSITION PROFILE

Job Title: **Sr Director Finance** **Job Code:**

Salary Grade:
Department: **FLSA Status: Exempt**

Reports to: **Chief Financial Officer**

Prepared By:
Date: **4/22/2015**
Revision Date:

POSITION OVERVIEW:

The Sr Director Finance has overall responsibility and oversight for financial analysis and reporting, health cost and administrative budgeting and forecasting, pricing and rate development, rate filing, CMS Bid filing, and medical expense trend evaluation for the Iowa Medicaid program. The financial oversight has significant impact on the financial strategy, tactics, and results of Government business. The position will provide primary support to product development and evaluation.

The incumbent is responsible for managing a team of financial analysts and providing expert internal consulting to the Senior Vice President of Government Programs.

This position will coordinate closely with the Senior Vice President of Finance and the Chief Finance Officer (and CAO).

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
• Monthly and annual analysis and reporting of segment's financial operating results.	• Assures accurate financial reporting by staff. • Directs analysis of results and advises segment senior management of implications. • Assures the timely delivery of financial reporting to support the decision-making of the management teams of the Government/IB Segments.	35%
• Annual budgeting of health care costs and administrative expenses. Quarterly and multi-year forecasting of financial projections.	• Works closely with segment leadership to produce operating budgets for health care costs/revenues and administrative expenses. • Oversees support for quarterly forecasting (Outlook) and multi-year forecasting working closely with the Finance department. • Supports development of strategic plan by segment leadership. • Provide consultation on development of administrative cost efficiencies.	15%
• Medical Cost trend analysis and reporting.	• Works closely with Finance Department team to analyze and report on medical cost trend for reporting and forecasting. Also, works with Finance team on IBNR levels, reserve levels, claims retro activity reporting, and restated financials. • Provides reporting and consultation to segment senior leadership on management of medical loss ratio and cost management strategies. Oversees reporting on medical costs for strategies and tactics for care management/coordination and provider management.	25%

• Supervise Finance and actuarial staff for Government/IFB segments	• Provide leadership, supervision, and coaching to finance and actuarial staff. • Assure that staff complete assigned responsibilities and meet deadlines. • Prioritize staff activities. • Assure that staff have adequate tools and resources to successfully complete responsibilities. • Assure staff (and career) development.	25%
	Total %	100%

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

Education/Experience: (Include any required licensure/certifications)
Bachelor's Degree in finance or related area.
Experience: 10 years including 5 years of management experience
Specific experience:

- Advanced degree (MA, MBA, MHA) or significant related experience preferred.
- Experience in financial analysis and reporting in health care, insurance, managed care, or financial services preferred.
- Oversight of actuarial and/or underwriting services a plus.
- Experience in Government finance a plus.

Skills/Abilities:

- Strong oral and written communication and presentation skills.
- Self directed and can develop and lead a technical team.
- Ability to analyze and interpret complex financial data.
- Skill in budgeting, forecasting, and development of financial modeling.
- Knowledge of medical cost trend drivers.
- Understanding of regulatory environment and requirements.
- Strong project management skills.

DIRECT/INDIRECT REPORTS *(if any)*:

- Number of direct reports and titles __
- Number of indirect reports (total number in department/area) ___

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

- Oversee development of Government health care cost budgets and department administrative budgets. Assist segment leadership in managing budgets. Develop and manage team administrative budget.

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MEDICA POSITION PROFILE

Job Title: Vice President Iowa Medicaid

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to: SVP Government Programs

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

The Vice President, Iowa Medicaid is responsible for overall leadership of the Iowa program division, including management of the profit and loss, product development, quality improvement, public health, operations and compliance for the Iowa lines of business. This key individual will hold the ultimate accountability for the vision, strategy, planning, execution, performance, compliance and internal and external communication related to Medica's Iowa lines of business. The position exercises strategic control over planning short and long-term fiscal viability of these products in addition to formulating and administrating policies.

This role also contributes to developing Medica's overall strategy and has a responsibility to help achieve Medica's overall goals and objectives.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Lead Iowa Medicaid Segment	Meet organizational and departmental objectives as jointly established with Sr. Leadership Develop, propose and implement product strategy to Executive management as well as manage results to achieve pre-established objectives. Segments profit and loss accountability. Manage revenue and health care costs. Lead health and quality improvement initiatives, and community outreach Oversight of marketing and sales activities	30%

Manage Department Activities	Effectively and efficiently, manage segment's various department activities including, program development and regulatory oversight. Motivate and lead a high performance management team. Attract, recruit, and retain highly talented staff on the management team. Foster a success-oriented, accountable environment and ensure that employees have clarity regarding what is expected of them. Ensure that goals, policies, lines of authority and communication are clearly understood and consistently articulated. Emphasis will be placed on high standards in both execution and performance outcomes. Develop and manage departmental administrative budget. Improve efficiency and reduce administrative costs Also work collaboratively with Finance to meet regulatory required reporting goals and manage the financial health of the segment.	30%
Manage external contacts including regulators	Responsible for negotiating DHS contract and payment rates Ensure Medica's compliance with federal and state government regulatory requirements Manage community partnerships, key provider relations and public relations for Government Programs.	15%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:
Education Level: Bachelor's Degree. Master's Degree preferred.
Major: Business, health administration or related field
Years of experience required: 10+ years
Specific types of experience required:
10 or more years of experience in developing and managing financially successful Medicare and Medicaid products within a managed care environment
10 or more years of experience in working with regulators and member advocacy groups
10 or more years of project management experience including complex project implementation
10 or more years of experience in managing direct reports
Led a health care delivery system (care system) and has experience in working with health care providers with varying clinical degrees
Managed product compliance for Medicare and Medicaid products with federal (Centers for Medicare and Medicaid Services) and state regulators
Significant experience in working with low income, ethnically diverse and senior populations
Led product and rate negotiations with Medicaid state agency
Experience negotiating total cost of care type provider contracts with large health systems

REQUIRED CERTIFICATIONS/LICENSURE:
None

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _15____%
Lifting/Carrying Weight: _20 lbs____
Other special Requirements: _____

SKILLS/ABILITIES:
Strong verbal and written communication skills
Must have strong planning and financial management skills, accountable for results
Strong people management skills and experience
Strong interpersonal and relationship building skills including community relations experience
Ability to manage multiple projects and complex processes simultaneously
Prioritization skills
Creative problem solving skills and innovative approach
Ability to analyze regulatory policy proposals
Ability to develop and execute contracts with provider organizations
Ability to complete and analyze competitive analyses
Ability to set strong performance goals and standards and then measure, monitor and take corrective actions as necessary
Government relationship skills

DIRECT/INDIRECT REPORTS *(if any)***:**

Number of direct reports and titles: 6
1 Medical Director
1 Clinical Operations Director
1 Compliance Officer
1 Marketing Communications Manager
1 Call Center Manager
1 Policy Manager

Number of indirect reports (total number in department/area):

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:** Responsible for profit and loss and staying within target administrative costs

Exhibit A: Release of Information

(Return this completed form behind Tab 6 of the Bid Proposal.)

Medica Health Plans (name of bidder) hereby authorizes any person or entity, public or private, having any information concerning the bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Agency.

The bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Agency or may otherwise hurt its reputation or operations. The bidder is willing to take that risk. The bidder agrees to release all persons, entities, the Agency, and the State of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

Medica Health Plans

Printed Name of Bidder Organization

Signature of Authorized Representative 5/20/15

) **Geoff Bartsh**

Printed Name

Exhibit B: Primary Bidder Detail Form & Certification

(Return this completed form behind Tab 6 of the Proposal. If a section does not apply, label it "not applicable "')

Primary Contact Information (individual who can address issues re: this Bid Proposal)	
Name:	Geoff Bartsh
Address:	401 Carlson Parkway, Minnetonka, MN 55305
Tel:	952-992-2461
Fax:	952-992-3550
E-mail:	Geoff.Bartsh@Medica.com

Primary Bidder Detail	
Business Legal Name ("Bidder"):	Medica Health Plans
"Doing Business As" names, assumed names, or other operating names:	None
NAIC Number:	52626
Parent Corporation, if any:	Medica Holding Company
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	Health Maintenance Corporation, tax-exempt under section 501 (c)(4) of the Internal Revenue Code.
State of Incorporation/organization:	Minnesota
Primary Address:	401 Carlson Parkway, Minnetonka, MN 55305
Tel:	952-992-2900
Fax:	952-992-3550
Local Address (if any):	401 Carlson Parkway, Minnetonka, MN 55305
Addresses of Major Office and other facilitie that may <contribute to performance under this RFP/Contract:	401 Carlson Parkway, Minnetonka, MN 55305
Number of Employees:	1,354
Number of Years in Business:	Incorporated in 1974
Primary Focus of Business:	Insurance
Federal Tax ID:	41-1242261
Bidder's Accounting Firm:	McGladrey, LLP
If Bidder is currently registered to do busines in Iowa, . provide the Date of Registration:	Our license application is in progress
Do you plan on using subcontractors if . awarded this Contract? {If "YES," submit a Subcontractor Disclosure Form for each Proposed subcontractor.}	YES

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (Tab/Page)	Statutory Basis for Confidentiality	Description/Explanation
Removed Trade Secret/Confidential		

		(i)

BID PROPOSAL CERTIFICATION

By signing below, Bidder certifies that:

1. Reserved;
2. Bidder accepts all capitation rates established by the Agency via the Agency's actuary.
3. Bidder has reviewed the Additional Certifications, which are incorporated herein by reference, and by signing below represents that Bidder agrees to be bound by the obligations included therein.
4. Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;
5. Reserved;
6. Bidder has received any amendments to this RFP issued by the Agency;
7. Bidder either is currently registered to do business in Iowa or agrees to register if Bidder is awarded a Contract pursuant to this RFP;
8. The person signing this Bid Proposal certifies that he/she is the person in the Bidder's organization responsible for, or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive agreements outlined above;
9. Bidder specifically stipulates that the Bid Proposal is predicated upon the acceptance of all terms and conditions stated in the RFP and the Sample Contract without change.
10. Bidder certifies that the Bidder organization has sufficient personnel resources available to provide all services proposed by the Bid Proposal, and such resources will be available on the date the RFP states services are to begin. Bidder guarantees personnel proposed to provide services will be the personnel providing the services unless prior approval is received from the Agency to substitute staff;
11. Bidder certifies that if the Bidder is awarded the contract and plans to utilize subcontractors at any point to perform any obligations under the contract, the Bidder will (1) notify the Agency in writing prior to use of the subcontractor, and (2) apply all restrictions, obligations, and responsibilities of the resulting contract between the Agency and contractor to the subcontractors through a subcontract. The contractor will remain responsible for all Deliverables provided under this contract.
12. Bidder guarantees the availability of the services offered and that all Bid Proposal terms, including price, will remain firm until a contract has been executed for the services contemplated by this RFP or one year from the issuance of this RFP, whichever is earlier; and,
13. Bidder certifies it is either a) registered or will become registered with the Iowa Department of Revenue to collect and remit Iowa sales and use taxes as required by Iowa Code chapter 423; or b) not a "retailer" of a "retailer maintaining a place of business in this state" as those terms are defined in Iowa Code subsections 423.1(42) & (43). The Bidder also acknowledges that the Agency may declare the bid void if the above certification is false. Bidders may register with the Department of Revenue online at: http://www.state.ia.us/taxlbusinesslbusiness .h tml.

By signing below, I certify that I have the authority to bind the Bidder to the specific terms, conditions and technical specifications required in the Agency's Request for Proposals (RFP) and offered in the Bidder's Proposal. I understand that by submitting this Bid Proposal, the Bidder agrees to provide services described herein which meet or exceed the specifications of the Agency's RFP unless noted in the Bid Proposal and at the prices quoted by the Bidder. I certify that the contents of the Bid Proposal are true and accurate and that the Bidder has not made any knowingly false statements in the Bid Proposal.

Signature:	Geoff Bartsh
Printed Name/Title:	Geoff Bartsh VP+GM State Public Programs
Date:	5/20/15

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Disclosure of Ownership, Control and Management Information, and Exclusions Statement ("Disclosure Form")

I. Instructions

This form must be completed and submitted to Medica Health Plans ("Medica"). A new Disclosure Form is required and must be submitted when any information in your original form has changed. This Disclosure Form is to be completed to ensure compliance with government program requirements pertaining to: (1) disclosure of ownership, control and management; and (2) exclusions of individuals and entities from government programs as set forth in your contract with Medica and Medica's administrative requirements.

The disclosure, reporting and exclusion requirements apply to partnerships and both non-profit and for-profit corporations, including without limitation limited liability companies. Governmental entities, such as counties that are not organized as corporations, are not required to complete this Disclosure Form. Section VII (Definitions) clarifies which individuals and entities you must provide information about in the Disclosure Form. The definitions are based on law, regulation, and instructions from regulatory authorities.

Important Note: For the purposes of this Disclosure Form, the term "Person with an Ownership or Control Interest" is not limited to persons or corporations with an ownership interest. For example, it also includes:

(i) officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies; and

(ii) partners of a partnership, including without limitation limited liability partnerships.

See Section VII for a complete definition of "Person with an Ownership or Control Interest" as well as definitions of other key terms such as "Managing Employee," "Provider," and "Agent."

Please complete this Disclosure Form whether or not you have any information to report. If more space is needed, please attach additional information on a separate page.

For assistance in completing this Disclosure Form, please reference the Definitions provided under Section VII.

II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS	DBA (Doing Business As), if applicable		
[redacted]			
ADDRESS			NPI/UMPI
[redacted]			
CITY	STATE	ZIP CODE	OFFICE PHONE NUMBER
New York	NY	10003	( )
FEDERAL EMPLOYER ID (FEIN)	MN TAX ID		
[redacted]	N/A		

III. Structure

Check the entity type that describes your structure:

☐ Sole Proprietorship ☐ Partnership ☐ Other Partnership (i.e., LP, LLP, LLLP) ☐ Limited Liability Co

☒ For Profit Corporation ☐ Non-Profit Corporation ☐ Public Corporation ☐ State ☐ Other _____

IV. Ownership, Control and Management Information

A. Please provide the following information for each Managing Employee, and Person with an Ownership or Control Interest in you as a Provider, or in any Subcontractor in which you as a Provider have direct or indirect ownership of 5% or more. All fields must be completed. The date of birth and social security number (SSN) are required if a *person's* name is provided, and the federal employer identification (FEIN) number is required if an *entity's* name is provided.

IMPORTANT: This table lists Managing Employee and the direct owner only.

No.	Full Legal Name	Address Individuals – list home address Entities – list primary business address, every business location and P.O. Box	Date of Birth	SSN or FEIN	% Ownership Interest, if applicable
1	MPH Acquisition Corporation	115 Fifth Avenue, 7th Floor, New York, NY 10003	Incorporation date 08/26/2010	[redacted]	100%
2	[redacted]				[redacted]
3	[redacted]				[redacted]
4	[redacted]				[redacted]

B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in subsection IV (A) as a spouse, parent, child or sibling, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

No.	Full Legal Name	SSN	Name of Person Related To	Related Person's SSN	Relationship
1	N/A				
2					
3					

C. For each Person with an Ownership or Control Interest listed in subsection IV(A) who also has an ownership or control interest in a disclosing entity other than that indicated in subsection IV(A), please provide the following information. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	SSN or FEIN	Name of Other Organization	% Ownership Interest
1	N/A				
2					

3					

V. Excluded Individuals or Entities

A. Are there any employees, Persons with an Ownership or Control Interest in you as a Provider, or any of your Managing Employees or Agents who are or have ever:

- Been excluded from participation in Medicare or any of the State health care programs?

☐ Yes ☒ No

- Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs?

☐ Yes ☒ No

- Had civil money penalties or assessments imposed under Section 1128A of the Social Security Act (that is, federal fraud and abuse law civil monetary penalty provisions)?

☐ Yes ☒ No

B. Do you as a Provider have any agreements for the provision of items or services related to Medica's obligations under its contracts with the Minnesota Department of Human Services (DHS) or the Centers for Medicare and Medicaid Services (CMS) with an individual or entity who: (i) has been excluded from participation in Medicare or any of the State health care programs; (ii) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or other state or jurisdiction since the inception of those programs; or (iii) had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

☐ Yes ☒ No

If you answered "Yes" to any of the above questions, list the name and social security number (SSN) or federal employer identification number (FEIN) of the individual or entity, and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in, or exclusion from participation in, Medicare, Medicaid, or other federally funded government health care programs, or imposition of civil money penalties or assessments under Section 1128A of the Social Security Act).

No.	Full Legal Name	SSN or FEIN		Reason
1				
2				
3				
4				

VI. Certification

I am authorized to bind the entity named in this document and I certify that the above information is true and correct. I will notify Medica of any changes to this information.

NAME (Print)	TITLE
SIGNATURE	DATE
EMAIL ADDRESS	

Return a completed, signed Disclosure Form to Medica as follows:

Email a scanned copy of the signed form to your Medica contract manager. You may also mail the form to: Medica Health Plans, Mail Route CP225, P.O. Box 9310, Minneapolis, MN 55440-9310. If you have any questions, please call your contract manager.

VII. DEFINITIONS

For the purpose of this disclosure, the following definitions apply:

1. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Provider.

2. **Managing Employee** means an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the Provider, or part thereof, or who directly or indirectly conducts the day-to-day operations of the Provider, or part thereof.

3. **Person with an Ownership or Control Interest** means a person or corporation that:
   A) has an ownership interest, directly or indirectly, totaling 5% or more in the Provider;
   B) has a combination of direct and indirect ownership interests equal to 5% or more in the Provider;
   C) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Provider, if that interest equals at least 5% of the value of the property or assets of the Provider;
   D) is an officer or director of a Provider organized as a corporation (this includes officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies); or
   E) is a partner in a Provider organized as a partnership, including without limitation limited liability partnerships.

4. **Provider** means an individual or entity that: A) is engaged in the delivery of health care services and is legally authorized to do so by the state in which the individual or entity delivers services; and B) has entered into an agreement with Medica to provide health care services to Medica members, including members enrolled through Medica's contracts with DHS or CMS. For purposes of this disclosure, "Provider" also means a vendor providing non-health care services through an agreement with Medica to members enrolled through Medica's government program contracts with DHS or CMS, provided those services are significant and material to Medica's obligations under the respective government program contract.

5. **Subcontractor** means an individual, agency, or organization to which the Provider has contracted (or a person with an employment, consulting or other arrangement with the Provider) for the provision of items and services that are significant and material to the Provider's contract with Medica and Medica's obligations under its contracts with DHS or CMS.

Disclosure of Ownership and Management Information & Exclusions Statement for Vendors

I. Instructions

This statement must be completed and submitted to Medica. A new statement is required and must be submitted when any information in your original statement has changed.

This form is to be completed to ensure compliance with government program requirements pertaining to: (1) disclosure of ownership; (2) exclusions of individuals and entities from government programs as set forth in your contract with Medica; and (3) compliance program requirements.

The requirements of this statement apply to both for-profit and non-profit organizations. They also apply to counties and Minnesota state agencies. Section VII (definitions) clarifies which individuals and entities are required to comply with this statement. The definitions are based on law, regulation, and government program instructions.

Note: For the purposes of this statement, the term "Person with an Ownership or Control Interest" includes:
(i) senior officers and individual board members of for-profit and non-profit corporations; and
(ii) partners of a partnership.
("Person with an Ownership or Control Interest" also includes persons or corporations having certain percentage ownership interests as defined in Section VII(4)).

This statement also applies to "Agents" and "Managing Employees," as defined in Section VII, to the extent provided in this document.

Please complete this statement whether or not you have any information to report. If more space is needed, please attach additional information on a separate page.

For assistance in completing this statement, please reference the Definitions provided under Section VII.

II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS OptumHealth Care Solutions, Inc.	DBA (Doing Business As)		
ADDRESS 6300 Olson Memorial Highway			NPI/UMPI
CITY Golden Valley	STATE MN	ZIP CODE 55427	OFFICE PHONE NUMBER ( )
FEDERAL EMPLOYER ID (FEIN) [redacted]	MN TAX ID		

(Rev. April 2012)

III. Structure

Check the entity type that describes your structure:

☐ Sole Proprietorship ☐ Partnership ☐ Other Partnership (i.e., LP, LLP, LLLP) ☑ Corporation

☐ Limited Liability Co. ☐ Non-Profit ☐ County ☐ State

IV. Ownership & Control Interests

A. Please provide the following information for each Managing Employee, and Person with an Ownership or Control Interest in you as a Vendor, or in any Subcontractor in which you as a Vendor have direct or indirect ownership of 5% of more. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	Date of Birth	SSN or FEIN	% Ownership Interest
1	OptumHealth Holdings, LLC	9900 Bren Road East Minnetonka, MN 55343			100%
2	[redacted]				[redacted]
3	[redacted]				[redacted]
4	[redacted]				[redacted]
5	[redacted]				[redacted]

B. If any Person with an Ownership or Control Interest listed in subsection IV(A) is related to another Person with an Ownership or Control Interest listed in subsection IV(A) as a spouse, parent, child or sibling, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

No.	Full Legal Name	SSN or FEIN	Name of Person Related To	Related Person's SSN or FEIN	Relationship
1	N/A				
2					

C. For each Person with an Ownership or Control Interest listed in subsection IV(A) who also has an ownership or control interest in an organization other than that indicated in subsection IV(A), please provide the following information. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	SSN or FEIN	Name of Other Organization	% Ownership Interest
1	See Attachment A				
2					
3					

V. Excluded Individuals or Entities

A. Are there any employees, Persons with an Ownership or Control Interest in you as a Vendor, or any of your Managing Employees or Agents who are or have ever:

- Been excluded from participation in Medicare, Medicaid, or other federally funded government programs or any of the state health care programs?

☐ Yes ☑ No

- Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or other federally funded government programs in Minnesota or other state or jurisdiction since the inception of those programs?

☐ Yes ☑ No

- Had civil money penalties or assessments imposed under Section 1128A of the Social Security Act (that is, federal fraud and abuse law civil monetary penalty provisions)?

☐ Yes ☑No

B. Do you as a Vendor have any agreements for the provision of items or services related to the health plan's obligations under its contract with the Minnesota Department of Human Services ("DHS") or the Centers for Medicare and Medicaid Services ("CMS") with an individual or entity who: (i)) has been excluded from participation in Medicare, Medicaid, or other federally funded government programs or any of the state health care programs; (ii) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or other federally funded government programs in Minnesota or other state or jurisdiction since the inception of those programs; or (iii) had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

☐ Yes ☑No

If you answered "Yes" to any of the above questions, list the name and social security number or Tax ID of the individual or entity, and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in or exclusion from participation in Medicare, Medicaid, or other federally funded government programs, or imposition of civil money penalties or assessments under Section 1128A of the Social Security Act).

No.	Full Legal Name	SSN or FEIN	Reason
1			
2			
3			
4			

VI. Certification

I am authorized to bind the entity and I certify that the above information is true and correct. I will notify Medica of any changes to this information.

NAME (Print)	TITLE
SIGNATURE	DATE
EMAIL ADDRESS	

Return a completed, signed statement to Medica as follows:

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VII. DEFINITIONS

For the purpose of this statement, the following definitions apply:

1. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Vendor.

2. **Downstream Entity** means any party that enters into an acceptable written arrangement below the level of the arrangement between Medica and Vendor. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

3. **Managing Employee** means an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the Vendor, or part thereof, or who directly or indirectly conducts the day-to-day operations of the Vendor, or part thereof.

4. **Person with an Ownership or Control Interest** means a person or corporation that:
   A) has an ownership interest, directly or indirectly, totaling 5% or more in the Vendor;
   B) has a combination of direct and indirect ownership interests equal to 5% or more in the Vendor;
   C) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Vendor, if that interest equals at least 5% of the value of the property or assets of the Vendor; or
   D) is an officer or director of the Vendor (if organized as a corporation) or is a partner in the Vendor (if organized as a partnership).

5. **Vendor** means an individual or entity that has entered into an agreement with Medica and is engaged in the provision of items and services that are significant and material to Medica's obligations under its contract with the Minnesota Department of Human Services or the Centers for Medicare and Medicaid Services.

6. **Subcontractor** means an individual, agency, or organization to which the Vendor has contracted (or a person with an employment, consulting or other arrangement with the Vendor) for the provision of items and services that are significant and material to the Vendor's contract with Medica and Medica's obligations under its contract with DHS or CMS.

ATTACHMENT A

Legal Entity Name	Entity Address	Federal Tax ID	Name of Other Organization	% Ownership Interest
OptumHealth Financial Services, Inc.	[redacted]	[redacted]	N/A	[redacted]
Collaborative Care Holdings, LLC	[redacted]	[redacted]	N/A	[redacted]
Unimerica Insurance Company	[redacted]	[redacted]	N/A	[redacted]
HealthAllies Inc.	[redacted]	[redacted]	N/A	[redacted]
Distance Learning Network, Inc.	[redacted]	[redacted]	N/A	[redacted]
United Behavioral Health	[redacted]	[redacted]	N/A	[redacted]
Connections, Inc.	[redacted]	[redacted]	N/A	[redacted]
Logistics Health, Inc.	[redacted]	[redacted]	N/A	[redacted]

[redacted]

Entity Name	Title	Entity Address	Federal Tax ID	Name of Other Organization	% Ownership Interest
HealthAllies, Inc.	[redacted]	[redacted]	[redacted]	N/A	N/A
OptumHealth Care Solutions, Inc.	[redacted]	[redacted]	[redacted]	N/A	N/A
Wellness, Inc.	[redacted]			N/A	N/A

[redacted]

Entity Name	Title	Entity Address	Federal Tax ID	Name of Other Organization	% Ownership Interest
ACN Group IPA of New York, Inc.	[redacted]	[redacted]	[redacted]	N/A	N/A
ACN Group of California, Inc.	[redacted]	[redacted]	[redacted]	N/A	N/A
Arizona Physicians IPA, Inc.	[redacted]			N/A	N/A
Corporate Support Limited	[redacted]			N/A	N/A
Focus EAP Ltd.	[redacted]			N/A	N/A
HealthAllies, Inc.	[redacted]	[redacted]	[redacted]	N/A	N/A
International Psychological Service Pty Limited	[redacted]			N/A	N/A
OptumHealth Care Solutions, Inc.	[redacted]	[redacted]	[redacted]	N/A	N/A
Personal Performance Consultants UK Limited	[redacted]			N/A	N/A
PPC International II, LLC	[redacted]			N/A	N/A
PPC International, L.L.C.	[redacted]			N/A	N/A
PPC Worldwide Canada EAP Services Ltd.	[redacted]			N/A	N/A
PPC Worldwide Canada EAP Services Ltd.	[redacted]			N/A	N/A
PPC Worldwide Pty Ltd	[redacted]			N/A	N/A
U.S. Behavioral Health Plan, California	[redacted]			N/A	N/A
United Behavioral Health	[redacted]	[redacted]	[redacted]	N/A	N/A
United Behavioral Health of New York, I.P.A., Inc.	[redacted]			N/A	N/A
United Resource Networks IPA of New York, Inc.	[redacted]			N/A	N/A

Disclosure of Ownership and Management Information & Exclusions Statement for Vendors

I. Instructions

This statement must be completed and submitted to Medica. A new statement is required and must be submitted when any information in your original statement has changed.

This form is to be completed to ensure compliance with government program requirements pertaining to: (1) disclosure of ownership; (2) exclusions of individuals and entities from government programs as set forth in your contract with Medica; and (3) compliance program requirements.

The requirements of this statement apply to both for-profit and non-profit organizations. They also apply to counties and Minnesota state agencies. Section VII (definitions) clarifies which individuals and entities are required to comply with this statement. The definitions are based on law, regulation, and government program instructions.

Note: For the purposes of this statement, the term "Person with an Ownership or Control Interest" includes:
(i) senior officers and individual board members of for-profit and non-profit corporations; and
(ii) partners of a partnership.
("Person with an Ownership or Control Interest" also includes persons or corporations having certain percentage ownership interests as defined in Section VII(4)).

This statement also applies to "Agents" and "Managing Employees," as defined in Section VII, to the extent provided in this document.

Please complete this statement whether or not you have any information to report. If more space is needed, please attach additional information on a separate page.

For assistance in completing this statement, please reference the Definitions provided under Section VII.

II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS United Behavioral Health	DBA (Doing Business As) In Minnesota: United Behavioral Health, Inc.		
ADDRESS 425 Market Street, 14th Floor			NPI/UMPI
CITY San Francisco	STATE CA	ZIP CODE 94105	OFFICE PHONE NUMBER ( )
FEDERAL EMPLOYER ID (FEIN) [redacted]	MN TAX ID [redacted]		

(Rev. April 2012)

III. Structure

Check the entity type that describes your structure:

☐ Sole Proprietorship ☐ Partnership ☐ Other Partnership (i.e., LP, LLP, LLLP) ☒ Corporation

☐ Limited Liability Co. ☐ Non-Profit ☐ County ☐ State

IV. Ownership & Control Interests

A. Please provide the following information for each Managing Employee, and Person with an Ownership or Control Interest in you as a Vendor, or in any Subcontractor in which you as a Vendor have direct or indirect ownership of 5% of more. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	Date of Birth	SSN or FEIN	% Ownership Interest
1	OptumHealth Holdings, LLC	[redacted]	[redacted]	[redacted]	[redacted]
2					
3					

B. If any Person with an Ownership or Control Interest listed in subsection IV(A) is related to another Person with an Ownership or Control Interest listed in subsection IV(A) as a spouse, parent, child or sibling, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

No.	Full Legal Name	SSN or FEIN	Name of Person Related To	Related Person's SSN or FEIN	Relationship
1	Not Applicable				
2					
3					

C. For each Person with an Ownership or Control Interest listed in subsection IV(A) who also has an ownership or control interest in an organization other than that indicated in subsection IV(A), please provide the following information. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	SSN or FEIN	Name of Other Organization	% Ownership Interest
1	Not Applicable				
2					
3					

V. Excluded Individuals or Entities

A. Are there any employees, Persons with an Ownership or Control Interest in you as a Vendor, or any of your Managing Employees or Agents who are or have ever:

- Been excluded from participation in Medicare, Medicaid, or other federally funded government programs or any of the state health care programs?

☐ Yes ☒ No

- Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or other federally funded government programs in Minnesota or other state or jurisdiction since the inception of those programs?

☐ Yes ☒ No

- Had civil money penalties or assessments imposed under Section 1128A of the Social Security Act (that is, federal fraud and abuse law civil monetary penalty provisions)?

☐ Yes ☒ No

B. Do you as a Vendor have any agreements for the provision of items or services related to the health plan's obligations under its contract with the Minnesota Department of Human Services ("DHS") or the Centers for Medicare and Medicaid Services ("CMS") with an individual or entity who: (i)) has been excluded from participation in Medicare, Medicaid, or other federally funded government programs or any of the state health care programs; (ii) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or other federally funded government programs in Minnesota or other state or jurisdiction since the inception of those programs; or (iii) had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

☐ Yes ☒ No

If you answered "Yes" to any of the above questions, list the name and social security number or Tax ID of the individual or entity, and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in or exclusion from participation in Medicare, Medicaid, or other federally funded government programs, or imposition of civil money penalties or assessments under Section 1128A of the Social Security Act).

No.	Full Legal Name	SSN or FEIN	Reason
1			
2			
3			
4			

VI. Certification

I am authorized to bind the entity and I certify that the above information is true and correct. I will notify Medica of any changes to this information.

NAME (Print)	TITLE
SIGNATURE	DATE
EMAIL ADDRESS	

Return a completed, signed statement to Medica as follows:

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VII. DEFINITIONS

For the purpose of this statement, the following definitions apply:

1. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Vendor.

2. **Downstream Entity** means any party that enters into an acceptable written arrangement below the level of the arrangement between Medica and Vendor. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

3. **Managing Employee** means an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the Vendor, or part thereof, or who directly or indirectly conducts the day-to-day operations of the Vendor, or part thereof.

4. **Person with an Ownership or Control Interest** means a person or corporation that:
   A) has an ownership interest, directly or indirectly, totaling 5% or more in the Vendor;
   B) has a combination of direct and indirect ownership interests equal to 5% or more in the Vendor;
   C) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Vendor, if that interest equals at least 5% of the value of the property or assets of the Vendor; or
   D) is an officer or director of the Vendor (if organized as a corporation) or is a partner in the Vendor (if organized as a partnership).

5. **Vendor** means an individual or entity that has entered into an agreement with Medica and is engaged in the provision of items and services that are significant and material to Medica's obligations under its contract with the Minnesota Department of Human Services or the Centers for Medicare and Medicaid Services.

6. **Subcontractor** means an individual, agency, or organization to which the Vendor has contracted (or a person with an employment, consulting or other arrangement with the Vendor) for the provision of items and services that are significant and material to the Vendor's contract with Medica and Medica's obligations under its contract with DHS or CMS.

MEDICA®

Disclosure of Ownership, Control and Management Information, and Exclusions Statement ("Disclosure Form")

I. Instructions

This form must be completed and submitted to Medica Health Plans ("Medica"). A new Disclosure Form is required and must be submitted when any information in your original form has changed. This Disclosure Form is to be completed to ensure compliance with government program requirements pertaining to: (1) disclosure of ownership, control and management, and (2) exclusions of individuals and entities from government programs as set forth in your contract with Medica and Medica's administrative requirements.

The disclosure, reporting and exclusion requirements apply to partnerships and both non-profit and for-profit corporations, including without limitation limited liability companies. Governmental entities, such as counties that are not organized as corporations, are not required to complete this Disclosure Form. Section VII (Definitions) clarifies which individuals and entities you must provide information about in the Disclosure Form. The definitions are based on law, regulation, and instructions from regulatory authorities.

Important Note: For the purposes of this Disclosure Form, the term "Person with an Ownership or Control Interest" is not limited to persons or corporations with an ownership interest. For example, it also includes:

(i) officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies; and

(ii) partners of a partnership, including without limitation limited liability partnerships.

See Section VII for a complete definition of "Person with an Ownership or Control Interest" as well as definitions of other key terms such as "Managing Employee," "Provider," and "Agent."

Please complete this Disclosure Form whether or not you have any information to report. If more space is needed, please attach additional information on a separate page.

For assistance in completing this Disclosure Form, please reference the Definitions provided under Section VII.

II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS	DBA (Doing Business As), if applicable		
MedImpact Healthcare Systems, Inc.	N/A		
ADDRESS			NPI/UMPI
10181 Scripps Gateway Court			N/A
CITY	STATE	ZIP CODE	OFFICE PHONE NUMBER
San Diego	CA	92131	[redacted]
FEDERAL EMPLOYER ID (FEIN)	MN TAX ID		
[redacted]	[redacted]		

III. Structure

Check the entity type that describes your structure:

☐ Sole Proprietorship ☐ Partnership ☐ Other Partnership (i e . LP, LLP, LLLP) ☐ Limited Liability Co.

☒ For Profit Corporation ☐ Non-Profit Corporation ☐ Public Corporation ☐ State ☐ Other _____

IV. Ownership, Control and Management Information

A. Please provide the following information for each **Managing Employee**, and **Person with an Ownership or Control Interest** in you as a Provider, or in any Subcontractor in which you as a Provider have direct or indirect ownership of 5% or more. All fields must be completed. The date of birth and social security number (SSN) are required if a *person's* name is provided. and the federal employer identification (FEIN) number is required if an *entity's* name is provided.

No.	Full Legal Name	Address Individuals – list home address Entities – list primary business address. every business location and P.O. Box	Date of Birth	SSN or FEIN	% Ownership Interest, if applicable
1	MedImpact Holdings. Inc.	[redacted]	N/A	[redacted]	[redacted]
2	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
3	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in subsection IV (A) as a spouse, parent, child or sibling, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

No.	Full Legal Name	SSN	Name of Person Related To	Related Person's SSN	Relationship
1	N/A				
2					
3					

C. For each Person with an Ownership or Control Interest listed in subsection IV(A) who also has an ownership or control interest in a disclosing entity other than that indicated in subsection IV(A), please provide the following information. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	SSN or FEIN	Name of Other Organization	% Ownership Interest
1	N/A				
2					
3					

V. Excluded Individuals or Entities

A. Are there any employees, Persons with an Ownership or Control Interest in you as a Provider, or any of your Managing Employees or Agents who are or have ever

- Been excluded from participation in Medicare or any of the State health care programs?

☐ Yes ☒ No

- Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs?

☐ Yes ☒ No

- Had civil money penalties or assessments imposed under Section 1128A of the Social Security Act (that is, federal fraud and abuse law civil monetary penalty provisions)?

☐ Yes ☒ No

B. Do you as a Provider have any agreements for the provision of items or services related to Medica's obligations under its contracts with the Minnesota Department of Human Services (DHS) or the Centers for Medicare and Medicaid Services (CMS) with an individual or entity who: (i) has been excluded from participation in Medicare or any of the State health care programs; (ii) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or other state or jurisdiction since the inception of those programs; or (iii) had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

☐ Yes ☒ No

If you answered "Yes" to any of the above questions, list the name and social security number (SSN) or federal employer identification number (FEIN) of the individual or entity, and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in, or exclusion from participation in, Medicare, Medicaid, or other federally funded government health care programs, or imposition of civil money penalties or assessments under Section 1128A of the Social Security Act).

No.	Full Legal Name	SSN or FEIN	Reason
1	N/A		
2			
3			
4			

VI. Certification

I am authorized to bind the entity named in this document and I certify that the above information is true and correct. I will notify Medica of any changes to this information.

NAME (Print)	TITLE
[redacted]	[redacted]

SIGNATURE	DATE
[redacted]	[redacted]

EMAIL ADDRESS
[redacted]

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2. **Managing Employee** means an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the Provider, or part thereof, or who directly or indirectly conducts the day-to-day operations of the Provider, or part thereof.

3. **Person with an Ownership or Control Interest** means a person or corporation that:
   A) has an ownership interest, directly or indirectly, totaling 5% or more in the Provider;
   B) has a combination of direct and indirect ownership interests equal to 5% or more in the Provider;
   C) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Provider, if that interest equals at least 5% of the value of the property or assets of the Provider;
   D) is an officer or director of a Provider organized as a corporation (this includes officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies); or
   E) is a partner in a Provider organized as a partnership, including without limitation limited liability partnerships.

4. **Provider** means an individual or entity that: A) is engaged in the delivery of health care services and is legally authorized to do so by the state in which the individual or entity delivers services; and B) has entered into an agreement with Medica to provide health care services to Medica members, including members enrolled through Medica's contracts with DHS or CMS. For purposes of this disclosure, "Provider" also means a vendor providing non-health care services through an agreement with Medica to members enrolled through Medica's government program contracts with DHS or CMS, provided those services are significant and material to Medica's obligations under the respective government program contract.

5. **Subcontractor** means an individual, agency, or organization to which the Provider has contracted (or a person with an employment, consulting or other arrangement with the Provider) for the provision of items and services that are significant and material to the Provider's contract with Medica and Medica's obligations under its contracts with DHS or CMS.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, wac Medica: 952-992-2580.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم Medica: 1-888-347-3630.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, позвоните Medica: 952-992-2580.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຣ໑ຫາ Medica: 1-888-347-3630.

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite Medica: 1-888-347-3630.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame a Medica: 952-992-2580.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅ Medica: 1-888-347-3630 ។

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi Medica: 952-992-2580.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, hu Medica: 952-992-2580.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsi bilbiltu Medica: 1-888-347-3630.

LB4-0034 (10-09)

CCP0911

If you want free help translating this information, call 1-888-347-3630.

This information is available in other forms to people with disabilities by calling 952-992-2580 (voice), or 1-888-347-3630 (toll free), or through the National Relay Center toll free at 1-800-855-2880 (TTY/TDD), or 7-1-1, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

American Indians: American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older this includes Elderly Waiver services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

COLLABORATIVE CARE PLAN FOR MINNESOTA SENIOR HEALTH OPTIONS (MSHO)/MINNESOTA SENIOR CARE PLUS (MSC+)

I. Member Information and Interdisciplinary Care Team Information

Member Name:	Health Plan ID Number:	Health Plan Name:	Today's Date:
Member Phone #:	DOB:	Product Enrollment Date:	
Case Mix:	Rate Cell:	Diagnosis:	
Member Address:	Assessment Date: Assessment Type: ☐ Initial HRA ☐ Annual Reassessment ☐ Change of Condition ☐ Other	Assessment Tool Used: ☐ Health Risk Assessment (*HRA*) ☐ LTCC (*May be used as HRA*) ☐ Other	
Does member have an Advance Directive? ☐ Yes ☐ No Was Advance Directive Discussed: ☐ Yes ☐ No If No, Reason:	Primary Language: ☐ English ☐ Hmong ☐ Spanish ☐ Somali ☐ Vietnamese ☐ Russian ☐ Other (*Type in the "other" language*) Is an Interpreter Needed: ☐ Yes ☐ No Name and Number of Interpreter (*If applicable*):		
Mental Health Diagnosis: (*If applicable*) ☐ N/A	Managed by Other Health Professionals? ☐ Yes ☐ No (Psychiatrist, Psychologist, Primary Care Physician) Need Goal?: ☐ Yes ☐ No ☐ Declined		

Interdisciplinary Care Team

Care Coordinator/Case Manager: Name: Phone #:	Primary Physician: Phone #: Fax #:	Clinic:
Emergency Contact Name & Phone:	Authorized Representative:	
Mental Health Targeted Case Manager: ☐ Yes ☐ No Name of MHTCM:	Phone Number of MHTCM:	

Other ICT Team Members Name	Relationship to Member	Receives Copy of Care plan?	Notes

II. Member's Strengths: *(e.g. current supports, what works, skills, talents, interests)*

Initial/Annual:
Update:

III. Member Choice of Personal Goals/Self-Management: *(What does the member want help with? Support requested? What activities will the member do to manage their health/condition?)*

Initial/Annual:
Update:

IV. Member Barriers to meeting goals or complying with plan (Discuss with member any issue that may be an obstacle to the member receiving or participating in the care plan)

Initial/Annual:
Update:

V. Caregiver

Caregiver listed on HRA/LTCC: ***(Caregivers are unpaid person(s) providing services; if there was no care giver, the service would have to be purchased.)***

☐ **Yes** ☐ **No**

If Yes, how was the caregiver assessment form completed?

☐ **Declined** ☐ **Face-to-Face** ☐ **Telephone** ☐ **Mail**

Date Completed:

VI. Health Prevention/Chronic Condition

Condition/Screening	An educational conversation must take place with the client on applicable topics. If client needs are identified, a goal must be created unless the client declines.			
	Check if educational conversation took place	Check if Goal Needed	Check if N/A, Contraindicated, Declined	Notes
Annual Exam *(Encourage if member new to health plan within last 6 months)*	☐	☐	☐	
Mammogram (Within past 2 years ages 65-75)	☐	☐	☐	
Incontinence (Evaluated by a physician?)	☐	☐	☐	
Colorectal Screening (Up to age 75)	☐	☐	☐	
At Risk for Falls (Afraid of falling, has fallen in the past).	☐	☐	☐	
Pneumovax (*Immunize at age 65 if not done previously. Re-immunize once if 1st pneumovax was received more than 5 years ago & before age 65)*	☐	☐	☐	
Flu shot *(Annually ages 50+ and persons at high risk.)*	☐	☐	☐	
Tetanus Booster *(Once every 10 years)*	☐	☐	☐	
Hearing Exam	☐	☐	☐	
Vision Exam	☐	☐	☐	
Dental Exam	☐	☐	☐	
Calcium Vitamin D Rx for Ca Vitamin D? (as directed by physician)	☐	☐	☐	

Aspirin **Rx for Aspirin?** **(as directed by physician)**	☐	☐	☐	
Blood Pressure: **(Blood Pressure Goal is <140/80 to age 75. After 75 based on individual)**	☐	☐	☐	
Cholesterol check	☐	☐	☐	
Diabetic routine checks as recommended by physician (Discuss with member: Neuropathy, Eye exam, Cholesterol, A1C)	☐	☐	☐	

Pain Screening: **Date:**	• **Are you experiencing any pain now or in the last 2 weeks?** ☐ **Yes** ☐ **No** • **Has member's pain affected their function or quality of life (e.g., activity level, mood, relationships, sleep or work)?** ☐ **Yes** ☐ **No** • **How often does member experience pain (Constantly, Daily, Once a Week or Not Often)?** • **At its worst, how severe is the member's pain (1 to 10 with 10 being the worst)?** • **Has member talked to their Healthcare Provider about how to handle their pain?** ☐ **Yes** ☐ **No**
Other:	
Medication Compliant?	☐ **Yes** ☐ **No (If not compliant with medications , please create a goal.)**
Disease Management Referral	☐ **Yes** ☐ **Declined** ☐ **N/A** **Diagnosis:**
List of Medications *(If not on LTCC)*	
Hospitalizations *(In*	

past year number and reason, date(s) if available)	
ER visits (In past year number and reason for visit; *dates, if available)*	

VII. Issues, Needs, and All Areas of Concern Identified on the LTCC Must be Addressed in the Care Plan

Rank by Priority	Member Goals	Intervention	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					

Care Coordinator/Case Manager Follow-up Plan:

☐ **Contact Once a Month for 3 Months**
☐ **Contact Every 3 Months**
☐ **Contact Every 6 Months**
☐ **Other**

VIII. Member Plan

HRA/LTCC-Care Coordinator/Case Manager (CC/CM) Recommendations: ***(Include services, supports, and interventions recommended/offered by the CC/CM. Document if member declines any recommendations).***

Initial/Annual:
Update:

Personal Risk Management Plan ***(If member or authorized representative refuses recommended waiver services as identified above, discuss potential consequences and plan.)***

Member/authorized representative accept responsibility for any risk associated with refusing recommended services.

Services Declined by: ☐ **Member** ☐ **Authorized representative**

Risk Plan discussed with: ☐ **Member** ☐ **Authorized representative** ☐ **PCP**

Risk Plan Includes:

☐ **Call 911**
☐ **Family/Friend Support**
☐ **Care coordinator/Case Manager contact**
☐ **Other**

☐ **N/A (Member accepts recommended services.)**

Emergency Plan:

As discussed with member/authorized representative, in the event of an emergency, member will (check all that apply):

☐ **Call 911** ☐ **Use Emergency Response Monitoring System**
☐ **Call Emergency Contact**
☐ **Call Other Informal Support Person Name: Phone:**
☐ **Other (describe)**

Self Preservation/Evacuation Plan:

If member is unable to evacuate independently in an emergency, describe evacuation plan:

If other self-preservation concerns or plans, describe:

Essential Services Backup Plan: (*when providers of essential services are unavailable)*

Member is receiving essential services ☐ **Yes** ☐ **No**

If Yes, briefly describe member's backup plan:

Community-Wide Disaster Plan:

As discussed with member/authorized representative, in the event of a community-wide disaster, (e.g.,

flood, tornado, blizzard), the member will (please describe plan):
Additional Case Notes:

IX. Choosing Community Long Term Care

☐ Yes ☐ No I have been offered a choice of home and community based services and Nursing Home Services if needed.

☐ Yes ☐ No I have been offered a choice of providers.

☐ Yes ☐ No I have annually received my appeals rights.

☐ Yes ☐ No I am aware that healthcare information about me will be kept private. (Data Privacy rights)

☐ Yes ☐ No I have discussed my plan of care with my care coordinator/case manager and have chosen the services I want.

☐ Yes ☐ No I agree with the plan of care as discussed with my care coordinator/case manager.

MEMBER/AUTHORIZED REPRESENTATIVE SIGNATURE:	DATE:
CARE COORDINATOR/CASE MANAGER SIGNATURE:	DATE:
CARE PLAN MAILED/GIVEN TO MEMBER ON:	DATE:
CARE PLAN OR SUMMARY MAILED/GIVEN TO PCP (verbal, phone, fax, EMR):	DATE:

Member Name **ID#**

X. Home and Community Based Service Plan/Budget Worksheet

Please include ALL services, e.g., skilled home care, custodial home care, home-and-community-based services, medical supplies, etc.

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Adult Day Care Bath							
Adult Day Services							
Customized Living Verification code: _ _____							
24-Hour Customized Living Verification code: __ _____							
Care Coordination/Case Management							
Care Coordination-Para-Professional							
Caregiver Support							

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Companion Services							
Foster Care							
Help w/MA, Finances, Other							
Homemaking							
Home Modification							
Home Delivered Meals							
Nurse Visits							
Home Health Aide							
Personal Care Assistant (PCA)							
PCA Supervision							
PERS							

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Respite							
Therapies at Home: PT, OT, ST							
Transportation							
Yard Work/Chores							
CDCS Services	**FSE:**	**Support Planner:**					
List of Equipment Member Has							
List of Supplies							

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Other: (supports, resources)							
Case Mix Level:	**CAP amount**	**Member Waiver Obligation if Known:**		**Total Cost of Authorized Services:**	**Notes:**		

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Member's name:

Medica Care System Personal Risk Management Plan

Address:	DOB:
City: , MN ZIP:	

Identified concern	Goal	Goal date	Intervention	Evaluation/Update
☐ Unsafe housing ☐ Declines recommended services ☐ Declines recommended DME/equipment ☐ Declines environmental safety recommendations ☐ Declines personal safety recommendations ☐ At risk to harm self or others ☐ Declines assessment/Care Coordinator contact ☐	☐ Able to access help in emergencies ☐ Contacts Care Coordinator to discuss plan and options. ☐ Will be safe from abusive, neglectful and/or exploitive persons and environments. ☐		☐ Provided education on available service/equipment/supply options. ☐ Provide education on and assess ability to call 911. ☐ Contact family, friends, neighbors or religious communities for member support. ☐ Mail business card or letter with Care Coordinator contact information to member ☐ Contact PCP ☐ File VA report ☐ Establish/Refer to Rep Payee ☐ Consult MBH ☐ Call 911 ☐	
☐	☐	☐	☐	☐
☐	☐	☐	☐	☐
Care Coordinator:			Date:	

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Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, wac Medica: 952-992-2580.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم Medica: 1-888-347-3630.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, позвоните Medica: 952-992-2580.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຣ໑ຫາ Medica: 1-888-347-3630.

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite Medica: 1-888-347-3630.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame a Medica: 952-992-2580.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅ Medica: 1-888-347-3630 ។

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi Medica: 952-992-2580.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, hu Medica: 952-992-2580.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsi bilbiltu Medica: 1-888-347-3630.

LB4-0034 (10-09)

CCP0911

If you want free help translating this information, call 1-888-347-3630.

This information is available in other forms to people with disabilities by calling 952-992-2580 (voice), or 1-888-347-3630 (toll free), or through the National Relay Center toll free at 1-800-855-2880 (TTY/TDD), or 7-1-1, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

American Indians: American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older this includes Elderly Waiver services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

COLLABORATIVE CARE PLAN FOR MINNESOTA SENIOR HEALTH OPTIONS (MSHO)/MINNESOTA SENIOR CARE PLUS (MSC+)

I. Member Information and Interdisciplinary Care Team Information

Member Name:	Health Plan ID Number:	Health Plan Name:	Today's Date:
Member Phone #:	DOB:	Product Enrollment Date:	
Case Mix:	Rate Cell:	Diagnosis:	
Member Address:	Assessment Date: Assessment Type: ☐ Initial HRA ☐ Annual Reassessment ☐ Change of Condition ☐ Other	Assessment Tool Used: ☐ Health Risk Assessment (*HRA*) ☐ LTCC (*May be used as HRA*) ☐ Other	
Does member have an Advance Directive? ☐ Yes ☐ No Was Advance Directive Discussed: ☐ Yes ☐ No If No, Reason:	Primary Language: ☐ English ☐ Hmong ☐ Spanish ☐ Somali ☐ Vietnamese ☐ Russian ☐ Other (*Type in the "other" language*) Is an Interpreter Needed: ☐ Yes ☐ No Name and Number of Interpreter (*If applicable*):		
Mental Health Diagnosis: (*If applicable*) ☐ N/A	Managed by Other Health Professionals? ☐ Yes ☐ No (Psychiatrist, Psychologist, Primary Care Physician) Need Goal?: ☐ Yes ☐ No ☐ Declined		

Interdisciplinary Care Team

Care Coordinator/Case Manager: Name: Phone #:	Primary Physician: Phone #: Fax #:	Clinic:
Emergency Contact Name & Phone:	Authorized Representative:	
Mental Health Targeted Case Manager: ☐ Yes ☐ No Name of MHTCM:	Phone Number of MHTCM:	

Other ICT Team Members Name	Relationship to Member	Receives Copy of Care plan?	Notes

II. Member's Strengths: *(e.g. current supports, what works, skills, talents, interests)*

Initial/Annual:
Update:

III. Member Choice of Personal Goals/Self-Management: *(What does the member want help with? Support requested? What activities will the member do to manage their health/condition?)*

Initial/Annual:
Update:

IV. Member Barriers to meeting goals or complying with plan (Discuss with member any issue that may be an obstacle to the member receiving or participating in the care plan)

Initial/Annual:
Update:

V. Caregiver

Caregiver listed on HRA/LTCC: ***(Caregivers are unpaid person(s) providing services; if there was no care giver, the service would have to be purchased.)***

☐ **Yes** ☐ **No**

If Yes, how was the caregiver assessment form completed?

☐ **Declined** ☐ **Face-to-Face** ☐ **Telephone** ☐ **Mail**

Date Completed:

VI. Health Prevention/Chronic Condition

Condition/Screening	An educational conversation must take place with the client on applicable topics. If client needs are identified, a goal must be created unless the client declines.			
	Check if educational conversation took place	Check if Goal Needed	Check if N/A, Contraindicated, Declined	Notes
Annual Exam *(Encourage if member new to health plan within last 6 months)*	☐	☐	☐	
Mammogram (Within past 2 years ages 65-75)	☐	☐	☐	
Incontinence (Evaluated by a physician?)	☐	☐	☐	
Colorectal Screening (Up to age 75)	☐	☐	☐	
At Risk for Falls (Afraid of falling, has fallen in the past).	☐	☐	☐	
Pneumovax (*Immunize at age 65 if not done previously. Re-immunize once if 1st pneumovax was received more than 5 years ago & before age 65)*	☐	☐	☐	
Flu shot *(Annually ages 50+ and persons at high risk.)*	☐	☐	☐	
Tetanus Booster *(Once every 10 years)*	☐	☐	☐	
Hearing Exam	☐	☐	☐	
Vision Exam	☐	☐	☐	
Dental Exam	☐	☐	☐	
Calcium Vitamin D Rx for Ca Vitamin D? (as directed by physician)	☐	☐	☐	

Aspirin **Rx for Aspirin?** **(as directed by physician)**	☐	☐	☐	
Blood Pressure: **(Blood Pressure Goal is <140/80 to age 75. After 75 based on individual)**	☐	☐	☐	
Cholesterol check	☐	☐	☐	
Diabetic routine checks as recommended by physician (Discuss with member: Neuropathy, Eye exam, Cholesterol, A1C)	☐	☐	☐	

Pain Screening: **Date:**	• **Are you experiencing any pain now or in the last 2 weeks?** ☐ **Yes** ☐ **No** • **Has member's pain affected their function or quality of life (e.g., activity level, mood, relationships, sleep or work)?** ☐ **Yes** ☐ **No** • **How often does member experience pain (Constantly, Daily, Once a Week or Not Often)?** • **At its worst, how severe is the member's pain (1 to 10 with 10 being the worst)?** • **Has member talked to their Healthcare Provider about how to handle their pain?** ☐ **Yes** ☐ **No**
Other:	
Medication Compliant?	☐ **Yes** ☐ **No (If not compliant with medications , please create a goal.)**
Disease Management Referral	☐ **Yes** ☐ **Declined** ☐ **N/A** **Diagnosis:**
List of Medications *(If not on LTCC)*	
Hospitalizations *(In*	

past year number and reason, date(s) if available)	
ER visits (In past year number and reason for visit; *dates, if available)*	

VII. Issues, Needs, and All Areas of Concern Identified on the LTCC Must be Addressed in the Care Plan

Rank by Priority	Member Goals	Intervention	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					

Care Coordinator/Case Manager Follow-up Plan:

☐ **Contact Once a Month for 3 Months**
☐ **Contact Every 3 Months**
☐ **Contact Every 6 Months**
☐ **Other**

VIII. Member Plan

HRA/LTCC-Care Coordinator/Case Manager (CC/CM) Recommendations: ***(Include services, supports, and interventions recommended/offered by the CC/CM. Document if member declines any recommendations).***

Initial/Annual:
Update:

Personal Risk Management Plan ***(If member or authorized representative refuses recommended waiver services as identified above, discuss potential consequences and plan.)***

Member/authorized representative accept responsibility for any risk associated with refusing recommended services.

Services Declined by: ☐ **Member** ☐ **Authorized representative**

Risk Plan discussed with: ☐ **Member** ☐ **Authorized representative** ☐ **PCP**

Risk Plan Includes:

☐ **Call 911**
☐ **Family/Friend Support**
☐ **Care coordinator/Case Manager contact**
☐ **Other**

☐ **N/A (Member accepts recommended services.)**

Emergency Plan:

As discussed with member/authorized representative, in the event of an emergency, member will (check all that apply):

☐ **Call 911** ☐ **Use Emergency Response Monitoring System**
☐ **Call Emergency Contact**
☐ **Call Other Informal Support Person Name: Phone:**
☐ **Other (describe)**

Self Preservation/Evacuation Plan:

If member is unable to evacuate independently in an emergency, describe evacuation plan:

If other self-preservation concerns or plans, describe:

Essential Services Backup Plan: (*when providers of essential services are unavailable)*

Member is receiving essential services ☐ **Yes** ☐ **No**

If Yes, briefly describe member's backup plan:

Community-Wide Disaster Plan:

As discussed with member/authorized representative, in the event of a community-wide disaster, (e.g.,

flood, tornado, blizzard), the member will (please describe plan):
Additional Case Notes:

IX. Choosing Community Long Term Care

☐ Yes ☐ No I have been offered a choice of home and community based services and Nursing Home Services if needed.

☐ Yes ☐ No I have been offered a choice of providers.

☐ Yes ☐ No I have annually received my appeals rights.

☐ Yes ☐ No I am aware that healthcare information about me will be kept private. (Data Privacy rights)

☐ Yes ☐ No I have discussed my plan of care with my care coordinator/case manager and have chosen the services I want.

☐ Yes ☐ No I agree with the plan of care as discussed with my care coordinator/case manager.

MEMBER/AUTHORIZED REPRESENTATIVE SIGNATURE:	DATE:
CARE COORDINATOR/CASE MANAGER SIGNATURE:	DATE:
CARE PLAN MAILED/GIVEN TO MEMBER ON:	DATE:
CARE PLAN OR SUMMARY MAILED/GIVEN TO PCP (verbal, phone, fax, EMR):	DATE:

Member Name **ID#**

X. Home and Community Based Service Plan/Budget Worksheet

Please include ALL services, e.g., skilled home care, custodial home care, home-and-community-based services, medical supplies, etc.

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Adult Day Care Bath							
Adult Day Services							
Customized Living Verification code: _ _____							
24-Hour Customized Living Verification code: __ _____							
Care Coordination/Case Management							
Care Coordination-Para-Professional							
Caregiver Support							

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Companion Services							
Foster Care							
Help w/MA, Finances, Other							
Homemaking							
Home Modification							
Home Delivered Meals							
Nurse Visits							
Home Health Aide							
Personal Care Assistant (PCA)							
PCA Supervision							
PERS							

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Respite							
Therapies at Home: PT, OT, ST							
Transportation							
Yard Work/Chores							
CDCS Services	**FSE:**	**Support Planner:**					
List of Equipment Member Has							
List of Supplies							

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Other: (supports, resources)							
Case Mix Level:	**CAP amount**	**Member Waiver Obligation if Known:**		**Total Cost of Authorized Services:**	**Notes:**		

Name:	**ID#:**

Signature Sheet

- ☐ An explanation and choice of home and community-based services, consumer-directed support services and waivered services has been provided.
- ☐ I have been offered a choice of qualified service providers for services I am receiving.
- ☐ I participated in developing my individual Plan of Care with my Medica Care Coordinator and agree with it.
- ☐ I understand that healthcare information about me will be kept private (Data Privacy).
- ☐ I have been given a choice between community care or nursing home placement.
- ☐ I have been given an opportunity to ask questions and understand I will receive a copy of my Service Plan when it has been finalized.
- ☐ I have participated in the assessment and information is accurate to the best of my knowledge.
- ☐ I have been informed of my right to appeal and have been provided with information on how to appeal.
- ☐ My Medica Care Coordinator has reviewed the Medica Care Coordination document and I understand my right to complain if I am unhappy.
- ☒ I have reviewed my care team listing, and I agree with the persons identified as my care team. My Medica Care Coordinator and I have discussed a plan of care along with options for follow-up contacts.
  At this time it will be: ☐ monthly ☐ quarterly ☐ semi-annually ☐ annually

Member Signature	Date
Signature/Relationship to member (if member representative)	Date
Care Coordinator Signature	Date

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MEDICA POSITION PROFILE

Job Title: Behavioral Health Manager

Job Code:
Salary Grade:

Department: Health Management
FLSA Status: Exempt
Reports to:
Revision Date: 4/22/15

POSITION OVERVIEW:

The Behavioral Health Manager is responsible for ensuring that Medica's behavioral health operations, which include the operations of any behavioral health subcontractors, are in compliance with the terms of the Contract. The Behavioral Health Manager must coordinate with all functional areas, including quality management, utilization management, network development and management, provider relations, member outreach and education, member services, contract compliance and reporting.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility

Management of Behavioral Health program operations	• Implements all Behavioral health management programs and services for government business and effectively monitors, manages and allocates resources to achieve business initiatives. • Responsible for program implementation. • Tracks and evaluates productivity, program performance and the performance guarantees. Develops program recommendations. • Collaborates closely with Medica's Government business/clinical leadership to ensure seamless operations and service. • Develops and assures business processes/program workflows are implemented consistently, evaluated for effectiveness and efficiency and are improved. • Is responsible for performance management, supervision, and direction of staff. • Acts as a subject matter expert for Behavioral Health for Medica, our clients and in project teams. • Serves as key contact for government case management for representation of the program and problem resolution of operational issues and implementation of action plans. • Maintains communication between key stakeholders and departments such as Customer Service, Claims Operations, Provider Services, Medical Directors, Pharmacy, and Account Management. • Collaborates closely with other areas within Health Management; Utilization Management, Health Innovation, Pharmacy and HCE to ensure collaboration and alignment, as well as operational linkages and efficiencies, including vendors and MBH. • Develops and oversees process of customer and regulatory audits for the team. • Monitors case quality to ensure competence in case management and care support decision-making, documentation and compliance with regulatory, accreditation and policy/procedure changes. • Provides leadership to the team in the context of Medica's direction and goals as an organization.	**65%**

Regulatory and Accreditation Compliance: assessment, monitoring and implementation	• Assures reasonable compliance with regulatory/accreditation standards and implements departmental action plans as necessary. • Develops and implements compliance with department policies and procedures. • Monitors audit results, assesses business case recommendations • Participates in customer audits, and audits for accreditation and regulatory purposes. • Assesses and implements compliance obligations as required by government and accreditation entities. • Ensure adequate staff training	**15%**

Monitor, track and report trends to facilitate benefit design, medical policy decisions and improve operational efficiencies	• Develops and refines as needed data collection tools, systems and reports to support operational performance and improvements. • Develops and maintains measurement reporting tools and reports and provides representation of data. • Is responsible for open communication between team and senior management regarding reports and recommendations. • Responsible to work with departmental and cross-functional teams to implement above noted opportunities, insuring all regulatory requirements maintained.	**20%**
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

Education/Experience: (Include any required licensure/certifications)

1) Iowa licensed behavioral health professional such as a psychologist, psychiatrist, social worker, psychiatric nurse, marriage and family therapist or mental health counselor, with experience in both mental health and substance use disorder services**.** Minimum of 8 years clinical experience.
2) Minimum of 5 years managed care experience in Behavioral Health program management
3) Experience leading case management programs.
4) Experience with implementing regulations, legislation, rules and/or laws and accreditation standards.
5) Experience with utilization management and case management tools, procedures and programs.
6) Experience with data collection, assessment tools, reporting and analysis.
7) Past experience with complex project management required; proven track record of accomplishing strategic goals and projects.

Skills/Abilities:

1) Demonstrated leadership skills including: excellent interpersonal communication skills, creative and innovative problem-solving ability, critical thinking and independent decision-making ability, group facilitation, negotiation, change, conflict management and performance management skills.
2) Demonstrated process improvement and organizational skills.
3) Demonstrated ability to analyze data, conduct root cause analysis, understand and solve multi-dimensional problems, implement necessary improvement plans.
4) Presentation skills, success with managing a client and regulatory audience
5) Experienced with Microsoft Office Suite / Visio; case mgt. tools, related IT tools
6) Is a self-starter; can initiate project plans and actions once problem has been identified.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles:

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

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MEDICA POSITION PROFILE

Job Title: **Chief Financial Officer**

Job Code:

Salary Grade:

Department:

FLSA Status: Exempt

Reports to:

Prepared By:
Date: **4/22/2015**
Revision Date:

POSITION OVERVIEW:

The CFO has overall responsibility and oversight for financial analysis and reporting, health cost and administrative budgeting and forecasting, pricing and rate development, rate filing, CMS Bid filing, and medical expense trend evaluation for the Iowa Medicaid program. The financial oversight has significant impact on the financial strategy, tactics, and results of Government business. The position will provide primary support to product development and evaluation.

The incumbent is responsible for managing a team of financial analysts and providing expert internal consulting to the Senior Vice President of Government Programs.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
• Monthly and annual analysis and reporting of segment's financial operating results.	• Assures accurate financial reporting by staff. • Directs analysis of results and advises segment senior management of implications. • Assures the timely delivery of financial reporting to support the decision-making of the management teams of the Government/IB Segments.	35%
• Annual budgeting of health care costs and administrative expenses. Quarterly and multi-year forecasting of financial projections.	• Works closely with segment leadership to produce operating budgets for health care costs/revenues and administrative expenses. • Oversees support for quarterly forecasting (Outlook) and multi-year forecasting working closely with the Finance department. • Supports development of strategic plan by segment leadership. • Provide consultation on development of administrative cost efficiencies.	15%
• Medical Cost trend analysis and reporting.	• Works closely with Finance Department team to analyze and report on medical cost trend for reporting and forecasting. Also, works with Finance team on IBNR levels, reserve levels, claims retro activity reporting, and restated financials. • Provides reporting and consultation to segment senior leadership on management of medical loss ratio and cost management strategies. Oversees reporting on medical costs for strategies and tactics for care management/coordination and provider management.	25%

• Supervise Finance and actuarial staff for Government/IFB segments	• Provide leadership, supervision, and coaching to finance and actuarial staff. • Assure that staff complete assigned responsibilities and meet deadlines. • Prioritize staff activities. • Assure that staff have adequate tools and resources to successfully complete responsibilities. • Assure staff (and career) development.	25%
	Total %	100%

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

Education/Experience: (Include any required licensure/certifications)
Bachelor's Degree in finance or related area.
Experience: 10 years including 5 years of management experience
Specific experience:

- Advanced degree (MA, MBA, MHA) or significant related experience preferred.
- Experience in financial analysis and reporting in health care, insurance, managed care, or financial services preferred.
- Oversight of actuarial and/or underwriting services a plus.
- Experience in Government finance a plus.

Skills/Abilities:

- Strong oral and written communication and presentation skills.
- Self directed and can develop and lead a technical team.
- Ability to analyze and interpret complex financial data.
- Skill in budgeting, forecasting, and development of financial modeling.
- Knowledge of medical cost trend drivers.
- Understanding of regulatory environment and requirements.
- Strong project management skills.

DIRECT/INDIRECT REPORTS *(if any)*:

- Number of direct reports and titles __
- Number of indirect reports (total number in department/area) ___

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

- Oversee development of Government health care cost budgets and department administrative budgets. Assist segment leadership in managing budgets. Develop and manage team administrative budget.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Community Outreach Coordinator

Job Code:
Salary Grade:

Department:

FLSA Status: Exempt

Reports to: Marketing Manager

Prepared By:
Revision Date: 5/1/2014

POSITION OVERVIEW:

The Community Engagement Coordinator is responsible for developing community-based relationships to enhance Medica's presence and relationships in the community. This position will work to build and sustain relationships with community organizations that serve members and potential members. The primary responsibility of the Community Engagement Coordinator is to partner with the Community Health team to identify, implement and evaluate community engagement activities.

This position assists the Director of Community Health in developing annual plans for general community outreach and member engagement including but not limited to: health fairs, professional conferences, community partner presentations, member advisory forums, fireside chats, and sponsorship opportunities.

Strong project management and relational skills are essential attributes for this position. In addition, this position must be flexible, provide timely responses, have strong listening skills and the ability to think big picture. Strong technical skills in the Microsoft Office suite are also required.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Events coordination	Manage and maintain events database Research opportunities for new health fairs, professional conferences and community events Create a calendar of events for the year Coordinate SPP's participation in health fairs and professional conferences including registration, working with Accounts Payable, sponsorships, collateral, and staff training and attendance Serve as the point person for events	40%
Community partnerships	Work with Directory of Community Health to identify, initiate and deepen relationships with various community stakeholders Create and implement annual outreach plan Schedule and personally conduct at least 8 presentations quarterly throughout Medica's service area Develop and conduct an annual stakeholder feedback survey	40%
Member/ stakeholder feedback	Organize MSHO member stakeholder forum and annual member input forums Identify, organize and attend community fireside chats with Medica members Assist with the Community Advisory Council and Advisory meetings	20%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree or equivalent experience required
Major: Communications, social work or a health-related field
Years of experience required: 3 years

Specific types of experience required:
Minimum 3 years of health plan experience or similar industry
Project management experience preferred
Experience building relationships in the community

REQUIRED CERTIFICATIONS/LICENSURE:
None

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

- ✓ Excellent written and verbal communication, facilitation, and presentation skills
- ✓ Demonstrated ability to communicate and work effectively with all levels of management
- ✓ Strong project management skills, including the ability to concurrently manage multiple projects and deliver results on schedule
- ✓ Flexible and adaptable
- ✓ Strong computer skills

DIRECT/INDIRECT REPORTS *(if any)***:**

Number of direct reports and titles: None

Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:**

Manage to departmental budget

MEDICA®

MEDICA POSITION PROFILE

Job Title: Compliance Officer

Job Code:
Salary Grade:
FLSA Status: Exempt

Department:

Reports to: Vice President, Iowa Medicaid

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

The Compliance Officer is responsible for planning, directing and managing all aspects of Medica's compliance program and compliance function including maintaining an effective Compliance Program, Implementation of new laws and regulations across the organization, oversight of Medica's HIPAA Privacy program. This position reports to the Vice President, IA Operations and will work closely with Medica's Legal Department, all Medica business units and compliance leads to build and maintain a legally and practically effective compliance program.

This position will be responsible for the daily operations of all aspects of Medica's Compliance functions in the IA location. In brief, the position must understand effective compliance, industry standards and practices, HIPAA Privacy requirements, HIPAA Security requirements, Medica's Implementation process and standards, and Medica's Vendor Management function. The position will be responsible for providing direction and leadership to all Compliance Operations staff, compliance lead staff and business unit staff for implementation and compliance support.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
Maintain an effective compliance program	• Develop and manage an annual strategic plan for ensuring effective compliance program elements across the organization. Program elements will address the following: 1. Procedures and standards of conduct 2. Compliance oversight 3. Training and education 4. Reporting and investigating 5. Enforcement and discipline 6. Monitoring and auditing 7. Response and prevention	25%
	• Work closely with the Vice President, Compliance and Privacy to develop, document and complete the Compliance Operations annual business plan.	
	• Develop, review, ensure and document systems and structures to ensure the effectiveness of Medica's compliance program.	
	• Direct the assessment of key compliance risks and direct the development and documentation of an annual compliance auditing plan	
	• Serve as oversight to Corporate Compliance Regulatory Manager and compliance leads concerning all aspects of Medica's compliance program, including issue identification and resolution, project management strategy, training and risk management.	

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
	• Work with the Corporate Compliance and Privacy Manager and contract leads as necessary to enhance, update and document structures and processes to resolve identified issues to minimize risk for the organization.	
	• Prepare reports for Medica's Board and officers on the status of Medica's compliance program activities.	
	• Maintain a solid understanding of business unit operations, department interaction and the impact of each program element in the business in order to implement an effective overall compliance program	
	• Oversee management of Medica's Integrity Line and Internal Compliance reporting processes to ensure all reports are investigated and resolved based on Medica's policy, standards and procedures for compliance reporting.	
Provide leadership and direction to all compliance lead and business unit staff so that the Compliance Process Management approach is consistently executed across Medica.	• Provide leadership and direction to Corporate Compliance Regulatory Manager, compliance lead staff, and business unit staff to support comprehensive understanding and execution of CPM standards.	25%
	• Provide Oversight to ensure consistent use of Compliance Process Management by designated compliance business unit staff to ensure implementation standards are met for new laws, regulations and regulator audit findings.	
	• Direct development and documentation for annual auditing and monitoring plans for all key organizational risks.	
	• Provide oversight and direction as necessary to ensure any identified corrective actions are completed and documented.	
	• Provide direction and compliance support as necessary to implementation teams to help project leads consistently deliver measurable results. Identify and resolve barriers for implementation teams as necessary.	
	• Work with business unit Vice Presidents to ensure appropriate compliance representation and accountability across the organization.	
Provide leadership and direction to Medica's Compliance Privacy Program to meet legal and business requirements	• Work with Medica's Vice President, Compliance and Privacy, to maintain a legally and practically effective Compliance Privacy program based on the seven core elements of effective compliance and that is incorporated into the overall business structure to meet business and legal requirements.	30%
	• Direct implementation and ensure the effectiveness of Medica-wide Privacy policies that address legal requirements and are consistent with Medica's business operations. Provide direction and support to compliance lead staff to develop appropriate department level procedures to support the organization's Privacy policies.	
	• Manage reporting and complaint process, annual training, monitoring and auditing plan, written standards and procedures, etc.	
	• Serve as oversight for Medica's business unit staff and compliance leads concerning all aspects of Medica's Privacy program, including issue identification and resolution, project management strategy, training and risk management.	
	• Manage comprehensive implementation plans to ensure effective compliance with the requirements.	

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
	• Provide oversight to Compliance and Privacy Manager as necessary to enhance, update and document structures and processes to resolve identified vendor compliance and privacy issues.	
	• Provide direction and strategy to develop and implement effective auditing and monitoring protocols to ensure Medica's privacy practices meet legal and business requirements.	
	• Direct development and administration of annual compliance and privacy training as required by the Privacy regulations.	
Oversee daily operations of Compliance department to meet administrative and department requirements.	• Provide oversight and direction to all compliance staff for daily work and to meet department goals and objectives.	10%
	• Represent Corporate Compliance on committees and workgroups as requested by Vice President, Compliance and Privacy.	
	• Work closely with the Vice President, Compliance and Privacy to maintain the Compliance Operations budget in compliance with Medica's business expense management procedures and requirements.	
	• Meet with staff at regular 1/1s to address work and professional development needs.	
Achieve full compliance with Medica's policies and procedures	• Review, update, and create policies annually or as needed for the Corporate Compliance department.	10%
	Total %	100%

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

Education/Experience:

- Bachelors or equivalent of seven to ten years supervisory/management experience
- Five to seven years compliance related experience required
- Understanding of Medica's Compliance Process Management standards and the GoldMine for Compliance software application.
- Solid understanding of health care/managed care industry including knowledge of managed care operations, customer needs and cost trends.
- Solid understanding of regulatory environments and compliance program guidelines, including state and federal laws.
- Solid understanding of HIPAA Privacy and Security requirements and implementation standards
- Solid Understanding of "fraud and abuse," "consumer protection" laws, and "managed care" laws preferred.

Skills/Abilities:

- Demonstrated success leading teams and managing/executing complex projects across organizations.
- Must be able to appropriately challenge "conventional wisdom."
- Must be able to develop innovative solutions that balance legal and business needs.
- Must demonstrate exceptional analytical, planning, issue identification and resolution skills.
- Ability to analyze situations and make appropriate decisions.
- Proven ability to communicate effectively with all levels of an organization.
- Demonstrated ability to organize complex information and to effectively report information to senior management.

- Ability to develop and deliver training to staff.
- Ability to operate independently and handle multiple, complex projects with a high degree of initiative required.

DIRECT/INDIRECT REPORTS *(if any)***:**

- Number of direct reports and titles:

1 Product Administration Manager
2 Compliance Analysts
1 Program Integrity Manager
1 Grievance and Appeals Manager

- Number of indirect reports (total number in department/area):

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:**

- Support development of Compliance Operations annual budget
- Meet all business expense requirements as directed by Medica policies and procedures.

ESSENTIAL COMPETENCIES:

5=Master, 3=Skilled, 1=Novice	1	2	3	4	5
Dealing with Ambiguity Can effectively cope with change, and is able to shift gears comfortably. Can decide and act without having the total picture. Can comfortably handle risk and uncertainty.				x	
Customer Focus Is dedicated to meeting the expectations and requirements of internal and external customers. Acts with customers in mind. Establishes and maintains effective relationships with customers and gains their trust and respect. Uses data/information for improvements in products/services.					x
Effective Team Player Blends people into teams when needed; a team player; creates strong morale and spirit; creates a feeling of belonging in the team and fosters open dialogue; lets people finish and be responsible for their work; defines success in terms of the whole team and shares wins and successes.					x
Interpersonal Savvy Relates well to all kinds of people—up, down, and sideways, inside and outside the organization. Builds appropriate rapport, and constructive and effective relationships. Uses diplomacy and tact. Can communicate effectively in written and verbal formats.				x	
Problem Solving Uses rigorous logic and methods to solve difficult problems with effective solutions. Looks beyond the obvious and doesn't stop at the first answers. Probes all fruitful sources for answers.					x
Drive for Results Can be counted on to exceed goals successfully. Constantly and consistently takes initiative. Is quality focused and bottom-line oriented. Steadfastly pushes self and others for results.					x

ADDITIONAL COMPETENCIES RELATED TO POSITION:

▪

Medica is committed to compliance with all laws and regulations that govern our work. It is every Medica employee's responsibility to follow the laws and regulations that govern our work and to abide by the Medica Standards of Business Conduct, as demonstrated by...

1. *Consistently conducting your work in accordance with the laws, regulations and policies that govern that work;*
2. *Attending Medica's Compliance Program Training;*
3. *Participating in Compliance Program activities, as appropriate for your job duties; and*
4. *Supporting all elements of the Compliance Program and the Allina Employee Standards of Business Conduct, including but not limited to, reporting good faith compliance concerns.*

APPROVALS:

_____ _____

Manager (print) Date

_____ _____

Medica Human Resources Date

MEDICA®

MEDICA POSITION PROFILE

Job Title: Director, Pharmacy

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to:

Prepared By:
Revision Date: 04/20/2015

POSITION OVERVIEW:

This position is responsible for programs and services provided by the Pharmacy Management area. The position performs administrative functions as needed to ensure pharmacy programs are compliant with all company policies, state, and federal regulations.

The Director of Pharmacy is a key member of the Pharmacy Management team and a key contributor to strategy and process planning. Projects vary from program design and implementation at the operational level to strategic planning efforts that span every department within Medica.

This position manages a complex set of interrelated activities involving internal and external stakeholders to meet strategic goals. This person has a strong understanding of managed care and PBM business practice and processes with the ability to effectively navigate a large health care organization. This person understands the unique needs of customers including members, providers, employers/brokers and fellow employees.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Direct, Develop and Implement Medica's Clinical Pharmacy Programs	Development and coordination of operational processes relating to clinical programs Mail Order cost review and report Medicare Part D Pay for Performance Quantity Limit opportunities Oversee and provide strategic direction for miscellaneous clinical and strategic projects assigned to department Pharmacy Academic Detailing Medication Therapy Management Delegation Oversight Activities	20%
Formulary Development, Implementation and Maintenance	Oversight of Formulary including: determination of therapeutic drug classes presented to P&T; formulary exception and prior authorization processes; distribution of formulary Facilitation of P&T	20%
Pharmaceutical Manufacturer Relations	Develop profitable relations with pharmaceutical manufacturers representatives and management Asses opportunities and negotiate rebate contracts or grants in support of Medica's clinical initiatives Direct PBM regarding rebate contract administration Review PBM rebate contracts and assess opportunities for pursuing direct contracting with manufacturers	15%

PBM and Pharmacy Network Management	Oversee PBM's audit plan, reports and results. Ensure PBM performing to contract provisions. Evaluate network and revise contracts, as needed Address Pharmacy Provider requests in cooperation with PBM Manage PBM to create accurate and efficient pharmacy benefit plan administration that delivers client and member satisfaction	15%
Department Administration	Managing day-to-day team responsibilities Recruiting, hiring, training, and coaching team members Developing job descriptions and goals for team members Establishing priorities in conjunction with Senior Director Health Management, Medical Directors, Directors within Quality and Care Management, and other business units. Foster good communications with staff, customers and other company departments through interpersonal relationships and formal communication skills Represent Pharmacy Clinical Programs at management level during meetings or presentations Assist in Preparation of Pharmacy budget yearly	15%
Benefit design input, interpretation and development	Provide expertise to Product Management and MBS in the design and implementation of new prescription benefits Ensure benefits are supported in member and provider agreements Utilize PBM and HCE reporting and analytic tools to determine value of proposed benefit changes Establish PBM's ability to support benefit design	15%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Pharmacist
Years of experience required: 5 years

Specific types of experience required:
5+ years experience in pharmacy benefit management or managed care
Bachelors degree (required), Pharmacist (highly desired), MBA (desirable)
Excellent communication skills in both one-to-one and group settings
Ability to develop business relations with Pharmacy Providers and Pharmacy Benefit Management (PBM) vendor
Experience in contract negotiations, preferable in rebate contracting
Minimum of 3 years in management/leadership position
Knowledge of applicable state and federal laws

REQUIRED CERTIFICATIONS/LICENSURE:
Registered Pharmacist required, with a current pharmacy license that is in good standing (MN preferred)

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:
Demonstrated leadership abilities

Excellent communication skills in both one-to-one and group settings
Excellent communication skills (oral and written)
The ability to handle multiple, unrelated tasks in a high pressure environment
Strong service/marketing orientation in dealing with internal and external contacts
Ability to develop business relations with Pharmacy Providers and Pharmacy Benefit Management (PBM) vendor
Self directed, able to work with limited direct supervision

DIRECT/INDIRECT REPORTS *(if any)***:**

Number of direct reports and titles: 4

Manager, Clinical Pharmacy Programs
Manager, Pharmacy Operations
Government Pharmacy Services Manager
Manager, Client Service & Program Development

Number of indirect reports (total number in department/area):

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:**

Prepare and accountable for Budget #20001412

MEDICA®

MEDICA POSITION PROFILE

Job Title: **Director, Clinical Operations**

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to:

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

Health and Populations Management are at the cornerstone of improving Medica's members' health and life-long wellbeing. Through innovation and the creation of care system capabilities, Medica is complimenting the population health abilities of our partner health systems while advancing our members' self-management capabilities. Optimizing the core health management functions of case management, utilization review, pharmacy management, prior authorization and wellness coaching functions are equally essential. This role will be part of a dynamic and innovative team which has accountability for creating value in healthcare, addressing challenges of medical care spending and partnering with health systems around accountable care models.

The Director, Clinical Operations provides overall leadership of day-to-day clinical operations for the Iowa Medicaid program. This role is responsible for the performance and compliance of all functions related to the program including:

Health Improvement – Health and Wellness Coaching, Healthy Pregnancy, Treatment Decision Support, Program Development and Evaluation
Health Support –Case Management, Utilization Management
Quality and Affordability – Policy development, Compliance and Accreditation, Regulatory Analytics
Pharmacy Service
Long Term Care

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)

Lead Clinical Operations Activities	Effectively and efficiently manage various department activities including the following: Population health management including improvement in medical expense trend Enhanced member self-management Health Improvement – Health and Wellness Coaching, Healthy Pregnancy, Treatment Decision Support, Program Development and Evaluation Health Support – Case Management, Utilization Management Quality and Affordability – Policy Development, Compliance and Accreditation, Regulatory Analytics Pharmacy Services Long Term Care	70%
Manage and coach direct reports and staff. Provide leadership to supporting departments.	Role model and foster a culture of teamwork, collaboration, shared success, partnership and transparency. Motivate and lead a high performance management team. Attract, recruit, and retain highly talented staff. Provide supervision and coaching to management team. Foster a success-oriented, accountable environment and ensure that employees have clarity regarding what is expected of them. Mutually establish and evaluate annual direct reports goals.	30%
Total		100%

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree + experience; Master's Degree preferred and/or experience in clinical care or public health settings.
Major: Business Administration or Health Administration or similar field
Years of experience required: 5-10 years

Specific types of experience required:

Five to Ten years population health management or managed care with management experience
Leadership experience with large, organized delivery systems and personal experience working within an integrated delivery system
Knowledge of state and federal regulations
Knowledge of quality standards (NCQA, JCAHO, URAC) and how to apply/implement/interpret for managed care setting
Knowledge of data, data analysis, measurement systems, evaluation methods, preferably study designs
Demonstrated experience in building collaborative relationships both within and outside of a large health care organization
Experience in process improvement or process design with demonstrated results
Experience with managing/facilitating physician committees/work groups

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Naturally collaborative high trust style, with strong relationship building skills.
Ability to think and act in a strategic manner while executing to achieve desired results.
Executive who understands health plan and provider systems.
Able to function in a system with shared accountabilities and still hold reports and others accountable for coordinating across functions and achieving objectives.
Excellent communication and relationship development skills

Analytical, able to interpret data reports and translate into an action plan
Strong oral and written communication skills.
Strong strategic and business planning and financial management skills, accountable for results
Strong people management skills and experience
Ability to manage multiple projects and complex processes simultaneously
Prioritization skills
Strong interpersonal relationship skills including community relations experience
Ability to set strong performance goals and standards and then measure, monitor and take corrective actions as necessary

DIRECT/INDIRECT REPORTS *(if any)***:**
Number of direct reports and titles: 4
1 UM and Quality Manager
1 Care Coordination manager
1 Long Term Care Manager
1 Pharmacy Manager

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:**

MEDICA®

MEDICA POSITION PROFILE

Job Title: Facilities Manager

Job Code:
Salary Grade:

Department: HRLF Administration

FLSA Status: Exempt

Reports to: Director Facilities

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

The purpose of this position is to manage all services involved in facilities management, office services and real estate for Iowa Medicaid to ensure an effective and cost efficient operation.

This includes planning for space and real estate, the daily churn of space and staff, implementation of policies and processes to assure the operational effectiveness of the workplace. It includes all areas related to furniture inventory, landlord relationship, mail, document management, shipping & receiving, office supplies, food service, conference management, reception, switchboard, safety, security, facility emergency preparedness, housekeeping, life-safety, office equipment, and utility management.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Facilities Management & Real Estate	Ensure that the company has the appropriate amount of space required to meet its business and staffing plan. This is performed through strategic planning, management of employee churn, space planning and realignment, maintaining space standards and policies related to space. Use of CAD/CAFM products to maintain accurate and timely data. Oversee the Staff Action process to facilitate the On-Boarding, Move and Termination process with HR and IT. Provides construction management when necessary. Manage all assets related to the operation and furnishings of the building. Ensure inventory levels are intelligently managed, equipment is deployed and utilized, purchase product based on established standards and customer requirements. Ensure maintenance and housekeeping items are maintained to establish service levels. Operates the hot line to handle customer request, maintain job tickets to tract issues, escalates problems to the appropriate source. Coordinate landlord issues on behalf of Medica, manages sub lease agreements, negotiates leases and related issues and ensures that landlord live up to lease agreements.	45%

Office Services and Security and Safety	Direct the management of the Mail and Document Management operation. Provides mail and document services that meet the company's business requirements, are cost effective and customer focused. Direct the management of the Security Operation to ensure a safe and secured work environment for the staff. Protect the assets of the company, control building access and develop safety and security policies that complement the business. Oversee the collection and destruction of confidential waste. Manage the vending and coffee services to provide a quality and reasonable product Ensures that AV, room set up, catering and support activities are provided based on customer expectations.	30%
Other	Oversee HRLF's compliance to the 3rd party contracting process, coordinates activity with Compliance, maintain files and database. Manage out sourced vendors to perform major service functions for the company. Manages Facilities Management expense budgets ensure policy and procedures are followed and that the operation comes in on target on an annual basis. Oversee the development of a facility BCP/DR plan and annually update and test data to ensure reliability.	25%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Business admin, architecture, finance or engineering services
Years of experience required: 10+ years

Specific types of experience required:
Position requires college degree in business administration, architecture, or engineering services.
10 + years experience in corporate real estate, facilities, interior design. CFM, FM or FMA designation helpful.
Demonstrated project and construction management experience.
Multi site operational experience highly desirable
Experience with real estate leases and negotiation process
Experienced with 3rd party contractors and purchasing process and procedures.
Purchasing experience and extensive management of 3rd party contractors required.
IFMA or BOMA membership helpful.

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Ability to manage multiple projects
Must be detailed orientated
PC skilled, CAD and CAFM knowledgeable
Must be politically sensitive and able to operate in an changing environment

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles:

Number of indirect reports (total number in department/area):

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

MEDICA®

MEDICA POSITION PROFILE

Job Title: Grievance and Appeals Manager

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to: Compliance Officer

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

The Grievance and Appeals Manager is responsible for the administration of the member appeals, grievance and organization determination processes for Medicare and Medicaid members.

This role is responsible for ensuring that all processes and procedures related to the handling of grievances, organization determinations and appeals are in accordance with regulatory requirements and that staff receive regular and on-going communication/training. The Manager must ensure that the staff has current and accurate procedures, and the Manager must ensure grievances, organization determinations and appeals are audited on a regular and consistent basis. The Manager is responsible for implementing quality improvement processes as appropriate.

The incumbent serves as the compliance expert for critical functions including appeals, grievances, organization determinations and call center operations. They are responsible for intake and assessment of regulatory guidance related to these functions. They work collaboratively with functional area staff within Medica and Medica's vendors to interpret and implement the requirements in a timely and compliant manner. This role also maintains compliance monitoring metrics and reporting mechanisms to evaluate and ensure compliance with Medicare requirements. This position conducts ongoing oversight of the Medicare functions and performs validation of auditing and monitoring results that are reported by functional areas within Medica and Medica's vendors. They recommend and oversee interventions based on their assessment of the results. They work collaboratively with the functional areas to implement effective interventions, process improvements and corrective actions.

This position actively participates in regulatory audits and audit readiness activities. They serve as the compliance lead for the functional areas described above to ensure a continuous state of audit readiness and they ensure effective execution of corrective action plans in response to any deficiencies.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)

Serve as compliance lead for the guidance intake, assessment and implementation process	• Serve as the lead compliance expert for functional areas including appeals, grievances, organization determinations and call center operations, and as assigned, by providing compliance leadership and subject matter expertise. • Serve as the primary compliance contact for Medica staff and vendors that perform these functions. • Manage the intake, assessment and interpretation of regulations and guidance related to the assigned functional areas. • Coordinate training and communication of requirements to functional areas within Medica and vendors . • Project manage and oversee the implementation of requirements in a timely and effective manner. • Develop policies, procedures, training, auditing tools and monitoring protocols to ensure compliance with the requirements. • Develop and conduct training for functional areas within Medica and vendors. • Ensure complete and timely documentation of compliance with Medicare requirements.	20
Oversee functional auditing and monitoring activities; analyze and validate results	• Actively participate in an annual risk analysis to identify risk areas and prioritize areas of focus for compliance auditing and monitoring activities. • Develop, implement and maintain compliance monitoring metrics and reporting mechanisms to evaluate compliance with Medicare requirements. • Analyze and validate auditing and monitoring results from functional areas within Medica and vendors • Identify service and operational problems and improvement opportunities, and ensure appropriate reporting of issues to management. • Provide recommendations for improvements or corrections and oversee their implementation.	20
Actively participate in regulatory audits and audit readiness activities	• Actively participate in audit readiness activities to ensure proper preparation by Medica functional areas and vendors . • Lead audit readiness activities for the functional areas described above, and as assigned. • Develop and conduct training for functional areas on regulatory audit topics, including file preparation and interviewing. • Conduct thorough quality review and analysis of audit documents, sample files and universes. • Actively participate in regulatory audits conducted by external auditors. • Ensure complete and timely documentation of audit activities.	20
Coordinate and ensure effective execution of corrective actions	• Develop and implement corrective action plans for identified compliance matters and in response to audits. • Provide compliance expertise in the development and implementation of solutions to address compliance matters.	10

Managerial Oversight- Consumer Affairs	• Manage all member appeals, organization determinations and grievances. • Manage and oversee audits of appeals, organization determinations and grievances to ensure all requirements are met, including compliance with regulations, quality standards and customer satisfaction. • Oversee external review process. • Oversee CTM complaint and ensure they are resolved within appropriate timelines. • Manage DHS and CMS complaint and appeal reports and ensure submission is accurate and timely. • Monitor standards for quality, turnaround time, effectiveness and productivity. Provide leadership and coaching to direct reports through consistent 1:1's and team meetings, manage and measure team workload, performance and administer incentive program. • Work with direct reports to develop yearly goals, measure progress against the goals and performs the annual performance reviews. • Creates a positive climate among the team and rewards goal achievement. • Research, recommend and approve training and development opportunities for direct reports.	30%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: College degree, or equivalent experience
Years of experience required: 5 years

Specific types of experience required:
Minimum 5 years insurance or managed care experience
Minimum 2 years experience in a supervisory/management position

SKILLS/ABILITIES:

Strong customer focus and ability to quickly identify and resolve problems.
Knowledge of specific Medicare functional areas, including organization determinations, appeals, grievances, and call center
Ability to manage multiple responsibilities/priorities simultaneously
Proven ability to communicate effectively including strong written and verbal skills.
Must be able to develop innovative solutions that balance legal and business needs.
Strong drive for results and accountability
Must demonstrate strong analytical and problem identification and resolution skills.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: 4 Consumer Affairs Advisors
Number of indirect reports (total number in department/area): 0

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

- Limited administrative budget responsibilities.

MEDICA®

MEDICA POSITION PROFILE

Job Title: HR Generalist

Job Code:
Salary Grade:
FLSA Status: Exempt

Department:

Reports to:

Prepared By:
Revision Date: 4/21/2015

POSITION OVERVIEW:

The human resource generalist is responsible for performing HR-related duties on a professional level and works closely with senior HR management in supporting designated geographic regions. This position carries out responsibilities in the following functional areas: employee relations, training, performance management, onboarding, policy implementation, recruitment/employment, affirmative action and employment law compliance.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Human Resources Capacity	Administers various human resource plans and procedures for all company personnel; assists in the development and implementation of personnel policies and procedures.. Participates in developing department goals, objectives and systems. Provides policy and procedure interpretation to employees and leaders to ensure compliance with State and Federal laws and mandates. Conducts recruitment for exempt and nonexempt personnel, students and temporary employees; writes and places advertisements and conducts new-employee orientations. Handles employee relations counseling, outplacement counseling and exit interviewing. Participates in administrative staff meetings and attends other meetings and seminars. Performs other related duties as required and assigned.	60%
Problem Solving/Consulting	Assists in evaluation of reports, decisions and results of business department in relation to established goals. Recommends new approaches, policies and procedures to effect continual improvements in efficiency of business areas/departments and offers people solutions when appropriate.	30%

Project Management.	Creates project plans for execution of HR initiatives or solutions at the local/geographic location as required. Provides status updates to HR and business leaders to ensure continued focus and buy-in for projects.	10%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:
Education Level: Bachelor's Degree
Major: Human Resources or related field
Years of experience required: 2 years
Specific types of experience required:
Thorough understanding of State and Federal employment laws and HR capabilities.

REQUIRED CERTIFICATIONS/LICENSURE:
PHR certification preferred.

ADA STATEMENT:
Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.
Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:
Excellent oral communication skills
Excellent writing skills
Ability to present company position persuasively
Strong relationship building skills
Effective project management abilities
Solid presentation skills
Strong organizational skills
Ability to assimilate information from various sources and recommend courses of action
Ability to work in a rapidly changing environment and adjust priorities quickly

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: None
Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Long Term Care Manager

Job Code:
Salary Grade:
FLSA Status:

Department:

Reports to: Director of Clinical Operations

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

The position is responsible for the oversight of implementation, coordination, and day-to-day management of the state's community based and facility programs. Additionally, this position oversees the long-term care provider reviews, utilization reviews, member satisfaction surveys, and member health and welfare.

Role includes:

- Comprehensive understanding of CMS rules and regulations.
- Stay current with institutional practices, policies, legislation and provide training as needed
- Liaison to the State, external vendors, clinicians, Operations staff

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)

Implement, coordinate and manage community and facility based programs	Implements case management programs, chronic condition coaching programs and treatment decision support program and effectively monitors, manages and allocates resources to achieve business initiatives. Responsible for oversight and maintenance of operations related to new business implementation, reporting of care coordination performance guarantees, communication with care coordination client sites to insure seamless customer service. Responsible for project management activities Maintains communication between key stakeholders and departments Conducts assessment, monitoring, analysis and communication of community and facility program utilization data and identifies opportunities for improvement. Provides operations management to the unit while maintaining teamwork and collaboration Has a good understanding of member benefits (such as familiarity with Certificate of Coverage, Elderly Waiver, Medicare, and Medicaid benefits Stays current on Medicare, Medicaid and state policy program changes and attends pertinent DHS trainings Partners with external vendors to ensure the member's needs are followed through.	50%
Utilization and Facilitation	Management oversight of the following activities: • Understanding of health plan benefits and coordinate discharge/referral plan as necessary. • The process for verbal and written communication of review outcomes to facilities, physicians and members. • Early identification and assessment of members for potential inclusion in a comprehensive case management program. Refers members for ongoing complex case management accordingly • Assists Member Services, Claims and Provider Services with issues that require medical interpretation or definition. • Assures adherence to all regulatory and compliance requirements. • Assures the protection of confidentiality of utilization review, quality management information and beneficiary identification	40%
Stay current with community and facility based programs policies, legislation and provide training as needed	Attend internal/external meetings in regards to community based and facility programs Develop and modify training materials and collaborate with other team members to provide training to partners	10%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major:
Years of experience required: 5 years Long Term Care policy

Specific types of experience required:

Bachelor's degree preferred.
Minimum of 5 years of clinical experience. Some experience in working directly or with programs that serve frail members is preferred.
Past experience working with Skilled Nursing Facilities
Current RN licensure
Experience in training adult learners a plus.
Experience in implementing regulations, contract provisions and best practice standards
Strong project management experience, including organizing, planning, and executing projects from vision through implementation

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: 5-10 %
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Demonstrated success in managing and developing relationships with diverse stakeholders
Comprehensive knowledge of CMS rules and regulations
Knowledge of health plan operations
Demonstrated interpersonal communication skills, creative and innovative problem-solving ability, process improvement and organizational skills, critical thinking and independent decision making ability.
Knowledge of the Medicare Part A Skilled Care Coverage Benefit
Ability to work with Skilled Nursing Home Providers
Knowledge and ability to work with DHS
Knowledge of Community and Long Term Care Programs
Excellent written and verbal communication skills
Willingness to travel
Proficient in the Microsoft Office Suite
Data management skills

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: None
Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Medical Director

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to:

Prepared By:
Revision Date: 0/20/2015

POSITION OVERVIEW:

The Medical Director is responsible for oversight of all Iowa Medicaid Program clinical activities. This includes program development, medical management, health policy development and risk management activities of Medica. The Medical Director will provide medical leadership and community visibility for the noted areas of responsibility. The incumbent is also responsible for Quality Management and Improvement across all medical programs.This position requires a solid medical and business mind, and an ability to develop and implement medical programs and policies that effectively balance provider, patient, and health plan interests. It is expected that the Medical Director effectively creates strong collaborative relationships with provider systems, governmental and community organizations, and Medica staff. The Medical Director must be comfortable working with multidisciplinary teams and diverse communities.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Clinical Leadership of Medica's Iowa Medicaid Programs Business	Provide the clinical leadership to Medica's Iowa Medicaid Program business. This includes program development, executing and coordinating clinical protocol and utilization management processes, leading interdisciplinary teams of direct care and management staff. Specific duties include but are not limited to: • Clinical program development and support of Care Coordination and Nurse Practitioner programs • Medical direction and development of clinical protocols and utilization management processes. • Leading clinical interdisciplinary teams with staff of diverse health care backgrounds. • Medical leadership in quality improvement, CMS star rating, risk adjustment, and health education outreach programs. • Medical direction on clinical aspects of government products. • Participate in escalated utilization management and benefit exception decisions and facility claims audits.	50%
Actively participate in meetings and committees	Actively participate in department meetings and activities that further Medica's goals related to Health Management and Government Programs. Attends and participates in scheduled quality committee meetings with IA DHS. Directs internal Utilization Management Committee meetings.	20%

Support Medica's provider relation strategy with adult living facilities, Medica Care System and contracted care system providers	Work in conjunction with Medica Government Programs, Health Management and Network management staff to develop and maintain productive relationships with adult living facilities and Medica's Care Systems and network providers. This includes developing visible relationships with these providers, working with these providers on quality improvement, utilization, care coordination activities, providing input into contracting strategies and co-leading contracted care system medical directors' meetings.	10%
Provide Health education programming to clinical staff, members and other stakeholders	• Develop and deliver health education training to clinical staff on a routine basis through large group trainings, interdisciplinary team meetings, etc. • Develop and provide health education programming to members at annual member meetings, newsletter articles, website pieces, etc. • Be available to speak to the community on health related topics.	10%
Participate in creating health care policy with government stakeholders and other health plans.	Keep current on CMS clinical policies and changes. Represent Medica on various community, government, and Council of Health Plan Committees.	10%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Doctorate
Major: Medical Degree
Years of experience required: 7+ years

Specific types of experience required:

Must be a licensed physician in Minnesota with current Board certification, preferably in a primary care specialty; current license to practice must be without restrictions.
7+ years' experience in health care, including:

- at least 4 years' experience in the clinical practice of medicine
- 3 or more years in medical management which must include leadership in delivery system/hospital or in health plan management.

Experience in Medicare and State Public Programs is strongly preferred.

REQUIRED CERTIFICATIONS/LICENSURE:

Licensed Physician

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _30__%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Required:
High integrity, morals, and mission driven focus
Outstanding written and verbal communications skills
Strong process management and strategic planning skills
Physician executive leadership experience with proven success in developing and implementing clinical programs
Knowledge in analyzing data to identify opportunities, develop clinical programs, and measure outcomes
Ability to influence and drive discussions toward resolution

Strongly Desired:
Previous program development for Medicare and/or State Public Programs in case management, utilization management, quality improvement, and population health are strongly desired.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: None

Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Manager, Care Coordination

Department: Health Management
Reports to: Director of Clinical Operations
Revision Date: 4/20/15

Job Code:
Salary Grade:
FLSA Status: Exempt

POSITION OVERVIEW:

This position is responsible for daily operations and the performance of the Clinical Care Coordination and Case Management teams. This includes:

- Relationship building within Medica and its vendor partners to prioritize, integrate and coordinate interventions for population segments based on medical, behavioral and social needs
- Relationship building with provider care teams as accountable partners facilitating member self-care management
- Adoption of transformational interventions and case management models for conditions and populations driving medical expense trend
- Population specific care coordination
- Population specific complex case management
- EOL management
- Transitional care management (post-discharge)
- Predictive modeling and proactive member identification
- Specialty medical condition management (i.e., transplant, HRP)

This position is responsible for providing overall direction to clinical staff and is responsible for the implementation, evaluation, intervention and improvement of programs delivered for the government lines of business. The case management activities in the team are engineered to deliver process oriented outcomes, through focus on a comprehensive established plan of care, collaborative interactions with the member and provider, and the Medica Case Manager assuming assertive, purposeful direction of the case.

This team manager will be required to monitor and prioritize significant regulatory and customer requirements, and accreditation standards to ensure reasonable compliance at all times. This role is critical to Medica, as the team directed will provide critical feedback to the member and the provider to intervene and influence decision-making regarding clinical plan and management of the member. This individual will identify areas for process improvement and work closely with monitoring data for trends, identifying opportunities for improvement and implementing improvement plans, as appropriate, and as directed by the Medical Directors and the HM leadership.

This position is responsible for analyzing and taking appropriate action on operational and program data to support staff/operations management, as well as multiple reports of program outcomes.

This individual must be capable of strategic thinking and mature social/business judgment in situations with Medica staff, members and providers involving risk and conflict. This position works directly with all managers and directors within the Health Management department, the medical directors, the Customer Call Center, and Provider Services areas in Medica. This individual must be comfortable working with senior management to support program deliverables and when cases with risk to Medica are identified. This position regularly interacts with Account Management and Government Markets divisions, and the segment clinical programs to address customer linkages and needs. Must have excellent presentation skills and ability to reflect confidence and clinical skills with consultants, regulators, and employers.

The manager partners with other leaders in Health Management and throughout Medica to develop strategy around case management interventions to manage utilization of health care services.

The manager understands, articulates and supports the organization's mission, vision, goals and strategies, and maintains confidentiality of all privileged information.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
Management of business/program operations	• Leads and manages the program and team as outlined under the Position Overview section. • Implements all case management programs and services for government business and effectively monitors, manages and allocates resources to achieve business initiatives. • Responsible program implementation. • Tracks and evaluates productivity, program performance and the performance guarantees. Develops program recommendations. • Collaborates closely with Medica's Government business/clinical leadership to ensure seamless operations and service. • Develops and assures business processes/program workflows are implemented consistently, evaluated for effectiveness and efficiency and are improved. • Is responsible for performance management, supervision, and direction of staff. • Acts as a subject matter expert for case management for Medica, our clients and in project teams. • Serves as key contact for government case management for representation of the program and problem resolution of operational issues and implementation of action plans. • Maintains communication between key stakeholders and departments such as Customer Service, Claims Operations, Provider Services, Medical Directors, Pharmacy, and Account Management. • Collaborates closely with other areas within Health Management; Utilization Management, Health Innovation, Pharmacy and HCE to ensure collaboration and alignment, as well as operational linkages and efficiencies, including vendors and MBH. • Develops and oversees process of customer and regulatory audits for the case management team. • Monitors case quality to ensure competence in case management and care support decision-making, documentation and compliance with regulatory, accreditation and policy/procedure changes. • Provides leadership to the case management team in the context of Medica's direction and goals as an organization.	**35%**

Maintain efficient departmental operational systems and processes	• Ensures conformance to processes, policies and procedures, quality improvement activities and customer requirements. • Provides oversight for policies and procedures used in decision making by case management staff for Medica government products. • Delivers reporting for departmental dashboard • Facilitates team meetings and team building activities. • Creates positive team climate by setting individual and team goals and achieving results, eliminating non-value added activities, and recognizing and rewarding good work. • Assesses business tools, processes and systems to aid in efficiencies and accuracy of decisions. Integrate team processes with those of Utilization Management, segment operations, pharmacy, MBH, and other departments (i.e., Provider Services, Claims Operations and Account Management departments). • Responsible for support in establishing unit budget and monitoring • Completes and ensures compliance with business policies/ procedures. • Assess staffing/structure impacts due to change, and implement plans as necessary. • Work with Supervisor to assess work distribution and staffing ratios.	**35%**
Regulatory and Accreditation Compliance: assessment, monitoring and implementation	• Assures reasonable compliance with regulatory/accreditation standards and implements departmental action plans as necessary. • Develops and implements compliance with department policies and procedures. • Monitors audit results, assesses business case recommendations • Participates in customer audits, and audits for accreditation and regulatory purposes. • Assesses and implements compliance obligations as required by government and accreditation entities. • Ensure adequate staff training	**15%**
Monitor, track and report trends to facilitate benefit design, medical policy decisions and improve operational efficiencies	• Develops and refines as needed data collection tools, systems and reports to support operational performance and improvements. • Develops and maintains measurement reporting tools and reports and provides representation of data. • Is responsible for open communication between team and senior management regarding reports and recommendations. • Responsible to work with departmental and cross-functional teams to implement above noted opportunities, insuring all regulatory requirements maintained.	**15%**
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

Education/Experience: (Include any required licensure/certifications)

1) RN with active state license required, Bachelors degree required (prefer post-graduate degree)
2) Minimum of 8 years clinical experience.
3) Minimum of 5 years managed care experience in health management (utilization, case, or disease management),
4) Experience leading case management programs.
5) Experience with implementing regulations, legislation, rules and/or laws and accreditation standards.
6) Experience with utilization management and case management tools, procedures and programs.
7) Experience with data collection, assessment tools, reporting and analysis.
8) Minimum of 5 years experience with management of professional staff.
9) Past experience with complex project management required; proven track record of accomplishing strategic goals and projects.

Skills/Abilities:

1) Demonstrated leadership skills including: excellent interpersonal communication skills, creative and innovative problem-solving ability, critical thinking and independent decision-making ability, group facilitation, negotiation, change, conflict management and performance management skills.
2) Demonstrated process improvement and organizational skills.
3) Demonstrated ability to analyze data, conduct root cause analysis, understand and solve multi-dimensional problems, implement necessary improvement plans.
4) Presentation skills, success with managing a client and regulatory audience
5) Experienced with Microsoft Office Suite / Visio; case mgt. tools, related IT tools
6) Is a self-starter; can initiate project plans and actions once problem has been identified.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: 1 Behavioral Health Manager

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

- Manages department budget with oversight from Director/VP. Monitors team expenditures. Supports the Director in planning and setting annual budget.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Manager Claims Administration

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to:

Prepared By:
Revision Date: 4/20/2015

POSITION OVERVIEW:

is responsible for policy and procedures in billing, and claims. This position forms, manages, and monitors these functions performed by Medica employees.

The Manager Claims Administration is responsible for the productivity and quality of the billing and claims functional areas. The position is responsible for implementing controls to ensure compliance standards are met, and for creating and implementing auditing/monitoring processes to ensure Health Plan performance standards are met or exceeded.

This position provides leadership, functional advice and is responsible for establishing and managing processes that ensure accurate implementation and interpretation of the customer benefits (including compliance with applicable federal and state laws). This position also manages interdepartmental relations and processes for accurate and efficient handoffs and tracking of progress within Medica and our vendors.

This manager will also be a key participant in Process Improvement projects such as enrollment portal enhancements, workflow improvements, new product roll-outs, renewal rates, program builds, team creation and implementation, platform implementations, etc. Under the leadership of the Director, this manager will be a team player in many of these projects.

This position is expected to build relationships with both internal and external customers.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Management	Manage billing and claims business policy & procedures. Recommend, approve and implement changes as appropriate (particularly in regard to Medica's compliance of federal and state laws). Work with other Operations manager to maximize overall productivity. Manage, coach and develop direct reports. Monitor key performance metrics, and take corrective action as necessary to ensure acceptable performance levels for accuracy and timeliness. This includes individual performance of direct reports. Key Responsibilities may include: - Work with direct reports dedicated to claims examination to manage the day to day inventory of their respective queues to ensure that turnaround time guarantees are consistently met. Develops and implements strategy for cost recovery.	60%
Communication and Direction	Collaborates with key teams (Corporate Shared Services, and Finance), to outline, drive, and execute the appropriate project plans and scorecards to monitor and manage the key projects. Meet with and educate appropriate parties regarding issues/trends to avoid repeated errors (e.g., sales, claim service staff, customers, may include providers.) Contacts appropriate business partners to correct systems errors as needed. Proactively communicates with and advise key leadership regarding process improvements and ongoing initiatives. Maintains adequate communication regarding project status, risks, issues and priorities with leadership business and project team. Direct and communicate training activities from needs assessment, material design, delivery and evaluation to ensure consistent application of all operational policies and procedures. Manages cross functional teams to expand the organization's view of these key initiatives.	20%
Project Management	Be a key contributor to projects. Identify and solve for service trends or issues that impact Medica's customers. Be a resource for other departments on impacts to the operational areas when corporate initiatives are being implemented. Create, develop, and implement teams when necessary for new business projects and programs.	20%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree or Equivalent Experience
Major: Business Administration or Healthcare Administration
Years of experience required: 5-8 years

Specific types of experience required:
Knowledge of health care industry/products/benefits is required
Knowledge of Medica's operational systems is a plus
In-depth knowledge of health plan enrollment and billing processes, contact center, health claim processing, health plan operations business processes, claims systems and linkages
Project management and/or business analysis experience
Previous experience supervising/managing a team of people for at least 5 years

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.
Travel: ____%
Lifting/Carrying Weight: ____
Other special Requirements: _____

SKILLS/ABILITIES:

Ability to effectively manage internal staff and exceed corporate goals
Strong interpersonal and relationship building skills
Drive and capability to create, implement, and oversee a new business function
Good understanding of basic operational and administrative processes (contact center, enrollment, billing, claims)
Decision-making and analytical skills
Strong written and verbal communication skills
The ability to work across the organization to influence individuals who don't have a direct report line to them, and achieve the required project deadlines and meet/exceed corporate goals
Individual must have strong business acumen, analytical abilities, and problem solving abilities to review data and trends and then manage/work with individuals to identify root causes and implement effective solutions
Good presentation skills are necessary and meeting facilitation skills are a plus
Strong business process/workflow knowledge

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: possibly 4 – 8 enrollment specialists; 3-4 Billing analysts, 9-14 service representatives, 3-4 claims examiners.
Number of indirect reports (total number in department/area):
This position indirectly guides the activities of cross organizational teams can include up to 20-40 people. Individuals represented are internal Medica staff, key points of contact representing our customers, Phoenix project members, and vendors.

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Contract and Vendor Management

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to:

Prepared By:
Date: 4/21/2015

POSITION OVERVIEW:

This position has major responsibility for vendor management issues as well as delegation oversight processes.

This position also leads a team of auditors and liaisons that perform duties in line with financial stewardship and compliance guidance.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Successfully manage the contractual relationships with vendors	Monitor the core elements of each contract and ensure compliance. Assure vendors meet performance standards as outlined in vendor agreements. Schedule and lead regular business meetings with each vendor to identify and resolve contractual and operational issues. Develop and maintain regular communications with each vendor. Identify and work with Medica Legal department to issue appropriate amendments to the master agreements. Negotiate vendor agreements. If needed, prepare and issue an RFP to accurately assess market value for vendor services and select vendor.	40%

Develop and maintain contact liaison relationship with each vendor and all relevant internal Medica departments.	Triage operational issues with each vendor. Triage operations issues from Medica departments. Determine appropriate resolution to operational issues. Develop and oversee joint project management groups for larger operational or implementation issues. Communicate resolution of operational issues to relevant Medica departments. Maintain a history of operational processes to respond to similar requests as they arise. Communicate vendor performance to relevant Medica departments. Maintain and manage overall perception of vendor effectiveness.	30%
Project Management	Provide project management for new or changing business activities as assigned.	10%
Mange the delegation oversight process	Co-chair a bi-weekly oversight team which monitors each vendor's performance on delegated activities. Issue corrective action plans if needed; review vendor responses and communicate resolution. Attend Medica delegation committee; communicate and report status of vendor performance on delegated activities. Make recommendations for continued delegation or removal of delegation status. Communicate vendor delegation performance to appropriate Medica departments including, compliance, legal, SIU and customer service.	10%

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Healthcare related field
Years of experience required: 5 years

Specific types of experience required:

BA/BS in healthcare related field
5 years of managed care/health plan experience required
Legal/regulatory/compliance experience preferred
Vendor Relations experience desirable

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____

Other special Requirements: _____

SKILLS/ABILITIES:

Excellent interpersonal/relationship skills
Proven ability to communicate effectively
Strong written communication skills
Strong organizational skill
Strong drive for results and accountability
Demonstrated success leading project teams and managing/executing complex projects across organizations.
Knowledge of 'managed care' laws preferred.
Must be able to develop innovative solutions that balance legal and business needs.
Must demonstrate strong analytical, and problem identification and resolution skills.
Ability to handle multiple, complex projects with a high degree of initiative.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: 3
Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: Fiduciary responsibility regarding transportation spend as it relates to transportation options and stewardship of federal monies in driving results.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Mgr Information Systems and Security

Job Code:
Salary Grade:

Department: Information Technology

FLSA Status: Exempt

Reports to:

Prepared By:
Revision Date: 04.20.2015

POSITION OVERVIEW:

The Manager of Data Integration will lead the team responsible for the development and implementation of data integration services solutions. This includes but is not limited to those solutions using Medica's Tibco integration engine (EAI/EDI), internal and external data feeds and data transformation efforts. The position will interface primarily with IT technical resources but is also exposed to business owners to insure that technical solutions will meet business requirements.

The incumbent will serve as a liaison between Medica and DHS or its designee, regarding claims submissions, capitation payment, member eligibility, enrollment and other data transmission interface issues. Responsible for ensuring all IT system security and controls, program data transaction, data exchanges and other information system requirements are in compliance and data submission requirements are met.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Management of the Data Integration Department	General management duties of EC team (coaching, 1:1 meetings, team meetings, issue escalation and problem solving, performance appraisals) Creation and maintenance of team policies and procedures, keeping in sync with IT departmental processes (software development life cycle, Quality Assurance, test strategies, etc) Ensure daily operations are functioning to health plan and business partner expectations, operating in a timely and efficient manner Strategic planning for future department and IT initiatives and opportunities Recruitment/Selection/Retention of team members, in partnership with Human Resources Development, monitoring and reporting of departmental goals and metrics Attend and participate in departmental, divisional and Medica management meetings Conduct and coordinate tactical and strategic resource planning for the DI team	45%

Promotion of Data Integration Capabilities within Medica	Internal Medica consultant and expert for Integration (new concepts/initiatives/transactions); identify opportunities for use of Medica's integration technology Education and training of Medica staff, including departmental presentations. Attend industry meetings and task forces, collaborative efforts Provide subject matter expertise to Medica resources regarding hub infrastructure	20%
Information security	This position will ensure appropriate security controls and policies are implemented and are effective in protecting the organization and programs. • Perform ongoing information security risk assessments and audits. Ensure appropriate corrective action • Monitor compliance with information security policies and procedures, ensuring appropriate corrective action • Monitor the access control systems to assure appropriate access levels are maintained	35%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Computer science, programming or related field
Years of experience required: 7 years

Specific types of experience required:

5+ years experience in the information technology field
3 or more years of experience in a staff leadership or personnel management role
3 or more years experience in application and business partner integration
2 or more years of experience using Tibco as an integration tool, preferred
3 or more years JAVA programming experience
Meaningful experience and demonstrated knowledge of the following:
Project Management
IT Resource Management
IT Infrastructure (hardware, network, security)
Database (Logical Design, Physical Design)
Production Support
Technical Architecture

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Excellent analytical and problem solving abilities
Ability to work in a team environment
Demonstrated strength in verbal and written communication
Collaborative style with the ability to work with staff at all levels of a complex organization.
Exceptional customer service skill set
Demonstrated competency in coordinating multiple projects/activities
Proven ability to organize and coordinate

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: None
Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Mgr Marketing Communications

Job Code:
Salary Grade:

Department: Corporate Communications

FLSA Status: Exempt

Reports to: Vice President, Iowa Medicaid

Prepared By:
Revision Date: 4/21/2015

POSITION OVERVIEW:

Responsible for strategic communications planning and ownership of all communications disciplines and tactics for specified audience(s). Ensures that the key communications needs of the Government and Health Management teams are met. Ensures that messages and related communications vehicles are well targeted and in sync with overall corporate objectives and messages. Directs the creative team and/or consultant/agency in the development of on-target, creative, cost-effective marketing communications materials. Selects and oversees external vendors and consultants. Often serves as primary concept developer and occasionally copywriter. Presents concepts and final creative to customers. Ensures communications meet legal and compliance standards.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Assessment and Planning	Works closely with Government and Health Management along with other internal clients to determine communications needs and then develops strategic communication project plans encompassing multiple communications elements to serve a business purpose. Maintains alignment of messaging and strategy across initiatives and departments. Represent communications function on cross-functional business teams	25%
Manages Communications Team and Resources	Oversees the work of Corporate Communications Specialist, who directly reports to Corporate Communications Manager. Evaluates resource requirements. Selects and oversees the work of external vendors and consultants, when needed, who provide such services as copywriting, photography, printing and graphic design services. Establishes time lines and accountabilities, ensuring projects are completed on time. Forges productive relationships with internal stakeholders and external partners. In conjunction with Director of Corporate Communications, develops communications budget and manages budget, ensuring that projects stay within budget.	50%
Creative direction	Serves as creative director on all projects. Contributes to creative process in concept development and occasionally copywriting. Oversees the development of creative, including overarching concepts, copy and final product. Edits materials to ensure they are on target in message and are accurate. Works closely with Sales, Product, Legal and other subject matter experts and stakeholders.	25%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Communications
Years of experience required: 5 years

Specific types of experience required:

This person must have a BA/BS in communications, journalism, public relations or a related communications field and 5+ years of related experience. Excellent strategic planning and project management skills, including budgeting are required. Experience in leading a team; excellent writing, editing, and proofreading skills; experience in print production and electronic production capabilities are also required. Communications experience in healthcare or the insurance industry is preferred, but not required.

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

The desired candidate must have the ability to turn verbal direction into written communications and be able to multi-task.
The candidate must have excellent listening skills, and needs to be resourceful and able to switch gears at any time.
S/he will receive direct communication from the communications director and needs to be able to execute and meet deadlines.
Must be able to demonstrate strategic thinking in dealing with key internal customers
The desired candidate will also have strong project management skills.
Must be able to prioritize, negotiate and juggle resources, and have the ability to work with budget management.
Microsoft Office skills also required.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles:
3 Community Outreach Coordinators

Number of indirect reports (total number in department/area):

Manages relationships with key outside vendors, including printers, designers, copywriters and photographers.

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

In conjunction with Director of Marketing Communications, responsible for developing marketing communications budget and ensuring that projects stay within budget.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Mgr, Member & Provider Service Call Center

Job Code:
Salary Grade:
FLSA Status: Exempt

Department:

Reports to: Sr. Director, Government Programs Call Center

Prepared By:
Revision Date: 04/20/2015

POSITION OVERVIEW:

This position is responsible for managing Member and Provider service call center and staff. The manager is accountable for achieving call center standards. This position is responsible for developing and managing relationships with internal and external customers, including interfacing with the leadership and CMS to ensure that needs are being identified and addressed and that call trends are reported to the organization. The Call Center Manager is responsible for the development and implementation of methods, systems and strategies that support customer and provider needs/requests. The manager works closely with the director to ensure the day to day operations of the call center are being met

This position is directly responsible for managing direct contact with Medica's membership and providers. It is imperative that customers receive the highest level of service possible in every interaction. The Call Center Manager provides the leadership necessary to meet our mission statement of "Exceeding our Customer's Expectation".

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)

Managerial Oversight/General Department Operations	Lead the department into achievement of the call center standards, as defined by senior management. Responsible for the identification and quick resolution of vendor errors or processes that impact calls volume. Facilitate the identification, resolution and communication of member service issues and inquiries. Escalate issues requiring further investigation to other appropriate areas within Medica. Evaluate and monitor call center performance metrics, work processes, and quality approach to ensure service needs are being met. Implement corrective actions as necessary. Report service metrics and standards as appropriate. Monitor staffing structure and associated ratios to regularly achieve Member Service performance targets. Develop forecasts, future staffing and resource requirements for the Customer Service unit. Ensure cross training among service staff to maintain proper service levels, to provide career advancement tracks to staff and to adjust quickly to any staff turn over. Ensure up-to-date policies, procedures and reference materials are available to all call center personnel. Conduct research and analysis of phone service technologies and benchmarks. Implement modifications or enhancements as necessary.	35%
Personnel Management	Manage the interviewing, hiring, training and staff development activities as needed. Provide direct supervision for the department supervisors and other key staff in the unit. Facilitate individual and team communication by conducting regular 1:1 and team meetings Perform annual performance reviews, set clear goals and objectives for each employee, team and the call center overall. Act as a mentor and guide on identifying, investigating and resolving department, personnel or administrative issues Promote a positive working climate that supports open and honest communication, integrity, service quality and customer focus. Provide opportunities for employee development, such as networking, external training and development programs.	35%
IA Service Representative	Represent Government Programs Service through active participation on standing and ad hoc internal committees. Share all pertinent information with department management and staff as necessary. Collaborate with other service areas within Medica to leverage collective knowledge and ensure clear delineation of service responsibilities. Promote Government Programs call centers internally to enhance understanding of interdependencies and the impact of organizational changes/initiatives on the call center. Make recommendations to Medica regarding operational improvements to prevent persistent service problems. Support Government Programs leadership in communicating issues and concerns and provide suggestions for improvement.	30%
	Total %	**100%**

<u>ESSENTIAL QUALIFICATIONS/REQUIREMENTS</u>:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Business, management, or healthcare field
Years of experience required: 5 years

Specific types of experience required:
Bachelor's degree in business, management or healthcare field is required
5 years experience working in a customer service environment in managed care.
2 years experience in a supervisory/management position in a call center.
Medicare knowledge/experience required

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Ability to manage multiple responsibilities/priorities simultaneously
Results-driven with a focus on performance management as it relates to both people and metrics
Strong negotiation and conflict management skills needed with the ability to effectively work through difficult situations
Customer focused
Strong written and verbal communications
Computer literate-specifically Microsoft Word, Power Point and Excel
Experience in working with various call center software (i.e., ACD, IVR, Workforce Management)
Strong ability to think creatively in multiple situations
Strong presentation and organizational skills

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles:

2 Customer Service Supervisors
2 Q/A Analysts

Number of indirect reports and titles:
30 Customer Service Representatives

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

Direct allocation of resources within budget guidelines
Assist Director and VP on annual budget planning and preparation

MEDICA®

MEDICA POSITION PROFILE

Job Title: Mgr, Member Svc Call Ctr

Job Code: MCS383
Salary Grade: 112

Department: Iowa Medicaid

FLSA Status: Exempt

Reports to: Director, Government Programs

Prepared By:
Revision Date: 4/222/15

POSITION OVERVIEW:

Medicaid is a fast paced call center that serves as the first point of contact for Medicaid members and their representatives, prospects, termed members and other stakeholders. The call center staff must have a broad range of knowledge regarding Medicaid products and services, benefits, enrollment, claims, billing, grievances and appeals.

This position is responsible for managing call center and staff. The manager is accountable for achieving call center standards. It is the manager's responsibility to support Medica's Market Business Segments by managing the operations of the call center. This position is responsible for developing and managing relationships with internal and external customers, including interfacing with the leadership and CMS to ensure that needs are being identified and addressed and that call trends are reported to the organization. The Call Center Manager is responsible for the development and implementation of methods, systems and strategies that support customer needs/requests. The manager works closely with the director to ensure the day to day operations of the call center are being met. The accountabilities of the manager includes working with Real Time Operations team to develop monthly forecasts, staffing requirements and development of staff schedules to ensure the call center is staffed appropriately during business hours. The manager communicates and supports call center supervisors to ensure alignment with team schedules. This position takes the lead on all new call center technology roll-outs and system enhancements for Customer Service. The manager is responsible for evaluating and monitoring Government Programs performance metrics, work processes and quality approaches to ensure service needs are being met.

As part of the Leadership team in member service and because of their knowledge, advancement opportunities should be high. This person could potentially move to a higher level of management such as Director or VP. This person would also have several opportunities in Sales and Marketing, Health Care Services, Provider Services, Product Administration, etc.

This position is directly responsible for managing direct contact with Medica's membership. It is imperative that customers receive the highest level of service possible in every interaction. The Call Center Manager provides the leadership necessary to meet our mission statement of "Exceeding our Customer's Expectation".

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Managerial Oversight/General Department Operations	Lead the department into achievement of the call center standards, as defined by senior management. Responsible for the identification and quick resolution of vendor errors or processes that impact calls volume. Facilitate the identification, resolution and communication of member service issues and inquiries. Escalate issues requiring further investigation to other appropriate areas within Medica. Evaluate and monitor Government Programs Call Center call response and performance metrics, work processes, and quality approach to ensure service needs are being met. Implement corrective actions as necessary. Report service metrics and standards as appropriate. Monitor staffing structure and associated ratios to regularly achieve Member Service performance targets. Develop forecasts, future staffing and resource requirements for the Customer Service unit. Ensure cross training among Government Programs Service staff to maintain proper service levels, to provide career advancement tracks to staff and to adjust quickly to any staff turn over. Ensure up-to-date policies, procedures and reference materials are available to all Government Programs Call Center personnel. Conduct research and analysis of phone service technologies and benchmarks. Implement modifications or enhancements as necessary.	35%
Personnel Management	Manage the interviewing, hiring, training and staff development activities as needed. Provide direct supervision for the department supervisors and other key staff in the unit. Facilitate individual and team communication by conducting regular 1:1 and team meetings Perform annual performance reviews, set clear goals and objectives for each employee, team and the call center overall. Act as a mentor and guide on identifying, investigating and resolving department, personnel or administrative issues Promote a positive working climate that supports open and honest communication, integrity, service quality and customer focus. Provide opportunities for employee development, such as networking, external training and development programs.	35%
IA Medicaid Service Representative	Represent Government Programs Service through active participation on standing and ad hoc internal committees. Share all pertinent information with department management and staff as necessary. Collaborate with other service areas within Medica to leverage collective knowledge and ensure clear delineation of service responsibilities. Promote Government Programs call centers internally to enhance understanding of interdependencies and the impact of organizational changes/initiatives on the call center. Make recommendations to Medica regarding operational improvements to prevent persistent service problems. Support Government Programs leadership in communicating issues and concerns and provide suggestions for improvement.	30%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Business, management, or healthcare field
Years of experience required: 5 years

Specific types of experience required:
Bachelor's degree in business, management or healthcare field is required
5 years experience working in a customer service environment in managed care.
2 years experience in a supervisory/management position in a call center.
Medicare knowledge/experience required

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Ability to manage multiple responsibilities/priorities simultaneously
Results-driven with a focus on performance management as it relates to both people and metrics
Strong negotiation and conflict management skills needed with the ability to effectively work through difficult situations
Customer focused
Strong written and verbal communications
Computer literate-specifically Microsoft Word, Power Point and Excel
Experience in working with various call center software (i.e., ACD, IVR, Workforce Management)
Strong ability to think creatively in multiple situations
Strong presentation and organizational skills

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: TBD

Number of indirect reports (total number in department/area): TBD

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

Direct allocation of resources within budget guidelines
Assist Director and VP on annual budget planning and preparation

MEDICA®

MEDICA POSITION PROFILE

Job Title: Mgr Provider Service Center

Job Code: MPS312
Salary Grade: 112
FLSA Status: Exempt

Department: IA Medicaid

Reports to: Director, Provider Service Center

Prepared By:
Revision Date: 4/21/15

POSITION OVERVIEW:

The Manager of the Provider Service Center is responsible for the operations and performance targets for one of Medica's call centers servicing contracted and non-contracted providers. This call center is accountable for responding to provider inquiries and complaints. It represents the first point of contact for providers to inquire or communicate regarding accuracy and timeliness of claims payments, referral procedures, product information, benefit verification and general plan information. This position is accountable for managing and reacting to staffing needs, technology shifts, conflict resolution and other organizational demands while continuously improving upon the service to the provider community.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Personnel Management	Conduct interviewing, hiring, training and staff development activities as needed. Facilitate individual and team communication by conducting regular 1:1 and team meetings Perform annual performance reviews Act as a mentor and guide on identifying, investigating and resolving provider service, personnel or administrative issues	25%
Provider Representative	Represent Provider Service through active participation on standing and ad hoc internal committees. Share all pertinent information with department management and staff as necessary. Collaborate with other service areas within Medica to leverage collective knowledge and ensure clear delineation of service responsibilities. Promote the PSC teams internally to enhance understanding of interdependencies and the impact of organizational changes/initiatives to the provider community. Make recommendations to Medica regarding operational improvements to prevent persistent provider service problems.	25%

Provider Service Center Operations	Facilitate the identification, resolution and communication of provider service issues and inquiries. Escalate issues requiring further investigation to other appropriate areas within Medica. Respond directly to providers regarding PSC complaints and issues requiring managerial attention. Evaluate and monitor Provider Service Center call response and performance metrics, work processes, and quality approach to ensure service needs are being met. Implement corrective actions as necessary. Report service metrics and standards as appropriate. Monitor staffing structure and associated ratios to regularly achieve Provider Service performance targets. Ensure cross training among Provider Service staff to maintain proper service levels, to provide career advancement tracks to staff and to adjust quickly to any staff turn over. Ensure up-to-date policies, procedures and reference materials are available to PSC personnel. Prepare and manage the Provider Service Center budget. Conduct research and analysis of phone service technologies and benchmarks. Implement modifications or enhancements as necessary.	50%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Business management, health services administration, or other relevant discipline
Years of experience required: 5 years

Specific types of experience required:

Minimum of five to eight years combined experience in customer service management, call center management or provider relations.
Previous experience in health care claim (CMS 1500 and UB-04) analysis and resolution

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Proven ability in conflict management and negotiation.
Ability to translate complex data into understandable, usable information and tools.
Knowledge of Call Center environments and terminology's
Working knowledge of standard management processes, controls, and tools, including budgeting, performance monitoring, and information systems.
Collaborative management style with the ability to work with staff at all levels of a complex organization.
Exceptional communication tools, both verbal and written.

Additional Competencies:
The Manager of the Provider Service Center must possess a tremendous amount of composure and ability to comprehend people and situations quickly.
Process management skills are imperative to evaluate and manage a call center environment.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles:
Provider Service Center Supervisor
Quality, PAA, Super Rep Supervisor (

Number of indirect reports (total number in department/area

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

Responsible for the Provider Service Center cost center budget (providing input on budget creation, monitoring of expenditures, etc.)
Responsible for approval of any Provider Service Center expense reports

MEDICA®

MEDICA POSITION PROFILE

Job Title: Manager, Quality Management

Job Code:
Salary Grade:

Department: IA Medicaid

FLSA Status: Exempt

Reports to: Clinical Operations Director

Prepared By:
Revision Date: 4/21/15

POSITION OVERVIEW:

The Manager, Quality Management is responsible for quality improvement initiatives, audits, and other regulatory compliance activities developed either internally or by outside regulatory agencies to comply with overall quality requirements. These requirements are established by state and national agencies. This position is responsible for designing, developing, and implementing quality initiatives for Medicaid in Iowa. The manager will link with needed resources throughout the organization or externally as necessary, as well as maintain reporting and professional relationships with involved regulatory agencies and provider clinics involved in ongoing initiatives or quality audits. This position manages delegation review and oversight of care coordination entities providing care coordination services.

This critical position ensures the right quality and compliance measures are proactively taken by Medica. This helps to ensure that the health plan successfully prepares for and passes regulatory audits, keeps ongoing contacts with public members and providers, and avoids any fines arising from being out of compliance. This position leads and manages audits required by CMS or DHS with minimal notice. The Manager must be flexible and creative in order to meet constantly emerging or revised requirements.

The success of this role will determine Medica's success in Medicaid programs in terms of meeting regulatory requirements related to quality. Additionally, valuable gains in quality improvement areas can reduce overall costs for the organization as well as identify new modes of care delivery that could benefit both Medica and its enrolled members. Several of the activities managed in the Regulatory Quality area have direct financial impact for Medica. This position represents Medica on both state and national groups which work to improve the measures used to evaluate metrics for government programs populations.

The Manager, Quality Management and related staff are required to work with a number of data sources and information resources to collect data and identify regulatory reporting needs. These needs must be met in a timely fashion and require work with regulatory agencies to review and evaluate Medica's compliance with requirements. This position will require creativity in terms of identifying t current research and reporting needs , monitoring potential new metrics, how they can best be met, and how to maintain regulatory relationships throughout the process. This individual must have the ability to manage and support staff with largely independent roles.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)

Lead the development and implementation of **Medicaid** regulatory reporting and quality initiatives.	Maintain compliance with appropriate sections of DHS contracts, in cooperation with Medicaid Compliance staff Ensure Medica staff from a variety of departments complete and submit reports timely per DHS specifications by educating them on requirements, supporting data collection, and reminders of timelines. Participate in external and internal committees which develop metrics to evaluate Medicaid products. Maintain compliance with all Medicaid HEDIS and CAHPS reporting requirements as they are developed. Maintain participation in ongoing projects in connection with PIP initiatives, communicate with key Medica staff to ensure corporate support and prevent duplication of efforts.. Work with Health Improvement to ensure the design and implementation of clinical focus studies meet Medicaid member needs. Manage delegation review and oversight of the Care System, County, and Agency Care Coordination entities providing services to the Care Coordination Products. Provide overall leadership of Medicaid quality initiatives. Oversee and identify areas for improvement relating to customer satisfaction surveys, evaluation and reporting. Provide principal quality assurance liaison with DHS, special advisory committees and work groups related to Medicaid activities. Maintain liaison with Health Management, Clinical Operations, and Health Management Analytics internally to ensure sufficient resources to meet Medicaid regulatory and quality requirements.	50%
Lead Quality improvement initiatives	Provide overall leadership for Medicaid quality initiatives. Ensure staff utilizes process improvement and project management strategies and tactics to achieve goals. Coordinate government programs QA activities with other health plan QA activities to ensure efficient cost management, for example work on the Collaborative Assessment and Care Plan and the Collaborative PIP/QIP efforts. Collect data in cooperation with Health Management Analytics and conduct trend analysis to identify opportunities for quality improvement initiatives based on current Medicaid program and claims experience. Identify and actively lobby for quality priorities for Medicaid products. Design, implement, evaluate and report specific quality initiatives related to Medicaid programs in cooperation with Health Management Analytics, the HEDIS Improvement Team, Delegation Oversight Committee, and others. Assist Medica's quality department as the Government Programs lead in meeting NCQA accreditation requirements and other external research objectives. Represent Medicaid QA activities on QIS committee, UM Committee, Delegation Committee, and other committees or boards as needed. Maintain relationship with utilization management to determine QA/UM standards. Monitor delegate Corrective Action Plans	30%
Provide supervision of direct reports	Conduct face to face meetings with the direct reports on a routine basis to discuss performance, development opportunities, etc. Communicate accurate and timely information to team members to enhance their effectiveness and the efficiency of the programs. Employ a coaching management style. Research, recommend and approve training and development opportunities for direct reports. Work with direct reports to develop yearly goals, measure progress against the goals and perform the annual performance reviews. Create a positive climate among the team and recognize and reward achievement.	20%

	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:
Education Level: Bachelor's Degree
Major:
Years of experience required: 5 years

Specific types of experience required:
At least 5 years of experience in designing, developing and implementing healthcare quality initiatives;

2+ years work with quality measures, for example collecting and/or analyzing IA Community Measurement measures, HEDIS, CAHPS, and/or member survey result

3+ years experience in a managed care environment with background knowledge of Medicaid/ and/or Medicare regulations and standards; and

2 years experience managing and coaching direct reports. Comfortable with direct reports who often work external to the office.

Past experience as a Care Coordinator preferred

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: __ 15___%
Lifting/Carrying Weight: ___20 lbs__
Other special Requirements: _____

SKILLS/ABILITIES:

Ability to operate independently and to handle multiple priorities with a high degree of initiative
Ability to develop strong partnerships with influencers at Medica, health plans, regulators, etc.
Strong analytic, issue identification and resolution skills
Demonstrated ability through previous experiences to interact with regulatory agencies
Strong project management skills required
Excellent verbal skills in telephonic interactions, small and large groups and in face-to-face communications
Excellent written communication skills
Demonstrated strong integration skills
Demonstrated learning ability
Computer experience and general understanding of data collection methods

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: TBD

Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

MEDICA®

MEDICA POSITION PROFILE

Job Title: Manager, Utilization Management and Quality

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt
Reports to: **Director of Clinical Operations**
Revision Date: 4/21/2015

POSITION OVERVIEW:

This position is responsible for daily operations of the following functions:

- Provider transaction intake and assignment
- Inpatient and outpatient service data entry
- Notification and authorization intake and processing
- Oversight of clinical review functions associated with service authorization, including pre-service, concurrent, retrospective review and regulatory compliance
- Clinical appeal processing
- National Accounts Utilization Management and Care Coordination
- Regulatory Compliance for Care Management programs and functions
- Care management program/intervention development, operations and evaluation

The clinical appeal, notification and utilization management functions have significant regulatory requirements and the manager must have a comprehensive knowledge of state and federal regulations and accreditation standards to ensure compliance at all times. This position is responsible for providing overall direction to staff. It is also responsible for the implementation, evaluation, intervention and improvement of utilization management, clinical appeals and notification programs. This role is critical to Medica, providing feedback to the organization to influence decision-making regarding clinical cases. This individual will identify areas for process improvement and work closely with monitoring data for trends, identifying opportunities for improvement and implementing improvement plans, as appropriate and as directed by the Director, Quality & Health Management Compliance.

This position is responsible for documenting regular program statistics for regular management reports, analyzing the data reports and acting upon them appropriately.

This individual must be capable of strategic thinking and functioning calmly in situations involving risk and conflict. This position works directly with all managers and directors within the Health Management department, the medical directors, and all customer and provider service areas in Medica. This individual must be comfortable working with senior management when cases with risk to Medica are identified.

The manager partners with other leaders in Health Management and throughout Medica to develop strategy around clinical appeals and utilization management interventions to manage utilization of health care services.

This position is responsible for achieving and maintaining compliance to key Minnesota and Federal rules and laws of managed care as well as maintaining Medica's accreditation status.

The manager understands, articulates and supports the organization’s mission, vision, goals and strategies, and maintains confidentiality of all privileged information.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
Management of business/program operations	• Implements all care management programs and services (e.g. notification, prior authorization, and clinical appeals, etc.) and effectively monitors, manages and allocates resources to achieve business initiatives. • Oversees the criteria and participates in the process of placing items on prior authorization, keeping items on and removing items. Works with appropriate workgroups and committees throughout the process. • Responsible for oversight and maintenance of operations related to national product line of business including new business implementation, reporting of care coordination performance guarantees, communication with Optum Care Coordination client sites to insure seamless customer service. • Manages, reviews and implements policies and procedures used in decision making by care management, clinical appeals and notification staff. • Is responsible for ongoing supervision and performance management of direct reports. • Acts as a subject matter expert for notification, prior authorization and clinical appeals in project teams. • Serves as key contact for problem resolution for operational issues and implementation of action plans. • Maintains communication between key stakeholders and departments such as Customer Service, Government Programs, Claims Operations, Provider Services, Medical Directors, and Pharmacy. • Collaborates closely with other areas within Health Improvement (e.g. Health & Wellness, Program Operations and Program Development and Evaluation) to ensure alignment and operational efficiencies. • Monitors staff training, to ensure competence in case decision-making, documentation and compliance with regulatory, accreditation and policy/procedure changes. • Provides management to the notification, prior authorization and clinical appeals units while maintaining teamwork and collaboration with the direction and needs of Medica • Collaborates closely with Director, Quality & Health Management Compliance and others as appropriate to determine member identification, intervention and program evaluation for the department.	**35%**

Maintain efficient departmental operational systems and processes	• Ensures conformance to processes, policies and procedures, quality improvement activities and customer requirements. • Provides oversight for notification, prior authorization and clinical appeals processes to insure timely and accurate transmission and distribution of information for prior authorization and appeal functions. • Provides oversight for technical policies used in decision making by staff for Medica regional and national products. • Is responsible for initiating team problem solving by managing change and diversity within the team and other departments. • Facilitates team meetings and team building activities. • Creates positive climate motivated by achievement, minimize non-productive and restrictive rules, set high standards and recognize and reward good work. • Assesses business tools, processes and systems to aid in efficiencies and accuracy of decisions. Integrate team processes with those of Health & Wellness and other departments as appropriate (e.g. Customer and Provider Services and Claims Operations departments). • Is responsible for establishing unit budget and monitoring throughout the year; completes and ensures accuracy of paperwork in compliance with business policies/procedures. • Responsible for continuous oversight of call flow and phone wait times for cost saving and process improvement opportunities. • Assess staffing/structure impacts due to change, and implement plans as necessary. • Work with Supervisors to assess work distribution and staffing ratios.	**35%**
Regulatory and Accreditation Compliance: assessment, monitoring and implementation	• Assures compliance with regulatory and accreditation standards and implements departmental action plans as necessary • Develops and implements compliance with department policies and procedures. • Monitors (audits) policy/procedure compliance and COC compliance, closes gaps with corrective action plans. • Participates in surveys and audits for accreditation and regulatory purposes. • Assess and implement compliance obligations for all states in which Medica is licensed to operate. • Ensure adequate staff training on regulatory, accreditation and policy/procedure changes. • Monitor (audit) policy/procedure compliance through inter-rater reliability testing and other means, close gaps with corrective action plans and improvement plans.	**15%**
Monitor, track and report trends to facilitate benefit design, Medical policy decisions and improve operational efficiencies	• Assesses adequacy of and refine as needed data collection tools, systems and reports to support continuous operational improvements • Develops and maintains measurement reporting tools and reports and provides representation of data as required by business unit. • Conducts continuous assessment, monitoring, analysis and communication of data and opportunities for improvement. • Is responsible for open communication between team and senior management regarding findings. • Responsible to work with departmental and cross-functional teams to implement above noted opportunities, insuring all regulatory requirements maintained.	**15%**
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

Education/Experience: (Include any required licensure/certifications)

1) RN with active Minnesota license required, Bachelors degree required (or equivalent work experience in a health-related) field
2) Minimum of 5 years clinical experience. Minimum of 5 years managed care experience in utilization, case management, benefit appeals and quality improvement.
3) Experience with implementing regulations, legislation, rules and/or laws and accreditation standards.
4) Experience with utilization management and case management tools, procedures and programs. Knowledge of utilization management criteria sets.
5) Experience with implementing regulations, legislation, rules and/or laws and accreditation standards
6) Experience with regulatory and accrediting agencies, legal departments and staff.
7) Experience with data collection, assessment tools, reporting and analysis.
8) Minimum of 2 years experience with management of professional staff.
9) Past experience with complex project management required; proven track record of accomplishing strategic goals and projects.

Skills/Abilities:

1) Demonstrated leadership skills including: excellent interpersonal communication skills, creative and innovative problem-solving ability, critical thinking and independent decision-making ability, group facilitation, negotiation, change, conflict management skills and coaching skills.
2) Demonstrated process improvement and organizational skills.
3) Demonstrated ability to analyze data, conduct root cause analysis, solve multi-dimensional problems, implement necessary improvement plans and achieve business excellence through these efforts.
4) Experienced with Microsoft Office Suite / Visio; can rapidly learn new IT systems
5) Is a self-starter; can initiate project plans and actions once problem has been identified. Can act independently.
6) Ability to use data to drive results

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles

- 4 UM Nurses
- 2 Review Coordinators
- 1 Quality Analyst

- Number of indirect reports (total number in department/area)

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

- Manages department budget with oversight from Director. Monitor department expenditures. Assists Director in setting annual budget needs.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Manager, Utilization Management

Job Code*:*
Salary Grade: 113
FLSA Status: Exempt

Department: IA Medicaid

Reports to: Director, Health Management

Prepared By:
Creation Date: 4/21/15

POSITION OVERVIEW:

The Utilization Management (UM) Manager is responsible for being the first line resource for concurrent review and prior authorization staff. This includes, training on policies and procedures to assure compliance with policies and regulatory requirements. The Manager provides oversight of the daily management of concurrent review staff, appeals and auditing functions, and assuring that all staff provides a level of customer service that meets or exceeds the organizations expectations.
The Manager is also responsible to understand, promote and audit the principles of Utilization Management to facilitate the right care at the right time in the right setting. Identify trends or issues in the UM process that require further evaluation for their quality or utilization implications and bring these items to the attention of the Director. Communicate effectively and interact with the Medical Directors, hospitals, provider offices, and staff daily or as indicated regarding UM issues. Possess care coordination skills including but not limited to, development and monitoring of care plans, post discharge call, Vital Care referrals, and hospital contracts. Organize and facilitate weekly UM meetings to disseminate new information.
Know Medica's policies and procedures and be prepared to address those staff members who do are not in compliance. Verify that patient confidentiality is maintained by the staff and that HIPAA compliance is observed at all times.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Identification and Utilization Management	• Oversight of hospital census monitoring and follows identified admission processes for case identification, utilization and management. • Monitoring of handoffs from notification associate to start clinical review in a timely manner according to policies. • Identifies trends and factors which contribute to delays in discharge and works to reduce those trends. • Prepares reports on utilization information, including admissions, discharges, authorization denials, use of covered services and other pertinent performance data, as directed	10%

Utilization & Facilitation	Management oversight of the following activities: • The Review and analysis of medical information either telephonically or onsite, in order to determine the medical necessity of continued stay according to review standards. Utilization management, transfer coordination, discharge planning and review of authorizations for covered services as needed for members. • Presents facility-patient status updates and addresses barriers to discharge/transition at regularly held concurrent review rounds. • Early identification and assessment of members for potential inclusion in a comprehensive case management program. Refers members for ongoing complex case management accordingly. • Understanding of health plan benefits and coordinate discharge/referral plan as necessary. • Post service review process. • Assures adherence to all regulatory and compliance requirements. • Assures the protection of confidentiality of utilization review, quality management information and beneficiary identification • Documentation of utilization reviews in Care Management software system. • The process for verbal and written communication of review outcomes to facilities, physicians and members. • Length of stay negotiations and discharge plans with facility. • Appeals related to the review determinations. • Assists Member Services, Claims and Provider Services with issues that require medical interpretation or definition.	65%
Evaluation	Management oversight of the following activities: • Scheduled MD Rounds at Medica to discuss cases with case managers, Medical Directors and leadership. • Participate in compliance audits and interrater reliability	15%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Nursing
Years of experience required: Requires 5+ years of nursing experience, 2 years in an acute care setting, and 1 year of Utilization Management or case management preferred. 2+ years Supervisory experience.

Specific types of experience required:

Professional RN license in state required.
BSN or BS/BA preferred with a minimum of five years clinical experience
Managed care experience preferred.
Hospital utilization management or case management experience a plus
Working knowledge of Milliman Care Guidelines or InterQual in review determination process.
Demonstrated experience in utilization management, facility concurrent review, discharge planning and transfer coordination.

REQUIRED CERTIFICATIONS/LICENSURE:

RN License in IA

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: Minimal – to onsite hospital and to Medica
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Experience with management of clinical and non-clinical staff
Experience working with multiple age groups, medical, surgical background and a generalized level of understanding across specialty care areas
Ability to assume responsibility and exercise good judgement in making decisions within the scope of authority of the position
Ability to think and work effectively under pressure and accurately complete tasks within established times
Strong customer service skills, strong decision making skills, active, listening skills, patience, independence and excellent organizational skills
Ability to think creatively, negotiate and access resources
Excellent verbal and written skills
Basic PC use and basic typing skills
Ability to work independently
Highly organized, time management skills, requires ability to make decisions under stress and manage multiple complex issues on a daily basis
Ability to demonstrate flexibility and adaptability in an ever changing health care environment

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: TBD
Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Product Administration Manager

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to: Compliance Officer

Prepared By:
Revision Date: 4/21/2015

POSITION OVERVIEW:

The Product Manager is responsible for developing, implementing and managing a portfolio of products/programs for the assigned market. This role is also responsible for developing and monitoring a multiyear strategy for product/program performance.

The incumbent develops and manages competitive offerings by overseeing market research, defining product requirements/features, designing the overall customer experience and managing the product performance life cycle. The PM works to ensure on-time delivery of new products to the market.

The role is a self directed position that collaborates with internal departments including the Sales, Account Management, Communications, Compliance, Legal, IT, Network, Operations, Brokers, Consultants and governmental agencies.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Product/Program Development	• Developing new products/program and features, enhancements, portfolio revisions and product/program discontinuation as needed to achieve market position, membership goals and profitability targets. • Leading cross-functional teams responsible for assessing/implementing new/revised or enhanced product/program designs. • Incorporate voice of the customer in product/program roadmap. • Assess requirements, design, develop and implement new process and tools to support products/programs.	20%

Product/Program Implementation	• Leads and manages cross-functional product/program implementation teams. • Mapping and managing the customer experience (point of sale, service and on-line). • Collaborating with Communications in the development of product collateral, marketing and communications initiatives. • Responsible for conducting internal training and serving as subject matter expert for external training.	25%
Product Performance	• Assessing market and competitive positioning in support of product/program strategies. • Providing product performance feedback to key stakeholders. • Monitoring and reporting on-going performance of product portfolio(s) including customer satisfaction, membership growth/retention and operational performance. • Develop course correction proposals, as needed, based on metrics. • Responsible for ensuring product/program meets regulatory and compliance requirements.	30%
Communication development	• Creates, approves and coordinates distribution of member materials	20%
Special Projects	• Support and assist in projects assigned by leadership.	5%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Healthcare, business administration or marketing
Years of experience required: 5 – 7 years

Specific types of experience required:

- 5 - 7 plus years experience in product/program development, design and implementation of healthcare products within a large healthcare/managed care company.
- At least 2-3 years experience leading and managing cross-functional teams
- Project management skills preferred

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Knowledge of health care and health care operations.
Ability to lead and motivate cross-functional/cross-organization teams
Excellent written and verbal communication skills, including conflict management
Experience with cross-organization leadership in planning and moving product plan objectives forward
Demonstrated history of strong project management and completion of projects with measurable results
Strong project management, health plan operations and product lifecycle management experience required
Detail oriented and results driven
Expertise in resolving complex issues with all levels of employees and leadership
Ability to multi-task and prioritize work with a variety of internal and external customers simultaneously
Proficient in the Microsoft Office Suite

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: None

Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*: None

Responsible for input and monitoring of cost and expense associated with product/program development, implementation, and resources required to achieve Medica's profitability and membership goals.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Program Integrity Manager

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to:

Prepared By:
Revision Date: 04/21/2015

POSITION OVERVIEW:

The Program Integrity Manager is responsible for oversight of the Special Investigations Unit and Regulatory Investigations.

The Special Investigations Unit is responsible for protecting the Plan, it's membership, and the provider community from financial and health risks by identifying, investigating, and eliminating abusive and fraudulent billing practices. Consistent with Medica's mission, abuse and fraud management ensures a high quality, cost-effective health care experience for our customers across the continuum of care.

The Regulatory Investigations area responds to to complaints filed by state regulatory agencies such as the Attorney General's Office, Department of Commerce and Department of Health and complaint letters directed to Medica's Board of Directors and Senior Management.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Staff Leadership	Coaches and develops direct reports. Promotes and models appropriate communication skills and continuous improvement principles relative to team department and organizational issues. Communicates accurate and timely information to team members to maximize compliance and performance. Coordinates training and development opportunities for team members. Establish strong and effective relationships with customers.	15%
Other	Develop, maintain, and enhance collaborative relationships with the AG's office, FBI, DOH, DHS, OIG, local law enforcement and other external agencies to address abuse and fraud issues affecting Medica members and providers as well as the entire community. Information exchange coordination for sharing of information with law enforcement (HIPAA).	5%

Complex case identification and investigation. Investigation of provider, member, broker or employer fraud	1. Conduct investigation and analysis of pending, current and historical claim experience of a physician, clinic or facility identified. a) Conduct audit activities and produce reports by identifying abusive trends, setting criteria for appropriate sample size, and developing an action plan for review. b) Initiate an internal investigation of resources such as system reports, review of the provider contract and correspondence file, and interviews with respective Plan staff. c) Conduct medical record review and/or patient interviews to evaluate accuracy of billing practices. d) Conduct and/or assist investigations with the most complex patient, provider and related party interviews. e) Represent Medica in court when a case is litigated. Serve as the primary contact for all external law enforcement cases, as the point person to receive all requests for information and participate in the external case task forces when needed. Identification and investigation of member fraud and abuse. Enforce member compliance with Certificates of Coverage (COC) for enrollment eligibility, authentic claim submissions, and appropriate use of member identification cards. Work collaboratively with other Medica departments to develop improvements in abuse and fraud detection and to create and implement system-wide enhancements to achieve financial savings and minimize financial liability for the Plan.	30%
Management of day to day operation of Special Investigations	Review referrals for investigation and assign cases as appropriate for investigation. Monitor case management, in order to achieve department goals and complete unit initiatives. Ensure continued development and updating of departmental policies and procedures. Identify and facilitate cost savings opportunities, including policy and procedure development and implementation of prospective and retrospective investigations. Develop and implement Abuse and Fraud training programs and materials to educate internal staff and external customers. Develop, maintain and enhance abuse and fraud monitoring, tracking and detection tools to identify patterns and trends and assure accurate reflection of abuse and fraud incidents and financial savings. Establish proactive measures through prospective analysis and monitor deviations in coding and billing patterns to prevent financial loss. Recover overpayments identified through retrospective analysis. Serve as a consultant to credentialing and contracting staff during screening processes and contract negotiations to minimize financial liability for the Plan. Work in coordination with credentialing and contracting staff to develop disciplinary action when appropriate. These recommendations may include placement on administrative hold, a formal corrective action plan, or termination of participation status resulting in financial savings for the Plan. Develop and implement ongoing monitoring of abuse and fraud programs to assure the integrity of control systems. Ensure effective communication and coordination within Medica and between Medica and United Health Care. File annual Fraud and Abuse Plan with the Minnesota Department of Human Services (DHS) to ensure compliance with contract requirements.	40%

Regulatory Investigations	1. Manage investigations of complaints filed by state regulatory agencies and complaints directed to Medica's Board of Directors and Senior Management. 2. Prepare monthly reports for review by Senior Management identifying any trends/gaps and forward to the appropriate department for root cause analysis and fix.	10%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:
Education Level: Bachelor's Degree
Major:
Years of experience required: 10+years

Specific types of experience required:
A bachelor's degree in criminal justice, business management, health services, or related field or equivalent combination of education and experience.
The qualified candidate will have at least 10 years in the field, with at least five years of management experience.
Established working relationship with law enforcement agencies is preferred.

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

The desired candidate will have experience in criminal/civil insurance investigation and have a working knowledge of provider contracts, member certificates of coverage and claims processing procedures.
Demonstrated experience and skills in public speaking.
Excellent written and verbal communication skills.
Conflict management and negotiation skills are also important.
Experience testifying in criminal and/or civil litigation cases.

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles:
7 (Manager, Sr. Investigator, Int. Investigator, Associate Investigator, Legal/Administrative Assistant)

Number of indirect reports (total number in department/area): 15

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

Oversee a total budget of approximately $1.7 million.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Provider Relationship Manager

Job Code:
Salary Grade:

Department: Network Management

FLSA Status: Exempt

Reports to: Network Management Director

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

The Provider Relationship Manager is responsible for the management of contracting negotiations, provider relationships and network development within the Iowa Medicaid program.

The processes performed in the Network Management department are fundamental to delivering cost-effective, accessible care to subscribers. It is critically important that the negotiating process be compliant with regulatory and accreditation requirements, company policies and procedures, as well as consistency with strategic objectives. Since unit cost is one of the principal drivers of organizational profitability, close collaboration with other departments is required. The incumbent is required to identify and cultivate key provider relationships for consideration of this financial model as well as a thorough understanding of the underpinnings of financial modeling.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Negotiations & Contracting	Successfully develop, negotiate & execute contracting arrangements with providers Maintain positive working relationships with Medica's key providers Coordinate negotiations and ongoing provider relationship activities with Provider Finance, Operations and Legal in understanding data analytics, operational compatibility and sound legal instruments Ensure contracts are completed in a timely and accurate fashion Identify contracting opportunities within program area, determine data needs and perform analyses	50%
Provider Relations	Maintain positive working relationships with Medica's key providers Manage provider networks in program area	30%

Department Activities	Comply with department and company-wide policies & procedures and training requirements Recommend P&P changes where gaps exist Participate in cross-functional department workgroups as assigned	20%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:

Education Level: Bachelor's Degree
Major: Business Administration or Finance
Years of experience required: 3 years

Specific types of experience required:

A proven track record as a successful contract negotiator for health care services, provider or health plan
A proven track record of cultivating and maintaining effective, collaborative external relationships where the parties trust information that's conveyed
Conceptual and operational understanding of claims payment and financial reporting systems and methods
The ability to communicate complex concepts in a simple, concise manner
Strong financial and quantitative skills
A working knowledge of contracts and interaction with legal staff
Strategic-thinking skills with the ability to conceptualize a wide range of outcomes and probabilities and to provide advice based on the most likely successful outcome
The ability to make decisions with confidence
An understanding and appreciation for standardizing processes to generate efficiencies and improve service levels

REQUIRED CERTIFICATIONS/LICENSURE: N/A

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:

Interact with provider economics in an iterative process that determines reimbursement terms throughout the negotiation process
Effectively communicate with operations to ensure appropriate claims adjudication

In addition, this individual must be of high integrity, diplomatic and persuasive in his/her negotiations with providers in order to maintain long-term contractual relationships

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: TBD

Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:** None

MEDICA®

MEDICA POSITION PROFILE

Job Title: Public Policy Manager

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to: Vice President, Iowa Medicaid

Prepared By:
Revision Date: 4/21/2015

POSITION OVERVIEW:

This position supports the Vice President of Public Policy and Government Relations and is responsible for managing Medica's public policy agenda and interests. This position is responsible for tracking state and federal legislation and regulation, communicating policy issues within the organization, conducting health policy research and working with the Government Relations Director and the Vice President of Public Policy and Government Relations to achieve Medica's public policy agenda.

This person works at the direction of the Vice President of Public Policy and Government Relations and the Vice President of Public Policy and Government Relations or his/her delegates oversee this person's work.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Monitor state and federal legislative/regulatory activities and appropriately assess their impacts against Medica's business needs	Monitor legislation and regulations introduced at the state and federal levels, appropriately identify relevant legislation and regulations and track their outcome. Assist the Director of Legislative Affairs in monitoring relevant legislative floor sessions, committee meetings and conference committees Participate with Trade Association activities related to Medica's legislative agenda. Prepare comment letters and other communication in response to proposed state and federal regulations or requests for information Act as a resource to elected officials and their staff on matters of health care policy Assist the VP of Public Policy and Government Relations in working with interest groups to workout differences in legislative language	25%
Communicate all relevant state and federal legislation and regulation to appropriate staff and gain their input as dictated by business needs	Gather and catalogue internal input on specific legislative/regulatory proposals from impacted business units and legal staff Provided written and oral summaries of legislative proposals and activities as directed by the VP of Public Policy and Government Relations Respond to employee questions regarding specific public policy issues	20%

Research and make recommendations on current health care policy issues	Monitor trade organizations' activities including AHIP the Minnesota Council of Health Plans and others Conduct research as directed on all health policy issues and prepare white papers or summaries as needed Assist the VP of Public Policy and Government Relations and the Director of Government Relations in developing Medica's public policy position on relevant health care topics	15%
Provide public policy support to business segments	Work with identified Business Segments to understand their business needs and the impact of public policy changes on their business Serve as a resource to business segments on current and proposed legislation and regulations	15%
Represent Medica and its public policy interests in public forums such as Trade Associations and other committees and task forces as necessary	Attend the Minnesota Council of Health Plan committee meetings, including public policy, legal and regulatory and government programs. Attend the Minnesota Chamber of Commerce public policy committee meetings Participate and/or ensure appropriate staffing on task forces, working groups and other committees as dictated by business needs	20%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:
Education Level: Bachelor's Degree
Major:
Years of experience required: 2 years
Specific types of experience required:
Thorough understanding of legislative process
J.D. or Masters in health care or public policy preferred

REQUIRED CERTIFICATIONS/LICENSURE:

ADA STATEMENT:
Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.
Travel: _____%
Lifting/Carrying Weight: _____
Other special Requirements: _____

SKILLS/ABILITIES:
Excellent oral communication skills
Excellent writing skills
Ability to present company position persuasively
Strong relationship building skills
Effective project management abilities
Solid presentation skills
Strong organizational skills
Ability to assimilate information from various sources and recommend courses of action
Ability to work in a rapidly changing environment and adjust priorities quickly

DIRECT/INDIRECT REPORTS *(if any)*:

Number of direct reports and titles: None
Number of indirect reports (total number in department/area): None

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:** None

MEDICA®

MEDICA POSITION PROFILE

Job Title: **Sr Director Finance** **Job Code:**

Salary Grade:
Department: **FLSA Status: Exempt**

Reports to: **Chief Financial Officer**

Prepared By:
Date: **4/22/2015**
Revision Date:

POSITION OVERVIEW:

The Sr Director Finance has overall responsibility and oversight for financial analysis and reporting, health cost and administrative budgeting and forecasting, pricing and rate development, rate filing, CMS Bid filing, and medical expense trend evaluation for the Iowa Medicaid program. The financial oversight has significant impact on the financial strategy, tactics, and results of Government business. The position will provide primary support to product development and evaluation.

The incumbent is responsible for managing a team of financial analysts and providing expert internal consulting to the Senior Vice President of Government Programs.

This position will coordinate closely with the Senior Vice President of Finance and the Chief Finance Officer (and CAO).

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility
• Monthly and annual analysis and reporting of segment's financial operating results.	• Assures accurate financial reporting by staff. • Directs analysis of results and advises segment senior management of implications. • Assures the timely delivery of financial reporting to support the decision-making of the management teams of the Government/IB Segments.	35%
• Annual budgeting of health care costs and administrative expenses. Quarterly and multi-year forecasting of financial projections.	• Works closely with segment leadership to produce operating budgets for health care costs/revenues and administrative expenses. • Oversees support for quarterly forecasting (Outlook) and multi-year forecasting working closely with the Finance department. • Supports development of strategic plan by segment leadership. • Provide consultation on development of administrative cost efficiencies.	15%
• Medical Cost trend analysis and reporting.	• Works closely with Finance Department team to analyze and report on medical cost trend for reporting and forecasting. Also, works with Finance team on IBNR levels, reserve levels, claims retro activity reporting, and restated financials. • Provides reporting and consultation to segment senior leadership on management of medical loss ratio and cost management strategies. Oversees reporting on medical costs for strategies and tactics for care management/coordination and provider management.	25%

• Supervise Finance and actuarial staff for Government/IFB segments	• Provide leadership, supervision, and coaching to finance and actuarial staff. • Assure that staff complete assigned responsibilities and meet deadlines. • Prioritize staff activities. • Assure that staff have adequate tools and resources to successfully complete responsibilities. • Assure staff (and career) development.	25%
	Total %	100%

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

Education/Experience: (Include any required licensure/certifications)
Bachelor's Degree in finance or related area.
Experience: 10 years including 5 years of management experience
Specific experience:

- Advanced degree (MA, MBA, MHA) or significant related experience preferred.
- Experience in financial analysis and reporting in health care, insurance, managed care, or financial services preferred.
- Oversight of actuarial and/or underwriting services a plus.
- Experience in Government finance a plus.

Skills/Abilities:

- Strong oral and written communication and presentation skills.
- Self directed and can develop and lead a technical team.
- Ability to analyze and interpret complex financial data.
- Skill in budgeting, forecasting, and development of financial modeling.
- Knowledge of medical cost trend drivers.
- Understanding of regulatory environment and requirements.
- Strong project management skills.

DIRECT/INDIRECT REPORTS *(if any)*:

- Number of direct reports and titles __
- Number of indirect reports (total number in department/area) ___

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)*:

- Oversee development of Government health care cost budgets and department administrative budgets. Assist segment leadership in managing budgets. Develop and manage team administrative budget.

MEDICA®

MEDICA POSITION PROFILE

Job Title: Vice President Iowa Medicaid

Job Code:
Salary Grade:
Department:
FLSA Status: Exempt

Reports to: SVP Government Programs

Prepared By:
Revision Date: 4/22/2015

POSITION OVERVIEW:

The Vice President, Iowa Medicaid is responsible for overall leadership of the Iowa program division, including management of the profit and loss, product development, quality improvement, public health, operations and compliance for the Iowa lines of business. This key individual will hold the ultimate accountability for the vision, strategy, planning, execution, performance, compliance and internal and external communication related to Medica's Iowa lines of business. The position exercises strategic control over planning short and long-term fiscal viability of these products in addition to formulating and administrating policies.

This role also contributes to developing Medica's overall strategy and has a responsibility to help achieve Medica's overall goals and objectives.

KEY ACCOUNTABILITIES:

Key Accountability	Desired Key Actions to Successfully Achieve Key Role Accountabilities	% Overall Job Responsibility (Increments of 5%)
Lead Iowa Medicaid Segment	Meet organizational and departmental objectives as jointly established with Sr. Leadership Develop, propose and implement product strategy to Executive management as well as manage results to achieve pre-established objectives. Segments profit and loss accountability. Manage revenue and health care costs. Lead health and quality improvement initiatives, and community outreach Oversight of marketing and sales activities	30%

Manage Department Activities	Effectively and efficiently, manage segment's various department activities including, program development and regulatory oversight. Motivate and lead a high performance management team. Attract, recruit, and retain highly talented staff on the management team. Foster a success-oriented, accountable environment and ensure that employees have clarity regarding what is expected of them. Ensure that goals, policies, lines of authority and communication are clearly understood and consistently articulated. Emphasis will be placed on high standards in both execution and performance outcomes. Develop and manage departmental administrative budget. Improve efficiency and reduce administrative costs Also work collaboratively with Finance to meet regulatory required reporting goals and manage the financial health of the segment.	30%
Manage external contacts including regulators	Responsible for negotiating DHS contract and payment rates Ensure Medica's compliance with federal and state government regulatory requirements Manage community partnerships, key provider relations and public relations for Government Programs.	15%
	Total %	**100%**

ESSENTIAL QUALIFICATIONS/REQUIREMENTS:

EDUCATION/EXPERIENCE:
Education Level: Bachelor's Degree. Master's Degree preferred.
Major: Business, health administration or related field
Years of experience required: 10+ years
Specific types of experience required:
10 or more years of experience in developing and managing financially successful Medicare and Medicaid products within a managed care environment
10 or more years of experience in working with regulators and member advocacy groups
10 or more years of project management experience including complex project implementation
10 or more years of experience in managing direct reports
Led a health care delivery system (care system) and has experience in working with health care providers with varying clinical degrees
Managed product compliance for Medicare and Medicaid products with federal (Centers for Medicare and Medicaid Services) and state regulators
Significant experience in working with low income, ethnically diverse and senior populations
Led product and rate negotiations with Medicaid state agency
Experience negotiating total cost of care type provider contracts with large health systems

REQUIRED CERTIFICATIONS/LICENSURE:
None

ADA STATEMENT:

Professional Work Environment. Ability to move freely within an office environment and operate keyboard, phone and other office equipment as required for position, plus any additional requirements indicated below.

Travel: _15____%
Lifting/Carrying Weight: _20 lbs____
Other special Requirements: _____

SKILLS/ABILITIES:
Strong verbal and written communication skills
Must have strong planning and financial management skills, accountable for results
Strong people management skills and experience
Strong interpersonal and relationship building skills including community relations experience
Ability to manage multiple projects and complex processes simultaneously
Prioritization skills
Creative problem solving skills and innovative approach
Ability to analyze regulatory policy proposals
Ability to develop and execute contracts with provider organizations
Ability to complete and analyze competitive analyses
Ability to set strong performance goals and standards and then measure, monitor and take corrective actions as necessary
Government relationship skills

DIRECT/INDIRECT REPORTS *(if any)***:**

Number of direct reports and titles: 6
1 Medical Director
1 Clinical Operations Director
1 Compliance Officer
1 Marketing Communications Manager
1 Call Center Manager
1 Policy Manager

Number of indirect reports (total number in department/area):

BUDGETARY/FISCAL RESPONSIBILITIES *(if any)***:** Responsible for profit and loss and staying within target administrative costs

TECHNICAL ASSISTANCE BRIEF | February 2015

CHCS Center for Health Care Strategies, Inc.

Strategies for Hiring and Training Care Managers in Integrated Programs Serving Medicare-Medicaid Beneficiaries

By Brianna Ensslin and Sarah Barth, Center for Health Care Strategies

IN BRIEF

Effective care coordination and care management are essential to delivering person-centered, quality care in programs that integrate services for individuals dually eligible for Medicare and Medicaid. The health plan staff responsible for providing these services must have unique qualifications and training to meet members' social service and medical needs. This brief, developed with support from the California HealthCare Foundation and The SCAN Foundation, shares strategies for hiring and training care managers used by five health plans with integrated care programs that may be helpful to other health plans and states.

Health plans and their staff play an important role in programs that integrate care for Medicare-Medicaid beneficiaries and other individuals with high medical and social service needs. Whether these plans operate as part of a Medicaid managed long-term services and supports (MLTSS) program or as Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), or Medicare-Medicaid Plans (MMPs), their underlying goal is to make the navigation of services seamless for members.

Health plan care managers are essential to the success of integrated care programs for Medicare-Medicaid beneficiaries who often have complex needs and tenuous social supports. Care managers may be responsible for performing a variety of tasks, including: (1) conducting assessments; (2) developing care plans; (3) arranging visits to care providers; (4) ensuring medication reconciliation; (5) connecting individuals to social and community supports; and (6) developing a trusting relationship that supports the care team's ability to best serve the individual. Different types of staff may be responsible for some or all of these tasks depending on the health plan and the integrated care product (i.e., FIDE-SNP, MMP, etc.). Health plans with robust care manger training strategies often are more successful in building strong, trusting relationships with their members. These relationships enable health plans to learn more about members' needs and, ultimately, better address them.

With support from the California HealthCare Foundation and The SCAN Foundation, the Center for Health Care Strategies (CHCS) interviewed five health plans operating integrated care products (i.e., D-SNPs, FIDE-SNPs, MMPs, and MLTSS plans) about their strategies for hiring and training care managers. This brief shares these strategies to help other health plans and their state partners build stronger integrated care programs for Medicare-Medicaid beneficiaries. Note that this report uses the term *care manager* to broadly encompass the different titles that health plans give to staff who

Made possible through support from the California HealthCare Foundation and The SCAN Foundation.

perform both clinical and non-clinical care and service coordination and management functions. Other titles for this position include case manager, care coordinator, and service coordinator.

Methods

Drawing from its work with states and plans and with input from external experts,[1] CHCS selected five health plans to interview based on three criteria: (1) variety of integrated products; (2) years of experience; and (3) geographic diversity. CHCS conducted interviews with staff members from each health plan, ranging from chief executive officers to training managers.[2]

The five health plans interviewed – Independent Care Health Plan (*i*Care) (Wisconsin); Medica (Minnesota); 'Ohana Health Plan (Hawaii); Shared Health (Tennessee); and VNSNY CHOICE Health Plans (New York) – offer a range of integrated products, including five MLTSS programs, four D-SNPs, two FIDE-SNPs, and one MMP (see details below). Two of the health plans (*i*Care and Medica) were among the nation's first integrated models in the mid-1990s. Others, including 'Ohana and Shared Health, offer perspectives from health plans that have implemented integrated products more recently. The selected health plans operate in widely distributed geographic areas – in urban, as well as rural settings. In particular, 'Ohana offers unique insight into working with staff spread across remote locations.

Plan (State)	Product Line	Geographic Areas	Year Established	Enrollment
***i*Care (WI)**	D-SNP	Southeastern Wisconsin	2006	5,000
	FIDE-SNP/ MLTSS	4 Counties	2010	800 (440 are dually eligible)[3]
Medica (MN)	FIDE-SNP	Statewide	1997	10,000
	MLTSS	Statewide	2005	3,000
'Ohana (HI)	D-SNP[4]	Statewide	2008	6,800
	MLTSS	Statewide	2008	3,600[5]
Shared Health (TN)	D-SNP	Statewide	2014	4,000
	MLTSS	Statewide	2010	10,000
VNSNY CHOICE (NY)	D-SNP	12 Counties	1998	12,000
	MLTSS	33 Counties	1998	18,000
	MMP	New York City and 7 Counties	2015	18,000[6]

Strategies for Care Manager Hiring and Training

Based on interviews with staff in five health plans, CHCS identified the following broad strategies to guide the hiring and training of care managers:

1. Hire diverse staff with strong community connections.
2. Develop tailored training approaches that provide foundational skills, address members' diverse needs, and incorporate state resources.
3. Use multiple training modes tailored to each new hire.
4. Align training programs and staff across integrated care programs.
5. Dedicate staff or departments exclusively to training.
6. Standardize training of delegates while allowing for flexibility.
7. Address new program requirements and issues in ongoing training.
8. Cultivate internal feedback mechanisms through open dialogue and shared learning.

The sections that follow describe these strategies and how interviewed plans put them into practice.

1. Hire diverse staff with strong community connections.

The health plans interviewed hire care managers with diverse backgrounds and credentials, including licensed clinical social workers, registered nurses, and non-licensed bachelor's-, associate's-, or high school-level professionals with experience in home health care (Exhibit 1). The plans look for individuals with backgrounds and expertise beyond just medical, including connections to and knowledge of members' communities (e.g., experience with a 211 system[7]). Knowledge of social determinants of health, specifically the impact of housing instability on members' health, and how to connect individuals to housing resources are also critical qualifications.

During the recruitment process, targeted interviewing strategies can help determine a candidate's emotional intelligence and passion for serving the population. *i*Care uses behavioral-based interviewing to evaluate the suitability of a candidate's experiences to a care manager position. For example, rather than asking a potential candidate if she or he has had experience with difficult-to-manage cases, the behavioral-based interview question asks "tell us a time when you successfully managed a specific situation with a difficult challenging case. What did you do and how did you know it was successful?"

'Ohana uses a regional approach in which local managers recruit, interview, and hire new care manager staff, rather than having human resources select candidates. This approach enables the plan to select applicants with a diverse set of skills and connections to the community. In addition, all of 'Ohana's local managers were care managers before being promoted, giving them a better understanding of the skills needed to perform the job. Shared Health emphasizes the importance of hiring staff with hospice or home health backgrounds who have experience going into members' homes. VNSNY CHOICE is a health plan and a home health provider, making it uniquely positioned to recruit care managers from within its ranks. In addition to home care experience, the plan looks for care managers who have a track record of improving member outcomes.

EXHIBIT 1: **Care Manager Qualifications**[8]

Plan/State	Product Line	Qualifications

***i*Care**	D-SNP	• Bachelor's degree in social service field (required)
		• Certification or licensure in social work in the state of Wisconsin or eligibility for certification and licensure (preferred)
		• Previous managed care experience (preferred)
		• Other preferred qualifications:
		  • Knowledge and experience with the community
		  • Knowledge of social determinants of health
		  • Experience as a social worker working for Adult Protection Services, the Bureau of Child Welfare, or in private settings (new graduates with high potential considered, but given a longer orientation and additional mentoring.)

	FIDE-SNP and MLTSS	• Registered nurse or nurse practitioner licensed in the state of Wisconsin (required)
		• Case manager certification (preferred)
		• At least two years of related health care experience (preferred)
		• Other preferred qualifications:
		  • Previous home health, managed care or case management experience
		  • Previous experience working with persons with older adults in a health care setting
		  • General knowledge of Medicaid and Medicare benefits

Medica	FIDE-SNP and MLTSS	• Registered nurses and licensed clinical social workers (LCSWs) (required) • At least one year of home- and community-based experience (preferred)
'Ohana	D-SNP and MLTSS	• Registered nurse; licensed clinical social worker; health care professional (i.e., master's degree in social work (non-LCSW), master's degree in gerontology or LPN) or bachelor's degree with strong ties to the community and services (i.e., background with the state processing social services) • Experience with the community (strongly preferred)
Shared Health	D-SNP and MLTSS	• Registered nurse or master's degree in social work
VNSNY CHOICE	D-SNP	• Registered nurse or master's degree in social work
	MLTSS	• Experience with LTSS, home- and community-based services, and Medicare-Medicaid enrollees (preferred) • Considering new criteria, including demonstrated knowledge of New York State regulations regarding Medicaid, MLTSS, health plans preferred, experience with managed care environments preferred, effective oral, written and inter-personal skills required, efficient with personal computers required. Certification in case management is required.
	MMP	• Not available

2. Develop tailored training approaches that provide foundational skills, address members' diverse needs, and incorporate state resources.

Some of the health plans interviewed use vendor-developed training curricula, while others create courses internally, based upon the unique structures of their programs and the ethnic, cultural, and religious characteristics of their members (Exhibit 2). Plans operating under a larger corporate structure supplement materials from their parent organization with approaches and resources tailored to their local needs. In addition to training required by states (e.g., on uniform assessment tools/systems), some health plans incorporate additional resources (e.g., on special populations) offered by state Medicaid, mental health, or other agencies.

VNSNY CHOICE's MLTSS care manager training program uses materials supplied by its care management system vendor. The training uses 16 standard modules developed by the Case Management Society of America to provide foundational learning on care coordination.[9] The plan supplements these materials with additional content specific to its members (i.e., VNSNY CHOICE serves a large Asian community in New York City). VNSNY CHOICE's MLTSS care managers are also offered training on advanced illness, population health management, and behavioral health provided by the New York Department of Mental Health. This is in addition to training on the Uniform Assessment System, which is required by New York State.

Care manager staff across all of *i*Care's products use an online system, Relias Learning, to provide the foundational skills and modules of training. Staff in *i*Care's FIDE-SNP/MLTSS plan receive annual training on the state of Wisconsin's Resource Allocation Decision Method, which guides the allocation of long-term services and supports to achieve person-centered outcomes. *i*Care also offers trainings on specialized topics (e.g., dementia care) developed by the state, some of which are available through YouTube. 'Ohana has its own training program, but its corporate parent, WellCare Health Insurance of Arizona, also administers standardized web-based training to all employees on topics such as HIPAA[10] compliance.

What is the Structure of Care Manager Training?

The plans interviewed have a variety of training structures tailored to their organizational needs. *i*Care's training curriculum for FIDE-SNP/MLTSS care managers has three components: (1) readiness; (2) proficiency; and (3) ongoing training. The readiness phase starts with a two-week, 20-hour, classroom-based orientation on the FIDE-SNP/MLTSS model. New staff are paired with mentors and shadow their activities as a care manager (i.e., home visits, assessments, and clinic visits). After two-to-three months of shadowing, the proficiency phase's classroom-based learning begins, diving deeper into theories behind care management. For example, *i*Care trains care managers to use motivational interviewing to identify members' readiness for change. Trainees take a comprehension test at the beginning and end of their 90-day probationary period. Additional training on areas identified for improvement may be provided as necessary.

'Ohana's one-week, in-person training covers its care management systems and details key concepts, including:

- What is managed care?/What does the managed care plan do?
- How does the managed care plan interface with service delivery at the community level?
- What is a care manager?
- What is the interplay between Medicare and Medicaid?
- What are implications of Medicare rules for Medicare-Medicaid enrollees?
- What is third-party liability?

EXHIBIT 2: **Overview of Common Training Curriculum Topics**[11]

Curriculum Topics	Plan				
	*i*Care[a]	Medica[b]	'Ohana	Shared Health[c]	VNSNY CHOICE
Plan and Community Requirements/Resources					
Community resources	X	X	X	X	X
Coordination of services/benefits across programs/agencies	X	X	X	X	X
Plan benefits	X	X	X	X	X
Patient Engagement					
Hard-to-reach/engage populations	X	X	X		X
Motivational interviewing	X	X	X		
Social Determinants and Other Care Plan Needs					
Care manager safety during in-home visits	X	X		X	X
Development of care management plans	X	X	X		X
Domestic violence	X				X
End-of-life planning	X	X	X		X
Housing instability	X				X
Poverty	X				X
Substance abuse	X	X			X
Trauma-informed care	X				

[a] Training for care managers in *i*Care's D-SNP product does not cover care managers' safety during home visits or trauma-informed care.
[b] Medica's care manager training also covers state/legislative/contract changes that impact its programs, mental health/dementia, transportation, and other health related topics (e.g., medication adherence).
[c] Shared Health's also trains new care managers on diversity, exercise, and fall prevention. Ongoing care manager training covers additional topics including, Alzheimer's disease, disaster preparedness, traumatic brain injury, adult protective services, and local housing authority and senior housing representatives.

3. Use multiple training modes tailored to each new hire.

To train care managers with different learning styles, the health plans interviewed offer classroom-based instruction and hands-on, experience-based training, as well as computer-based and in-person training (Exhibit 3). While computer-based training may be more convenient, the opportunity for dialogue that occurs during in-person training provides more dynamic learning opportunities, allowing staff to work through issues collaboratively. Most health plans interviewed use interactive training to give new staff exposure to the range of scenarios they will encounter.

VNSNY CHOICE uses a combination of e-learning, webinars, and didactic training methods, but prefers e-learning because of its efficiency, accessibility, and ease of updating content. Orientation is offered monthly, with new staff often beginning the online modules prior to orientation. VNSNY CHOICE is currently analyzing data on its MLTSS members to tailor training materials to address reasons for member readmissions, grievances, and other population-specific topics and concerns.

Medica uses an electronic and paper-based manual as the foundation for its care manager training in conjunction with an intensive mentoring program. Care managers are paired with a seasoned mentor with whom they conduct home visits. New hires observe their mentor, and, at each individual's pace, begin taking the lead during home visits under mentor supervision. Webinar trainings on specific topics and guest speakers complement the mentorship. Most of Medica's staff work remotely, making the webinars an efficient mode of training.

EXHIBIT 3: **Modes of Training Delivery**

Training Mode	Plan and Product Line							
	*i*Care		Medica		'Ohana	Shared Health		VNSNY CHOICE
	MLTSS and FIDE-SNP	D-SNP	MLTSS	FIDE-SNP	MLTSS and D-SNP	D-SNP	MLTSS	MLTSS, D-SNP, and MMP
Classroom learning	X	X	X	X	X	X	X	
Field-based training/Skills labs	X		X	X			X	X
Manuals	X		X	X				
Presentations/ Slides	X	X	X	X	X		X	
Web-based resources/ E-learning	X	X	X	X		X		X
Shadowing/ Mentoring	X	X	X	X	X		X	
Guest speakers/ Specialists	X	X	X	X	X			
Member handbook	X	X	X	X	X			

4. Align training programs and staff across integrated care programs.

All of the interviewed health plans operate integrated care programs in multiple product lines. Some health plans use different care managers and training strategies across programs, while others use the same staff and training approach for more than one program (Exhibit 4). Aligning training efforts can simplify a health plan's administrative functions. One of the plans interviewed favors a single-staff structure to facilitate smooth member transitions between products. Using the same staff across programs requires training on the distinctions between services available to address the specific needs of members in different programs.

'Ohana saw opportunities to be more member-centric and improve the experience of members transitioning between its MLTSS and D-SNP programs. Subsequently, 'Ohana now uses the same care managers across both programs, allowing staff and members to maintain established relationships. *i*Care uses the same training and staff for its MLTSS plan and FIDE-SNP, but different staff and training approach for its D-SNP. Shared Health is also interested in using the same care manager staff across its MLTSS and D-SNP products, but differences in state contract staffing ratios across the programs have prevented this approach. The plan is working with the state of Tennessee to explore the ability to align staffing and training across products.

EXHIBIT 4: **Health Plan Training Programs by Integrated Program Model**

Plan	Product Line	Training Approach
***i*Care**	MLTSS	One shared training program with same staff across products
	FIDE-SNP	
	D-SNP	One training program and set of staff
Medica	FIDE-SNP	One training program and set of staff with differences in benefits and processes highlighted
	MLTSS	
'Ohana	D-SNP	One shared training program with same staff across products
	MLTSS	
Shared Health	D-SNP	One training program and set of staff
	MLTSS	One training program and set of staff
VNSNY CHOICE	D-SNP	One training program and set of staff
	MLTSS	One training program and set of staff
	MMP	Elements of training based upon MLTSS/D-SNP approach but tailored for MMP. For instance, its care management system has been tailored for the MMP and thus has subsequently tailored trainings.

5. Dedicate staff or departments exclusively to training.

Most of the health plans interviewed have full-time staff who are responsible for developing and updating care manager training materials and conducting trainings. Some of the plans said that promoting former care managers to serve as trainers brings valuable on-the-ground experience and understanding of members to the role. Full-time trainers are a good resource for care managers, particularly those who work remotely and do not have day-to-day access to peers. Additionally, plans reported that full-time trainers are crucial to ensuring that training approaches and materials are continually adapted to address identified areas of improvement and incorporate the latest best practices.

*i*Care created a lead care manager-educator position for its D-SNP. This employee spends half his time on staff orientation and the other half on ongoing staff training. *i*Care also hired a full-time person for curriculum development and training for its MLTSS plan/FIDE-SNP since the plan

had previously found it difficult for staff to split their time between training and managing caseloads.

6. Standardize training of delegates while allowing for flexibility.

Health plans may contract with a third-party organization to provide care management services. Health plans can provide their own structured training materials, but also allow contracted entities the flexibility to tailor trainings and systems to their organizational processes and culture.

Medica contracts with more than 60 entities throughout Minnesota to supply approximately 400 care managers. To ensure compliance with contract requirements, the plan conducts an audit of the delegate entity's structure and systems before the delegate's staff begin managing plan members. Medica requires delegate entities to train staff with the manual and tools it provides, but allows delegates to supplement this training with additional material to adapt to the organization's and staff's needs. In addition, Medica also offers delegates an annual care management basics training. The plan's clinical liaison team is also available to delegate staff to answer care management process and policy questions and provide individualized training as needed. The plan's trainers conduct annual care plan chart audits and reviews to ensure that delegates are complying with contractual training requirements. Delegate entities may use their own documentation systems, but are required to use the plan's forms. If delegate entities have forms similar to Medica's, the plan allows the delegates to use their own forms after Medica reviews and approves them.

Quality Measurement and Training Evaluation

The health plans interviewed are identifying ways to evaluate the effectiveness of their training programs and return-on-investment for different approaches. *i*Care considers its investment in training as critical to attaining its goals of providing high-quality, cost-effective care within a capitated payment system. *i*Care is reviewing both financial data and member outcomes measures to assess its training approach. VNSNY CHOICE is enhancing its quality dashboard by linking care manager training to member outcomes. The plan will evaluate care managers yearly based on measures of their member panels' outcomes, such as incidents of falls and medication adherence.

7. Address new program requirements and issues in ongoing training.

All interviewed health plans have mechanisms to ensure that staff receive timely information regarding program and policy changes, and industry best practices. Webinars and newsletters are commonly used to inform staff of new information. Storing these resources on a shared drive or intranet allows staff to view them at their convenience.

For its D-SNP, *i*Care uses its intranet to share ideas and trends, and for staff to ask questions of colleagues. For its FIDE-SNP/MLTSS product, *i*Care distributes a bi-weekly newsletter and uses team meetings to inform staff about new policies. VNSNY CHOICE intends to tailor ongoing care manager training to address issues identified by reviewing member outcomes. The state of New

York holds monthly training webinars for care managers on topics such as performance-based improvement strategies and improving the customer experience. VNSNY CHOICE is creating a mechanism to bring together health plans to discuss best practices that arise in the monthly state-led webinars.

'Ohana's corporate company, WellCare Health Insurance of Arizona, offers a resource called WellCare University that provides ongoing information and training supports, as well as re-certification requirement information. This supplements 'Ohana's efforts to keep care managers up-to-date on critical topics, such as domestic violence, that are often identified and addressed during weekly in-person staff meetings.

Keeping Geographically Remote Staff Engaged

'Ohana works to keep all staff connected, with particular focus on keeping remote staff engaged in the organization and in touch with their peers. Staff on two of Hawaii's smaller islands use dial-in numbers to join the plan's weekly staff meetings. The plan gathers all of its care managers for an annual, two-day training and team-building retreat. 'Ohana supports opportunities for remote care managers to fly into the plan's main office on Oahu a few times a year.

8. Cultivate internal feedback mechanisms through open dialogue and shared learning.

The health plans interviewed emphasized the need to create a culture that promotes open dialogue among care managers and their supervisors using both formal and informal structures to share and solicit information. Interviewees stressed that cultivating a creative environment that supports "no-blame" idea sharing is essential for continued quality improvement.

*i*Care uses several mechanisms to encourage self-assessment, feedback, and dialogue. The plan issues care manager report cards that track progress toward meeting quality goals. Care managers and their supervisors use the report cards to review their assessment/care plan completion rates, areas where they are strong, and areas where they need improvement and/or assistance. *i*Care's weekly grand rounds offer a less structure mechanism for dialogue. During the sessions, staff review profiles of members who have been hospitalized for more than a week and help develop a multidisciplinary approach to care transitions. The interdisciplinary perspectives of grand rounds provide ongoing, cross-discipline learning opportunities for staff.

Shared Health's "Beefs and Bravos" offers a periodic opportunity for health plan staff to get together and share what is and is not working in its care management efforts and explore organizational improvements. Even more simply, *i*Care groups care managers in quadrants of cubicles, which helps create a collegial atmosphere conducive to sharing. Staff are encouraged to ask questions of one another, helping new hires to feel welcome and existing staff to continually learn from each other.

Innovations in Care Manager Training and Supports Used by Shared Health and the State of Tennessee

Following are additional innovations in care manager training and supports used by Shared Health, headquartered in Chattanooga, Tennessee, and the state of Tennessee:

- **Care Manager Support Center:** Shared Health's care manager support center is staffed with member associates, each of whom support between 12-14 care managers in completing administrative and follow-up tasks. As a result, care managers have more time to spend with members. Training care managers is also more focused on care management functions since it does not need to cover so many administrative tasks. Providing this type of support may help improve care manager retention rates as it allows these front-line staff to focus on what they are passionate about.
- **Personal Safety Training and Support:** As health plans move away from telephonic care coordination, it is critical to train staff to identify potential threats to their personal safety while visiting individuals in their home. Shared Health provides safety training to care managers who will be conducting in-home visits to its members. Each of Shared Health's care managers are provided safety bags containing an emergency blanket, flashlight, and other supplies. An external vendor is used to teach basic self-defense to staff.
- **Ongoing State Provided Training:** To train geographically widespread health plan staff on its MLTSS level of care assessment tool, the state of Tennessee uses both webinars and a web-based training that is available 24/7. In addition, the state's monthly newsletter highlights training issues identified for improvement. A call center/help desk logs calls from care managers, which informs the issues in the newsletter.[12]

Conclusion

With the right support and training, care managers can build strong relationships with health plan members and help them achieve their personal goals. Health plans with staff that are closely connected to the community are better able to tailor approaches and maximize available resources and supports. Health plans can partner with state agencies to benefit from state experience and expertise and learn from other health plans when developing care manager trainings and ongoing learning opportunities. There is no "one size fits all" approach to training staff. Striking a balance between formal training structures and a culture of shared learning promotes team building and an environment of continued quality improvement. The health plan training strategies identified in this brief provide approaches that other health plans can incorporate into their care manager training practices.

ACKNOWLEDGEMENTS

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

[1] Alice Lind, Manager, Grants and Program Development, Washington Health Care Authority and Jim Verdier, Senior Fellow, Mathematica Policy Research provided input on plans to interview.

[2] Interviews used a standardized discussion guide reviewed by staff at the California HealthCare Foundation, The SCAN Foundation, and the Health Plan of San Mateo. The Health Plan of San Mateo was selected based on knowledge of its efforts to revamp its training approach.

[3] The Family Care Partnership program combines the features of a FIDE-SNP and MLTSS product.

[4] 'Ohana's D-SNP functions similarly to a FIDE-SNP.

[5] 'Ohana's MLTSS plan enrollment figure may include some enrollees that are also in the D-SNP.

[6] Projected enrollment.

[7] The 211 system is a nationwide program of community-based call centers providing confidential information and online resources for people in need. These call centers connect individuals with local social service organizations to access: (1) housing; (2) food; (3) family/legal support; (4) health and mental health services; and (5) employment/income support.

[8] Exhibit 1 is not an exhaustive list of all preferred or required qualifications across plans.

[9] The Case Management Society of America's (CMSA) Career and Knowledge Pathways (CKP) training program consists of 16 course modules that correlate the component of the CMSA Standards of Practice for Case Management. See: http://www.cmsa.org/Individual/Education/CareerandKnowledgePathways/tabid/832/Default.aspx.

[10] Health Insurance Portability and Accountability Act of 1996 which outlines security rules for sharing healthcare information.

[11] Exhibit 2 is not an exhaustive list of all topics covered in initial and ongoing care manager training.

[12] C. Ingram, A. Lind, and B. Ensslin. Uniform Assessment Practices in Medicaid Managed Long-Term Services and Supports Programs. Center for Health Care Strategies, September 2013. Available at: http://www.chcs.org/media/Uniform_Assessment_in_MLTSS_9-6-13_FINAL.pdf.

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COLLABORATIVE CARE PLAN FOR MINNESOTA SENIOR HEALTH OPTIONS (MSHO)/MINNESOTA SENIOR CARE PLUS (MSC+)

I. Member Information and Interdisciplinary Care Team Information

Member Name:	Health Plan ID Number:	Health Plan Name:	Today's Date:
Member Phone #:	DOB:	Product Enrollment Date:	
Case Mix:	Rate Cell:	Diagnosis:	
Member Address:	Assessment Date: Assessment Type: ☐ Initial HRA ☐ Annual Reassessment ☐ Change of Condition ☐ Other	Assessment Tool Used: ☐ Health Risk Assessment (*HRA*) ☐ LTCC (*May be used as HRA*) ☐ Other	
Does member have an Advance Directive? ☐ Yes ☐ No Was Advance Directive Discussed: ☐ Yes ☐ No If No, Reason:	Primary Language: ☐ English ☐ Hmong ☐ Spanish ☐ Somali ☐ Vietnamese ☐ Russian ☐ Other (*Type in the "other" language*) Is an Interpreter Needed: ☐ Yes ☐ No Name and Number of Interpreter (*If applicable*):		
Mental Health Diagnosis: (*If applicable*) ☐ N/A	Managed by Other Health Professionals? ☐ Yes ☐ No (Psychiatrist, Psychologist, Primary Care Physician) Need Goal?: ☐ Yes ☐ No ☐ Declined		

Interdisciplinary Care Team

Care Coordinator/Case Manager: Name: Phone #:	Primary Physician: Phone #: Fax #:	Clinic:
Emergency Contact Name & Phone:	Authorized Representative:	
Mental Health Targeted Case Manager: ☐ Yes ☐ No Name of MHTCM:	Phone Number of MHTCM:	

Other ICT Team Members Name	Relationship to Member	Receives Copy of Care plan?	Notes

II. Member's Strengths: *(e.g. current supports, what works, skills, talents, interests)*

Initial/Annual:
Update:

III. Member Choice of Personal Goals/Self-Management: *(What does the member want help with? Support requested? What activities will the member do to manage their health/condition?)*

Initial/Annual:
Update:

IV. Member Barriers to meeting goals or complying with plan (Discuss with member any issue that may be an obstacle to the member receiving or participating in the care plan)

Initial/Annual:
Update:

V. Caregiver

Caregiver listed on HRA/LTCC: ***(Caregivers are unpaid person(s) providing services; if there was no care giver, the service would have to be purchased.)***

☐ **Yes** ☐ **No**

If Yes, how was the caregiver assessment form completed?

☐ **Declined** ☐ **Face-to-Face** ☐ **Telephone** ☐ **Mail**

Date Completed:

VI. Health Prevention/Chronic Condition

Condition/Screening	An educational conversation must take place with the client on applicable topics. If client needs are identified, a goal must be created unless the client declines.			
	Check if educational conversation took place	Check if Goal Needed	Check if N/A, Contraindicated, Declined	Notes
Annual Exam *(Encourage if member new to health plan within last 6 months)*	☐	☐	☐	
Mammogram (Within past 2 years ages 65-75)	☐	☐	☐	
Incontinence (Evaluated by a physician?)	☐	☐	☐	
Colorectal Screening (Up to age 75)	☐	☐	☐	
At Risk for Falls (Afraid of falling, has fallen in the past).	☐	☐	☐	
Pneumovax (*Immunize at age 65 if not done previously. Re-immunize once if 1st pneumovax was received more than 5 years ago & before age 65)*	☐	☐	☐	
Flu shot *(Annually ages 50+ and persons at high risk.)*	☐	☐	☐	
Tetanus Booster *(Once every 10 years)*	☐	☐	☐	
Hearing Exam	☐	☐	☐	
Vision Exam	☐	☐	☐	
Dental Exam	☐	☐	☐	
Calcium Vitamin D Rx for Ca Vitamin D? (as directed by physician)	☐	☐	☐	

Aspirin **Rx for Aspirin?** **(as directed by physician)**	☐	☐	☐	
Blood Pressure: **(Blood Pressure Goal is <140/80 to age 75. After 75 based on individual)**	☐	☐	☐	
Cholesterol check	☐	☐	☐	
Diabetic routine checks as recommended by physician (Discuss with member: Neuropathy, Eye exam, Cholesterol, A1C)	☐	☐	☐	

Pain Screening: **Date:**	• **Are you experiencing any pain now or in the last 2 weeks?** ☐ **Yes** ☐ **No** • **Has member's pain affected their function or quality of life (e.g., activity level, mood, relationships, sleep or work)?** ☐ **Yes** ☐ **No** • **How often does member experience pain (Constantly, Daily, Once a Week or Not Often)?** • **At its worst, how severe is the member's pain (1 to 10 with 10 being the worst)?** • **Has member talked to their Healthcare Provider about how to handle their pain?** ☐ **Yes** ☐ **No**
Other:	
Medication Compliant?	☐ **Yes** ☐ **No (If not compliant with medications , please create a goal.)**
Disease Management Referral	☐ **Yes** ☐ **Declined** ☐ **N/A** **Diagnosis:**
List of Medications *(If not on LTCC)*	
Hospitalizations *(In*	

past year number and reason, date(s) if available)	
ER visits (In past year number and reason for visit; *dates, if available)*	

VII. Issues, Needs, and All Areas of Concern Identified on the LTCC Must be Addressed in the Care Plan

Rank by Priority	Member Goals	Intervention	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					

Care Coordinator/Case Manager Follow-up Plan:

☐ **Contact Once a Month for 3 Months**
☐ **Contact Every 3 Months**
☐ **Contact Every 6 Months**
☐ **Other**

VIII. Member Plan

HRA/LTCC-Care Coordinator/Case Manager (CC/CM) Recommendations: ***(Include services, supports, and interventions recommended/offered by the CC/CM. Document if member declines any recommendations).***

Initial/Annual:
Update:

Personal Risk Management Plan ***(If member or authorized representative refuses recommended waiver services as identified above, discuss potential consequences and plan.)***

Member/authorized representative accept responsibility for any risk associated with refusing recommended services.

Services Declined by: ☐ **Member** ☐ **Authorized representative**

Risk Plan discussed with: ☐ **Member** ☐ **Authorized representative** ☐ **PCP**

Risk Plan Includes:

☐ **Call 911**
☐ **Family/Friend Support**
☐ **Care coordinator/Case Manager contact**
☐ **Other**

☐ **N/A (Member accepts recommended services.)**

Emergency Plan:

As discussed with member/authorized representative, in the event of an emergency, member will (check all that apply):

☐ **Call 911** ☐ **Use Emergency Response Monitoring System**
☐ **Call Emergency Contact**
☐ **Call Other Informal Support Person Name: Phone:**
☐ **Other (describe)**

Self Preservation/Evacuation Plan:

If member is unable to evacuate independently in an emergency, describe evacuation plan:

If other self-preservation concerns or plans, describe:

Essential Services Backup Plan: (*when providers of essential services are unavailable)*

Member is receiving essential services ☐ **Yes** ☐ **No**

If Yes, briefly describe member's backup plan:

Community-Wide Disaster Plan:

As discussed with member/authorized representative, in the event of a community-wide disaster, (e.g.,

flood, tornado, blizzard), the member will (please describe plan):
Additional Case Notes:

IX. Choosing Community Long Term Care

☐ Yes ☐ No I have been offered a choice of home and community based services and Nursing Home Services if needed.

☐ Yes ☐ No I have been offered a choice of providers.

☐ Yes ☐ No I have annually received my appeals rights.

☐ Yes ☐ No I am aware that healthcare information about me will be kept private. (Data Privacy rights)

☐ Yes ☐ No I have discussed my plan of care with my care coordinator/case manager and have chosen the services I want.

☐ Yes ☐ No I agree with the plan of care as discussed with my care coordinator/case manager.

MEMBER/AUTHORIZED REPRESENTATIVE SIGNATURE:	DATE:
CARE COORDINATOR/CASE MANAGER SIGNATURE:	DATE:
CARE PLAN MAILED/GIVEN TO MEMBER ON:	DATE:
CARE PLAN OR SUMMARY MAILED/GIVEN TO PCP (verbal, phone, fax, EMR):	DATE:

Member Name **ID#**

X. Home and Community Based Service Plan/Budget Worksheet

Please include ALL services, e.g., skilled home care, custodial home care, home-and-community-based services, medical supplies, etc.

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Adult Day Care Bath							
Adult Day Services							
Customized Living Verification code: _ _____							
24-Hour Customized Living Verification code: __ _____							
Care Coordination/Case Management							
Care Coordination-Para-Professional							
Caregiver Support							

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Companion Services							
Foster Care							
Help w/MA, Finances, Other							
Homemaking							
Home Modification							
Home Delivered Meals							
Nurse Visits							
Home Health Aide							
Personal Care Assistant (PCA)							
PCA Supervision							
PERS							

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Respite							
Therapies at Home: PT, OT, ST							
Transportation							
Yard Work/Chores							
CDCS Services	**FSE:**	**Support Planner:**					
List of Equipment Member Has							
List of Supplies							

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Other: (supports, resources)							
Case Mix Level:	**CAP amount**	**Member Waiver Obligation if Known:**		**Total Cost of Authorized Services:**	**Notes:**		

MEDICA®

Member's name:

Medica Care System Personal Risk Management Plan

Address:	DOB:
City: , MN ZIP:	

Identified concern	Goal	Goal date	Intervention	Evaluation/Update
☐ Unsafe housing ☐ Declines recommended services ☐ Declines recommended DME/equipment ☐ Declines environmental safety recommendations ☐ Declines personal safety recommendations ☐ At risk to harm self or others ☐ Declines assessment/Care Coordinator contact ☐	☐ Able to access help in emergencies ☐ Contacts Care Coordinator to discuss plan and options. ☐ Will be safe from abusive, neglectful and/or exploitive persons and environments. ☐		☐ Provided education on available service/equipment/supply options. ☐ Provide education on and assess ability to call 911. ☐ Contact family, friends, neighbors or religious communities for member support. ☐ Mail business card or letter with Care Coordinator contact information to member ☐ Contact PCP ☐ File VA report ☐ Establish/Refer to Rep Payee ☐ Consult MBH ☐ Call 911 ☐	
☐	☐	☐	☐	☐
☐	☐	☐	☐	☐
Care Coordinator:			Date:	

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COLLABORATIVE CARE PLAN FOR MINNESOTA SENIOR HEALTH OPTIONS (MSHO)/MINNESOTA SENIOR CARE PLUS (MSC+)

I. Member Information and Interdisciplinary Care Team Information

Member Name:	Health Plan ID Number:	Health Plan Name:	Today's Date:
Member Phone #:	DOB:	Product Enrollment Date:	
Case Mix:	Rate Cell:	Diagnosis:	
Member Address:	Assessment Date: Assessment Type: ☐ Initial HRA ☐ Annual Reassessment ☐ Change of Condition ☐ Other	Assessment Tool Used: ☐ Health Risk Assessment (*HRA*) ☐ LTCC (*May be used as HRA*) ☐ Other	
Does member have an Advance Directive? ☐ Yes ☐ No Was Advance Directive Discussed: ☐ Yes ☐ No If No, Reason:	Primary Language: ☐ English ☐ Hmong ☐ Spanish ☐ Somali ☐ Vietnamese ☐ Russian ☐ Other (*Type in the "other" language*) Is an Interpreter Needed: ☐ Yes ☐ No Name and Number of Interpreter (*If applicable*):		
Mental Health Diagnosis: (*If applicable*) ☐ N/A	Managed by Other Health Professionals? ☐ Yes ☐ No (Psychiatrist, Psychologist, Primary Care Physician) Need Goal?: ☐ Yes ☐ No ☐ Declined		

Interdisciplinary Care Team

Care Coordinator/Case Manager: Name: Phone #:	Primary Physician: Phone #: Fax #:	Clinic:
Emergency Contact Name & Phone:	Authorized Representative:	
Mental Health Targeted Case Manager: ☐ Yes ☐ No Name of MHTCM:	Phone Number of MHTCM:	

Other ICT Team Members Name	Relationship to Member	Receives Copy of Care plan?	Notes

II. Member's Strengths: *(e.g. current supports, what works, skills, talents, interests)*

Initial/Annual:
Update:

III. Member Choice of Personal Goals/Self-Management: *(What does the member want help with? Support requested? What activities will the member do to manage their health/condition?)*

Initial/Annual:
Update:

IV. Member Barriers to meeting goals or complying with plan (Discuss with member any issue that may be an obstacle to the member receiving or participating in the care plan)

Initial/Annual:
Update:

V. Caregiver

Caregiver listed on HRA/LTCC: ***(Caregivers are unpaid person(s) providing services; if there was no care giver, the service would have to be purchased.)***

☐ **Yes** ☐ **No**

If Yes, how was the caregiver assessment form completed?

☐ **Declined** ☐ **Face-to-Face** ☐ **Telephone** ☐ **Mail**

Date Completed:

VI. Health Prevention/Chronic Condition

Condition/Screening	An educational conversation must take place with the client on applicable topics. If client needs are identified, a goal must be created unless the client declines.			
	Check if educational conversation took place	Check if Goal Needed	Check if N/A, Contraindicated, Declined	Notes
Annual Exam *(Encourage if member new to health plan within last 6 months)*	☐	☐	☐	
Mammogram (Within past 2 years ages 65-75)	☐	☐	☐	
Incontinence (Evaluated by a physician?)	☐	☐	☐	
Colorectal Screening (Up to age 75)	☐	☐	☐	
At Risk for Falls (Afraid of falling, has fallen in the past).	☐	☐	☐	
Pneumovax (*Immunize at age 65 if not done previously. Re-immunize once if 1st pneumovax was received more than 5 years ago & before age 65)*	☐	☐	☐	
Flu shot *(Annually ages 50+ and persons at high risk.)*	☐	☐	☐	
Tetanus Booster *(Once every 10 years)*	☐	☐	☐	
Hearing Exam	☐	☐	☐	
Vision Exam	☐	☐	☐	
Dental Exam	☐	☐	☐	
Calcium Vitamin D Rx for Ca Vitamin D? (as directed by physician)	☐	☐	☐	

Aspirin **Rx for Aspirin?** **(as directed by physician)**	☐	☐	☐	
Blood Pressure: **(Blood Pressure Goal is <140/80 to age 75. After 75 based on individual)**	☐	☐	☐	
Cholesterol check	☐	☐	☐	
Diabetic routine checks as recommended by physician (Discuss with member: Neuropathy, Eye exam, Cholesterol, A1C)	☐	☐	☐	

Pain Screening: **Date:**	• **Are you experiencing any pain now or in the last 2 weeks?** ☐ **Yes** ☐ **No** • **Has member's pain affected their function or quality of life (e.g., activity level, mood, relationships, sleep or work)?** ☐ **Yes** ☐ **No** • **How often does member experience pain (Constantly, Daily, Once a Week or Not Often)?** • **At its worst, how severe is the member's pain (1 to 10 with 10 being the worst)?** • **Has member talked to their Healthcare Provider about how to handle their pain?** ☐ **Yes** ☐ **No**
Other:	
Medication Compliant?	☐ **Yes** ☐ **No (If not compliant with medications , please create a goal.)**
Disease Management Referral	☐ **Yes** ☐ **Declined** ☐ **N/A** **Diagnosis:**
List of Medications *(If not on LTCC)*	
Hospitalizations *(In*	

past year number and reason, date(s) if available)	
ER visits (In past year number and reason for visit; *dates, if available)*	

VII. Issues, Needs, and All Areas of Concern Identified on the LTCC Must be Addressed in the Care Plan

Rank by Priority	Member Goals	Intervention	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					

Care Coordinator/Case Manager Follow-up Plan:

☐ **Contact Once a Month for 3 Months**
☐ **Contact Every 3 Months**
☐ **Contact Every 6 Months**
☐ **Other**

VIII. Member Plan

HRA/LTCC-Care Coordinator/Case Manager (CC/CM) Recommendations: ***(Include services, supports, and interventions recommended/offered by the CC/CM. Document if member declines any recommendations).***

Initial/Annual:
Update:

Personal Risk Management Plan ***(If member or authorized representative refuses recommended waiver services as identified above, discuss potential consequences and plan.)***

Member/authorized representative accept responsibility for any risk associated with refusing recommended services.

Services Declined by: ☐ **Member** ☐ **Authorized representative**

Risk Plan discussed with: ☐ **Member** ☐ **Authorized representative** ☐ **PCP**

Risk Plan Includes:

☐ **Call 911**
☐ **Family/Friend Support**
☐ **Care coordinator/Case Manager contact**
☐ **Other**

☐ **N/A (Member accepts recommended services.)**

Emergency Plan:

As discussed with member/authorized representative, in the event of an emergency, member will (check all that apply):

☐ **Call 911** ☐ **Use Emergency Response Monitoring System**
☐ **Call Emergency Contact**
☐ **Call Other Informal Support Person Name: Phone:**
☐ **Other (describe)**

Self Preservation/Evacuation Plan:

If member is unable to evacuate independently in an emergency, describe evacuation plan:

If other self-preservation concerns or plans, describe:

Essential Services Backup Plan: (*when providers of essential services are unavailable)*

Member is receiving essential services ☐ **Yes** ☐ **No**

If Yes, briefly describe member's backup plan:

Community-Wide Disaster Plan:

As discussed with member/authorized representative, in the event of a community-wide disaster, (e.g.,

flood, tornado, blizzard), the member will (please describe plan):
Additional Case Notes:

IX. Choosing Community Long Term Care

☐ Yes ☐ No I have been offered a choice of home and community based services and Nursing Home Services if needed.

☐ Yes ☐ No I have been offered a choice of providers.

☐ Yes ☐ No I have annually received my appeals rights.

☐ Yes ☐ No I am aware that healthcare information about me will be kept private. (Data Privacy rights)

☐ Yes ☐ No I have discussed my plan of care with my care coordinator/case manager and have chosen the services I want.

☐ Yes ☐ No I agree with the plan of care as discussed with my care coordinator/case manager.

MEMBER/AUTHORIZED REPRESENTATIVE SIGNATURE:	DATE:
CARE COORDINATOR/CASE MANAGER SIGNATURE:	DATE:
CARE PLAN MAILED/GIVEN TO MEMBER ON:	DATE:
CARE PLAN OR SUMMARY MAILED/GIVEN TO PCP (verbal, phone, fax, EMR):	DATE:

Member Name **ID#**

X. Home and Community Based Service Plan/Budget Worksheet

Please include ALL services, e.g., skilled home care, custodial home care, home-and-community-based services, medical supplies, etc.

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Adult Day Care Bath							
Adult Day Services							
Customized Living Verification code: _ _____							
24-Hour Customized Living Verification code: __ _____							
Care Coordination/Case Management							
Care Coordination-Para-Professional							
Caregiver Support							

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Companion Services							
Foster Care							
Help w/MA, Finances, Other							
Homemaking							
Home Modification							
Home Delivered Meals							
Nurse Visits							
Home Health Aide							
Personal Care Assistant (PCA)							
PCA Supervision							
PERS							

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Respite							
Therapies at Home: PT, OT, ST							
Transportation							
Yard Work/Chores							
CDCS Services	**FSE:**	**Support Planner:**					
List of Equipment Member Has							
List of Supplies							

Support/Service	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider of Purchased or Volunteer Services	Payment Type (Private, HMO, Medicare, MA, Title III, Waiver, Alternative Care)	Schedule/Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Other: (supports, resources)							
Case Mix Level:	**CAP amount**	**Member Waiver Obligation if Known:**		**Total Cost of Authorized Services:**	**Notes:**		

Name:	**ID#:**

Signature Sheet

- ☐ An explanation and choice of home and community-based services, consumer-directed support services and waivered services has been provided.
- ☐ I have been offered a choice of qualified service providers for services I am receiving.
- ☐ I participated in developing my individual Plan of Care with my Medica Care Coordinator and agree with it.
- ☐ I understand that healthcare information about me will be kept private (Data Privacy).
- ☐ I have been given a choice between community care or nursing home placement.
- ☐ I have been given an opportunity to ask questions and understand I will receive a copy of my Service Plan when it has been finalized.
- ☐ I have participated in the assessment and information is accurate to the best of my knowledge.
- ☐ I have been informed of my right to appeal and have been provided with information on how to appeal.
- ☐ My Medica Care Coordinator has reviewed the Medica Care Coordination document and I understand my right to complain if I am unhappy.
- ☒ I have reviewed my care team listing, and I agree with the persons identified as my care team. My Medica Care Coordinator and I have discussed a plan of care along with options for follow-up contacts.
  At this time it will be: ☐ monthly ☐ quarterly ☐ semi-annually ☐ annually

Member Signature	Date
Signature/Relationship to member (if member representative)	Date
Care Coordinator Signature	Date

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WHEN & WHERE *to get care*

Call Medica CallLink® 24 hours a day if you have questions about when and where to get care:
1-866-715-0915 - TTY users call the National Relay Center: 1-800-855-2880

Doctor's Office

It is best to see your doctor for problems that are not urgent. Your doctor knows your health history and can access your medical records

- Regular yearly check-ups
- Minor illnesses: strep, ear and sinus infections, cold and flu-like symptoms, sore throat, bladder infection
- Medication management
- Seasonal allergies
- Follow-up care to illness or injury
- Vaccinations: Tetanus, Flu, Pneumonia, HPV
- Any conditions noted on Convenience Care and Urgent Care sections

Convenience Care

Walk-in clinics located in pharmacies, retail stores and grocery stores (MinuteClinic®, Target Clinic®)

- Minor illnesses: strep, ear and sinus infections, cold and flu-like symptoms, sore throat, bladder infection
- Skin Treatments: rash and minor skin infections
- Minor Injuries: burns, bruises and blisters
- Other: blood pressure checks, sports physicals

Urgent Care

Non-emergencies - no appointment necessary - after hours, weekends and holidays

- Minor illnesses: strep, ear and sinus infections, cold and flu-like symptoms, sore throat, bladder infection
- Headaches and migraines
- Skin Treatments: rash and skin infections, cuts
- Injuries: strains, sprains and minor broken bones
- Dental pain

Emergency Room

If your situation seems life threatening, go to an ER or call 911 right away.

Only go to the emergency room for a true emergency - wait times can be long

- Heavy bleeding
- Large open wounds
- Signs of stroke (sudden change in vision, sudden weakness, sudden trouble talking)
- Chest pain
- Major burns
- Severe head injury
- Trouble breathing

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КУДА и КОГДА

обращаться за медицинской помощью

Чтобы узнать подробнее, куда и когда можно обратиться за медицинской помощью, позвоните в *Medica CallLink*® по круглосуточному номеру: 1-866-715-0915. При использовании телетайпа обратиться в национальный коммутационный центр по телефону: 1-800-855-2880.

Поликлиники	**На прием к врачу лучше идти не в экстренных случаях. Ваш лечащий врач знаком с историей вашего здоровья и имеет доступ к вашей медицинской карте.** ▪ Регулярный ежегодный осмотр ▪ Нетяжелые заболевания: стрептококковая инфекция, ушные инфекции и синуситы, симптомы простуды и гриппа, ангина, инфекции мочевого пузыря ▪ Назначение и контроль приема лекарственных препаратов ▪ Сезонные аллергии ▪ Наблюдение во время болезни или после травмы ▪ Прививки: противостолбняка, против гриппа, пневмонии и папилломавирусной инфекции ▪ А также все заболевания, отмеченные в разделах «Клиники первичной/профилактической помощи (Convenience Care) » и «Клиники неотложной помощи (Urgent Care)»
Клиники первичной/ прооофилактической помощи (Convenience Care)	**Клиники, принимающие без предварительной записи, при аптеках и магазинах (MinuteClinic®, Target Clinic®)** ▪ Нетяжелые заболевания: стрептококковая инфекция, ушные инфекции синуситы, симптомы простуды и гриппа, ангина, инфекции мочевого пузыря ▪ Лечение кожных заболеваний: сыпь и нетяжелые кожные инфекции ▪ Нетяжелые травмы: ожоги, синяки и волдыри ▪ Прочее: измерение артериального давления, профилактический осмотр для занятий спортом.
Клиники неотложной помощи (Urgent Care)	**Клиники неотложной помощи принимают без предварительной записи в нерабочие часы, выходные и праздничные дни.** ▪ Нетяжелые заболевания: стрептококковая инфекция, ушные инфекции и синуситы, симптомы простуды и гриппа, ангина, инфекции мочевого пузыря ▪ Головная боль и мигрень ▪ Лечение кожных заболеваний: сыпь и кожные инфекции, порезы ▪ Травмы: растяжения, вывихи и нетяжелые переломы костей ▪ Зубная боль
Экстренная помощь/Скорая помощь (Emergency Room) Если существует угроза жизни, сразу же отправляйтесь в пункт скорой помощи или вызывайте «скорую» по номеру 911.	**Обращайтесь в пункт скорой помощи только в экстреннных случаях – время ожидания в очереди может быть значительным** ▪ Сильное кровотечение ▪ Обширные открытые раны ▪ Признаки инсульта (внезапное нарушение зрения, внезапная слабость, внезапное нарушение речи) ▪ Боль в области груди ▪ Сильные ожоги ▪ Тяжелая черепно-мозговая травма ▪ Затрудненное дыхание

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GOORMA & MEELMA

Helista daryeel

Wac Medica CallLink® 24 saac maalintii haddii hayso su'aalo la xidhiidha goorta iyo meesha laga helo daryeel: 1-866-715-0915 – isticmaalayaasha TTY wac Xarunta National Relay Center: 1-800-855-2880

Xafiiska Dhakhtarka

Waxa fiican inaad dhakhtar ka aragto dhibaatooyinka aan degdega ahayn. Dhakhtarkaagu wuxu yaqaan taariikhda caafimaadkaaga oo wuxu geli karaa xogta caafimaadkaaga

- Baadhitaanada sannadlaha ee joogtada ah
- Jirro khafiifa: infekshanka dhuunta, dhagaha iyo sanka, calaamado hargab iyo ifilo u-eg, dhuun xanuun, infekshanka kaadi-haysta
- Maamulka Dawooyinka
- Xasaasiyadda xilliga
- Daryeelka la-socodka jirro ama dhaawac
- Tallaalo: Tetano, Hargab, Kolbaariyo, HPV
- Xaalad kasta oo ku taal qaybaha Daryeelka Haboon iyo Daryeelka Degdega

Daryeel Haboon

Rugta furan eek u taal farmisiiyaha, macdaarada iyo dukaanada adeegsiga (MinuteClinic®, Target Clinic®)

- Jirro khafiifa: infekshanka dhuunta, dhagaha iyo sanka, calaamado hargab iyo ifilo u-eg, dhuun xanuun, infekshanka kaadi-haysta
- Daawaynta maqaarka: finan iyo infekshanka maqaarka
- Jirro khafiifa: gubasho, burbur iyo xagashooyin
- Kale, fiirinta dhiig-karka, baadhitaanada isboortiga

Daryeel Degdega

Aan xaalad degdega ahayn – aanu ballan daruuri ahayn – saacadaha danbe, wiigendyada iyo fasaxyada

- Jirro khafiifa: infekshanka dhuunta, dhagaha iyo sanka, calaamado hargab iyo ifilo u-eg, dhuun xanuun, infekshanka kaadi-haysta
- Madaxxanuun iyo dhanjaf
- Daawaynta maqaarka: finan iyo infekshanka maqaarka, nabaro
- Dhaawacyo: murkacasho, cadgo' iyo jajab lafaha ah oo khafiifa
- Ilko Xanuun

Qolka Xaaladda Degdega

Haddii xaaladaadu u eg tahay mid nafta halis u ah, tag ER ama wac 911 isla markiiba.

Keliya u tag qolka xaaladda degdega wax degdega – wakhtiyada sugitaanka oo dheeraan kara

- Dhiigbax badan
- Nabaro waaweyn oo furan
- Calaamadaha faalijka (isbedel araghga ku-soo-boodo ah, itaal-darro ku-soo-boodo ah, dhib hadalka ah oo ku-soo-boodo ah)
- Laab (xabbad) xanuun
- Gubasho weyn
- Dhaawac weyn oo madaxa ah
- Dhibta neefsiga

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CUÁNDO Y DÓNDE
recibir atención

Llame a Medica CallLink® las 24 horas del día si tiene preguntas acerca de cuándo y dónde recibir atención: 1-866-715-0915 – Los usuarios de TTY deben llamar al National Relay Center: 1-800-855-2880

Consultorio del médico	**Es mejor que visite a su médico cuando tiene problemas que no son urgentes. Su médico conoce su historial de salud y tiene acceso a su expediente médico.** ▪ Chequeos anuales regulares ▪ Enfermedades menores: estreptococo, infecciones de oído y sinusitis, síntomas de gripe o resfriado, dolor de cabeza, infección urinaria ▪ Manejo de medicamentos ▪ Alergias estacionales ▪ Atención de seguimiento por enfermedad o lesión ▪ Vacunas: tétano, influenza, neumonía, PVH ▪ Cualquier afección que aparezca en las secciones Atención de conveniencia y Atención urgente
Atención de conveniencia	**Clínicas sin cita previa ubicadas en farmacias, tiendas minoristas y supermercados (MinuteClinic®, Target Clinic®)** ▪ Enfermedades menores: estreptococo, infecciones de oído y sinusitis, síntomas de influenza o resfriado, dolor de garganta, infección urinaria ▪ Tratamientos de la piel: sarpullido e infecciones menores de la piel ▪ Lesiones menores: quemaduras, moretones y ampollas ▪ Otros: mediciones de la presión arterial, pruebas físicas deportivas
Atención urgente	**Situaciones que no son de emergencia –no se necesita cita- horas no hábiles, fines de semana y feriados** ▪ Enfermedades menores: estreptococo, infecciones de oído y sinusitis, síntomas de influenza o resfriado, dolor de garganta, infección urinaria ▪ Dolores de cabeza y migrañas ▪ Tratamientos de la piel: sarpullido e infecciones de la piel, cortaduras ▪ Lesiones: esguinces, torceduras y fracturas de los huesos no graves ▪ Dolor dental
Sala de emergencias una situación que parece poner en riesgo la vida, diríjase a una sala de emergencias o llame al 911 de inmediato.	**Sólo vaya a la sala de emergencias cuando sea una emergencia verdadera; los tiempos de espera pueden ser largos** ▪ Hemorragia ▪ Heridas abiertas grandes ▪ Signos de derrame cerebral (cambio repentino en la visión, debilidad repentina, dificultad repentina para hablar) ▪ Dolor de pecho ▪ Quemaduras graves ▪ Lesión de cabeza grave ▪ Dificultad para respirar

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ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຣ໌ຫາ Medica: 1-888-347-3630.

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កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅ Medica: 1-888-347-3630 ។

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi Medica: 952-992-2580.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, hu Medica: 952-992-2580.

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Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsi bilbiltu Medica: 1-888-347-3630.

LB4-0035 (10-09)

CCP0911

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P.O. Box 9310
Minneapolis, MN 55440-9310

MEDICA®

<<today_date_mmmm_ddyyyy>>

<<ccms_user_address1>>

<<r_full_name>>
<<r_full_address>>

RE: <<m_full_name>>
Member ID #: <<m_id>>

Dear <<m_full_name>>:

On <<re_referral_request_date>>, we received an appeal requesting coverage of <<re_service_type1>> for <<m_full_name>>.

Results of the appeal review

This case has been reviewed by a <licensed nurse/pharmacist> and Medica physician board-certified in <specialty>.

On <<re_authorization_date>>, we determined that <<re_service_type1>> is <<re_event_status>> under your benefit plan for the following reason(s):

<Include the following paragraph for denials>
This service is not covered, as described in <Evidence of Coverage section title> of your Evidence of Coverage.

<Include in all letters>
<free form reason for denial>

The following reference number has been assigned to this appeal: <<re_authorization_number>>.

At any time and at no cost to you, you may request a written copy of:

- The rule or guideline used to make our decision
- The clinical judgment used to apply the terms of your plan to your medical circumstances
- Any other document or information related to this review

For a copy of this information or if you have any questions or concerns, please contact Medica's Clinical Appeals Department at 952-992-3201 or 1-800-292-2455 (toll free),

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Monday through Friday, 8 a.m. to 5 p.m. TTY/TDD: call the National Relay Center at 1-800-855-2880 (toll free) and ask for 1-800-292-2455 (toll free), Medica Clinical Appeals.

If you do not agree with this decision, you may request a State Fair Hearing. Please see the Appeal Rights below.

Sincerely,

<<ccms_user_full_name>>
<<ccms_user_position>>
Medica Clinical Appeals Department

cc: <<rp_full_name>>
<<sp_full_name>>

YOUR APPEAL RIGHTS

Who can help you understand this notice and your appeal rights?

We suggest you contact Medica Health Plans (Medica) first to talk about the decision but you are not required to do so. Our phone number is 952-992-2322 or 1-800-373-8335 (toll free). For TTY/TDD users, please call the National Relay Center toll free at 1-800-855-2880 and ask for, 1-800-373-8335 (toll free), Medica Customer Service.

A state ombudsman may be able to help. They can help you appeal to Medica or request a state fair hearing. They are neutral and not part of Medica.

Call: 651- 431-2660 or toll free 1-800-657-3729
TTY: 711 or 1-800-627-3529
Write: Ombudsman for State Managed Health Care Programs
Minnesota Department of Human Services
PO Box 64249
St. Paul, MN 55164-0249

Your county managed care advocate may also be able to help. Contact your county human services office and ask to speak to the county managed care advocate.

If you disagree with this decision, you have two options: You can (1) file a health plan appeal or (2) request a state fair hearing:

- You can choose to appeal to Medica or request a state fair hearing. You may do both at the same time. You do not have to finish one process before using the other.
- You must follow the timelines for appeals and state fair hearings.
- Tell why you disagree with the decision. If you need a decision quickly, state that in your appeal or request for a state fair hearing.
- If you decide to appeal it will NOT affect your eligibility for medical benefits.

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- There is no cost to you for filing an appeal or a state fair hearing.
- You can have a relative, friend, advocate, provider or lawyer help with your appeal or state fair hearing. Anyone may appeal on your behalf with your written consent. You may present your evidence and facts about the case in person, by telephone or in writing.
- Your health care provider may appeal a service authorization decision *without* your consent.

APPEAL TO Medica
Write to: Medica Health Plans
State Public Programs
P. O. Box 9310, CP340
Minneapolis, MN 55440-9310

Or call: Medica Customer Service at 952-992-2322 or 1-800-373-8335 (toll free). For TTY/TDD users please call [the National Relay Center toll free at 1-800-855-2880 and ask for 1-800-373-8335 (toll free), Medica Customer Service.

- You must appeal to Medica **within 90 days** after the date of this notice. You can appeal by phone or in writing.
- Tell us if your appeal is about an urgently needed service. If we agree that it is urgent, we will give you an answer within 72 hours. If we do not agree that the service is urgently needed, we will tell you within 24 hours. If you disagree, you may file a grievance with us or contact a state ombudsman.
- If your appeal is not urgent, we will notify you of our decision as quickly as required by your health condition, not to exceed seven (7) calendar days after your request for services. We may take up to 14 extra days if we need more information and it is in your best interest. We will tell you we are taking the extra time and why.

REQUEST A STATE FAIR HEARING
Write: Appeals Office or Fax: 651-431-7523
Minnesota Department of Human Services
PO Box 64941
St. Paul MN 55164-0941

- You must request a state fair hearing in writing **within 30 days** of the date of this notice. You have up to 90 days if you have a good reason for being late.
- A state fair hearing is a meeting held by a human services judge with you and Medica. Your hearing will be held by telephone unless you ask for a face to face meeting.
- The process generally takes between 30 and 90 days unless you request an expedited state fair hearing for an urgently needed medical service.
- If your hearing is about a service that was denied because it was not “medically necessary,” you may ask for a review by a medical expert. There is no cost to you.

Can my health care services continue during an appeal or state fair hearing?: If we are stopping or reducing your service you can ask to keep getting the service when you file an appeal or state fair hearing. The request to continue a service must be made **within 10 days** after the date of this notice or before the service is stopped, whichever is later. The treating provider must agree the service should continue. The service can continue until the appeal or state fair hearing is resolved. If you lose the appeal or state

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fair hearing, you may be billed for the service.

Medical records: You may ask to see documents considered by us during the appeal or state fair hearing process. You may request this information any time before or during the appeal or state fair hearing. You may need to put your request in writing. There is no cost to you.

Medica Choice Care℠ (MA) and Medica MinnesotaCare members
Call Medica Customer Service at 952-992-2322 or 1-800-373-8335 (toll-free)

Medica AccessAbility Solution® (SNBC), Medica DUAL Solution® (MSHO) and Medica Choice Care MSC+ members
Call Medica Customer Service at 952-992-2580 or 1-888-347-3630 (toll-free)

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយ ឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB3-0016 (3-13)

SPP1113

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[Department Name]
Business Continuity Plan

Updated 9/11/2014

Plan Information	Name	Contact Information
Plan Owner	[Plan Owner – Name]	[Work #] [Cell #]
Plan Owner Alternate	[Plan Owner Alternate– Name]	[Work #] [Cell #]
Power Outage Point of Contact (POC)	[Insert Name]	[Work #] [Cell #]
Power Outage Point of Contact (POC) Delegate	[Insert Name]	[Work #] [Cell #]
Crisis Management Team Representative	[Insert Name]	[Work #] [Cell #]
Crisis Management Team Alternate	[Insert Name]	[Work #] [Cell #]

Teams Covered by this Plan	Number of Employees	Number of Contractors
[Insert Team]	[Insert]	[Insert]

Executive Approval	Format (email / document)	Date
[Insert Name]		

NOTICE
This Business Continuity Plan is the confidential information of [COMPANY NAME]. Unauthorized use, reproduction, and distribution of this plan are prohibited.

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IMMEDIATE ACTION CHECKLIST

(If this is a disaster situation)

The first priority is the SAFETY of employees and others. The second priority is BUSINESS CONTINUITY. You play an important role in meeting these objectives.

What staff must do if ONSITE DURING "EVENT"

- Stay calm, do not rush, and do not panic
- If it is a medical situation, call 9-1-1, then call Physical Security at **[Number]** so they can escort emergency responders
- Evacuate or shelter in place as directed by **[COMPANY NAME]** Floor Marshalls, alarms, or PA announcements
- Take personal protective measures
- Gather your personal belongings and **[COMPANY NAME]** laptops only if it is safe to do so
- Do not enter the facility until you've been given permission to enter by the fire department, police department, and/or Floor Marshalls
- Proceed to onsite or offsite meeting place depending on extent of damage in the geographic area immediately upon vacating **[COMPANY NAME]** buildings to find out next steps
    - The **[Team Name]** will meet at **[Team Meeting Location]**. An alternate meeting site, should the primary location be unavailable is the **[Alternate Meeting Location]**.
    - Next steps will be determined at the meeting site. Should systems remain available while the office is not, the expectation will be for employees to work from home until an 'all clear' is given by the Business Resilience Command Team and communicated by **[Team Director]**.
- Business Continuity Plan Owners or their designates account for all employees, contractors, and visitors via headcounts, text messages, emails, or telephone calls and provide that information to the SVP of Human Resources, Learning and Facilities. Search and rescue is performed only by trained personnel
- Crisis Management Team Representatives/Alternates and Power Outage Points of Contact (POC) attend Business Resilience bridge calls as scheduled, are notified about Executive Leadership decisions, and receive ongoing status updates.

Contact Information:

- **[Team]** Bridge Line:
    - **[Number]**
    - Passcode: **[Passcode]**
    - Leader Pin: **[Pin]**
- Inclement Weather Hot Line
    - **[Number]**
- Business Resilience Team Bridge Line
    - **[Number]**
    - Passcode: **[Passcode]**
- Service Desk:
    - **[Number]**
- Physical Security:
    - **[Number]**

- If Information Security systems are affected, refer to the grid in Appendix 6.1 for support and maintenance information.

[Team] Contact Information

Name	Title	Phone #	Responsibility

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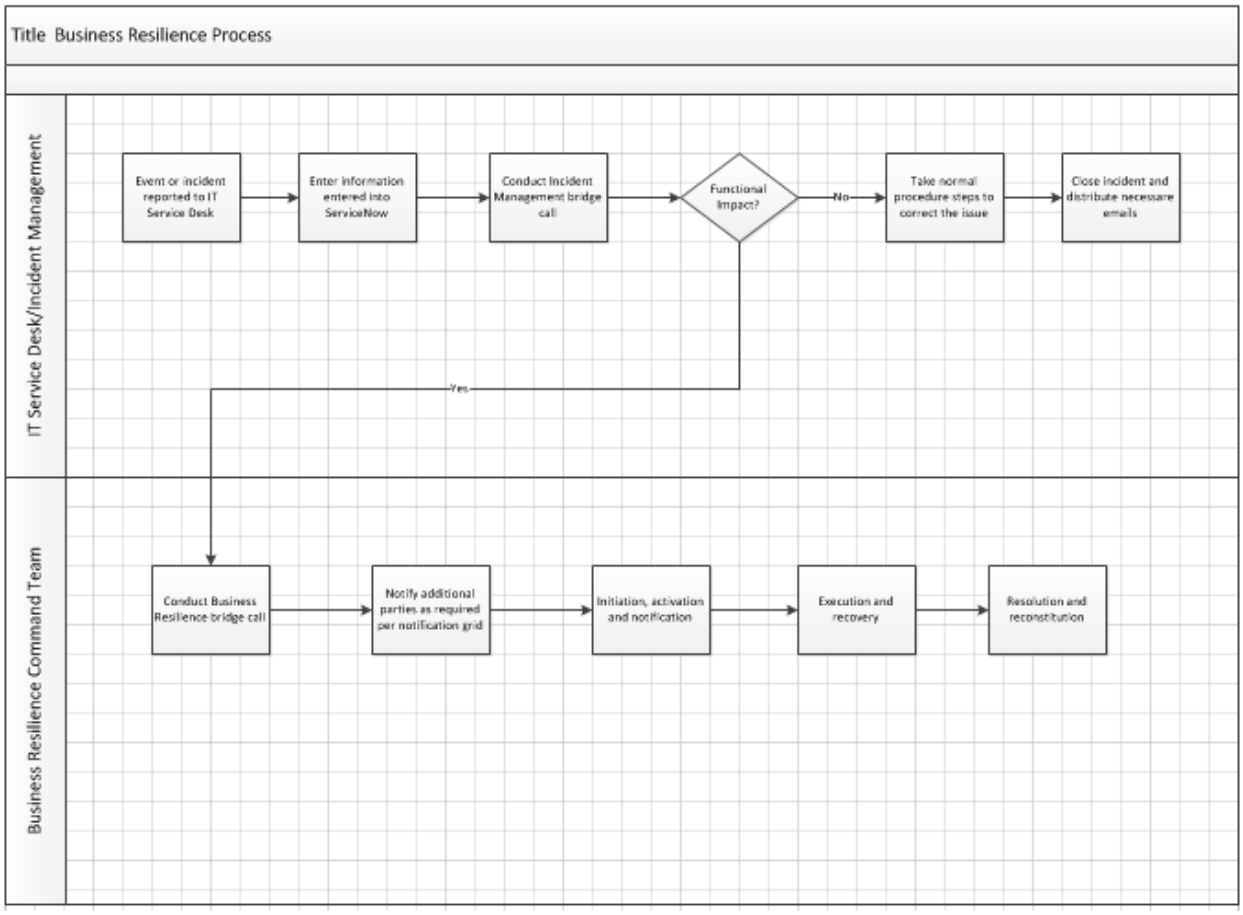
GENERIC TEMPLATE

1. Business Resilience Process

Events and incidents causing massive or potential disruption of **[COMPANY NAME]**'s core business needs may need to involve the Business Resilience Command Team (BRCT) and Business Continuity / Disaster Recovery. Such events and incidents include, but are not limited to, Major Storm/Storm Damage, Tornado, Flood/Water Damage, Spill, Bomb Threat, Vapor Release, Fire, Gas Leak/Explosion, Power Outage/Generator Failure, Pandemic Infection, Bioterrorism, Major System Outages, and so forth.



The decision as to whether an event or incident should be escalated to the Business Resilience Command Team (BRCT) is determined by IT Incident Management based on the following criteria:

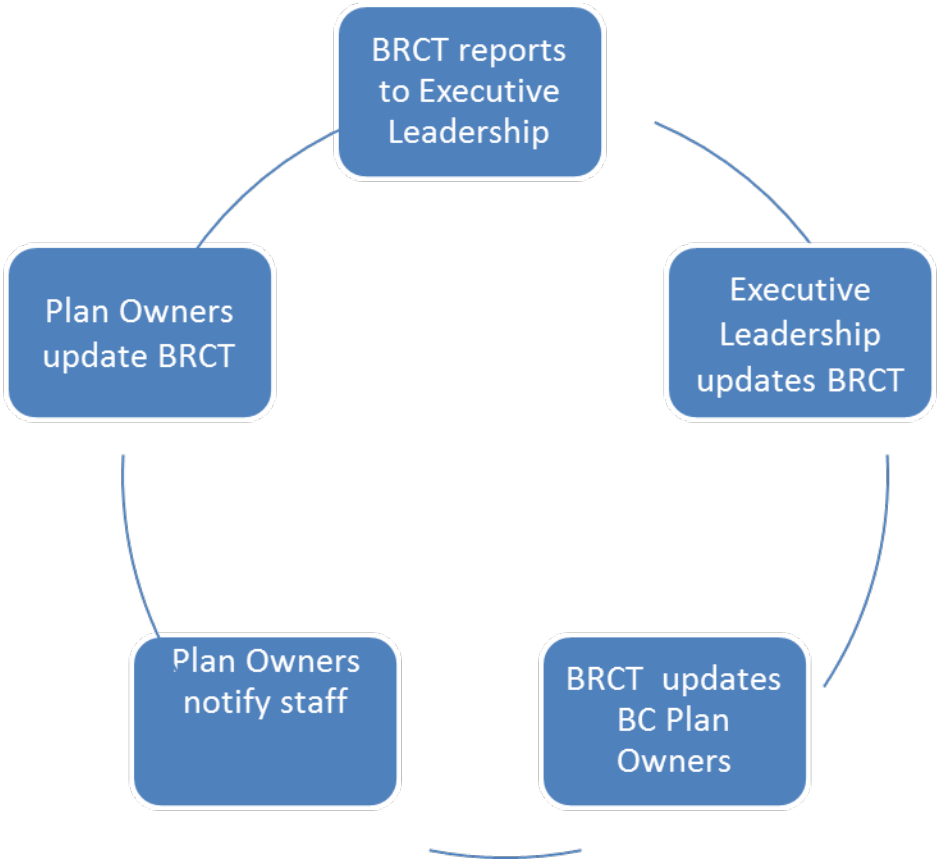
Functional Impact of the Event or Incident	
Category	**Definition**
None	No effect to the organization's ability to provide all services to all users
Low	Minimal effect; the organization can still provide all critical services to all users but has lost some efficiency
Medium	Organization has lost the ability to provide critical services to a subset of system users
High	Organization is no longer able to provide some critical services to any users

The decision to activate **[COMPANY NAME]**'s Business Resilience Process and the affiliated Business Continuity/Disaster Recovery Plans rests with **[COMPANY NAME]**'s Executive Leadership Team.

The diagrams below illustrate the basic Business Resilience process that will be followed. Modifications to this process may be necessary, depending on the specific situation.

Diagram 1.1 – Process flow for Business Resilience Response Decision-making

Diagram 1.2 – Communication Model during the Event or Incident



1.1 Timing and Communication Methods during a Crisis or Power Outage

The Business Resilience Command Team will establish the frequency and preferred method of communication with the Crisis Management Representatives/Alternates and Power Outage Points of Contact (POC) at time of the event or incident. Business Continuity Plan Owners will be given this information as soon as it is available.

Business Unit management teams will establish the frequency and preferred method of communication within their Line of Business during the Crisis or Power Outage.

Source Communicating	Communicates To	Timeline	Communication Timing	Communication Methods
IT	Crisis Management Representatives /Alternates & Power Outage Points of Contact (POC)	Initiation Phase	Bridge line text and email sent by IT	Text Message Email
IT	Crisis Management Representatives /Alternates & Power Outage Points of Contact (POC)	Initiation Phase	Crisis Management Representatives /Alternates & Power Outage Points of Contact (POC) join bridge line **[Number] [Passcode]** within 20 minutes of receipt of bridge line text or email	Bridge Line
Crisis Management Representatives /Alternates & Power Outage Points of Contact (POC)	Business Unit Leadership (SVPs, VPs, Directors)	Execution Phase	Crisis Management Representatives /Alternates & Power Outage Points of Contact (POC) leave voice mail, text and/or email status updates every 30 minutes for Business Unit Leadership	Voice Mail Text Message Email
IT	Crisis Management Representatives /Alternates & Power Outage Points of Contact (POC)	Execution Phase	Crisis Management Representatives /Alternates & Power Outage Points of Contact (POC) join bridge line **[Number] [Passcode]** as directed in bridge line texts and emails	Bridge Line
IT	Crisis Management Representatives /Alternates & Power Outage Points of Contact (POC)	Resolution Phase	Incident resolution all clear alert text and email sent at resolution	Text Message Email

1.2 Communication Channels During a Crisis or Power Outage

Business Resilience Bridge Line (used for Crises and Power Outages)

[Number]
[Passcode]

Crisis/Inclement Weather Hot Line – [Number]

Please designate one person from your team to be the Communication Link. Bridge lines are limited to the number of callers that can be on at one time.

Business Resilience Conference Bridges and Hotlines

Bridge Line	Phone Number	Passcode	Pin
Business Resilience	**[Number]**	**[Passcode]**	**[Pin]**
Incident Management	**[Number]**	**[Passcode]**	**[Pin]**
[COMPANY NAME] Crisis/Inclement Weather Hotline	**[Number]**	**[Passcode]**	**[Pin]**

1.3 Communication Plan Guidelines

You must contact the Business Resilience Command Team, Marketing & Communications, and Legal for approval prior to communicating the nature of the crisis. This is to ensure a consistent message is sent which addresses all concerns.

1. **Initial Crisis Acknowledgement**:

You will be notified of activation from your management team. Upon notification you will:

- ❑ Receive brief crisis update
- ❑ Take action as directed by your management team

2. **Internal Communications**:

Note: All internal communications must be approved by Business Resilience Command Team, Marketing & Communications, and Legal prior to distribution.

- ❑ Contact Business Resilience Command Center
- ❑ Determine communication recipients and required message
- ❑ Receive approval
- ❑ Distribute Communication
- ❑ Update Voicemail message to approved script

3. **Partners, Customers, Regulators and Vendors**:

Note: All external communications must be approved by Business Resilience Command Team, Marketing & Communications, and Legal prior to distribution. [Department] will be expected to contact third parties doing business with their department, upon direction from the **[Department]** management team. Calls should be carefully planned to ensure the appropriate people are given the approved message. Please see the contact information of key Vendors in Section 5 below.)

- ❑ Questions from customers, partners and vendors concerning the crisis must be referred to **[COMPANY NAME]**'s Media Relations Contact, if an answer is not readily available from information already made public.

- ❑ Review Contact information to determine appropriate partners and vendors. See Section 5 for more information on Vendor Contact Information.

- ❑ Draft communication points:
  - Information to customers, partners, and vendors must not vary from public information released by the company during the crisis
  - Provide situation update, impact, and next communication time.
  - All communications must respect the dignity and privacy of the persons affected by the crisis.

- ❑ Receive approval for distribution of communication from Business Resilience Command Team, Marketing & Communications, and Legal. Subsequent communications must follow these requirements.

- ❑ Distribute communication.

Floor Marshalls list

Floor Marshals			
Last Name	**First Name**	**Extension**	**Floor #**

2. Glossary

Bridge Line: A standing conference call line that allows individuals to connect to the conference call by dialing from anywhere in the world.

Business Continuity Planning: The creation and validation of a practiced logistical plan for how an organization will recover and restore partially or completely interrupted critical (urgent) functions within a predetermined time after a crisis or extended disruption. *Business Continuity Planning*, which is also called *Business Resilience Planning* (BRP), includes *Pandemic Planning* (i.e., planning for a loss of critical people) and Power Outage Planning (i.e., planning for loss of critical power). The logistical plan is called a Business Continuity Plan.

Business Continuity Plan: A business continuity plan is a roadmap or collection of procedures and information that is developed, compiled and maintained for continuing critical operations under adverse conditions.

Business Resilience: The ability of an organization's business operations to rapidly adapt and respond to adverse internal or external events or incidents and continue critical operations with limited impact to critical business functions. Business resilience umbrella includes Crisis Management, Business Continuity, and Disaster Recovery.

Business Resilience Command Team: Provides overall coordination of response and recovery support activities, coordinates the assessment process and recommends whether or not to activate the Business Continuity and Disaster Recovery Plans to Executive Leadership.

Calling Trees: A telephone procedure which can be used to notify staff of an emergency. A call tree is typically used to notify staff outside of normal business hours. A common arrangement is that one person will call or text a small group of staff members with a message, then those persons will call or text other staff and pass on the message, until finally all relevant members of staff have received the message.

Command Center: A designated location for Information Technology and Business Unit Leadership to meet in the event of a crisis, which is also known as a war room.

Crisis: Specific, unexpected, and non-routine events or series of events that create high levels of uncertainty and threat or perceived threat to an organization's high priority goals. The first three characteristics are that the event is 1. unexpected (i.e., a surprise), 2. creates uncertainty, and 3. is seen as a threat to important goals and critical operations.

Crisis Management: The process by which an organization deals with a major unpredicted event or incident that threatens to harm the organization, its stakeholders, or the general public. Three elements are common to most definitions of crisis: (a) a threat to the organization, (b) the element of surprise, and (c) a short decision time.

Business Resilience Command Center: The Business Resilience Command Center is a meeting area from which initial assessment, evaluation, coordination and decision making activities take place. The Business Resilience Command Center houses the Business Resilience Command Team during the Initiation, Notification, and Activation Phase and Execution and Recovery Phase.

Crisis Management Team: The Crisis Management Team consists of representatives and alternates from Business Units that provides overall coordination of Business Unit response and recovery support activities, coordinates the assessment process, and determines whether to activate the Business Unit's Business Continuity and/or Disaster Recovery Plans.

Disaster: An event that makes the continuation of critical Information Technology and Business Unit functions impossible.

Disaster Recovery: The process of planning for and restoring an organizations critical Information Technology infrastructure components or applications to a state of normality after the occurrence of a disastrous event or incident.

Disaster Recovery Plan: The documented process and procedures related to preparing for recovery or continuation of Information Technology infrastructure components and applications critical to an organization after a natural or human-induced disaster. It includes routine backups as well as procedures for restoring critical Information Technology infrastructure components and applications in a secondary location.

Emergency: A serious situation or occurrence that happens unexpectedly and demands immediate action.

Employee Assistance Program: An organization to assist individuals in coping with the grief and trauma of an event or incident.

Employee Crisis: A situation affecting or potentially affecting individuals employed by the company or on-site contractors, temps, members, or vendors.

Recovery Kit: A storage container, maintained in an offsite location (i.e., Recall), used to store items critical to Business Unit functions that cannot be replaced on short notice.

Recovery Procedures: Recovery Procedures document the actions necessary to respond to an event or incident and eventually restore critical processes. These procedures address both immediate short-term tasks and more time consuming long-term tasks.

Recovery Recommendations: At time of the event or incident occurrence, the Business Resilience Command Team will identify critical personnel to lead the recovery effort and select appropriate recovery strategies/solutions based on the severity of the event or incident. These collective strategies and assignments are referred to as the Recovery Recommendations.

Support Procedures: At time of the event or incident occurrence, the Business Resilience Command Team will activate designated recovery personnel who will provide overall support during response and recovery activities (e.g., damage assessment, acquisition of required resources, alternate facility preparation, etc.). Procedures that define overall support responsibilities and tasks are documented within the Business Resilience Command Team Plan.

5.2 Business Recovery Activities

The following template is to be filled out and updated according to the nature of the event or incident which caused the execution of the Business Continuity Plan. It is intended as a means of identifying the steps necessary to recover from an event or incident and identify responsible individuals from the team for completing the assigned task.

Item	Process	Response / Action Steps
1.0	**Crisis Analysis / Day to Day Process Detail processes in order of importance.**	**Assign responsibility by job function or title. Please note the location of process / training documentation**
1.1	Assess the crisis impact to the Information Security function within **[COMPANY NAME]**.	
1.2	Account for the presence, safety, and well-being of staff members, contractors and guests in the department.	
1.3	Contact Human Resources as appropriate to address any personnel issues (injury, death, missing persons, etc.)	
1.4	Determine Incident Reporting Requirements (see subsequent section) and assign Crisis Management Team contact responsibilities.	
1.5	Determine which employees will work from home or other offsite locations until a permanent facility is available. Communicate decision through Information Security Team members.	
1.6	Determine which activities or job processes will be suspended and notify employees. Coordinate communication for resumption of activities.	
1.7	Coordinate with Business Resilience Coordinator to secure appropriate space and access if appropriate.	
1.8	Enter a request via the Service Catalog or call the Service Desk (2-1010) to coordinate hardware, software, telecom and security access.	
1.9	Coordinate with Business Resilience, **[COMPANY NAME]** Communications,	

	and Legal to contact Third Party entities if appropriate.	
1.10	Ensure all Protected Health Information (PHI), both paper and electronic, in the possession or control of the department is accounted for and secure.	
1.11	Ensure that all Information Security business processes are occurring as appropriate based on the crisis and crisis assessment.	
1.12	Coordinate with Business Resilience Coordinator to retrieve Recovery Kit from Recall if appropriate.	N/A
1.13	Retrieve mail from the designated mail delivery point if relocated to an offsite location; triage mail and ensure delivery or communication of contents to appropriate Information Security team member.	
1.14	Add additional steps here.	

2.0	**DEPT RECOVERY PROCESSES** **List critical work functions and a high level description of the process in order of importance.**	**Assign responsibility by function or job title. Please reference the location of the detailed process / training documentation.**
2.1		
2.2		
2.3		
2.4		
2.5		

3.0	**PROVIDE RECOVERY SERVICES TO OTHER DEPTS** **List critical work functions and a high level description of the process in order of importance.**	**Assign responsibility by function or job title. Please reference the location of the detailed process / training documentation.**
3.1		
3.2		
3.3		

4.0	**ADVISE OTHER DEPARTMENTS**	**Assign responsibility by function or job title. Please reference the location of the detailed process / training documentation.**
4.1		
4.2		
4.3		

5.0	**RESUMPTION ACTIVITIES**	**Assign responsibility by function or job title. Please reference the location of the detailed process / training documentation.**
5.1		
5.2		

6.0	**DESCRIBE YOUR MANUAL WORKAROUNDS**	**How will you capture data that needs to be entered into a system or application? Assign responsibility by function or job title. Please reference the location**

		of the detailed process / training documentation.
6.1		
6.2		

[Department Specific]

1. Vendor List

Vendor	Application/Hardware	Sales Rep	Support Phone #	Additional Info

1. Vendor List

MEDICA

MEDICA CONNECTIONS®

a monthly publication for Medica network providers

May 2015

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GENERAL INFORMATION

ABN form can no longer be used for certain Medicare plans

In accordance with guidance from the Centers for Medicare and Medicaid Services (CMS), the Advance Beneficiary Notice of Noncoverage (ABN) form *cannot be used* for members in Medica Prime Solution® (the Medica Medicare Cost plan) and Medica DUAL Solution® (the Medica Medicare Advantage special needs plan). The form is intended for use with patient care covered under Medicare fee for service, so therefore providers should not use this form for patients receiving care under private Medicare plans.

The following outlines the Medica policy related to non-covered Medicare services, consistent with the most recent CMS guidance:

- If a service is *never* covered, for example, the member has been notified by a clear exclusion in the Medica Evidence of Coverage or the standardized denial notice prior to receipt of an item or service that it is not covered by Medica, then an organization determination (or pre-service determination) is not required. The provider, prior to rendering the service or providing the item, must inform the member in writing and obtain a written authorization from the member that: the member is fully aware that the service or item being provided is not covered by Medica under the member's benefit contract; *and* the member agrees to be financially responsible for the non-covered service or item if it is provided.
- If a provider believes an item or service *may not be covered*, or could be covered only under specific conditions, the provider must advise the member to request a pre-service determination from Medica *or* the provider can make this request on the member's behalf at the request of the member.

To determine if a service is covered:

- Providers should call the Medica Provider Service Center at 1-800-458-5512.
- Medica Prime Solution members should call Medica at 1-800-234-8755.
- Medica DUAL Solution members should call Medica at 1-888-347-3630.

Providers requesting a pre-service determination of coverage can also submit the following information for consideration by faxing it to the Medica Utilization Management department at 952-992-3556:

- all relevant clinical documentation;
- CPT and diagnosis codes;
- member's demographic information, including Medica ID number; and
- provider's name and location where services will be rendered (including facility, if applicable).

Providers who have questions may contact the Medica Provider Service Center at 1-800-458-5512.

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CLINICAL INFORMATION

Effective June 1, 2015:

Medica to make coverage policy changes

The following benefit determinations will be effective beginning with June 1, 2015, dates of service. These changes will apply to all Medica products including government products unless a particular health plan (whether commercial, Medicare or Medicaid) requires different coverage.

Expanded carrier testing for genetic diseases

Medica has reviewed expanded carrier testing for genetic diseases and has expanded the scope of the related coverage policy, formerly titled "Counsyl Universal Genetic Test," to include all expanded

carrier testing panels. Medica has determined that:

- Expanded carrier testing for genetic diseases *remains investigative and therefore not covered*. Examples of currently available panels include, but are not limited to, Counsyl Family Prep Screen, GoodStart Select, Inherigen, Inheritest, and Natera Horizon™ Multi-Disease Carrier Screening.
- Carrier screening using a targeted genetic panel for individuals of Ashkenazi Jewish ancestry *will be covered* when screening is done for disorders as recommended by the American College of Medical Genetics and the American College of Obstetricians and Gynecologists. Currently these disorders include: Tay Sachs disease, Canavan disease, cystic fibrosis, familial dysautonomia, Bloom syndrome, Fanconi anemia, Niemann-Pick disease, Gaucher disease, and Mucolipidosis IV.

Traditional carrier testing is done with targeted single gene screening associated with one disease (e.g., the cystic fibrosis transmembrane conductance regulator gene for cystic fibrosis). However, new methodologies have allowed for expanded carrier testing panels intended to identify genes representing multiple and generally unrelated disorders/conditions. This expanded testing is considered a non-targeted approach to carrier testing. Testing is done using buccal swabs, saliva, or blood specimens.

Currently, there is no standardization between similar expanded carrier genetic panels, with tests performed by different laboratories for the same conditions or diseases often testing different sets and combinations of genes. In addition to testing for standard conditions, expanded carrier testing includes many conditions that: are not routinely evaluated; are not addressed in professionally recognized guidelines; have a low prevalence in the general population (i.e., the individual is at very low risk of being a carrier); or has no known treatment.

Serum drug and antibody levels to monitor tumor necrosis factor inhibitors
Medica has reviewed these tests and has expanded the scope of the related coverage policy, formerly titled "Anti-Infliximab Antibody Level Testing to Monitor Infliximab Treatment," from monitoring of infliximab only to include monitoring of all tumor necrosis factor (TNF) inhibitors. Medica has determined that serum drug and antibody level testing to monitor TNF inhibitors *remains investigative and therefore not covered*.

Tumor necrosis factors are drugs used to treat a number of auto-immune system diseases, such as rheumatoid arthritis and Crohn's disease. Some patients develop antibodies to these drugs which may cause reactions and/or reduce its ability to control the disease. Blood tests to measure and monitor both the serum drug level and antibody level to these drugs have been proposed as a way to determine a patient's loss of response to the drug. TNF inhibitors include, but are not limited to, infliximab (Remicade), adalimumab (Humira), etanercept (Enbrel), golimumab (Simponi), and certolizumab pegol (Cimzia).

The complete text of the policies that apply to the determinations above will be available online or on hard copy:

- **See coverage policies at medica.com** as of June 1, 2015; or
- Call the Medica Provider Literature Request Line for printed copies of documents, toll-free at 1-800-458-5512, option 1, then option 5, ext. 2-2355.

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Help needed to improve colorectal cancer screening rate

Colorectal cancer screening is key in preventing the third most commonly diagnosed cancer in the United States. This cancer kills more men and women than nearly any other cancer — It is second only to lung cancer. However, about one-third of adults 50-75 years of age have *not* been screened. Medica highly encourages screening, and has signed on to the American Cancer Society's goal to have 80 percent of men and women 50-75 years of age screened for colorectal cancer by the year 2018. Providers are vital in achieving this goal.

A majority of providers believe that colorectal screening is highly important, but only 4 in 10 view it as a top health priority to communicate to their patients. A provider's recommendation is important as studies show that 8 out of 10 patients who participated in colorectal cancer screening chose the particular test they did because their doctor recommended it. Medica appreciates the help of providers in reaching the American Cancer Society's "80 x 18" goal by recommending screening to patients.

After encouraging patients to get screened, there are several testing options for them, such as a colonoscopy or fecal testing. It's important to note that a colonoscopy may be difficult for patients and can be perceived negatively due to the invasiveness of the test or fear of discomfort during the procedure. Fecal testing includes guaiac fecal occult blood test (gFOBT) or fecal immunochemical test (FIT). These tests reduce death from colorectal cancer, are safe, available, and easy to complete. Perhaps most importantly, they are done in the privacy of the patient's home. Evidence indicates these fecal screening tests detect colorectal cancer early when they are completed annually.

Tips for the FOBT or FIT:

- Never use in-office FOBT/FIT as a screening test at the time of a digital rectal exam.
- Perform test only on stool specimens collected by the patients at their home.
- FIT tests need to be billed with Current Procedural Terminology (CPT®) code of 82274.
- gFOBT tests need to billed with CPT code 82270.
- Tests should be billed on the day the test was performed and not on the day when the test was provided to the patient.
- Repeat annually, perhaps offering the test when patients come in for their annual flu shot.
- Be sure to follow up with patients who have a positive test.

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Effective June 1, 2015:

Medical policies and clinical guidelines to be updated

Medica will soon update one or more utilization management (UM) policies, coverage policies, Institute for Clinical Systems Improvement (ICSI) guidelines, and Medica clinical guidelines, as indicated

below. These policies will be effective June 1, 2015, unless otherwise noted.

Coverage policies — Revised

These versions replace all previous versions.

Name
Expanded Carrier Testing for Genetic Diseases *(formerly Counsyl Universal Genetic Test)*
Genetic and Pharmacogenetic Testing *(The following two policies were combined: Genetic Testing and Pharmacogenetic Testing)*
Percutaneous Disc Decompression Procedures (Percutaneous Discectomies, Nucleoplasty) *(formerly Percutaneous Disc Decompression Procedures (Manual, Automated or Laser Discectomy, and Plasma Disc Decompression [PDD]))*
Serum Drug Levels and Antibody Levels to Monitor Tumor Necrosis Factor (TNF) Inhibitors *(formerly Anti-Infliximab Antibody Level Testing to Monitor Infliximab)*
Topographic Genotyping (PathFinder TG®) for Diagnosis of Cancer

These documents will be available online or on hard copy:

- **View medical policies and clinical guidelines at medica.com** as of June 1, 2015; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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PHARMACY INFORMATION

Effective June 1, 2015:

Medica to expand oral oncology split-fill program

Medica is expanding its current specialty-drug split-fill program effective June 1, 2015. The oral oncology drugs being added to the split-fill program are:

- Bosulif
- Erivedge
- Inlyta
- Jakafi
- Tafinlar
- Xalkori
- Xtandi
- Zelboraf
- Zykadia
- Zytiga

This is in addition to nine drugs already included: Afinitor, Nexavar, Sprycel, Sutent, Tarceva, Targretin, Tasigna, Votrient, and Zolinza.

This program exists due to the fact that a patient may need to try multiple medications to find one that works for cancer treatment. By splitting the prescription fill, a specialty pharmacy can monitor the medication and determine if it is effective after the first 14 days before dispensing additional medication. Doing so avoids medication waste, saving costs for patients as well as payers. If an adverse event is noted, the specialty team can respond according to established protocols and can contact the physician as necessary.

Once the patient is tolerating therapy, the remainder of the month's supply of medication is shipped. The partial fill of a medication continues for the initial 3 months of treatment. The member pays 50 percent of a copayment on the first partial fill and then would pay the remaining 50 percent upon the completion fill. If side effects or problems are identified during an assessment, the medication would be held, thus preventing waste.

This program applies to Medica commercial and individual and family business (IFB) members. As a reminder, the main specialty-drug vendor for Medica is Fairview Specialty Pharmacy (Walgreens Specialty Pharmacy continues to handle certain medications).

(Update to "Medica to modify oral oncology split-fill program" article in the July 2014 edition of Medica Connections. **See July 2014 edition**.)

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NETWORK INFORMATION

Fourth-quarter PCR checks to be mailed in April 2015

By the end of April 2015, Medica plans to mail to eligible providers the physician contingency reserve (PCR) payment for the fourth quarter of 2014. This represents a 100-percent return of the fourth-quarter 2014 PCR withhold, plus interest, for the Medica Prime Solution® Medicare product. Checks will cover PCR withheld for claims with dates of service of October 1, 2014, through December 31, 2014, and dates paid of October 1, 2014, through March 31, 2015.

Note: Medica began processing claims with a 2 percent payment reduction in April 2013 due to federal sequestration. The 2 percent sequester reduction was in addition to the standard PCR withhold amount for Medica Prime Solution claims. This 2 percent cut *will not be included* in PCR returns.

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Effective June 15, 2015

Medica to update anesthesia reimbursement for all products

Effective June 15, 2015, Medica will update anesthesia reimbursement, increasing standard anesthesia conversion factors for all Medica products in both metro and regional service areas. The effect on reimbursement will vary by specialty and the mix of services provided. This update will not affect providers with custom anesthesia reimbursement.

Providers who have further questions may contact their Medica contract manager.

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ADMINISTRATIVE INFORMATION

Effective April 5, 2015:

Medica revises reimbursement policy

Medica has recently updated the reimbursement policy indicated below, effective with April 5, 2015, dates of processing. Such policies define when specific services are reimbursable based on the reported codes.

Reimbursement policies — Revised

These versions replace all previous versions.

Name
Ambulance *(updated code list)*

This revised policy is available online or on hard copy:

- **View reimbursement policies at medica.com**; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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PPO INFORMATION

Latest UHC provider bulletin available online

UnitedHealthcare (UHC) has published the latest edition of its *Network Bulletin* (March 2015). Highlights that may be of interest to LaborCare® network providers include:

- Reminder on prior authorization requirement for more orthopedic procedures— effective in April 2015
- Reminder on prior authorization requirement for injectable chemotherapy — scheduled for June 2015
- Laboratory Services Policy to be revised — scheduled for June 2015

View the March 2015 UHC provider newsletter

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Know of colleagues who should get this regularly? **Have them sign up**.

Medica Connections is published monthly by Medica and can be accessed online.
View the *Medica Connections* archive.

Health and Network Management leadership at Medica:
Mark Werner, MD, *Senior Vice President and Chief Clinical and Innovation Officer*
Jana Johnson, *Senior Vice President for Health and Provider Services*
Barbara Lynch, *Vice President for Network Management*
Dan Trajano, MD, *Vice President and Medical Director for Population Health*
James Hartert, MD, *Senior Medical Director for Health Management*
Kyle Kircher, MD, *Medical Director for Government Programs*
Alvaro Sanchez, MD, *Medical Director for Health Management*

***Medica Connections* editor:**
Hugh Curtler III
Medica, Marketing & Communications
Phone: 952-992-3354
Fax: 952-992-3377
E-mail: **hugh.curtler@medica.com**

For Medica contact and reference information, **see Medica points of contact for providers**.

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January 1, 2014

This booklet contains important information about your health care services.

Evidence of Coverage

Medica Choice Care

Prepaid Medical Assistance Program (PMAP)

MEDICA®

You belong.

Medica Choice Care℠ (MA) and Medica MinnesotaCare members
Call Medica Customer Service at 952-992-2322
or 1-800-373-8335 (toll-free)

Medica AccessAbility Solution® (SNBC),
Medica DUAL Solution® (MSHO)
and Medica Choice Care MSC+ members
Call Medica Customer Service at 952-992-2580
or 1-888-347-3630 (toll-free)

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយ ឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB3-0015 (3-13)

SPP0613

This information is available in other forms to people with disabilities by calling the above number, or through the National Relay Center toll free at 1-800-855-2880 (TTY/TDD), or 7-1-1, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

Medica will accept all eligible people who choose or are assigned to the Plan. We will not discriminate in regard to physical or mental condition, health status, need for or receipt of health services, claims experience, medical history, genetic information, disability, marital status, age, sex, sexual orientation, national origin, race, color, religion, or political beliefs. Medica will not use any policy or practice that has the effect of such discrimination.

Medica Health Plans
State Public Programs P.O. Box 9310, Route CP340
Minneapolis, MN 55440-9310

Medica Customer Service (English and other languages not listed below) 952-992-2322 or 1-800-373-8335 (toll free). TTY users please call the National Relay Center at 1-800-855-2880 (toll free) and ask for 1-800-373-8335 (toll free).

- Hmong: 952-992-2296
- Russian: 952-992-2294
- Somali: 952-992-2260
- Spanish: 952-992-2297
- Vietnamese: 952-992-2295

We are here to help Monday through Thursday 8 a.m. - 5 p.m.; and Fridays 9 a.m. – 5:00 p.m. We are closed daily from 12:00 p.m. to 12:30 p.m.

2015 ADDENDUM
TO THE EVIDENCE OF COVERAGE FOR
PREPAID MEDICAL ASSISTANCE PROGRAM (PMAP)

This Addendum describes changes to your 2014 Medica Choice Care℠ Evidence of Coverage. Keep this Addendum with your 2014 Medica Choice Care℠ Evidence of Coverage. The changes in this Addendum are effective January 1, 2015, unless noted otherwise.

If you have questions about your health care benefits or need to request a copy of your 2014 Medica Choice Care℠ Evidence of Coverage, call Medica Customer Service at 952-992-2322 or 1-800-373-8335 (toll-free). TTY users, please call the National Relay Center at 1-800-855-2880 (toll-free) and ask for 1-800-373-8335 (toll-free). You may also order a copy of your 2014 Medica Choice Care℠ Evidence of Coverage and other member materials on our website https://portal.medica.com/Member/SPPDocumentRequest

Section 7. Covered Services

Chiropractic Care

The following service is updated as follows:

- Manual manipulation (adjustment) of the spine to treat subluxation of the spine - Up to 24 visits per calendar year, visits exceeding 24 may require a service authorization

Doctor and Other Health Services

Federal approval has now been received for the following service:

- In-Reach Community-Based Services Coordination (IRSC) has been expanded to include children up to age 21 who have severe emotional disturbance (SED).

Early Intensive Developmental and Behavioral Intervention (EIDBI) Services

Upon federal approval, the following services will be covered for children up to age 21:

- Comprehensive Multi-Disciplinary Evaluation (CMDE)
- Applied Behavior Analysis (ABA) Interventions
- Developmental and Behavioral Interventions (DBI)
- Intervention Supervision
- Family/Caregiver Training and Counseling
- Individual Service Plan (ISP) Development and Monitoring
- Coordinated Care Conference
- Telemedicine Services

Mental Health/Behavioral Health Services

Federal approval has now been received for the following services:

- Clinical Care Consultation
- Family Psychoeducation Services

The following services are updated as follows:

- Adult Rehabilitative Mental Health Services (ARMHS) is available to members 18 or over
- Inpatient and outpatient treatment includes extended psychiatric inpatient hospital stay

Obstetrics and Gynecology (OB/GYN) Services

Federal approval has now been received for the following service:

- Doula Services by a qualified professional

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Welcome to Medica.

We are pleased to welcome you as a member of Medica Choice Care (referred to as “Plan” or “the Plan”).

Medica (referred to as “we,” “us,” or “our”) is part of the Prepaid Medical Assistance Program (PMAP). We coordinate and cover your medical services. You will get most of your health services through the Plan’s network of providers. When you need health care or have questions about your health services, you can call us. We will help you decide what to do next and which doctor see.

This Evidence of Coverage or EOC, together with any amendments that we may send to you, is our contract with you. It is an important legal document. Please keep it in a safe place.

This EOC includes:

- Contact information
- Information on how to get the care you need
- Your rights and responsibilities as a member of the Plan
- Information about cost sharing
- A listing of covered and non-covered health care services
- When to call your county worker
- Using the Plan coverage with other insurance or other sources of payment
- Information on what to do if you have a grievance (complaint) or want to appeal a Plan action, as defined in section 14
- Definitions

The counties in the Plan service area are as follows: Becker, Carlton, Cass, Clay, Crow Wing, Fillmore, Hennepin, Houston, Isanti, Mahnomen, Mille Lacs, Otter Tail, Olmsted, Polk, Rice, St. Louis, Wilkin, and Wright.

Please tell us how we're doing. You can call, email, or write to us at any time. (Section 1 of this EOC tells how to contact us.) Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with us. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

Section 1. Telephone numbers and contact information

How to contact our Customer Service

If you have any questions or concerns, please call, email, or write to Medica Customer Service. We will be happy to help you. Medica Customer Service's hours of service are Monday through Thursday 8 a.m. - 5 p.m.; and Fridays 9 a.m. – 5:00 p.m. We are closed daily from 12:00 p.m. to 12:30 p.m.

CALL: 952-992-2322 or 1-800-373-8335 (toll free)
TTY/TDD: Please call the National Relay Center at 1-800-855-2880 (toll free) and ask for 1-800-373-8335 (toll free).
WRITE: Medica Health Plans
State Public Programs P.O. Box 9310, Route CP340
Minneapolis, MN 55440-9310
VISIT: Medica, 401 Carlson Parkway, Minnetonka, MN 55305
WEBSITE: www.medica.com
EMAIL: https://portal.medica.com/Member/ContactUs

Our Plan contact information for certain services

Appeals and Grievances
Call Medica Customer Service at 952-992-2322 or 1-800-373-8335 (toll free). TTY users please call the National Relay Center at 1-800-855-2880 (toll free) and ask for 1-800-373-8335 (toll free). See Section 13 for more information.

Chemical Dependency Services
Call Medica Behavioral Health at 1-800-848-8327 (toll free). TTY users please call the National Relay Center at 1-800-855-2880 (toll free) and ask for 1-800-848-8327 (toll free).

Chiropractic Services
Call Medica Customer Service at 952-992-2322 or 1-800-373-8335 (toll free). TTY users please call the National Relay Center at 1-800-855-2880 (toll free) and ask for 1-800-373-8335 (toll free).

Dental Services
Your dental benefits are administered through Delta Dental of Minnesota, using the CivicSmiles℠ network. Call Delta Dental of Minnesota Customer Service at 651-406-5919 or 1-800-459-8574 (toll free). TTY: 1-800-916-9514 (toll free).

Durable Medical Equipment Coverage Criteria
Call Medica Customer Service at 952-992-2322 or 1-800-373-8335 (toll free). TTY users please call the National Relay Center at 1-800-855-2880 (toll free) and ask for 1-800-373-8335 (toll free).

Health Questions Phone Line
Call Medica CallLink® nurse line – available for you 24 hours every day at 1-866-715-0915 (toll free). TTY users please call the National Relay Center at 1-800-855-2880 (toll free) and ask for 1-866-715-0915 (toll free).

Interpreter Services

Sign language: Please call the National Relay Center at 1-800-855-2880 (toll free) and ask for 952-992-2322 or 1-800-373-8335 (toll free).

Spoken language: If you need an interpreter, call Medica Customer Service at 952-992-2292 or 1-800-601-1805 (toll free).

Mental Health/Behavioral Health Services
Call Medica Behavioral Health at 1- 800-848-8327 (toll free). TTY users please call the National Relay Center at 1-800-855-2880 (toll free) and ask for the number above.

Prescriptions
Call Medica Customer Service at 952-992-2322 or 1-800-373-8335 (toll free). TTY users please call the National Relay Center at 1-800-855-2880 (toll free) and ask for 1-800-373-8335 (toll free).

Transportation
Call Medica Provide-A-Ride SM at 952-992-2292 or 1-800-601-1805 (toll free). TTY users please call the National Relay Center at 1-800-855-2880 (toll free) and ask for 1-800-601-1805 (toll free). Please call at least two to five days before your appointment. We will be happy to assist you with a bus or cab ride, whichever is appropriate.

Other important contact information

People with hearing loss or a speech disability may call the following numbers to access the resources listed in this Evidence of Coverage: 711, Minnesota Relay Service at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service). Calls to these numbers are free.

Minnesota Department of Human Services

The Minnesota Department of Human Services (DHS) is a state agency that helps people meet their basic needs. It provides or administers health care, financial help, and other services. DHS administers the Medical Assistance program through counties. If you have questions about your eligibility for Medical Assistance, contact your county worker.

Ombudsman for State Managed Health Care Programs

The Ombudsman for State Managed Health Care Programs, at the Minnesota Department of Human Services, helps people enrolled in a health plan in resolving service and billing problems. They can help you file a grievance or appeal with us. The ombudsman can also help you request a state fair hearing. Call 651-431-2660 (Twin Cities metro area) or toll free 1-800-657-3729 (non-metro) or 1-800-627-3529 (TDD).

Section 2. Important information on getting the care you need

Each time you get health services, check to be sure that the provider is a Plan network provider. In most cases, you need to use Plan network providers to get your services. Members receive a Provider Directory. It lists Plan network providers. It is current as of the date it is printed. To verify current information, you can: call the provider, call Medica Customer Service at the phone number in Section 1, or visit our website listed in Section 1.

You chose or have been assigned to a Plan network doctor or clinic. This is your primary care clinic. We encourage you to consult with your primary care clinic for health services.

Your primary care clinic or doctor will arrange most of your medical care. It is important that one doctor knows about all your medical needs. The doctor can make sure you get the care you need.

You do not need a referral to see a Plan network specialist. However, your primary care clinic can provide most of the health care services you need, and will help coordinate your care.

Contact your primary care clinic for information about the clinic's hours, service authorizations, and to make an appointment. If you cannot go to your appointment, call your clinic right away.

You may change your primary care provider or clinic. To find out how to do this, call Medica Customer Service at the phone number in Section 1.

Transition of Care:

If you are a newly enrolled member who is currently receiving care from a provider who is not a Plan network provider, we will help you transition to a network provider.

Service authorizations:

Our approval is needed for some services to be covered. This is called service authorization. The approval must be obtained before you get the services or before we pay for them. Many of these services are noted in Section 7. For more information, call Medica Customer Service at the phone number in Section 1.

In most cases, you need to use Plan network providers to get your services. If you need a covered service that you cannot get from a Plan network provider, you must get a service authorization from us to see an out-of-network provider. Exceptions to this rule are:

- Open access services: family planning, diagnosis of infertility, testing and treatment of sexually transmitted diseases (STDs), and testing for AIDS or other HIV-related conditions are open access services. You can go to any doctor, clinic, pharmacy, or family planning agency, even if it is not in our network, to get these services.

- Emergency and post-stabilization services

For more information, call Medica Customer Service at the phone number listed in Section 1.

The Plan allows direct access to the providers in our network, but keeps the right to manage your care under certain circumstances, such as: transplant services. We may do this by choosing the provider you use and/or the services you receive. When we manage your care, our nurse care manager and network providers will coordinate your care. For more information, call Medica Customer Service at the phone number in Section 1.

If we are unable to find you a qualified Plan network provider, we must give you a standing service authorization for you to see a qualified specialist for any of the following conditions:

- A chronic (on-going) condition

- A life-threatening mental or physical illness

- A pregnancy that is beyond the first three months (first trimester)
- A degenerative disease or disability
- Any other condition or disease that is serious or complex enough to require treatment by a specialist

If you do not get a service authorization from us when needed, the bill may not be paid. For more information, call Medica Customer Service at the phone number in Section 1.

If a provider you choose is no longer in our Plan network, you must choose another Plan network provider. You may be able to continue to use services from a provider no longer a part of our Plan network for up to 120 days for the following reasons:

- An acute condition
- A life-threatening mental or physical illness
- A pregnancy that is beyond the first three months (first trimester)
- A physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least one year, or is likely to result in death.
- A disabling or chronic condition that is in an acute phase

If your doctor certifies that you have an expected lifetime of 180 days or less, you may be able to continue to use services for the rest of your life from a provider who is no longer part of our network.

For more information, call Medic Customer Service at the phone number in Section 1.

Covered and non-covered services:

Enrollment in the Plan does not guarantee that certain items are covered. Some prescription drugs or medical equipment may not be covered. This is true even if they were covered before.

Some services and supplies are not covered. All health services must be medically necessary for them to be covered services. Read this EOC carefully. It lists many services and supplies that are not covered. See Sections 7 and 8.

Some services are not covered under the Plan, but may be covered through another source. See Section 9 for more information. If you are not sure whether a service is covered, call our Medica Customer Service at the phone number in Section 1.

We may cover additional or substitute services under some conditions.

Cost sharing:

You may be required to contribute an amount toward some medical services. This is called cost sharing. You are responsible to pay your cost sharing amount to your provider. See Section 6 for more information.

Payments to providers:

We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. If you paid for a service that you think we should have covered, call Medica Customer Service.

You may get health services or supplies not covered by the Plan if you agree to pay for them. Providers must have you sign a form acknowledging that you will be responsible for the bill. Providers must have a signed form before providing services or supplies that are not covered by the Plan.

Interpreter services:

We will provide interpreter services to help you access services. This includes spoken language interpreters and sign language interpreters. Face-to-face oral language interpreter services are only covered if the interpreter is listed in the Minnesota Department of Health's Spoken Language Health Care Interpreter Roster. Please call Medica Customer Service at the phone number in Section 1 to find out which interpreters you can use.

Other health insurance:

If you have other health or dental insurance, tell us **before** you get care. We will let you know if you should use the Plan network providers or the health care providers used by your other insurance. We will coordinate with your other insurance plan. If your other health or dental insurance changes, tell your county worker.

If you have Medicare, you need to get most of your prescription drugs through the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services. The Plan does not pay for prescriptions that are covered under the Medicare Prescription Drug Program.

Private information:

We, and the health care providers who take care of you, have the right to see information about your health care. When you enrolled in the Minnesota Health Care Program, you gave your consent for us to do this. We will keep this information private according to law.

Restricted Recipient Program:

The Restricted Recipient Program is for members who have misused health services. This includes receiving health services that members did not need or using them in a way that costs more than they should.

You must get health services from one designated primary care, one pharmacy, one hospital, or other designated health services providers. You may also be

assigned to a home health agency. You may not be allowed to use the personal care assistance choice or flexible use options, or consumer directed services.

You will be restricted to these designated health care providers for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP).You must get a referral from your primary care provider to see a provider who is not a designated provider. Restricted recipients may not pay out-of-pocket to see a non-designated provider who is the same provider type as one of their designated providers.

Placement in the program will stay with you if you change health plans. Placement in the program will also stay with you if you change to MHCP fee-for-service. You will not lose eligibility for MHCP because of placement in the program.

At the end of the 24 months, your use of health services will be reviewed. If you still misused health services, you will be placed in the program for an additional 36 months of eligibility. You have the right to appeal placement in the Restricted Recipient Program. See Section 13.

Cancellation:

Your coverage with us will be canceled if you are not eligible for Medical Assistance or if you enroll in a different health plan.

If you are no longer eligible for Medical Assistance, you may be eligible to purchase health coverage through MNsure. For information about MNsure, call toll free 1-855-3MNSURE or 1-855-366-7873, or visit www.MNsure.org.

Section 3. Member Bill of Rights

You have the right to:

Get the services you need 24 hours a day, seven days a week. This includes emergencies.

Be told about your health problems.

Get information about treatments, your treatment choices, and how they will help or harm you.

Refuse treatment and get information about what might happen if you refuse treatment.

Refuse care from specific providers.

Know that we will keep your records private according to law.

File a grievance or appeal with us. You can also file a complaint with the Minnesota Department of Health.

Request a state fair hearing with the Minnesota Department of Human Services (also referred to as "the state"). You may request a state fair hearing before or at any time during our appeal process. You do not have to file an appeal with us before you request a state fair hearing.

Receive a clear explanation of covered home care services.

Request and receive a copy of your medical records. You also have the right to ask to correct the records.

Get notice of our decisions if we deny, reduce, or stop a service, or deny payment for a service.

Participate with providers in making decisions about your health care.

Be treated with respect, dignity, and consideration for privacy.

Give written instructions that inform others of your wishes about your health care. This is called a "health care directive." It allows you to name a person (agent) to decide for you if you are unable to decide, or if you want someone else to decide for you.

Be free of restraints or seclusion used as a means of: coercion, discipline, convenience, or retaliation.

Choose where you will get family planning services, diagnosis of infertility, sexually transmitted disease testing and treatment services, and AIDS and HIV testing services.

Get a second opinion for medical, mental health, and chemical dependency services.

Request a copy of this Evidence of Coverage at least once a year.

Get the following information from us, if you ask for it. Call Medica Customer Service at the phone number in Section 1.

- Whether we use a physician incentive plan that affects the use of referral services
- The type(s) of incentive arrangement used
- Whether stop-loss protection is provided
- Results of a member survey if one is required because of our physician incentive plan
- Results of an external quality review study from the state
- The professional qualifications of health care providers

Make recommendations about our rights and responsibilities policy.
Exercise the rights listed here.

Section 4. Member Responsibilities

You have the responsibility to:

Read this Evidence of Coverage and know which services are covered under the Plan and how to get them.

Show your health plan ID card and your Minnesota Health Care Program (ID) card every time you get health care. Also show the cards of any other health coverage you have, such as Medicare or private insurance.

Establish a relationship with a Plan network primary care doctor before you become ill. This helps you and your primary care doctor understand your total health condition.

Give information asked for by your doctor and/or health plan so the right care or services can be provided to you. Share information about your health history.

Work with your doctor to understand your total health condition. Develop mutually agreed-upon treatment goals when possible. If you have questions about your care, ask your doctor.

Know what to do when a health problem occurs, when and where to seek help, and how to prevent health problems.

Practice preventive health care. Have tests, exams and shots recommended for you based on your age and gender.

Contact us if you have any questions, concerns, problems or suggestions. Call Medica Customer Service at the phone number in Section 1.

Section 5. Your Health Plan ID Card

Each member will receive a Plan ID card.

Always carry your Plan ID card with you.

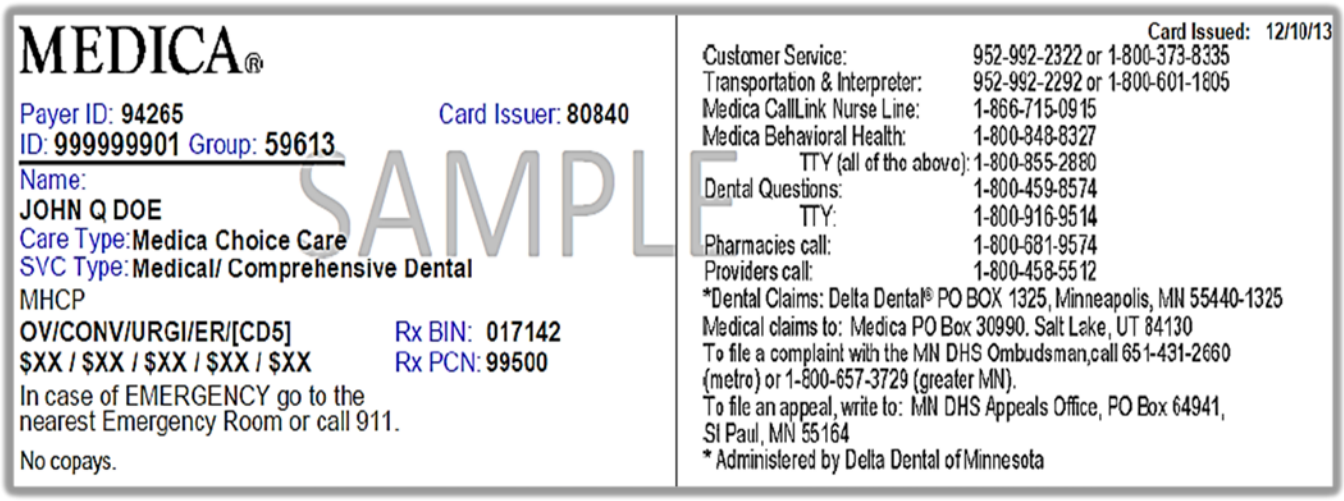
You must show your Plan ID card whenever you get health care.

You must use your Plan ID card along with your Minnesota Health Care Program (ID) card. Also show the cards of any other health coverage you have, such as Medicare or private insurance.

Call Medica Customer Service at the phone number in Section 1 right away if your ID card is lost or stolen. We will send you a new card.

Call your county worker if your Minnesota Health Care Program (ID) card is lost or stolen.

Here is a sample Plan ID card to show what it looks like:


MEDICA®

Payer ID: 94265 Card Issuer: 80840
ID: 999999901 Group: 59613
Name:
JOHN Q DOE
Care Type: Medica Choice Care
SVC Type: Medical/ Comprehensive Dental
MHCP
OV/CONV/URGI/ER/[CD5] Rx BIN: 017142
$XX / $XX / $XX / $XX / $XX Rx PCN: 99500
In case of EMERGENCY go to the nearest Emergency Room or call 911.
No copays.

SAMPLE

Card Issued: 12/10/13
Customer Service: 952-992-2322 or 1-800-373-8335
Transportation & Interpreter: 952-992-2292 or 1-800-601-1805
Medica CallLink Nurse Line: 1-866-715-0915
Medica Behavioral Health: 1-800-848-8327
TTY (all of the above): 1-800-855-2880
Dental Questions: 1-800-459-8574
TTY: 1-800-916-9514
Pharmacies call: 1-800-681-9574
Providers call: 1-800-458-5512
*Dental Claims: Delta Dental® PO BOX 1325, Minneapolis, MN 55440-1325
Medical claims to: Medica PO Box 30990. Salt Lake, UT 84130
To file a complaint with the MN DHS Ombudsman,call 651-431-2660 (metro) or 1-800-657-3729 (greater MN).
To file an appeal, write to: MN DHS Appeals Office, PO Box 64941, St Paul, MN 55164
* Administered by Delta Dental of Minnesota

Section 6. Cost Sharing

Cost sharing refers to your responsibility to pay an amount towards your medical costs. For people in the Prepaid Medical Assistance Program (PMAP), cost sharing consists only of copays.

If your income is at or below 100 percent of federal poverty guidelines, you will pay no more than five percent of your monthly family income for cost sharing. This may reduce the copay and deductible amount to less than the amounts listed here. DHS will tell us each month if you have a reduced cost sharing amount.

Copays

The members listed here **do not** have to pay copays for medical services that are covered by Medical Assistance (MA) under the Plan:

- Pregnant women (If you become pregnant, tell your county worker right away.)
- Members under age 21
- Members receiving hospice care
- Members residing in a nursing home, hospital, or other long-term care facility for more than 30 days

Some services require copays. A copay is an amount that you will be responsible to pay to your provider.

Copays are listed in the following chart:

Service	Copay Amount
Non-preventive visits – (such as visits for a sore throat, diabetes checkup, high fever, sore back, etc.) provided by a physician, physician assistant, advanced practice nurse, certified professional midwife, chiropractor, acupuncturist, podiatrist, audiologist, or eye doctor. There are no copays for mental health services.	$3.00

Diagnostic procedures (for example, endoscopy, arthroscopy)	$3.00
Emergency room visit when it is not an emergency	$3.50
Brand name prescriptions *The most you will have to pay in copays for prescriptions is $12.00 per month.*	$3.00
Generic prescriptions *The most you will have to pay in copays for prescriptions is $12.00 per month.*	$1.00

The most you will have to pay in copays for prescriptions is $12.00 per month. Copays will not be charged for some mental health drugs and most family planning drugs.

If you have Medicare, you must get most of your prescription drugs through a Medicare Prescription Drug Program (Medicare Part D) plan. You may have different copays with no monthly limit for some of these services.

You must pay your copay directly to your provider. Some providers require that you pay the copay when you arrive for the medical service. The hospital may bill you after your non-emergency visit to the emergency room.

If you are unable to pay the copay, the provider must still provide services. This is true even if you have not paid your copay to that provider in the past or if you have other debts to that provider. The provider may still bill you for the unpaid copays.

We get information from the state about which members do not have copays. You may need to pay a copay until you are listed in our system as a person who is exempt from copays.

Examples of services that **do not** have copays:

- Chemical dependency treatment
- Dental services
- Emergency services
- Eye glasses
- Family planning services and supplies
- Home care
- Immunizations
- Inpatient hospital stays
- Interpreter services
- Medical equipment and supplies
- Medical transportation
- Mental health services
- Preventive care visits, such as physicals
- Rehabilitation therapies
- Repair of eyeglasses
- Services covered by Medicare, except for Medicare Part D drugs
- Some mental health drugs (anti-psychotics)
- Some preventive screenings and counseling, such as cervical cancer screening and nutritional counseling
- Tests such as blood work and X-rays
- Tobacco use counseling and interventions
- 100% federally funded services at Indian Health Services clinics

This is not a complete list. Call Medica Customer Service at the phone number in Section 1 if you have questions.

Section 7. Covered Services

This section describes the major services that are covered under the Plan for Medical Assistance members. It is not a complete list. Some services have limitations. Some services require a service authorization. A service marked with an asterisk (*) means a service authorization is required or may be required. Make sure there is a service authorization in place before you get the service. All health care services must be medically necessary for them to be covered. Call Medica Customer Service at the phone number in Section 1 for more information.

Some services require cost sharing. Cost sharing refers to your responsibility to pay an amount toward your medical costs. See Section 6 for information about cost sharing and exceptions to cost sharing.

*Chemical Dependency Services

Covered Services:

- Assessment/diagnosis
- Outpatient treatment
- Inpatient hospital
- Residential non-hospital treatment
- Outpatient methadone treatment
- Detoxification *(only if required for medical treatment)*
- Room and board determined necessary by chemical dependency assessment *(through June 30, 2014. See Notes.)*

Notes:

See Section 1 for Chemical Dependency Services contact information.

A qualified assessor who is part of the Plan network will decide what type of chemical dependency care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment you must send us a request. We must get your request within five working days of when you get the results of your first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor not in the

Plan network. We will do this within five working days of when we get your request. If you agree with the second assessment, we will authorize services according to chemical dependency standards and the second assessment. You have the right to appeal. See Section 13 of this Evidence of Coverage.

Effective July 1, 2014, payment for room and board determined necessary by chemical dependency assessment is the responsibility of the Minnesota Department of Human Services. Room and board will no longer be covered through the Plan.

Child and Teen Checkups (C&TC)

Covered Services:

- Child and Teen Checkups (C&TC) preventive health visits include:
  - growth measurements
  - health education
  - health history including mental health, nutrition, and chemical use
  - developmental screening
  - mental health screening
  - physical exam
  - immunizations
  - laboratory tests
  - vision checks
  - hearing checks
  - regular dental checks

Notes:

C&TC is a health care program of well-child visits for members under age 21. C&TC visits help find and treat health problems early. How often a C&TC is needed depends on age:

- Birth to 2 years: 0-1, 2, 4, 6, 9, 12, 15, 18 and 24 months
- 3 to 21 years: 3, 4, 5, 6, 8, 10, 12, 14, 16, 18 and 20 years

Contact your Primary Care Clinic to schedule your C&TC visits.

Chiropractic Care

Covered Services:

- One evaluation or exam per year
- Manual manipulation (adjustment) of the spine to treat subluxation of the spine
- Acupuncture for chronic pain management within the scope of practice by chiropractors with acupuncture training or credentialing
- X-rays when needed to support a diagnosis of subluxation of the spine

Not Covered Services:

- Other adjustments, vitamins, medical supplies, therapies and equipment from a chiropractor

Dental Services (for adults except pregnant women)

Covered Services:

- Diagnostic services:
  - comprehensive exam *(once every five years)*
  - periodic exam (*once per calendar year)*
  - limited (problem-focused) exams *(once per day per provider)*
  - x-rays, limited to:
    - bitewing *(once per calendar year)*
    - single x-rays for diagnosis of problems
    - panoramic *(once every five years and as medically necessary for diagnosis and follow-up of oral and maxillofacial conditions and trauma; once every two years in limited situations)*
    - full mouth x-rays *(once every five years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center [ASC])*
- Preventive services:
  - cleaning (*up to four times per year if medically necessary)*
  - fluoride varnish *(once per calendar year)*

- Restorative services:
    - fillings
    - sedative fillings for relief of pain
- Endodontics (root canals) *(on anterior teeth and premolars only and once per lifetime; retreatment is not covered)*
- Periodontics:
    - gross removal of plaque and tartar (full mouth debridement) *(once every five years)*
    - scaling and root planing *(once every two years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center [ASC])*
- Prosthodontics:
    - removable prostheses (dentures and partials) *(once every six years per dental arch)*
    - relines, repairs, and rebases of removable prostheses (dentures and partials)
    - replacement of prosthesis that are lost, stolen, or damaged beyond repair under certain circumstances
    - Replacement of partial prostheses if the existing partial cannot be altered to meet dental needs
- Oral surgery *(limited to extractions, biopsies, and incision and drainage of abscesses)*
- Additional general services:
    - treatment for pain *(once per day)*
    - general anesthesia *(only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center [ASC])*
    - extended care facility/house call in certain institutional settings. These include: nursing facilities, skilled nursing facilities, boarding care homes, IMD's (Institutes of Mental Disease/Mental Illness), ICF/DDs (Intermediate Care Facilities for Persons with Developmental Disabilities) Hospices, METO (Minnesota Extended Treatment Options), and swing beds (a nursing facility bed in a hospital)
    - behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
    - oral or IV sedation

Notes:

See Section 1 for Dental Services contact information.

Dental Services (for children and pregnant women)

Covered Services:

- Diagnostic services:
  - comprehensive exam
  - periodic exam
  - limited (problem focused) exams
  - x-rays, limited to:
    - bitewing
    - single x-rays for diagnosis of problems
    - panoramic
    - full mouth x-rays
- Preventive services:
  - cleaning
  - fluoride varnish *(once every six months)*
  - sealants for children under age 21 *(one every five years per permanent molar)*
- Restorative services:
  - fillings
  - sedative fillings for relief of pain
  - Individual crowns *(must be made of prefabricated stainless steel or resin)*
- Endodontics (root canals) *(once per tooth per lifetime)*
- Periodontics:
  - gross removal of plaque and tartar (full mouth debridement)
  - scaling and root planing
- Prosthodontics:
  - removable prostheses (dentures and partials) (*once every three years per dental arch)*
  - relines, repairs, and rebases of removable prostheses (dentures and partials)
  - replacement of prosthesis that are lost, stolen, or damaged beyond repair under certain circumstances
  - replacement of partial prostheses if the existing partial cannot be altered to meet dental needs
- Oral surgery

- Orthodontics *(only when medically necessary for very limited conditions for children under age 21)*
- Additional general services:
  - treatment for pain
  - general anesthesia
  - extended care facility/house call in certain institutional settings. These include: nursing facilities, skilled nursing facilities, boarding care homes, IMD's (Institutes of Mental Disease/Mental Illness), ICF/DDs (Intermediate Care Facilities for Persons with Developmental Disabilities) Hospices, METO (Minnesota Extended Treatment Options), and swing beds (a nursing facility bed in a hospital) A school or Head Start program is not an extended care facility.
  - behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
  - oral or IV sedation

Notes:

See Section 1 for Dental Services contact information.

Diagnostic Services

Covered Services:

- Lab tests and X-rays
- Other medical diagnostic tests ordered by your doctor

Doctor and Other Health Services

Covered Services:

- Doctor visits including:
  - care for pregnant women
  - family planning – **open access service**
  - lab tests and x-rays
  - physical exams
  - preventive exams
  - preventive office visits
  - specialists
  - telemedicine consultation
  - vaccines and drugs administered in a doctor's office
  - visits for illness or injury
  - visits in the hospital or nursing home
- Immunizations
- Health Care Home services: care coordination for members with complex or chronic health care needs
- Clinical trial coverage: Routine care that is: 1) provided as part of the Protocol Treatment of a cancer Clinical Trial; 2) is usual, customary and appropriate to your condition; and 3) would be typically provided outside of a Clinical Trial. This includes services and items needed for the treatment of effects and complications of the Protocol Treatment.
- Podiatry services (debridement of toenails, infected corns and calluses, and other non-routine foot care)
- Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit
- Advanced practice nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist
- Community health worker care coordination and patient education services
- Health education and counseling (for example, smoking cessation, nutrition counseling, diabetes education)
- Blood and blood products
- Cancer screenings (including mammography, pap test, prostate cancer screening, colorectal cancer screening)
- Tuberculosis care management and direct observation of drug intake

- Counseling and testing for sexually transmitted diseases (STDS), AIDS and other HIV-related conditions - **open access service**
- Treatment for AIDS and other HIV-related conditions - **NOT** an open access service. You must see a provider in the Plan network.
- Treatment for sexually transmitted diseases (STDs) – **open access service**
- Acupuncture for chronic pain management by licensed acupuncturist or within the scope of practice by a licensed provider with acupuncture training or credentialing.
- Respiratory therapy
- Hospital In-reach Community-based Service Coordination: coordination of services targeted at reducing hospital emergency department (ED) use under certain circumstances. This service addresses health, social, economic, and other needs of members to help reduce usage of ED and other health care services.
- Community Paramedic Services: certain services provided by a community paramedic for some members. They must be part of a care plan ordered by your primary care provider and must meet other requirements. The services may include:
    - health assessments
    - chronic disease monitoring and education
    - help with medications
    - immunizations and vaccinations
    - collecting lab specimens
    - follow-up care after being treated at a hospital
    - other minor medical procedures.

Not Covered Services:

- Artificial ways to become pregnant (artificial insemination, including in-vitro fertilization and related services, fertility drugs and related services)

Emergency Medical Services and Post-Stabilization Care

Covered Services:

- Emergency room services
- Post-stabilization care
- Ambulance (air or ground)

Not Covered Services:

Emergency, urgent, or other health care services delivered or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

Notes:
In an emergency that needs treatment right away, either call 911 or go to the closest emergency room. Show them your Medica ID card and ask them to call your primary care doctor.

In all other cases, call your primary care doctor, if possible You can call the number 24 hours a day, seven days a week and get instructions about what to do.

If you are out of town, go to the closest emergency room. Show them your Medica ID card and ask them to call your primary care doctor.

You must call your Medica Customer Service within 48 hours or as soon as you can after getting emergency care at a hospital that is not a part of the Plan network.

Eye Care Services

Covered Services:

- Eye exams
- Eyeglasses, including identical replacement for loss, theft, or damage beyond repair
- Repairs to frames and lenses for eyeglasses covered under the Plan
- Tints or polarized lenses, when medically necessary
- Contact lenses, when medically necessary under certain conditions

Not Covered Services:

- Extra pair of glasses
- Eyeglasses more often than every 24 months, unless medically necessary
- Bifocal/Trifocal lenses without lines and progressive bifocals/trifocals
- Protective coating for plastic lenses
- Contact lenses supplies

Family Planning Services

Covered Services:

- Family planning exam and medical treatment – **open access service**
- Family planning lab and diagnostic tests – **open access service**
- Family planning methods (birth control pills, patch, ring, IUD, injections, implants) – **open access service**
- Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) – **open access service**
- Counseling and diagnosis of infertility, including related services – **open access service**
- Treatment for medical conditions of infertility – **NOT** an open access service. You must see a provider in the Plan network. Note: This service does not include artificial ways to become pregnant.
- Counseling and testing for sexually transmitted disease (STDs), AIDS, and other HIV-related conditions – **open access service**
- Treatment for sexually transmitted diseases (STDs) - **open access service**

- Voluntary sterilization – **open access service**
  Note: You must be age 21 or over and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.
- Genetic counseling - **open access service**
- Genetic testing – **NOT** an open access service**.** You must see a provider in the Plan network.
- Treatment for AIDS and other HIV-related conditions - **NOT** an open access service. You must see a provider in the Plan network.

Not Covered Services:

- Artificial ways to become pregnant (artificial insemination, including in-vitro fertilization and related services; fertility drugs and related services)
- Reversal of voluntary sterilization

Notes:

Federal and state law allow you to choose any physician, clinic, hospital, pharmacy, or family planning agency to get **open access services**. You can get open access services from any provider, even if they are not in the Plan network.

Hearing Aids

Covered Services:

- Hearing aids and batteries
- Repair and replacement of hearing aids due to normal wear and tear, with limits

***Home Care Services**

Covered Services:

- Skilled nursing
- Rehabilitation therapies to restore function (for example, speech, physical, occupational)

- Home health aide
- Private duty nursing
- Personal Care Assistant (PCA). Community First Services and Supports (CFSS) replaces PCA services upon federal approval.

<u>*Hospice</u>

Covered Services:

- Doctor, nurse, and other professional services
- Medical social services
- Medical equipment and supplies
- Physical, occupational, and speech therapies
- Short-term inpatient care, including respite care
- Counseling, including dietary counseling
- Home health aide and homemaker services
- Outpatient drugs for symptom management and pain relief

Notes:

You must elect hospice benefits to receive hospice services.

Members under the age of 21 receiving hospice services have coverage for services related to treatment of the terminal condition.

If you are interested in using hospice services, please call Medica Customer Service at the phone number in Section 1.

<u>Hospital - Inpatient</u>

Covered Services:

- Inpatient hospital stay
- Your semi-private room and meals
- Private room when medically necessary
- Tests and x-rays
- Surgery

- Drugs
- Medical supplies
- Therapy services (for example physical, occupational, speech, respiratory)

Not Covered Services:

- Personal comfort items, such as TV, phone, barber or beauty services, guest services

Hospital – Outpatient

Covered Services:

- Urgent care for conditions that are not as serious as an emergency
- Outpatient surgical center
- Tests and x-rays
- Dialysis
- Emergency room services
- Post-stabilization care

Interpreter Services

Covered Services:

- Spoken language interpreter services
- Sign language interpreter services

Notes:

Interpreter services are available to help you get services.

Oral interpretation is available for any language.

Face-to-face oral language interpreter services are only covered if the interpreter is listed in the Minnesota Department of Health's Spoken Language Health Care Interpreter Roster. See Interpreter Services in Section 1 for contact information and to find out which interpreters you can use.

Medical Equipment and Supplies

Covered Services:

- Prosthetics or orthotics
- Durable medical equipment (e.g., wheelchair, hospital bed, walker, crutches, and wigs for people with alopecia areata) Contact Medica Customer Service for more information on coverage and benefit limits for wigs.
- Repairs of medical equipment
- Batteries for medical equipment
- Some shoes when part of a leg brace or when custom molded
- Oxygen and oxygen equipment
- Medical supplies you need to take care of your illness, injury, or disability
- Diabetic equipment and supplies
- Nutritional/enteral products when specific criteria are met
- Incontinence products
- Family planning supplies – **open access service**. See Family Planning Services in this section.
- Augmentative communication devices, including electronic tablets

Not Covered Services:

- Constructive modifications to home, vehicle, or workplace, including bathroom grab bars
- Environmental products (such as air filters, purifiers, conditioners, dehumidifiers)
- Exercise equipment

Notes:

You need a prescription/doctor's order in order for medical equipment and supplies to be covered.

Please call the durable medical equipment coverage criteria phone number in Section 1 if you need more information on our durable medical equipment coverage criteria.

*Mental Health/Behavioral Health Services

Covered Services:

- Case management for transitional youth *(for members ages 17 through 20)*
- Crisis response services including:
  - Assessment
  - Intervention
  - Stabilization
  - Community intervention *(for members over age 18)*
- Diagnostic assessments including screening for the presence of co-occurring mental illness and substance use disorder
- Dialectical Behavioral Therapy (DBT) *(for members over age 18 who meet certain criteria)*
- Inpatient psychiatric hospital stay
- Mental Health Targeted Case Management (MH-TCM)
- Subacute psychiatric level of care *(for members under age 21)*
- Outpatient Mental Health Services including:
  - Explanation of findings
  - Clinical care consultation *(for members under age 21)* (upon federal approval)
  - Certified family peer specialists *(for members under age 21)* (upon federal approval)
  - Family psychoeducation services *(for members under age 21)* (upon federal approval)
  - Mental health medication management
  - Neuropsychological services
  - Psychotherapy (patient and/or family, family, crisis, and group)
  - Psychological testing
- Rehabilitative Mental Health Services including:
  - Assertive Community Treatment (ACT) *(for members over age 18)*
  - Adult day treatment *(for members over age 18)*
  - Adult Rehabilitative Mental Health Services (ARMHS) *(for members over age 18)*
  - Certified peer specialist support services in some situations
  - Children's mental health residential treatment services *(for members under age 21)*

**Requires or may require a service authorization.*

- Children's Therapeutic Services and Supports (CTSS) including Children's Day Treatment *(for members under age 21)*
- CTSS mental health service plan development *(for members under age 21)* (upon federal approval)
- Family psychoeducation services *(for members under age 21)* (upon federal approval)
- Intensive Residential Treatment Services (IRTS) *(for members over age 18)*
- Intensive Treatment Foster Care Services *(for members under age 21)* (upon federal approval)
- Partial Hospitalization Program
- Youth Assertive Community Treatment (Youth ACT): intensive non-residential rehabilitative mental health services *(for members ages 16 through 20)*

▪ Physician Mental Health Services including:
  - Health and behavior assessment/intervention
  - Inpatient visits
  - Psychiatric consultations to primary care providers
  - Physician consultation, evaluation, and management

▪ Treatment services at children's residential mental health treatment facilities (Rule 5 - children's group residential facilities with mental health certification). Treatment services do not include coverage for room and board. Room and board may be covered by your county. Call your county for information.

Not Covered Services:

The following services are not covered under the Plan but may be available through your county. Call your county for information. Also see Section 9.

▪ Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)

▪ Room and board associated with Intensive Residential Treatment Services (IRTS)

- Treatment and room and board services at certain children's residential mental health treatment facilities (Rule 5 - children's group residential facilities with mental health certification) in bordering states

Notes:

See Mental Health Services in Section 1 for information on where you should call or write.

Get mental health services from the Plan network of mental health providers.

If we decide no structured mental health treatment is necessary, you may get a second opinion. For the second opinion, we must allow you to go to any qualified health professional that is not in the Plan network. We will pay for this. We must consider the second opinion, but we have the right to disagree with the second opinion. You have the right to appeal our decision.

We will not determine medical necessity for court-ordered mental health services. Use a Plan network provider for your court-ordered mental health assessment.

Obstetrics and Gynecology (OB/GYN) Services

Covered Services:

- Prenatal, delivery, and postpartum care
- Childbirth classes
- Hospital services for newborns
- HIV counseling and testing for pregnant women – **open access service**
- Treatment for HIV-positive pregnant women
- Treatment for newborns of HIV-positive mothers
- Testing and treatment of sexually transmitted diseases (STDs) – **open access service**
- Pregnancy-related services received in connection with an abortion *(does not include abortion-related services)*
- Doula services by a qualified professional (upon federal approval or July 1, whichever is later)

- Services provided by a licensed health professional at licensed birth centers including services of certified professional midwives and licensed traditional midwives.

Not Covered Services:

- Abortion: This service is not covered under the Plan. It may be covered by the state. Call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll free) for coverage information. Also see Section 9.
- Planned home births

Notes:

You have "direct access" to OB-GYN for the following services: annual preventive health exam, including follow-up exams that your doctor says are necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get the direct access services you must go to a provider in the Plan network. For services labeled as **open access**, you can go to any doctor clinic, hospital, pharmacy, or family planning agency.

<u>*Out-of-area Services</u>

Covered Services:

- A service you need when temporarily out of the Plan service area
- A service you need after you move from our service area while you are still a Plan member
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- Medically necessary urgent care when you are outside of the Plan service area. (Call Medica Customer Service at the phone number in Section 1 as soon as possible.)
- Covered services that are not available in the Plan service area

Not Covered Services:

- Emergency, urgent, or other health care services or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

<u>*Out-of-network Services</u>

Covered Services:

- Certain services you need that you cannot get through a Plan network provider
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- A second opinion for mental health and chemical dependency
- Open access services
- Pregnancy-related services received in connection with an *abortion (does not include abortion-related services)*

<u>Prescription Drugs (for members who do NOT have Medicare)</u>

Covered Services:

- Prescription drugs
- Medication therapy management (MTM) services
- Certain over-the-counter drugs *(when prescribed by a qualified health care provider with authority to prescribe)*

Not Covered Services:

- Drugs used to treat erectile or sexual dysfunction
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs or products to promote weight loss
- Drugs not clinically proven to be effective

**Requires or may require a service authorization.*

Notes:
The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your doctor shows us that: 1) the drug that is normally covered has caused a harmful reaction to you; 2) there is a reason to believe the drug that is normally covered would cause a harmful reaction; or 3) the drug prescribed by your doctor is more effective for you than the drug that is normally covered. The drug must be in a class of drugs that is covered.

We will cover an antipsychotic drug, even if it is not on our drug list, if your provider certifies this is best for you. There is no copay for anti-psychotic drugs. In certain cases, we will also cover other drugs used to treat a mental illness or emotional disturbance even if the drug is not on our approved drug list. We will do this for up to one year if your provider certifies the drug is best for you and you have been treated with the drug for 90 days before: 1) we removed the drug from our drug list; or 2) you enrolled in the Plan. For most drugs, you can get only a *31* day supply at one time.

There are some drugs that are not on Medica's formulary. There is a process for requesting a formulary exception. Your provider may request an exception. Medica providers are notified of the drugs on Medica's formulary, which require service authorization. They are also informed about the process to get a service authorization. Certain criteria must be met for the drugs to be covered. That criteria is described above. If your condition meets the criteria, your provider will receive the authorization notice. If your exception request is denied, you have the right to appeal. You may call Medica Customer Service at the phone number in Section 1 for more information or see Section 13 of this Certificate.

If a pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by us under the Plan. If the pharmacy won't call your doctor, you can. You can also call Medica Customer Service at the phone number in Section 1 for help.

Prescription Drugs (for members who have Medicare)

Covered Services:

- Some over-the-counter products, some prescription cough and cold products, and some vitamins that are not covered under the Medicare Prescription Drug Program (Medicare Part D)

Not Covered Services:

- Prescription drugs that are eligible to be covered under the Medicare Prescription Drug Program (Medicare Part D)
- Drugs used to treat erectile or sexual dysfunction
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs or products to promote weight loss
- Drugs not clinically proven to be effective

Notes:

Medicare pays for most of your prescription drugs through the Medicare Prescription Drug Program (Medicare Part D). **You must enroll in a Medicare prescription drug plan** to receive most of your prescription drug services. You will get your prescription drug services through your Medicare prescription drug plan – not through our Plan. You may have to pay a copay for prescriptions covered by your Medicare prescription drug plan.

Effective January 1, 2014, Medicare Part D includes benzodiazepines and barbiturates. Medical Assistance no longer covers these drugs for people who have Medicare.

Rehabilitation

Covered Services:

- Rehabilitation therapies to restore function : physical therapy, occupational therapy, speech therapy
- Audiology services including hearing tests

Not Covered Services:

- Vocational rehabilitation
- Health clubs and spas

Surgery

Covered Services:

- Office/clinic visits/surgery
- Removal of port wine stain birthmarks
- Reconstructive surgery (for example, following mastectomy, following surgery for injury, sickness or other diseases; for birth defects)
- Anesthesia services
- Circumcision when medically necessary

Not Covered Services:

- Cosmetic surgery
- Sex reassignment surgery

*Transplants

Covered Services:

- Organ and tissue transplants, including: bone marrow, cornea, heart, heart-lung, intestine, intestine-liver, kidney, liver, lung, pancreas, pancreas-kidney, pancreatic islet cell, stem cell, and other transplants

**Requires or may require a service authorization.*

Notes:

The type of transplant must be: 1) listed in the Minnesota Department of Human Services Provider Manual; 2) a type covered by Medicare; or 3) be approved by the state's medical review agent.

Transplants must be done at transplant centers that meet the United Network for Organ Sharing (UNOS) standards or at Medicare approved transplant centers.

Stem cell or bone marrow transplants centers must meet the standards set by the Foundation for the Accreditation of Cellular Therapy (FACT).

Transportation to/from Medical Services

Covered Services:

- Emergency ambulance (air or ground)
- Non-emergency ambulance
- *Special transportation *(for members who, because of physical or mental impairment, cannot safely use a common carrier and do not need an ambulance)*
- Common carrier transportation (for example, bus, cab, or through volunteer driver programs)

Not Covered Services:

- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. These services are not covered under the Plan, but may be available through another source. Call your county for more information.

Notes:
If you need transportation to and from health services that we cover, call the Transportation phone number in Section 1. We will provide the most appropriate and cost-effective form of transportation.

The Plan is not required to provide transportation to your primary care clinic if it is over 30 miles from your home or if you choose a Specialty provider that is more than 60 miles from your home. Call the Transportation phone number in Section 1 if you do not have a primary care clinic that is available within 30 miles of your home and/or if it is over 60 miles to your specialty provider.

Urgent Care

Covered Services:

- Urgent care within the Plan service area
- Urgent care outside of the Plan service area

Not Covered Services:

- Urgent, emergency, or other health care services delivered or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

Notes:

An urgent condition is not as serious as an emergency. This is care for a condition that needs prompt treatment to stop the condition from getting worse. Urgent care is available 24 hours a day.

Call Medica Customer Service at the phone number in Section 1 as soon as possible when you get urgent care outside the Plan service area.

Section 8. Services we do not cover

If you get services or supplies that are not covered, you may have to pay for them yourself. Some "not covered" services and supplies are listed under each category in Section 7. Below is a list of other services and supplies that are not covered under the Plan. This is not a complete list. Call Medica Customer Service for more information.

- Health care services or supplies that are not medically necessary
- Supplies that are not used to treat a medical condition
- Hospital inpatient and nursing home incidental services, such as TV, phone, barber and beauty services, and guest services
- Cosmetic procedures or treatment
- Experimental or investigative services
- Emergency, urgent, or other health care services delivered or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.
- Homeopathic and herbal products
- Autopsies (exams that are done on the bodies of people who have died to find out the cause of death)

Section 9. Services that are not covered under the Plan but may be covered through another source

These services are not covered by us under the Plan, but may be covered through another source, such as the state, county, federal government, tribe, or a Medicare prescription drug plan. To find out more about these services, call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll free).

- Child welfare targeted case management
- Case management for members with developmental disabilities
- Intermediate care facility for members with developmental disabilities (ICF/DD)
- Nursing home stays
- Abortion services
- Medically necessary services specified in an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) that are provided by a school district and covered under Medical Assistance
- Prescriptions covered under the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services.
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Services provided by a state regional treatment center, a state-owned long term care facility, or an institution for mental disease (IMD), unless approved by us or the service is ordered by a court under conditions specified in law
- Services provided by federal institutions
- Waiver services provided under Home and Community Based Services waivers
- Job training and educational services
- Day training and habilitation services
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.

- Room and board associated with treatment services at children's residential mental health treatment facilities (Rule 5). Room and board may be covered by your county. Call your county for information.

Section 10. When to call your county worker

Call your county worker to report these changes:

- Name or address changes
- Pregnancy begin/end dates
- Addition or loss of a household member
- Lost or stolen Minnesota Health Care Program ID card
- New insurance or Medicare – begin/end dates
- New job or change in income

Section 11. Using the Plan coverage with other insurance

If you have other insurance, tell us before you get care. We will let you know if you should use the Plan network providers or the health care providers used by your other insurance. We will coordinate our payments with them. This is called "coordination of benefits." Examples of other insurance include:

- No-fault car insurance
- Workers' compensation
- Medicare
- Other Health Maintenance Organization (HMO) coverage
- Other commercial insurance

When you become a member of the Plan, you agree to:

- Let us send bills to your other insurance
- Let us get information from your other insurance
- Let us get payments from your other insurance instead of having payments sent to you
- Help us get payments from your other insurance

If your other insurance changes, call your county worker.

Section 12. Subrogation or other claim

This first paragraph applies to certain non-citizens in the Prepaid Medical Assistance Program (PMAP):

You may have other sources of payment for your medical care. They might be from another person, group, insurance company, or other organization. If you have a claim against another source for injuries, we will make a claim for medical care we covered for you. State law requires you to help us do this. The claim may be recovered from any settlement or judgment received by you from another source. This is true even if you did not get full payment of your claim. The amount of the claim will not be more than state law allows.

This second paragraph applies to members in the Prepaid Medical Assistance Program (PMAP), except certain non-citizens:

You may have other sources of payment for your medical care. They might be from another person, group, insurance company or other organization. Federal and state laws provide that Medical Assistance benefits pay only if no other source of payment exists. If you have a claim against another source for injuries, we will make a separate claim for medical care we covered for you. The laws require you to help us do this. The claim may be recovered from any source that may be responsible for payment of the medical care we covered for you. The amount of the claim will not be more than federal and state laws allow.

Section 13. Grievance, appeal and state fair hearing process

This section tells you about the grievance system including notices, grievances (complaints), appeals and state fair hearings. It tells you how and when to use the grievance system if you are not satisfied with your health care or disagree with a decision we make. It tells you about your rights when using the grievance system.

Please call Medica Customer Service at the phone number in Section 1 if you have questions or want help filing a grievance or appeal.

Grievance system terms to know:

A grievance is your complaint about any of the following:

- quality of care or services provided
- failure to respect your rights
- rudeness of a provider or employee
- delay in appropriate treatment or referral

A notice of action is a form or letter we send you to tell you about a decision we make on a claim, a request for service, or any other request. The notice will tell you how to file an appeal or request a state fair hearing if you disagree with our decision.

An appeal is your request for us to review a decision we made. You may ask for an appeal if you disagree with our decision in any of the following **actions** (decisions)**:**

- denial or limited authorization of the type or level of service
- reduction, suspension, or stopping of a service that was approved before
- denial of all or part of payment for a service
- not providing services in a reasonable amount of time
- not acting within required time frames for grievances and appeals
- denial of a member's request to get services out of network for members living in a rural area with only one health plan

Your provider may appeal on your behalf with your written consent. Your treating provider may appeal a service authorization decision *without* your consent.

A state fair hearing is your request for the state to review a decision we made. You may ask for a hearing if you disagree with any of the following:

- denial or limited authorization of the type or level of service
- denial of all or part of a payment for a service
- our failure to act within required timelines for service authorizations and appeals
- enrollment in the Plan
- any other action

If you disagree with our decision or have a grievance (complaint) about something other than a decision we made, you can do any of the following:

You can call Medica Customer Service at the phone number in Section 1 to file a grievance or appeal.

You can write to us to file a grievance or appeal. Write to the address listed in Section 1 under "Appeals and Grievances."

You can write to the Minnesota Department of Human Services to request a state fair hearing.

Write to: Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941

Or fax to: 651- 431-7523

You may request a state fair hearing at any time before, during, or after our appeal process. You do not have to file an appeal with us before you request a state fair hearing.

You can file a complaint with the Minnesota Department of Health.

Write to: Minnesota Department of Health
Health Policy and Systems Compliance Monitoring Division
Managed Care Systems
P.O Box 64882
St. Paul, MN 55164-0882

You can call or write to the Ombudsman for State Managed Health Care Programs. They may be able to help you with access, service, or billing problems. They can also help you file a grievance or appeal with us or request a state fair hearing.

Call: 651-431-2660 (Twin Cities metro area) or toll-free 1-800-657-3729 (non-metro area) or 1-800-627-3529 (TDD)

Or

Write to: Minnesota Department of Human Services
Ombudsman for State Managed Health Care Programs
P.O. Box 64249
St. Paul, MN 55164-0249

Important information about your rights when filing a grievance or appeal, or requesting a state fair hearing:

If you decide to file a grievance or appeal, or request a state fair hearing, it will not affect your eligibility for medical services. It will also not affect your enrollment in the health plan.

Your provider may file a grievance or appeal, or request a state fair hearing, on your behalf. The provider must have your written consent. Your treating provider may appeal service authorization decisions *without* your consent.

You can have a relative, friend, advocate, provider, or lawyer help with your grievance, appeal, or state fair hearing.

You may request a state fair hearing at any time before, during, or after the Plan appeal process. You do not have to file an appeal with us before you request a state fair hearing.

There is no cost to you for filing an appeal or requesting a state fair hearing. We may pay for some expenses such as transportation, childcare, photocopying, etc.

If you ask to see your medical records or want a copy, we or your provider must provide them to you at no cost. You may need to put your request in writing.

If you have seen a medical provider who is part of our Plan network and want another opinion, you can get a second opinion. You must see another Plan network medical provider.

If you have seen a mental health provider who is part of the Plan network and have been told that no structured mental health treatment is needed, you may get a second opinion. See "Mental Health Services" in Section 7 for more information.

If you have seen a chemical dependency assessor who is part of our Plan network and you disagree with the assessment, you may get a second opinion. See "Chemical Dependency Services" in Section 7 for more information.

You must follow the timelines for filing grievances, appeals, and state fair hearings. If you go over the time allowed, we may not review your grievance or appeal and the state may not accept your request for a hearing.

You must file a grievance with us **within 90 days** from the date of the incident about which you are complaining.

You must file an appeal with us **within 90 days** from the date on the notice of action.

You must request a state fair hearing **within 30 days** from the date on the notice of action or **within 30 days** from the date of the resolution of a Plan appeal. You have up to 90 days if you have a good reason for being late.

If we are stopping or reducing a service, you can keep getting the service if you file a health plan appeal or request a state fair hearing **within 10 days** from the date we send you the notice, or before the service is stopped or reduced,

whichever is later. **You must ask to keep getting the service when you file an appeal or request a state fair hearing.** The network provider who is treating you must agree that you should keep getting the service. The service can continue until the appeal or state fair hearing is resolved. If you lose the appeal or state fair hearing, you may be billed for these services.

For the Restricted Recipient Program, a member who receives a notice of restriction may file an appeal with us or may request a state fair hearing. You must file an appeal or request a state fair hearing **within 30 days** from the date on the notice from us. You have up to 90 days if you have a good reason for being late.

To file an oral grievance with us:

Call Medica Customer Service at the phone number in Section 1 and tell us about the problem.

We will give you a decision within 10 days. We may take up to 14 more days to make a decision if we need more information and it will be in your best interest. We will tell you within 10 days that we are taking extra time and the reasons why.

If your grievance is about our denial of an expedited appeal or a grievance about urgent health care issues, we will give you a decision within 72 hours.

If you do not agree with our decision, you can file a complaint with the Minnesota Department of Health. You can also call the Ombudsman for State Managed Health Care Programs for help. The contact information is listed earlier in this section.

To file a written grievance with us:

Send a letter to us about your grievance. Write to the address listed in Section 1 under “Appeals and Grievances.”

We can help you put your grievance in writing. Call Medica Customer Service at the phone number in Section 1 if you need help.

We will tell you that we received your grievance within 10 days.

We will give you a written decision within 30 days. We may take up to 14 extra days if we need more information and it is in your best interest. We will tell you we are taking the extra time and why.

If your grievance is about our denial of an expedited appeal, or a grievance about urgent health care issues, we will give you a decision within 72 hours.

If you do not agree with our decision, you can file a complaint with the Minnesota Department of Health. You can also call the Ombudsman for State Managed Health Care Programs for help. The contact information is listed earlier in this section.

To file an oral or written appeal with us:

Call Medica Customer Service at the phone number in Section 1. Tell us why you disagree with our decision. Oral appeals must be followed by a written and signed appeal, unless you are requesting an expedited, or "fast," resolution. We will help you complete a written appeal. We will ask you to sign and return the written appeal.

You can also send us a letter about your appeal. In the letter, explain why you disagree with our decision. Send the letter to the address listed in Section 1 under "Appeals and Grievances." We can help you write the appeal. Call Medica Customer Service at the phone number in Section 1 if you need help.

Expedited, or "fast" appeals, are for urgently needed services. If we agree that it is urgent, we will give you a decision within 72 hours. We will try to call you with the decision before we send the decision in writing.

We may take up to 14 extra days if we need more information and it is in your best interest. We will tell you we are taking the extra time and why.

If your appeal is not urgent, we will tell you within 10 days that we received it. We will give you a written decision within 30 days. We may take up to 14 extra days if we need more information and it is in your best interest. We will tell you we are taking the extra time and why.

The person making the decision will not be the same person who was involved in the prior review or decision-making.

If we are deciding an appeal about a service that was denied because it was not medically necessary, the decision will be made by a health care professional with appropriate clinical expertise in treating your condition or disease.

You or your representative may present your evidence in person, by telephone, or in writing.

You or your representative may examine the case file, including medical records and any other documents and records considered by us during the appeal process.

If you do not agree with our decision, you can request a state fair hearing with the Minnesota Department of Human Services**.** Write to the Department of Human Services Appeals Office. The contact information is listed earlier in this section. You may also call the Ombudsman for State Managed Health Care Programs for help. The contact information is listed earlier in this section.

To file a state fair hearing with the Minnesota Department of Human Services:

You must ask for a state fair hearing **within 30 days** from the date on the notice of action or **within 30 days** from the date of the resolution of the Plan appeal. You can have up to 90 days to request a state fair hearing if you have a good reason for being late.

A human services judge from the state Appeals Office will hold a hearing. You may attend the hearing in person or by telephone.

Tell the state why you disagree with the decision we made.
You can ask a friend, relative, advocate, provider, or lawyer to help you.

The process can take 30 - 90 days. If your hearing is about an urgently needed service, tell the Judge or the Ombudsman when you call or write to them.

If your hearing is about a service that was denied because it was not medically necessary, you may ask for review by a medical expert. This will be from an outside reviewer. There is no cost to you.

If you do not agree with the Minnesota Department of Human Services Appeals Office's decision, you may ask the state Appeals Office to reconsider their decision. Send a written request for reconsideration to the Minnesota Department of Human Services Appeals Office within 30 days from the date on the decision. The contact information is listed earlier in this section.

If you do not agree with the state's decision, you may appeal to the district court in your county.

Section 14. Definitions

These are the meanings of some words in this Evidence of Coverage.

Action: This includes:

- denial or limited authorization of the type or level of service
- reduction, suspension, or stopping of a service that was approved before
- denial of all or part of payment for a service
- not providing services in a reasonable amount of time
- not acting within required time frames for grievances and appeals
- denial of a member's request to get services out of network for members living in a rural area with only one health plan

Anesthesia: Drugs that make you fall asleep for an operation.

Appeal: Your oral or written request to us for review of an action. This request may also be from your provider acting on your behalf with your written consent. Oral appeals must be followed by a written and signed appeal, unless you are requesting an expedited resolution. We will help you complete a written and signed appeal.

Chemical Dependency: Using alcohol or drugs in a way that harms you.

Child: Member under age 21.

Child and Teen Checkups (C&TC): A special health care program of well-child visits for members under age 21. It includes screening to check for health problems. It also includes referrals for diagnosis and treatment, if necessary.

Clinical Trial: A qualified medical study test that is: subject to a defined peer review; sponsored by a clinical research program that meets federal and state rules and approved standards; and whose true results are reported.

Copay: An amount that you may be responsible to pay to the provider for specific medical services. Copays are usually paid at the time service is provided. See Section 6 for required copay amounts.

Cost Sharing: Amounts you may be responsible to pay toward your medical services. See Section 6 for information on cost sharing.

Covered Services: The health care services that are eligible for payment.

Direct Access Services: You can go to any provider in the Plan network to get these services. You do not need a referral or service authorization before getting services.

Durable Medical Equipment: Equipment that can withstand repeated use. It is used for a medical purpose. The equipment must be medically necessary and ordered by a doctor.

Emergency: A condition that needs treatment right away. It is a condition that a prudent person believes needs prompt care, and without prompt care, it could cause: serious physical or mental harm; continuing severe pain; serious damage to body functions, organs, or parts; or death. Labor and childbirth can sometimes be an emergency.

Enrollee: A person who is receiving services through a certain program, such as a Minnesota Health Care Program or Medicare.

Evidence of Coverage: What the document you are reading is called. This document tells you what services are covered under the Plan. It tells what you must do to get covered services. It tells your rights and responsibilities. It also tells our rights and responsibilities.

Experimental Service: A service that has not been proven to be safe and effective.

External Quality Review Study: A study about how quality, timeliness and access of care are provided by us. This study is external and independent.

Family Planning: Information, services, and supplies that help a person decide about having children. These decisions include choosing to have a child, when to have a child, or not to have a child.

Fee-for-Service: A method of payment for health services. The medical provider bills the Minnesota Department of Human Services (DHS) directly. DHS pays the provider for the medical services. This method is used when you are eligible for Minnesota Health Care Programs but are not enrolled in a health plan.

Formulary: The list of drugs covered under the Plan.

Grievance: A complaint about any matter other than an Action. This includes, but is not limited to:

- quality of care or services provided
- failure to respect your rights
- rudeness of a provider or employee
- delay in appropriate treatment or referral

Hospice: A special program for members who are terminally ill and not expected to live more than six months. It offers special services for the member and his or her family.

Inpatient Hospital Stay: A stay in a hospital or treatment center that usually lasts 24 hours or more.

Investigative Service: A service that has not been proven to be safe and effective.

Medically Necessary: Care that is appropriate for the condition. This includes care related to physical conditions and mental health. It includes the kind and level of service. It includes the number of treatments. It also includes where you get the service and how long it continues. Medically necessary care must:

- be the service that most other providers would usually order
- help you get better, or stay as well as you are
- help stop the condition from getting worse
- help prevent and find health problems

Medicare: The federal health insurance program for people age 65 or over. It is also for some people under age 65 with disabilities, and people with End Stage Renal Disease.

Medicare Prescription Drug Plan: An insurance plan that offers Medicare Prescription Drug Program (Medicare Part D) drug benefits.

Medicare Prescription Drug Program: The prescription drug benefit for Medicare enrollees. It is sometimes called Medicare Part D. Drug coverage is provided through a Medicare prescription drug plan.

Network: Our contracted health care providers for the Plan.

Notice of Action: A form or letter we send you to tell you about a decision on a claim, service, or any other action taken by us.

Ombudsman for State Managed Health Care Programs: A person at the Minnesota Department of Human Services who can help you with access, service or billing problems. The ombudsman can also help you file a grievance or appeal or request a state fair hearing.

Open Access Services: Federal and state law allow you to choose any physician, clinic, hospital, pharmacy, or family planning agency - even if not in our network - to get these services

Outpatient Hospital Services: Services provided at a hospital or outpatient facility that are not at an inpatient level of care. These services may also be available at your clinic or other health facility.

Out-of-Area Services: Health care provided to a member by an out-of-network network provider outside of the Plan service area.

Out-of-Network Services: Health care provided to a member by a provider who is not part of the plan network.

Physician Incentive Plan: Special payment arrangements between us and the doctor or doctor group that may affect the use of referrals. It may also affect other services that you might need.

Post-stabilization Care: A hospital service needed to help a person's conditions stay stable after having emergency care. It starts when the hospital asks for our

approval for coverage. It continues until: the person is discharged; our Plan network doctor begins care; or we, the hospital, and doctor agree to a different arrangement.

Prepaid Medical Assistance Program (PMAP): A program in which the state contracts with health plans to cover and manage health care services for Medical Assistance enrollees

Prescriptions: Medicines and drugs ordered by a medical provider.

Preventive Services: Services that help you stay healthy, such as routine physicals, immunizations, and well-person care. These services help find and prevent health problems. Follow-up on conditions that have been diagnosed (like a diabetes checkup) are ***not*** preventive.

Primary Care Clinic: The clinic you choose for your routine care. This clinic will provide most of your care.

Primary Care Provider: The doctor or other qualified health care provider you see at your primary care clinic. This person will manage your health care.

Provider: A qualified health care professional or facility approved under state law to provide health care.

Restricted Recipient Program: A program for members who have received medical care and have not followed the rules or have misused services. If you are in this program, you must get health services from one designated primary care provider, one pharmacy, one hospital or other designated health care provider. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs. Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months.

Second Opinion: If you do not agree with an opinion you get from a Plan network provider, you have the right to get an opinion from another provider. We will pay for this. For medical conditions, the second opinion will be from another Plan network provider. For mental health services, the second opinion will be from an

out-of- network provider. For chemical dependency services, the second opinion will be from a different qualified assessor who is not in the Plan network.

Service Area: The area where a person must live to be able to become or remain a member of the Plan. Contact Medica Customer Service at the phone number in Section 1 for details about the service area.

Service Authorization: Our approval that is needed for some services before you get them.

Standing Authorization: Written consent from us to see an out-of-network specialist more than one time (for ongoing care.)

State Fair Hearing: A hearing at the state to review a decision made by us. You must request a hearing in writing. You may ask for a hearing if you disagree with any of the following:

- a denial, termination, or reduction of services
- enrollment in the Plan
- denial in full or part of a claim for a service
- our failure to act within required timelines for service authorizations and appeals
- any other action

Subrogation: Our right to collect money in your name from another person, group, or insurance company. We have this right when you get medical coverage under this Plan for a service that is covered by another source or third party payer.

United States: For the purpose of this Evidence of Coverage, the United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, The Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Urgent Care: Care for a condition that needs prompt treatment to stop the condition from getting worse. An urgent condition is not as serious as an emergency. Urgent care is available 24 hours a day.

Section 15.

Advance Directives

Your right to use advance directives (such as a health care directive, living will, or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "advance directives". There are different types of advance directives and different names for them. Documents called "health care directives", "living will" and "power of attorney for health care" are examples of advance directives.

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores.

You can sometimes get advance directive forms from organizations that give people information about Medicare. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, you always have the right to accept or refuse medical or surgical treatment. It is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the Office of Health Facility Complaints at the Minnesota Department of Health at 651-201-4201 or toll-free at 1-800-369-7994.

How Medica Pays Providers

This section describes how we generally pay providers for health services.

Network providers

Network providers are paid using various types of contractual arrangements. These are intended to promote the delivery of health care in a cost efficient and effective manner. These arrangements are not intended to affect your access to health care. These payment methods may include:

1. A fee-for-service method, such as per service or percentage of charges, or
2. A risk-sharing arrangement, such as an amount per day, per stay, per episode, per case, per period of illness, per member or per service with targeted outcome.

The methods by which specific network providers are paid may change from time to time. Methods also vary by network provider. The primary method of payment under Medica Choice Care is fee-for-service.

Fee-for-service payment means that Medica pays the network provider a fee for each service provided. If the payment is per service, the network provider's payment is determined according to a set fee schedule. The amount the network provider receives is the lesser of the fee schedule or what the network provider would have otherwise billed. If the payment is percentage of charges, the network provider's payment is a set percentage of the provider's charge. The

amount paid to the network provider, less any applicable copayment, coinsurance or deductible, is considered to be payment in full.

Risk-sharing payment means that Medica pays the network provider a specific amount for a particular unit of service. These can be an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per member, or an amount per service with targeted outcome. Sometimes the amount paid is less than the cost of providing or arranging for a member's health services. Then the network provider may bear some of the shortfall. If the amount paid to the network provider is more than the cost of providing or arranging a member's health services, the network provider may keep some of the excess.

Withhold arrangements

Some network providers are paid on a fee-for-service basis. This includes most network physicians and clinics. Then Medica holds back some of the payment. This is sometimes referred to as a physician contingency reserve or holdback. The withhold amount generally will not exceed 15 percent of the fee schedule amount. In general, Medica does not hold back a portion of network hospitals' fee-for-service payments. However, when it does, the withhold amount will not usually exceed 5 percent of the fee schedule amount.

Network providers may earn the withhold amount based on Medica's financial performance as determined by Medica's Board of Directors and/or certain performance standards identified in the network provider's contract including, but not limited to, quality and utilization. Based on individual measures, the percentage of the withhold amount paid, if any, can vary among network providers.

Non-network providers

When a service from a non-network provider is covered, the non-network provider is paid a fee for each covered service that is provided. This payment may be less than the charges billed by the non-network provider.
For more information, call Medica Customer Service and ask for information about our physician incentive plans. We will send it to you within 30 days

Information About the Federal Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act is a federal law passed in 1998. It requires health insurers and group health plans that cover mastectomies to provide certain benefit if a member or enrollee picks reconstructive surgery after a mastectomy. The law also requires health plans to give members written notice that this coverage is available.

You will be pleased to know that Medica as been providing our members with these benefits even before the law was passed. Women who have breast cancer often have a mastectomy to remove all or part of the breast. Medica members who have undergone a mastectomy are covered for mastectomy benefits. Medica consults with the attending physician and patient about each case.

See your Evidence of Coverage. It will tell the specific benefit levels for the following services:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a balanced look.
- The cost of prosthesis and the treatment of any physical complications resulting from mastectomy. This includes treatment of lymphedema, the swelling sometimes caused by surgery.

Some members may have to pay a copayment. The copayment will be consistent with copayments for other benefits in your plan. To answer this question, see your Evidence of Coverage.

Effective: June 11, 2003
Revised: September 23, 2013

HOW MEDICA PROTECTS YOUR PRIVACY

Summary

There are several state and federal laws requiring Medica Health Plans, Medica Health Plans of Wisconsin and Medica Insurance Company (collectively, "Medica") to protect its members' personal *health* information. The most comprehensive regulations were issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These regulations have been updated from time to time. Essentially, HIPAA regulations require entities like Medica to provide you with information about how your protected health information may be used and disclosed, and to whom. This notice explains what your protected health information is. Regulations also describe how Medica must protect this information and how you can access your protected health information. Medica must follow the terms of its privacy notice. Medica may also change or amend its privacy notice as the laws and regulations change. However, if the notice is materially changed, Medica will make the revised privacy notice available to you.

There are also state and federal laws requiring Medica to protect your non-public personal *financial* information. The most comprehensive regulations were issued under the Gramm-Leach-Bliley Act ("GLBA"). The GLBA requires Medica to provide you with a notice about how your non-public personal financial information may be used and disclosed, and to whom.

When the law permits use and disclosure

The law permits Medica to use and disclose your personal health information for purposes of treatment, payment and health care operations without first obtaining your authorization. There are other limited circumstances when Medica may use and disclose your personal health information without your authorization, such as public health, regulatory and law enforcement activities. Whether personal health information is used or disclosed with or without your authorization, Medica uses and discloses personal health information only to those persons who need to know and only the minimum amount necessary to perform the required activity.

Your privacy rights

The law also gives you rights to access, copy and amend your personal health information. You have the right to request restrictions on certain uses and disclosures of your personal health information. You also have the right to obtain information about how and when your personal health information has been used and disclosed.

These duties, responsibilities and rights are described in more detail inside.

MEDICA'S PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED UNDER STATE AND FEDERAL LAW, INCLUDING HIPAA, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE IS INTENDED FOR MEDICA MEMBERS.

What is PHI?

Medica is committed to protecting and maintaining the privacy and confidentiality of information that relates to your past, present or future physical or mental health, healthcare services and payment for those services. HIPAA refers to this information as "protected health information" or "PHI.". PHI includes information related to diagnosis and treatment plans, as well as demographic information such as name, address, telephone number, age, date of birth, and health history.

How does Medica protect your PHI?

Medica takes its responsibility of protecting your PHI seriously. Where possible, Medica de-identifies PHI. Medica uses and discloses only the minimum amount of PHI necessary for treatment, payment and operations, or to comply with legal or similar requirements. In addition to physical and technical safeguards, Medica has administrative safeguards such as policies and procedures that require Medica's employees to protect your PHI. Medica also provides training on privacy and security to its employees.

Medica protects the PHI of former members just as it protects the PHI of current members.

Under what circumstances does Medica use or disclose PHI?

Medica receives, maintains, uses and shares PHI only as needed to conduct or support: (i) treatment-related activities, such as referring you to a doctor; (ii) payment-related activities, such as paying a claim for medical services; and (iii) healthcare operations, such as developing wellness programs. Additional examples of these activities include:

- Enrollment and eligibility, benefits management, and utilization management

- Customer service
- Coordination of care
- Health improvement and disease management (for example, sending information on treatment alternatives or other health-related benefits)
- Premium billing and claims administration
- Complaints and appeals, underwriting, actuarial studies, and premium rating (however, Medica is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes)
- Credentialing and quality assurance
- Business planning or management and general administrative activities (for example, employee training and supervision, legal consultation, accounting, auditing)
- Medica may, from time to time, contact you with important information about your health plan benefits. Such contacts may include telephone, mail or electronic mail messages.

With whom does Medica share PHI?
Medica shares PHI for treatment, payment and health care operations with your health care providers and other businesses that assist it in its operations. These businesses are called "business associates" in the HIPAA regulations. Medica requires these business associates to follow the same laws and regulations that Medica follows.

Public Health, Law Enforcement and Health Care Oversight. There are also other activities where the law allows or requires Medica to use or disclose your PHI without your authorization. Examples of these activities include:

- Public health activities (such as disease intervention);
- Healthcare oversight activities required by law or regulation (such as professional licensing, member satisfaction surveys, quality surveys, or insurance regulation);
- Law enforcement purposes (such as fraud prevention or in response to a subpoena or court order);
- Assisting in the avoidance of a serious and imminent threat to health or safety; and
- Reporting instances of abuse, neglect, domestic violence or other crimes.

Employee Benefit Plans. Medica has policies that limit the disclosure of PHI to employers. However, Medica must share some PHI (for example, enrollment information) with a group policyholder to administer its business. The group policyholder is responsible for protecting the PHI from being used for purposes other than health plan benefits.

Research. Medica may use or release PHI for research. Medica will ensure that only the minimum amount of information that identifies you will be disclosed or used for research. HIPAA allows Medica to disclose a very limited amount of your PHI, called a "limited data set" for research without your authorization. You have the right to opt-out of disclosing your PHI for research by contacting Medica as described below. If Medica uses any identifiers, Medica will request your permission first.

Family Members. Under some circumstances Medica may disclose information about you to a family member. However, Medica cannot disclose information about one spouse to another spouse, without permission. Medica may disclose some information about minor children to their parents. You should know, however, that state laws do not allow Medica to disclose certain information about minors – even to their parents.

When does Medica need your permission to use or disclose your PHI?

From time to time, Medica may need to use or disclose PHI where the laws require Medica to get your permission. Medica will not be able to release the PHI until you have provided a valid authorization. In this situation, you do not have to allow Medica to use or disclose your PHI. Medica will not take any action against you if you decide not to give your permission. You, or someone you authorize (such as under a power of attorney or court-appointed guardian), may cancel an authorization you have given, except to the extent that Medica has already relied on and acted on your permission.

Your authorization is generally required for uses and disclosures of PHI not described in this notice, as well as uses and disclosures in connection with:

- Psychotherapy Notes. Medica must obtain your permission before making most uses and disclosures of psychotherapy notes.
- Marketing. Subject to limited exceptions, Medica must also obtain your permission before using or disclosing your PHI for marketing purposes.

- Sales. Additionally, Medica is not permitted to sell your PHI without your permission. However, there are some limited exceptions to this rule—such as where the purpose of the disclosure of PHI is for research or public health activities.

What are your rights to your PHI?
You have the following rights with regard to the PHI that Medica has about you. You, or your personal representative on your behalf, may:

Request restrictions of disclosure. You may ask Medica to limit how it uses and discloses PHI about you. Your request must be in writing and be specific as to the restriction requested and to whom it applies. Medica is not required to always agree to your restriction. However, if Medica does agree, Medica will abide by your request.

Request confidential communications. You may ask Medica to send your PHI to a different address or by fax instead of mail. Your request must be in writing. Medica will agree to your request if it is able.

Inspect or obtain a copy of your PHI. Medica keeps a designated record set of its members' medical records, billing records, enrollment information and other PHI used to make decisions about members and their benefits. You have the right to inspect and get a copy of your PHI maintained in this designated record set. Your request must be in writing on Medica's form. If the PHI is maintained electronically in a designated record set, you have a right to obtain a copy of it in electronic form. Medica will respond to your request within thirty (30) days of receipt. Medica may charge you a reasonable amount for providing copies. You should know that not all the information Medica maintains is available to you and there are certain times when other individuals, such as your doctor, may ask Medica not to disclose information to you.

Request a change to your PHI. If you think there is a mistake in your PHI or information is missing, you may send Medica a written request to make a correction or addition. Medica may not be able to agree to make the change. For example, if Medica received the information from a clinic, Medica cannot change the clinic information—only the clinic can. If Medica cannot make the change, it will let you know within thirty (30) days. You may send a statement explaining

why you disagree, and Medica will respond to you. Your request, Medica's disagreement and your statement of disagreement will be maintained in Medica's designated record set.

Request an accounting of disclosures. You have the right to receive a list of disclosures Medica has made of your PHI. There are certain disclosures Medica does not have to track. For example, Medica is not required to list the times it disclosed your PHI when you gave Medica permission to disclose it. Medica is also not required to identify disclosures it made that go back more than six (6) years from the date you asked for the listing.

Receive a notice in the event of a breach. Medica will notify you, as required under federal regulations, of an unauthorized release, access, use or disclosure of your PHI. "Unauthorized" means that the release, access, use or disclosure was not authorized by you or permitted by law without your authorization. The federal regulations further define what is and what is not a "breach." Not every violation of HIPAA, therefore, will constitute a breach requiring a notice.

Request a copy of this notice. You may ask for a separate paper copy of this notice.

TO EXERCISE ANY OF THESE RIGHTS, PLEASE CONTACT CUSTOMER SERVICE AT THE TELEPHONE NUMBER ON THE BACK OF YOUR MEDICA ID CARD, OR CONTACT MEDICA AT P.O. BOX 9310, MINNEAPOLIS, MN 55440-9310.

File a complaint or grievance about Medica's privacy practices. If you feel your privacy rights have been violated by Medica, you may file a complaint. You will not be retaliated against for filing a complaint. To file a complaint with Medica, please contact Customer Service at the contact information listed above. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. To do so, write to the Office for Civil Rights, U.S. Department of Health & Human Services, 233 N. Michigan Ave Suite 240, Chicago, IL 60601.

About this notice.

Medica is required by law to maintain the privacy of PHI and to provide this notice. Medica is required to follow the terms and conditions of this notice. However, Medica may change this notice and its privacy practices, as long as the

change is consistent with state and federal law. If Medica makes a material change to this notice, it will make the revised notice available to you within sixty (60) days of such change.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE EXPLAINS HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE IS INTENDED FOR MEDICA MEMBERS.

How does Medica protect your information?

Medica takes its responsibility of protecting your information seriously. Medica maintains measures to protect your information from unauthorized use or disclosure. These measures include the use of policies and procedures, physical, electronic and procedural safeguards, secured files and buildings and restrictions on who and how your information may be accessed.

What information does Medica collect?

Medica may collect information about you including your name, street address, telephone number, date of birth, medical information, social security number, premium payment and claims history information.

How does Medica collect your information?

Medica collects information about you in a variety of ways. Medica obtains such information about you from:

- You, on your application for insurance coverage
- You, concerning your transactions with Medica, its affiliates or others
- Your physician, health care provider or other participants in the health care system.
- Your employer.
- Other third parties.

Under what circumstances does Medica use or disclose non-public personal financial information?

Medica uses your non-public financial information for its everyday business operations. This includes using your information to perform certain activities in order to implement and administer the product or service in which you are enrolled. Examples of these activities include enrollment, customer service, processing premium payment, claims payment transactions, and benefit management.

Medica may disclose your information to the following entities for the following purposes:

- To Medica's affiliates to provide certain products and services.
- To Medica's contracted vendors who provide certain products and services on Medica's behalf.
- To a regulatory authority, government agency or a law enforcement official as permitted or required by law, subpoena or court order.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT CUSTOMER SERVICE AT THE TELEPHONE NUMBER ON THE BACK OF YOUR MEDICA ID CARD, OR CONTACT MEDICA AT P.O. BOX 9310, MINNEAPOLIS, MN 55440-9310.

MEDICA®

PO Box 9310 Minneapolis, MN 55440-9310

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SPP50600-101213

2015 Member Handbook

For members of Medica Choice Care℠

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Medica Choice Care℠ (MA) and Medica MinnesotaCare members
Call Medica Customer Service at 952-992-2322 or 1-800-373-8335 (toll-free)

Medica AccessAbility Solution® (SNBC), Medica DUAL Solution® (MSHO) and Medica Choice Care MSC+ members
Call Medica Customer Service at 952-992-2580 or 1-888-347-3630 (toll-free)

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយ ឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

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LB3-0016 (3-13)

SPP1113

This information is available in other forms to people with disabilities by calling the above number, or through the National Relay Center toll free at 1-800-855-2880 (TTY/TDD), or 7-1-1, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

Medica will accept all eligible people who choose or are assigned to the Plan. We will not discriminate in regard to physical or mental condition, health status, need for or receipt of health services, claims experience, medical history, genetic information, disability, marital status, age, sex, sexual orientation, national origin, race, color, religion, or political beliefs. Medica will not use any policy or practice that has the effect of such discrimination.

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MEDICA®

Welcome to Medica Choice Care℠!

You belong to a health plan that is designed with your health and wellness needs in mind. At Medica, you're not only our customer; you're a member. We treat you as an important person because you are important – to yourself, your family and friends, and to us.

This handbook is your guide to Medica's services and resources. Choose as many programs and services that can help you reach your personal goals.

One of the programs that can help you reach your goals is **My Health Rewards by Medica**℠. Earn gift card rewards for you and your family when you complete basic health care steps. **Turn to page 14** in this handbook to learn more about the program and start earning your health rewards today!

If you have any questions about your health plan or the programs listed in this book, you can contact us by calling the numbers listed on the inside back cover of this handbook, or by visiting our website at **www.medica.com/SPPContactUs**.

Congratulations on taking the next step towards better health. We look forward to helping you achieve your health and wellness goals!

Sincerely,

Stephanie Kelly
Director of Customer Service Operations
Medica Government Programs

Services for You and Your Family

Medica Customer Service

We are here to help. You can call our Customer Service staff about your:

- Health care benefits
- A lost Medica member ID card
- Enrollment status
- Claims issues
- And much more

Our staff can talk to you in the following languages:

- English **952-992-2322**
- Hmong (Lus Hmoob) **952-992-2296**
- Russian (Русскиǐ) **952-992-2294**
- Somali (Soomaali) **952-992-2260**
- Spanish (Español) **952-992-2297**
- Vietnamese (Tiếng Việt) **952-992-2295**

If you don't see the language you wish to speak above, please call **952-992-2322** or **1-800-373-8335** (toll-free); TTY users, call the National Relay Center at **1-800-855-2880** (toll-free) and ask for the number above. Our hours are Monday through Thursday, 8 a.m. – 5 p.m.; Friday 9 a.m. – 5 p.m. We are closed daily from 12 p.m. – 12:30 p.m.

Interpreter Services

Need an interpreter for a health care appointment?

Interpreter services are covered services for you and your family. Medica will arrange foreign language or sign language interpreter services for medical, dental, mental health and substance abuse visits and picking up prescriptions.

- Call Customer Service at least **two to five** working days before your appointment
- Be ready to give your Medica member ID number and the doctor's full name and address

Call Medica Customer Service at the number and during the hours listed on the inside back cover of this handbook.

Member Tip:

Understanding symbols

This symbol describes something you can do at our website.

This symbol means that you can call Customer Service for more information or advice.

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Transportation Services

If you do not have access to a car, Medica will provide transportation to and from health care visits at no cost to you. To schedule transportation, follow the steps below:

- Call Medica Customer Service at least **two** working days before your appointment
- Tell them you need a ride to your health care visit
- Have your member ID number or Social Security number, and the doctor's full name and address available when you call

Note: We will provide transportation to your primary care provider within 30 miles from your home AND to your specialty provider within 60 miles from your home. Call us if your providers are further away.

To schedule transportation, please call Medica Customer Service at the number and during the hours listed on the inside back cover of this handbook.

Social Service Coordinators

Medica's Social Service Coordinators can help you find community services and resources you may need, such as:

- Housing infomation
- Financial assistance
- Parenting and childcare information
- Family violence resources
- Food, clothing, baby and household items
- And more

Call Medica Customer Service at the number and during the hours listed on the inside back cover of this handbook.

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Health and Wellness Coaching

Work one-on-one with a certified health coach to develop the knowledge, skills and motivation to manage your health and well-being.

- You tell us how you want your health to improve – we support you
- You set your health goals – we help you achieve them
- You take the active role – we help you make informed decisions

Your health coach will help you achieve your best possible health. You will be rewarded for achieving and exceeding your goals!

- Coaching is voluntary and confidential
- Participate no matter what your health status
- Coaches available Monday through Friday 7 a.m. – 8 p.m.; Saturday 9 a.m. – 5 p.m.

Nurse Line – Medica CallLink®

Call the Medica CallLink® Nurse Line any time you have questions about your health. Registered nurses are available at **1-866-715-0915** (toll-free) 24 hours a day, seven days a week, to:

- Discuss symptoms
- Answer health and medication questions
- Explain treatment options, including when to go to the doctor, hospital and other health care providers

Note: Always seek the advice of your doctor or other qualified health provider if you have questions about a medical condition. *The information offered by Medica CallLink® Nurse Line is not meant to provide a medical diagnosis or treatment.*

Member Tip:

How to find help

Medica CallLink® nurses are always available to help you find a retail health clinic or urgent care center near you.

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Member Tip:

Tips for healthy teeth

- Brush your teeth twice a day. Use fluoride toothpaste and a brush with soft bristles
- Replace your toothbrush every three or four months
- Floss your teeth once a day, after your last meal or snack of the day
- Have regular checkups with your dentist

Call your dentist right away if you experience problems with your teeth.

Delta Dental is a registered service mark of Delta Dental Plans Association ("DDPA"). DDPA has given Delta Dental of Minnesota permission to allow Medica to use the DDPA.

Dental Services

With Medica, you have dental care coverage through Delta Dental® of Minnesota. Their Customer Service staff can help:

- Explain what types of services are covered
- With billing issues
- Find a dental provider

Provide-A-Dentist program

The Provide-A-Dentist program can help you with dental appointments. First, look in your provider directory and try to make an appointment. If you can't get an appointment, call Delta Dental® of Minnesota Customer Service. They will connect you to a Provide-A-Dentist care coordinator who can help you:

- Find a dentist
- Schedule an appointment
- Set up transportation
- Set up interpreter services
- Schedule appointments for follow-up dental care

To contact Delta Dental® Customer Service, please see the phone number listed on the inside back cover of this handbook.

Mental Health and Chemical Dependency Services

At times, life can be demanding and stressful. Medica Behavioral Health* manages and arranges mental health and chemical dependency services for our members. If you or a family member need this help, all you need to do is call. Staff are available to take your call 24 hours a day, seven days a week.

Medica Behavioral Health staff can:

- Help select a provider who specializes in the services you need
- Locate a provider based on your preference (i.e., gender, culturally appropriate or language spoken)
- Help with locating additional services you may need
- Monitor the quality of care you receive

Call Medica Customer Service at the number and during the hours listed on the inside back cover of this handbook. Or visit **liveandworkwell.com** to learn more.

Crisis situations

If you have a crisis involving mental health, alcohol, or drugs, call Medica Behavioral Health right away. If you go to an Emergency Room, ask the hospital staff to call Medica Behavioral Health for you. Crisis services are available 24 hours a day, seven days a week. **For life-threatening emergencies, call 911**.

* United Behavioral Health manages the Medica Behavioral Health program.

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Pharmacy Services

How do I get my prescriptions filled?

- Ask your Medica provider to make sure the drug is on Medica's list of covered drugs (formulary) for Medica Choice Care℠/Medica MinnesotaCare.
- Fill your prescription at a network pharmacy
- Show the pharmacist your Medica member ID card

How do I know what drugs are covered?

If you would like a copy of the Medica Choice Care℠/Medica MinnesotaCare list of covered drugs (formulary), please call Medica Customer Service or go to **medica.com**.

If you need a drug that is not on Medica's list of covered drugs (formulary), your provider may request an exception. If your exception request is denied, you have the right to appeal. Call Customer Service for more information. We will cover anti-psychotic drugs even if they are not on our list of covered drugs (formulary), when your health care provider certifies that this is best for you.

If the pharmacy staff says the drug is not covered and asks you to pay, ask them to call your doctor. There may be another drug that will work and will be covered by Medica. If the pharmacy staff won't call your doctor, you can. You can also call Medica and we can help. You also have the right to appeal the denial. **We cannot pay you back if you pay for the drug.**

Where can I get my prescriptions filled?

You may fill your prescription at any participating pharmacy with Medica. If you plan to travel outside the Medica service area, you will need to fill your prescription at one of our network national pharmacies. They are:

- Target®
- Walgreens®
- Kmart®
- Wal-Mart®

Member Tip:

Prescription drugs for those with Medicare coverage

If you have Medicare, you will still have coverage for some drugs that Medicare will not pay for, including some over-the-counter (OTC) drugs.

Members with Medicare must use a Medicare Part D prescription drug plan for Part D coverage drugs. Contact your Medicare prescription drug plan if you have questions about how to get your Part D drugs.

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Eyewear Benefits

Your plan covers a new pair of eyeglasses every two years. Please see the eye care section of your Evidence of Coverage for more detailed information.

You can call Medica Customer Service for more information or go to **medica.com**.

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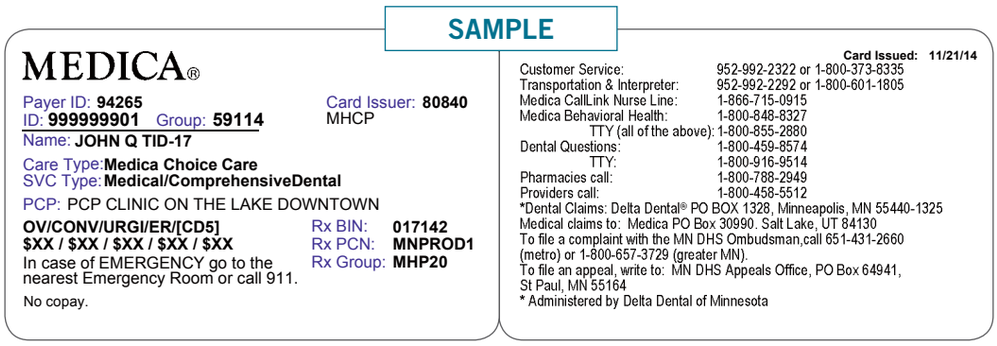
How To Get Care

At Medica, we believe our members deserve a great health care experience. We'll do our best to help you get the best health care services for you and your family. This starts by connecting you with health care providers who can provide the care you need. The first step to that is your Medica ID card.

Understanding your Medica ID card

Below is an example of what your ID card looks like. Show your ID card each time you visit your clinic. This card identifies you as a Medica member. Also, show any other health plan ID cards you may have – like Medicare, private insurance or a prescription drug plan.


SAMPLE

MEDICA®

Payer ID: **94265**
ID: **999999901** Group: **59114**
Name: **JOHN Q TID-17**
Card Issuer: **80840**
MHCP
Care Type: **Medica Choice Care**
SVC Type: **Medical/ComprehensiveDental**
PCP: PCP CLINIC ON THE LAKE DOWNTOWN
OV/CONV/URGI/ER/[CD5]
$XX / $XX / $XX / $XX / $XX
In case of EMERGENCY go to the nearest Emergency Room or call 911.
No copay.
Rx BIN: **017142**
Rx PCN: **MNPROD1**
Rx Group: **MHP20**

Card Issued: 11/21/14

Customer Service:	952-992-2322 or 1-800-373-8335
Transportation & Interpreter:	952-992-2292 or 1-800-601-1805
Medica CallLink Nurse Line:	1-866-715-0915
Medica Behavioral Health:	1-800-848-8327
TTY (all of the above):	1-800-855-2880
Dental Questions:	1-800-459-8574
TTY:	1-800-916-9514
Pharmacies call:	1-800-788-2949
Providers call:	1-800-458-5512

*Dental Claims: Delta Dental® PO BOX 1328, Minneapolis, MN 55440-1325
Medical claims to: Medica PO Box 30990. Salt Lake, UT 84130
To file a complaint with the MN DHS Ombudsman,call 651-431-2660 (metro) or 1-800-657-3729 (greater MN).
To file an appeal, write to: MN DHS Appeals Office, PO Box 64941, St Paul, MN 55164
* Administered by Delta Dental of Minnesota

Preventive Health Benefits

Get your routine physical exam or preventive care checkup, from your primary care provider, at no cost. For other services, you may have to pay a copay*. Please see your Evidence of Coverage for copays that may apply to you.

What is a routine physical exam or preventive care checkup?

Medica defines it as routine well visits, shots and certain screenings provided to you when you are not sick. Additional shots and screenings may be needed if you are at a higher risk. **Call your clinic today to make an appointment for a routine physical exam or preventive care checkup.**

Call Medica Customer Service at the number and during the hours listed on the inside back cover of this handbook.

Buzzwords:

*Copay

An amount that you are responsible to pay to the provider. Some adult members must pay a part of the provider's charges for some services. Copays are usually paid at the time service is provided.

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Member Tip:

Why should I schedule a routine physical exam or preventive care checkup now?

Prevention saves lives!

- 652,000 Americans die of Heart Disease each year
- 560,000 Americans die of Cancer each year
- 75,000 Americans die of Diabetes each year
- 63,000 Americans die of Influenza/Pneumonia each year

Source: National Centers for Health Statistics, 2005 Mortality Data.

Buzzwords:

*** Provider**

A health care professional or facility approved under State law to provide health care.

Primary Care

It's important to choose a primary care provider* who can take care of your basic health care needs when you are well and when you are sick. Having a primary care provider who is familiar with your medical history can save you time. It can also help improve the quality of care you receive.

Types of primary care providers:

- **Family practice providers** specialize in taking care of the general health of people, from infants to adults
- **Internists** focus on adult diseases, especially medical conditions that affect internal organs
- **Pediatricians** specialize in taking care of the general health of children, from birth to 21 years old
- **Obstetricians/gynecologists (OB/GYN)** specialize in pregnancy, childbirth and routine physical care of women's reproductive system

Other types of providers who often offer primary care services:

- **Physician Assistants** are advanced practice clinicians licensed to practice medicine with physician supervision
- **Nurse Practitioners** are advanced practice nurses who provide services similar to a doctor. They are trained in the diagnosis and management of common and complex medical conditions

If you want to learn about the professional qualifications of a physician or physician assistant, contact the Minnesota Board of Medical Practice at **612-617-2130**. If you want to learn about the professional qualifications of a nurse, contact the Minnesota Board of Nursing at **612-617-2270**. TTY users, please call **1-800-657-3709** (toll-free). Their hours are Monday through Friday, 8 a.m. – 4:30 p.m.

As a Medica member you have access to a large network of health care providers. In order to get full coverage for your care, you need to choose from a Medica network provider. This includes specialty care. When you make an appointment, ask if the provider is a Medica Choice Care℠/Medica MinnesotaCare provider. For help finding a provider or to ask if a provider is in-network you can:

- Call Medica CallLink® nurse line
- Medica Customer Service or
- Go to **medica.com** and follow > *Members > View List of Plans > choose Medica Choice Care or Medica MinnesotaCare > Physicians and Facilities*

Call Medica CallLink® or Medica Customer Service at the number and during the hours listed on the inside back cover of this handbook.

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Urgent Care and Retail Health Clinics

Urgent care centers are staffed by doctors and nurses. They offer after-hours care for minor illnesses and injuries. Urgent care centers are not for life-threatening emergencies.

Urgent care centers treat:

- Minor injuries and cuts
- Fractures and sprains
- Upper respiratory infections
- Urinary tract infections
- Eye or ear infections
- And much more

Retail health clinics are staffed with licensed providers. They can treat minor illnesses for people older than 18 months.

As a Medica member, you have access to a large network of urgent care centers across the state. Urgent care centers and retail health clinics are normally open in the evening, Monday through Friday. Some are also open on weekends and holidays. You do not need an appointment; just walk in. Care is given on a first-come, first-served basis. Please see your Provider Directory, **medica.com** or the end of this booklet for a list of participating after-hours clinics.

Medical Emergencies

Medical emergencies are conditions that need treatment right away. An emergency requires quick medical attention to preserve life; avoid serious physical or mental harm; avoid serious damage to bodily functions, organs or parts; or because there is continuing severe pain.

Signs of an emergency may include:

- Poisoning or drug overdose
- Trouble breathing or shortness of breath
- Pain or pressure in your chest or above your stomach
- Warning signs of a stroke: sudden dizziness or change in vision, sudden weakness or numbness, trouble speaking or understanding speech
- You can't stop vomiting
- Bleeding that will not stop after 10 minutes of pressure
- Coughing up blood or throwing up blood
- Feelings that you want to hurt other people or hurt or kill yourself
- Sudden sharp pain anywhere in the body
- Loss of consciousness or convulsions
- Broken bones
- Injury to your spine
- Change in mental status, such as unusual behavior
- Major burns

If you or a family member has any of these symptoms, go to an emergency room immediately or call 911.

Member Tip:

How Medica reviews new medical and behavioral health technology

Medica is interested in the newest advances in medicine. We always review new and current medical and behavioral health procedures, medical devices and drugs.

Medica medical directors do these reviews. The doctors use information from many sources before making a decision. They only approve coverage for drugs, devices and procedures that are safe and follow all laws.

These new drugs, devices and procedures are covered only when they improve patient care.

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Additional Resources and Information

Asthma Resources

Asthma can be managed so you can live a healthy, normal life. Medica's Health and Wellness Coaching program can provide the personal support and help you need to manage and treat your asthma symptoms. Call the number on the inside back cover of this handbook to speak to a health coach today.

If your child or teen suffers from asthma, Medica offers tools and resources to help you and your child learn how to manage this condition. The book *What To Do When Your Child Has Asthma* can help. It is for people who live with a child or teen with asthma. The book will help you and your child learn:

- How to recognize signs of asthma
- What can cause asthma attacks
- Why an asthma action plan is very important
- How medicine and a peak flow meter can help manage asthma
- How to talk to your child's daycare providers and teachers about asthma
- Why your child should exercise and how he or she can exercise safely

The book is available in English and Spanish at no cost to you. **To ask for a copy, call Medica Customer Service at the number and during the hours listed on the inside back cover of this handbook.**

Information for Pregnant Women

Women, Infants and Children Program (WIC)

You may be able to get free, nutritious food through your local WIC program. You can also learn about healthy foods to eat during your pregnancy. If you choose to breast-feed your baby, you can still get WIC benefits after the baby is born. Call WIC at **1-800-942-4030** (toll-free) for the WIC program nearest you. TTY users, please call the National Relay Center at **1-800-855-2880** (toll-free) and ask for the number above. Their hours are Monday through Friday, 8 a.m. – 4:30 p.m.

Pregnancy Notification

If you become pregnant, you must follow the instructions below in order for your insurance to be updated.

Call your county worker or ask your doctor for a Pregnancy Verification Form. You must complete the form and return it to your county worker.

Note: There are no copays for pregnant women.

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Healthy Pregnancy Program

Our Healthy Pregnancy Program can help you and your baby throughout your pregnancy and during the first six weeks after delivery. You can get information and support to have a safe and healthy pregnancy.

As a Medica member you can enroll in the program up to the 32nd week of your pregnancy.

Here are some highlights of the program:

- Talk with a program nurse and get your pregnancy questions answered
- Learn about prenatal care
- Identify any potential pregnancy risks and work with the nurse to address them
- Learn about resources available from Medica and in your community

About Violence

Violence touches many lives, and it's important to know the impact. Does your partner or someone who cares for you:

- Control or try to control where you go or how long you stay?
- Say cruel or hurtful things to you, or humiliate you privately or in front of others?
- Threaten you or cause you physical pain and/or injury?
- Make you feel afraid?
- Break objects, smash the wall with fists or throw objects at you or your children?

If you have answered "yes" to any of the above questions, you may be in an abusive relationship. If this is happening to you, you don't deserve it. You did not cause it to happen and there is help for you in the community. Everyone deserves to be treated with respect.

Resources are available to help victims of violence. If you feel you are a violence victim, don't delay! Call **1-800-799-7233** (toll-free) or First Call for Help at **1-800-543-7709** (toll-free) to find out about safe shelters, 24-hour crisis/support lines, transportation help, legal support, and information about community financial resources. TTY users, please call **1-800-787-3224** (toll-free).

In an emergency, call 911.

Member Tip:

Physically or sexually hurting someone is against the law

Facts about violence in the home:

- Abuse is a crime—the most unreported crime in America
- Six million women are abused each year
- Men are also abused
- Abuse occurs within all races, at every socioeconomic level and in every age group
- During pregnancy, violence often begins or becomes worse
- Fifty percent of all murders of women are committed by their significant others

Source: Centers for Disease Control and Prevention.

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Buzzwords:

***Grievance**

Expression of discontent about any matter other than an action. This includes, but it not limited to discontent with:

- quality of care or services provided
- failure to respect your rights

***Appeal**

Your oral or written request to us for review of an action. This request may also be from your provider acting on your behalf with your written consent. Oral appeals must be followed by a written and signed appeal, unless you are requesting an expedited resolution. We will help you complete a written and signed appeal.

Information on Grievances and Appeals

The Ombudsman for State Managed Health Care Programs, at the Minnesota Department of Human Services, helps people enrolled in a health plan in resolving service and billing problems. They can help you file a grievance* or appeal* with us. The Ombudsman can also help you request a State Fair Hearing. Call **651-431-2660** or **1-800-657-3729** (toll-free).

Enrollee Bill of Rights

You have the right to:

- Get the services you need 24 hours a day, seven days a week. This includes emergencies.
- Be told about your health problems.
- Get information about treatments, your treatment choices, and how they will help or harm you.
- Refuse treatment and get information about what might happen if you refuse treatment.
- Refuse care from specific providers.
- Know that we will keep your records private according to law.
- File a grievance or appeal with us. You can also file a complaint with the Minnesota Department of Health.
- Request a state fair hearing with the Minnesota Department of Human Services (also referred to as “the state”). You may request a state fair hearing before or at any time during our appeal process. You do not have to file an appeal with us before you request a state fair hearing.
- Receive a clear explanation of covered home care services.
- Request and receive a copy of your medical records. You also have the right to ask to correct the records.
- Get notice of our decisions if we deny, reduce, or stop a service, or deny payment for a service.
- Participate with providers in making decisions about your health care.
- Be treated with respect, dignity, and consideration for privacy.
- Give written instructions that inform others of your wishes about your health care. This is called a “health care directive.” It allows you to name a person (agent) to decide for you if you are unable to decide, or if you want someone else to decide for you.
- Be free of restraints or seclusion used as a means of: coercion, discipline, convenience, or retaliation.
- Choose where you will get family planning services, diagnosis of infertility, sexually transmitted disease testing and treatment services, and AIDS and HIV testing services.

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- Get a second opinion for medical, mental health, and chemical dependency services.
- Request a copy of your Evidence of Coverage at least once a year.
- Get the following information from us, if you ask for it. Call Medica Customer Service at the phone number in Important Medica Telephone Numbers section.
  - Whether we use a physician incentive plan that affects the use of referral services
  - The type(s) of incentive arrangement used
  - Whether stop-loss protection is provided
  - Results of a member survey if one is required because of our physician incentive plan
  - Results of an external quality review study from the state
  - The professional qualifications of health care providers
- Make recommendations about our rights and responsibilities policy.
- Exercise the rights listed here.

Enrollee Responsibilities

You have the responsibility to:

- Read your Evidence of Coverage and know which services are covered under the Plan and how to get them.
- Show your health plan ID card and your Minnesota Health Care Program ID card every time you get health care. Also show the cards of any other health coverage you have, such as Medicare or private insurance.
- Establish a relationship with a Plan network primary care doctor before you become ill. This helps you and your primary care doctor understand your total health condition.
- Give information asked for by your doctor and/or health plan so the right care or services can be provided to you. Share information about your health history.
- Work with your doctor to understand your total health condition. Develop mutually agreed-upon treatment goals when possible. If you have questions about your care, ask your doctor.
- Know what to do when a health problem occurs, when and where to seek help, and how to prevent health problems.
- Practice preventive health care. Have tests, exams and shots recommended for you based on your age and gender.
- Contact us if you have any questions, concerns, problems or suggestions. Call Medica Customer Service at **952-992-2322** or **1-800-373-8335** (toll-free); TTY users, call the National Relay Center at **1-800-855-2880** (toll-free) and ask for the numbers above. Our hours are Monday through Thursday, 8 a.m. – 5 p.m., and Friday 9 a.m. – 5 p.m. We are closed daily from 12:00 p.m. – 12:30 p.m.

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My Health Rewards by Medica℠

Prevention programs and more…at no cost to you!

The My Health Rewards program is designed to encourage Medica Choice Care℠, Medica MinnesotaCare and Medica AccessAbility Solution® members to receive preventive care and lead healthy lifestyles.

This program offers you:

- Gift cards for getting certain preventive care
- Health handbooks
- Quit Tobacco program offering a gift card upon completion

In the next pages, we have a summary for each program. We also include vouchers for those programs where you can earn gift cards. These programs require you to have a health care provider confirm the completed test or visit.

If you have questions, want a health handbook, or want to participate in one or more of the gift card programs, please call Medica Customer Service at the number and during the hours listed on the inside back cover of this handbook.

Follow these simple steps to start earning your "Health Rewards" today:

- Step 1: Fill out the vouchers in this booklet with your personal information
- Step 2: Gently cut out the voucher from the book and bring it with you to your doctor's appointment
- Step 3: Have the doctor or nurse sign and date your voucher
- Step 4: Put your completed voucher in the mail—be sure to follow the mailing instructions on the voucher
- Step 5: Watch for your gift card to arrive in the mail!

My Health Rewards by Medica℠ is an optional program that may be changed or discontinued at any time; however, Medica will make every effort to notify members in advance of any changes to the program. Terms and conditions are applied to gift cards.

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My Health Rewards by Medica℠

For Medica members on Medical Assistance, MinnesotaCare and Special Needs Basic Care.

Child & Teen Checkups (C&TC) and Blood Lead Testing

- **Birth through 14 months**
  Earn up to $75 for six C&TC visits from birth through 14 months.
- **15 months through 20 years**
  Earn a $10 gift card each year for a C&TC visit.
- **Blood Lead Testing**
  Earn a $50 gift card for a blood lead test at 12 and 24 months.

$

Earn rewards for healthy choices!
Choose between a Target GiftCard or WALMART® gift card.

Best for Baby & Me

Earn up to $80 for prenatal and postnatal visits. Get the *What to Do When You're Having a Baby* book at no cost to you.

Preventive Screenings

Earn a $15 gift card when you get a:

- Mammogram
- Pap Test
- Colon Cancer Screening Test
- Chlamydia Screening

Car Seat

Medica will provide children up to 2 years of age an infant/toddler safety car seat. Education on how to properly install and use the car seat also will be provided.

Healthy Living

- **Quit Tobacco**
  Work with a trained counselor or online program for help to quit tobacco. Receive nicotine replacement therapy at no cost to you. Earn rewards for completing the program.
- **Health Coaching**
  Work with a health coach to set personal goals. Earn rewards for reaching your goals.
- **Health Club Membership***
  Fit Choices by Medica℠ offers a $20 credit toward monthly fitness center fees for MinnesotaCare members. The Silver&Fit® Fitness Program offers no cost membership to network fitness centers for Medica AccessAbility Solution® members.
- **Health Handbooks**
  Medica offers five easy-to-read health handbooks. These books are for prenatal care, sick kids, kids with asthma, teens and senior health.
- **Asthma, Diabetes and Weight Loss Camps****
  Kids who qualify may attend summer camps at no cost.

For more information visit **medica.com/EarnRewards** or call Medica Customer Service at the numbers listed on the back page.

MEDICA®

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To be eligible for the programs offered by My Health Rewards by Medica, you must:

- Be a Medica Choice Care (MA), Medica Choice Care (MSC+), Medica MinnesotaCare, or Medica AccessAbility Solution (SNBC) member at the time of service.
- Meet program and age requirements.

Medica Choice Care (MA) and MinnesotaCare members

Call Medica Customer Service at 952-992-2322 or 1-800-373-8335 (toll-free)

Monday – Thursday: 8 a.m. to 12 p.m. and 12:30 p.m. to 5 p.m.
Friday: 9 a.m. to 12 p.m. and 12:30 p.m. to 5 p.m.

Lus Hmoob (Hmong)	952-992-2296
Русский (Russian)	952-992-2294
Soomaali (Somali)	952-992-2260
Español (Spanish)	952-992-2297
Tiếng Việt (Vietnamese)	952-992-2295

Medica Choice Care (MSC+) and Medica AccessAbility Solution (SNBC) members

Call Medica Customer Service at 952-992-2580 or 1-888-347-3630 (toll-free)

Monday – Thursday: 8 a.m. to 5 p.m.
Friday: 9 a.m. to 5 p.m.

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TTY/TDD users please call the National Relay Center at 1-800-855-2880 and ask for Medica Customer Service.

Attention. If you need free help interpreting this document, call the above number.

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Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

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Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

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* You must be a MinnesotaCare member, 18 years and older to participate in Fit Choices by Medica or be a Medica AccessAbility Solution member to participate in Silver&Fit®.

** You must be a Medica Choice Care or MinnesotaCare member and meet certain medical and age requirements to be eligible for asthma, diabetes, or weight loss camp.

My Health Rewards by Medica is an optional program that may be changed or discontinued at any time; however, Medica will make every effort to notify members in advance of any changes to the program.

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PO Box 9310, Minneapolis, MN 55440-9310

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My Health Rewards by Medica℠ is a service mark of Medica Health Plans.

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My Health Rewards by Medica®

VOUCHER

Up to a $75 value!

Child and Teen Checkups: Birth through 14 months

Depending on how many Child and Teen Checkups (C&TC) visits your child has from birth through 14 months old, you can earn one of the following gift cards:

- $10 for 1 C&TC visit
- $20 for 2 C&TC visits
- $30 for 3 C&TC visit
- $40 for 4 C&TC visits
- $50 for 5 C&TC visit
- **$75 if all 6 C&TC visits are received!**

TO BE COMPLETED BY PARENT/GUARDIAN			
Child's first name	Middle initial	Last name	Child's date of birth
Telephone number	Child's Medica ID number		
Street address			Apt. no.
City		State	Zip code
Parent/guardian's first name	Middle initial	Last name	Gift card choice NEW ❑ Target® ❑ Walmart®

To be eligible for a gift card you must:

- Mail this voucher to Medica within 90 days of your child's sixth C&TC visit (or within 90 days of the last visit recorded if your child will not be having all six visits by 14 months).
- Be a member of Medica Choice Care, Medica MinnesotaCare or Medica AccessAbility Solution on the day of the C&TC visit(s).

Incomplete vouchers will be returned. If a gift card choice is not made, one will be selected for you. Please allow 4 to 6 weeks for your gift card to arrive in the mail.

TO BE COMPLETED BY CHILD'S HEALTHCARE PROVIDER					
1	**First C&TC visit** (age birth to 1 month)		4	**Fourth C&TC visit** (age 6 months)	
	Clinic staff	Date of visit		Clinic staff	Date of visit
2	**Second C&TC visit** (age 2 months)		5	**Fifth C&TC visit** (age 9 months)	
	Clinic staff	Date of visit		Clinic staff	Date of visit
3	**Third C&TC visit** (age 4 months)		6	**Sixth C&TC visit** (age 12 months)	
	Clinic staff	Date of visit		Clinic staff	Date of visit
Clinic name/clinic stamp			**Medica use only** Reviewed by		

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Medica Choice Care℠ (MA) and Medica MinnesotaCare members
Call Medica Customer Service at 952-992-2322
or 1-800-373-8335 (toll-free)

Medica AccessAbility Solution® (SNBC),
Medica DUAL Solution® (MSHO)
and Medica Choice Care MSC+ members
Call Medica Customer Service at 952-992-2580
or 1-888-347-3630 (toll-free)

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Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

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Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

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Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

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NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 25049 MINNEAPOLIS, MN

POSTAGE WILL BE PAID BY ADDRESSEE

My Health Rewards by Medica
MAIL ROUTE CP335
PO BOX 9310
MINNEAPOLIS, MN 55440-9745

Step ②: Fold along dotted line

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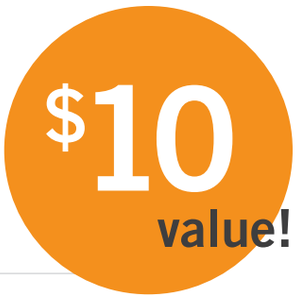
My Health Rewards by Medica®

VOUCHER



Child and Teen Checkups: 15 months to 20 years

You can earn a $10 gift card when your child has a Child and Teen Checkups (C&TC) visit at the following ages:

- 15 months
- 18 months
- Every year from 2 to 20 years old

TO BE COMPLETED BY PARENT/GUARDIAN			
Child's first name	Middle initial	Last name	Child's date of birth
Telephone number		Child's Medica ID number	
Street address			Apt. no.
City		State	Zip code
Parent/guardian's first name	Middle initial	Last name	Gift card choice NEW ❑ Target® ❑ Walmart®

To be eligible for a gift card you must:

- Mail this voucher to Medica within 90 days of your child's C&TC visit.
- Be a member of Medica Choice Care, Medica MinnesotaCare or Medica AccessAbility Solution on the day of the C&TC visit.

Incomplete vouchers will be returned. If a gift card choice is not made, one will be selected for you. Please allow 4 to 6 weeks for your gift card to arrive in the mail.

TO BE COMPLETED BY CHILD'S HEALTHCARE PROVIDER	
Provider signature	Date of visit
Clinic name/clinic stamp	**Medica use only** Reviewed by

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Medica Choice Care℠ (MA) and Medica MinnesotaCare members
Call Medica Customer Service at 952-992-2322
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Medica AccessAbility Solution® (SNBC),
Medica DUAL Solution® (MSHO)
and Medica Choice Care MSC+ members
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Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

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Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB3-0015 (3-13)

SPP0613

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My Health Rewards by Medica®

VOUCHER

Blood Lead Test: 9 months through 30 months

You can earn a $50 gift card for each blood lead test your child has at the following ages:

- The 12 month blood lead test can be given between 9 months and 15 months of age
- The 24 month blood lead test can be given between 15 months and 30 months of age

TO BE COMPLETED BY PARENT/GUARDIAN			
Child's first name	Middle initial	Last name	Child's date of birth
Telephone number	Child's Medica ID number		
Street address			Apt. no.
City		State	Zip code
Parent/guardian's first name	Middle initial	Last name	Gift card choice NEW ❑ Target® ❑ Walmart®

To be eligible for a gift card you must:

- Mail this voucher to Medica within 90 days of your child's blood lead test.
- Be a member of Medica Choice Care, Medica MinnesotaCare or Medica AccessAbility Solution on the day of the blood lead test.

Only one gift card per member per calendar year for the blood lead test. Incomplete vouchers will be returned. If a gift card choice is not made, one will be selected for you. Please allow 4 to 6 weeks for your gift card to arrive in the mail.

TO BE COMPLETED BY CHILD'S HEALTHCARE PROVIDER	
Provider signature	Date of blood lead test
Clinic name/clinic stamp	**Medica use only** Reviewed by

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or 1-800-373-8335 (toll-free)

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ໃນກໍລະນີ, ຖ້າທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອ ໃນການແປເອກະສານນີ້ນີ້ ,ຈົ່ງ ໂທຣ ເບີ້ ຫ້ ທ່ ານ ເ ວ ້ າ ຂ ້ າ ງ ເ ທ ິ ງ ນ ີ ້ .

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

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Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB3-0015 (3-13)

SPP0613

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NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 25049 MINNEAPOLIS, MN

POSTAGE WILL BE PAID BY ADDRESSEE

My Health Rewards by Medica
MAIL ROUTE CP335
PO BOX 9310
MINNEAPOLIS, MN 55440-9745

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Step ③: Tape voucher closed here

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My Health Rewards by Medica®

VOUCHER

$20 value!

Best for Baby & Me: First prenatal visit

You can earn a $20 gift card if one of the following applies to you:

- You are a Medica Choice Care, Medica MinnesotaCare or Medica AccessAbility Solution member at the time of your first prenatal visit and that visit occurs within 104 days of pregnancy
- Your first prenatal visit happens before you are a member *and* you have another prenatal visit within the first 42 days of your Medica Choice Care, Medica MinnesotaCare or Medica AccessAbility Solution coverage

TO BE COMPLETED BY MEMBER			
First name	Middle initial	Last name	
Date of birth	Telephone number	Member's Medica ID number	
Street address			Apt. no.
City	State	Zip code	Gift card choice NEW ❑ Target® ❑ Walmart®

To be eligible for a gift card you must:

- Mail this voucher to Medica within 90 days of your postpartum visit.
- Be a member of Medica Choice Care, Medica MinnesotaCare or Medica AccessAbility Solution on the day of the prenatal visit.

Incomplete vouchers will be returned. If a gift card choice is not made, one will be selected for you. Please allow 4 to 6 weeks for your gift card to arrive in the mail.

TO BE COMPLETED BY HEALTHCARE PROVIDER		
Date of first prenatal visit	Estimated due date	
Provider signature		Date
Clinic name/clinic stamp	**Medica use only** Reviewed by	

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ใบรถรจบ, ใจ้ขาก ท่ำมะัอฎาาม ภาานช่วยเหืือใบาามแปเอาะสาบัมธิ, จึ่ใช้ทรใบัทัพยเลาัขาูเถ้าบ้.

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Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

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LB3-0015 (3-13)

SPP0613

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BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 25049 MINNEAPOLIS, MN

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MAIL ROUTE CP335
PO BOX 9310
MINNEAPOLIS, MN 55440-9745

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My Health Rewards by Medica®

VOUCHER

Up to a $60 value!

Best for Baby & Me: Prenatal and postpartum visits

Depending on how many prenatal visits you have, you can earn one of the following gift cards:

- **$15 gift card** for having 8 to 9 prenatal visits
- **$30 gift card** for having 10 prenatal visits
- **$45 gift card** for having 11 or more prenatal visits
- **BONUS! Earn an extra $15** toward your gift card if you have a postpartum visit within 21 to 56 days of your delivery date

TO BE COMPLETED BY MEMBER			
First name	Middle initial	Last name	
Date of birth	Telephone number	Member's Medica ID number	
Street address			Apt. no.
City	State	Zip code	Gift card choice NEW ❑ Target® ❑ Walmart®

To be eligible for a gift card you must:

- Mail this voucher to Medica within 90 days of your postpartum visit.
- Be a member of Medica Choice Care, Medica MinnesotaCare or Medica AccessAbility Solution on the day of the prenatal and postpartum visits.

Incomplete vouchers will be returned. If a gift card choice is not made, one will be selected for you. Please allow 4 to 6 weeks for your gift card to arrive in the mail.

TO BE COMPLETED BY HEALTHCARE PROVIDER					
PRENATAL CARE VISITS					
1	Date of visit	Provider signature	7	Date of visit	Provider signature
2	Date of visit	Provider signature	8	Date of visit	Provider signature
3	Date of visit	Provider signature	9	Date of visit	Provider signature
4	Date of visit	Provider signature	10	Date of visit	Provider signature
5	Date of visit	Provider signature	11	Date of visit	Provider signature
6	Date of visit	Provider signature			

POSTPARTUM VISIT DATE AND BIRTH INFORMATION				
1	Baby delivery date	Postpartum visit date	Gestational age at birth	Weight of baby
Provider signature		Clinic name/clinic stamp		**Medica use only** Reviewed by

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Medica DUAL Solution® (MSHO)
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ໃນກໍລະນີ, ເຖົ້າທ່ານ ທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປພາສານັ້ນຣະ, ຈົ່ງໂທຣະໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

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Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

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My Health Rewards by Medica®

VOUCHER

$15 value!

Cervical Cancer Screening

You can earn a $15 gift card when you have a Pap test (for female members ages 21 to 64 years). Limit of one gift card each calendar year.

TO BE COMPLETED BY MEMBER			
First name	Middle initial	Last name	
Date of birth	Telephone number	Member's Medica ID number	
Street address			Apt. no.
City	State	Zip code	Gift card choice NEW ❑ Target® ❑ Walmart®

To be eligible for a gift card you must:

- Mail this voucher to Medica within 90 days of your Pap test.
- Be a member of Medica Choice Care, Medica MinnesotaCare or Medica AccessAbility Solution and between the ages of 21 and 64 years on the day you have the Pap test.

Incomplete vouchers will be returned. If a gift card choice is not made, one will be selected for you. Please allow 4 to 6 weeks for your gift card to arrive in the mail.

TO BE COMPLETED BY HEALTHCARE PROVIDER	
Provider signature	Date of Pap test
Clinic name/clinic stamp	**Medica use only** Reviewed by

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Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

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FIRST-CLASS MAIL PERMIT NO. 25049 MINNEAPOLIS, MN

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Step ③: Tape voucher closed here

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My Health Rewards by Medica®

VOUCHER

$15 value!

Breast Cancer Screening

You can earn a $15 gift card when you have a mammogram (for female members ages 40 to 75 years). Limit of one gift card each calendar year.

TO BE COMPLETED BY MEMBER			
First name	Middle initial	Last name	
Date of birth	Telephone number	Member's Medica ID number	
Street address			Apt. no.
City	State	Zip code	Gift card choice NEW ❑ Target® ❑ Walmart®

To be eligible for a gift card you must:

- Mail this voucher to Medica within 90 days of your mammogram.
- Be a member of Medica Choice Care, Medica MinnesotaCare or Medica AccessAbility Solution and between the ages of 40 and 75 years on the day you have the mammogram.

Incomplete vouchers will be returned. If a gift card choice is not made, one will be selected for you. Please allow 4 to 6 weeks for your gift card to arrive in the mail.

TO BE COMPLETED BY HEALTHCARE PROVIDER	
Provider signature	Date of mammogram
Clinic name/clinic stamp	**Medica use only** Reviewed by

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ກ້ານເຫັນວ່າທ່ານ ຕ້ອງການການຊ່ວຍເຫຼືອ ຖວກເອົາເປັນພາສາໂດຍບໍ່ເສຍຄ່າ ກະລຸນາໂທ ຫາເບີຂ້າງເທິງ ເພື່ອ ຂໍ.

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Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໃນກໍລະນີ, ຖ້າທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣະຈັບທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

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BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 25049 MINNEAPOLIS, MN

POSTAGE WILL BE PAID BY ADDRESSEE

My Health Rewards by Medica
MAIL ROUTE CP335
PO BOX 9310
MINNEAPOLIS, MN 55440-9745

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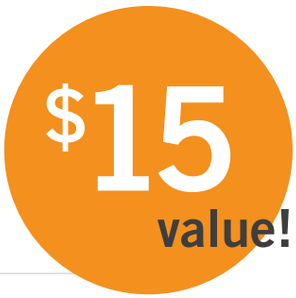
My Health Rewards by Medica®

VOUCHER



Colon Cancer Screening

You can earn a $15 gift card when you have a qualifying colon cancer screening test* (for female and male members ages 50 to 75 years). Limit of one gift card each calendar year.

TO BE COMPLETED BY MEMBER			
First name	Middle initial	Last name	
Date of birth	Telephone number	Member's Medica ID number	
Street address			Apt. no.
City	State	Zip code	Gift card choice NEW ❑ Target® ❑ Walmart®

To be eligible for a gift card you must:

- Mail this voucher to Medica within 90 days of your colon cancer screening test.
- Be a member of Medica Choice Care, Medica MinnesotaCare or Medica AccessAbility Solution and between the ages of 50 and 75 years on the day you have the colon cancer screening test.

Incomplete vouchers will be returned. If a gift card choice is not made, one will be selected for you. Please allow 4 to 6 weeks for your gift card to arrive in the mail.

TO BE COMPLETED BY HEALTHCARE PROVIDER	
Provider signature	Date of colon cancer screening test
Clinic name/clinic stamp	**Medica use only** Reviewed by

*Qualifying colon cancer screening tests include: Colonoscopy, Sigmoidoscopy, or Stool Test.

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Medica Choice Care℠ (MA) and Medica MinnesotaCare members
Call Medica Customer Service at 952-992-2322
or 1-800-373-8335 (toll-free)

Medica AccessAbility Solution® (SNBC),
Medica DUAL Solution® (MSHO)
and Medica Choice Care MSC+ members
Call Medica Customer Service at 952-992-2580
or 1-888-347-3630 (toll-free)

Attention. If you need free help interpreting this document, call the above number.

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Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

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Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

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Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

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My Health Rewards by Medica®

VOUCHER

$15 value!

Chlamydia Screening

You can earn a $15 gift card when you have a chlamydia screening test (for male and female members ages 16 to 24 years). Limit of one gift card each calendar year.

TO BE COMPLETED BY MEMBER OR PARENT/GUARDIAN			
First name	Middle initial	Last name	
Member's date of birth	Telephone number	Member's Medica ID number	
Street address			Apt. no.
City		State	Zip code
If member is under age 18, parent/guardian's first name, middle initial, and last name			Gift card choice NEW ❑ Target® ❑ Walmart®

To be eligible for a gift card you must:

- Mail this voucher to Medica within 90 days of your chlamydia screening.
- Be a member of Medica Choice Care, Medica MinnesotaCare or Medica AccessAbility Solution and between the ages of 16 and 24 years on the day you have the chlamydia screening.

Incomplete vouchers will be returned. If a gift card choice is not made, one will be selected for you. Please allow 4 to 6 weeks for your gift card to arrive in the mail.

TO BE COMPLETED BY HEALTHCARE PROVIDER	
Provider signature	Date of chlamydia screening
Clinic name/clinic stamp	**Medica use only** Reviewed by

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or 1-800-373-8335 (toll-free)

Medica AccessAbility Solution® (SNBC),
Medica DUAL Solution® (MSHO)
and Medica Choice Care MSC+ members
Call Medica Customer Service at 952-992-2580
or 1-888-347-3630 (toll-free)

Attention. If you need free help interpreting this document, call the above number.

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Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

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After Hours Clinic Directory

This is a list of some primary care clinics and some urgent care centers in the following counties:

- Anoka
- Carver
- Dakota
- Hennepin
- Ramsey
- Scott
- Washington

The clinics on this list are open before and/or after normal business hours. These clinics provide Child and Teen Checkups and/or urgent care services during those hours. Clinics listed in this directory meet **at least one** of the following conditions:

- The clinic is open at least one weekday by 7 a.m.
- The clinic is open at least one weekday until or later than 6 p.m.
- The clinic is open on Saturdays
- The clinic is open on Sundays

Some clinic hours have "urgent care only" next to them. These are times when that clinic is unable to provide Child & Teen Checkups.

Use this directory to your advantage! It can make scheduling Child & Teen Checkups and urgently needed care visits easy.

Member Tip:

A complete list of providers is in your Provider Directory

This list of providers in our network includes all the clinics, urgent and convenience care centers, dentists, and many other kinds of providers.

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ANOKA COUNTY

ANDOVER

CPMG–Andover Park Clinic
13819 Hanson Blvd NW
Andover, MN 55304
763-572-5700
Mon–Fri 7 a.m. to 9 p.m., *only urgent care after 6 p.m.*
Sat–Sun 9 a.m. to 5 p.m., *urgent care only*

Riverway Clinic–Andover
15245 Bluebird St NW
Andover, MN 55304
763-712-6500 clinic
763-712-6666 urgent care
Mon–Fri 8 a.m. to 9 p.m., *only urgent care after 5 p.m.*
Sat–Sun 9 a.m. to 5 p.m., *urgent care only*
Holidays hours vary, *urgent care only*

BLAINE

Multicare Associates–Blaine Medical Center
11855 Ulysses St NE, Suite 110
Blaine, MN 55449
763-785-4200
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 5 p.m

COLUMBIA HEIGHTS

Columbia Park Clinic
4000 Central Ave NE
Columbia Heights, MN 55421
763-572-5700
Mon–Thu 7:30 a.m. to 6 p.m.
Fri 7:30 a.m. to 5 p.m.

COON RAPIDS

Allina Medical Clinic–Coon Rapids
9055 Springbrook Dr NW
Coon Rapids, MN 55433
763-780-9155
Mon–Fri 7 a.m. to 9 p.m., *only urgent care after 5 p.m.*
Sat noon to 5 p.m., *urgent care only*
Sun 9 a.m. to 3 p.m., *urgent care only*

FRIDLEY

Fridley Childrens & Teenagers Medical Center
500 Osborne Rd NE, Suite 310
Fridley, MN 55432
763-236-2700
Mon–Thu 7 a.m. to 9 p.m., *only urgent care after 7 p.m.*
Fri 7a.m. to 9 p.m., *only urgent care after 5 p.m.*
Sat–Sun, Holidays 9 a.m. to 10:30 a.m., *urgent care only*

Fridley Plaza Clinic
6341 University Ave NE
Fridley, MN 55432
763-572-5700
Mon–Thu 7:30 a.m. to 6 p.m.
Fri 7:30 a.m. to 5 p.m.

Multicare Associates–Fridley Medical Center
7675 Madison St NE
Fridley, MN 55432
763-785-4500
Mon–Fri 8 a.m. to 8 p.m.
Sat 8 a.m. to noon

LINO LAKES

Fairview Lakes Lino Lakes Clinic
7455 Village Dr
Lino Lakes, MN 55014
651-717-3400
Mon 7:30 a.m. to 7 p.m.
Tue-Fri 7:30 a.m. to 5 p.m.

RAMSEY

Allina Medical Clinic–Ramsey
5300 Alpine Dr NW
Ramsey, MN 55303
763-236-0000
Mon, Fri 8 a.m. to 5 p.m.
Tue, Wed, Thu 8 a.m. to 8 p.m.
Sat 8 a.m. to noon, *urgent care only*

CARVER COUNTY

CHANHASSEN

Park Nicollet Clinic–Chanhassen
300 Lake Dr E
Chanhassen, MN 55317
952-993-4300
Mon–Fri 7 a.m. to 8 p.m, *only urgent care after 5.p.m.*
Sat–Sun 8 a.m. to 5 p.m., *urgent care only*

CHASKA

Allina Medical Clinic–Crossroads Chaska
3000 N Chestnut St, Suite 120
Chaska, MN 55318
952-448-2050
Mon–Fri 8 a.m. to 6 p.m.
Sat 8 a.m. to noon, *urgent care only*

Fairview Jonathan Clinic
1580 White Oak Dr
Chaska, MN 55318
952-448-3500
Mon–Fri 8 a.m. to 5 p.m.
Sat 8 a.m. to noon, *urgent care only*

Wayzata Children's Clinic
3000 Hundertmark Rd, Suite 13
Chaska, MN 55318
952-448-3847
Mon 8 a.m. to 8 p.m.
Tue-Fri 8 a.m. to 5 p.m
Sun noon to 3 p.m., *urgent care only*

WACONIA

Lakeview Clinic–Waconia
424 W State Hwy 5
Waconia, MN 55387
952-442-4461
Mon–Fri 8:30 a.m. to 5:30 p.m.
Sat 8:30 a.m. to noon, *urgent care only*

WATERTOWN

Lakeview Clinic–Watertown
309 Jefferson Ave SW
Watertown, MN 55388
952-955-1921
Mon–Fri 8:30 a.m. to 5:30 p.m.
Sat 8 a.m. to noon, *urgent care only*

DAKOTA COUNTY

APPLE VALLEY

Apple Valley Medical Center
14655 Galaxie Ave
Apple Valley, MN 55124
952-953-9224
Mon–Fri 8 a.m. to 8 p.m.

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Apple Valley Medical Center–Urgent Care
14655 Galaxie Ave
Apple Valley, MN 55124
952-432-4141
Mon–Sun 24 hours a day, *urgent care only*

Eagan Valley Pediatrics
14135 Cedar Ave S, Suite 100
Apple Valley, MN 55124
952-432-4373
Mon–Thu 8:30 a.m. to 7 p.m., *only urgent care after 5 p.m.*
Fri 8:30 a.m. to 5 p.m.
Sat 9 a.m. to noon, *urgent care only*

Fairview Cedar Ridge Clinic
15650 Cedar Ave
Apple Valley, MN 55124
952-997-4100
Mon, Thu 8 a.m. to 7 p.m.
Tue, Wed, Fri 8 a.m. to 5 p.m.
Sat 8 a.m. to noon, *urgent care only*

BURNSVILLE

Burnsville Family Physicians
625 E Nicollet Blvd, Suite 100
Burnsville, MN 55337
952-435-0303
Mon–Thu 8 a.m. to 8 p.m.
Fri 9 a.m. to 5 p.m.
Sat 9 a.m. to noon, *urgent care only*

Quello Clinic LTD–Burnsville
14000 Nicollet Ave, Suite 100
Burnsville, MN 55337
952-985-8200
Mon, Wed, Fri 8 a.m. to 5 p.m.
Tue, Thu 8 a.m. to 8 p.m.

Fairview Ridges Clinic
303 E Nicollet Blvd, Suite 160
Burnsville, MN 55337
952-460-4000
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 5:30 p.m.
Sat 8:30 a.m. to noon

Metropolitan Pediatric Specialists
303 E Nicollet Blvd, Suite 260
Burnsville, MN 55337
952-435-2450
Mon–Thu 8 a.m. to 7 p.m.
Fri 8 a.m. to 6 p.m.
Sun 10 a.m. to 1 p.m.

Southdale Pediatric Associates Ltd
501 E Nicollet Blvd, Suite 200
Burnsville, MN 55337
952-898-5900
Mon–Fri 8 a.m. to 5 p.m.
Mon–Thu 6 p.m. to 9 p.m., *urgent care only*
Sat 8 a.m. to noon, *urgent care only*

EAGAN

Allina Medical Clinic–Eagan
1110 Yankee Doodle Rd
Eagan, MN 55121
651-454-3970
Mon–Thu 7:30 a.m. to 8 p.m.
Fri 7:30 a.m. to 5 p.m.
Sat 9 a.m. to noon, same day appointments only

Eagan Child & Family Care
4178 Knob Dr, Suite A
Eagan, MN 55122
651-209-8640
Mon 8 a.m. to 6 p.m.
Tue 8 a.m. to 7 p.m.
Wed 8 a.m. to 5 p.m.
Thu 8:30 a.m. to 7 p.m.
Fri 8 a.m. to noon
Sat 8:30 a.m. to noon

Yankee Square Family Practice
3460 Washington Dr, Suite 102
Eagan, MN 55122
651-452-9240
Mon, Wed, Fri 8:30 a.m. to 5 p.m.
Tue 8:30 a.m. to 7 p.m.
Thu 8:30 a.m. to noon

FARMINGTON

Allina Medical Clinic–Farmington
3500 213th St W
Farmington, MN 55024
651-463-7181
Mon–Thu 8 a.m. to 6 p.m.
Fri 8 a.m. to 5 p.m.
Sat 9 a.m. to noon, *urgent care only*

HASTINGS

Allina Medical Clinic–Hastings
1210 1st St W
Hastings, MN 55033
651-438-1800
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 6 p.m.
Sat–Sun 8 a.m. to 4 p.m., *urgent care only*

Allina Medical Clinic–Hastings (Nininger)
1285 Nininger Rd
Hastings, MN 55033
651-480-4200
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 6 p.m.

INVER GROVE HEIGHTS

Aspen Medical Group–Inver Grove Heights
5565 Blaine Ave
Inver Grove Heights, MN 55076
651-450-8000
Mon–Fri 9 a.m. to 10 p.m., *only urgent care after 5 p.m.*
Sat–Sun 9 a.m. to 5 p.m., *urgent care only*

Dakota Pediatric Clinic
5975 Carmen Ave E
Inver Grove Heights, MN 55076
651-455-9697
Mon–Thu 9 a.m. to 6 p.m.
Fri 9:30 a.m. to 5 p.m.
Sat 9:30 a.m. to noon, *urgent care only*

Family Health Services–Inver Grove
2980 Buckley Way
Inver Grove Heights, MN 55076
651-457-2748
Mon–Fri 6 p.m. to 8:30 p.m.
Sat 9 a.m. to 5 p.m.
Sun 9 a.m. to 4 p.m.

LAKEVILLE

Dakota Pediatric Clinic
17504 Dodd Blvd
Lakeville, MN 55044
952-997-2572
Mon–Thu 9 a.m. to 6 p.m.
Fri 9 a.m. to 5 p.m.

WEST SAINT PAUL

Allina Medical Clinic–West St. Paul
150 Emerson Ave E
West Saint Paul, MN 55118
651-241-1800 Mon–Fri
651-241-1818 Sat & holidays
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 5 p.m.
Sat 9 a.m. to 4 p.m.
Holidays hours vary

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Family Health Services–Gorman Clinic
234 Wentworth Ave E
West Saint Paul, MN 55118
651-455-2940
Mon–Fri 8 a.m. to 5 p.m.

Mendakota Pediatrics
1880 Livingston Ave, Suite 102
West Saint Paul, MN 55118
651-552-7999
Mon, Thu, Fri 8:30 a.m. to 5 p.m.
Tue 10 a.m. to 7 p.m.
Wed 8:30 a.m. to noon
Sat 9 a.m. to noon

Pace-Pediatric & Adolescent Care of Minnesota
1547 Livingston Ave
West Saint Paul, MN 55118
651-451-8050
Mon, Wed, Thu 9 a.m. to 8 p.m.
Tue 8 a.m. to 6:30 p.m.
Fri 9 a.m. to 5 p.m.
Sat–Sun 9 a.m. to noon

HENNEPIN COUNTY

BLOOMINGTON

Aspen Medical Group–Bloomington
7920 Old Cedar Ave S
Bloomington, MN 55425
952-851-1000
Mon–Fri 8 a.m. to 10 p.m., *only urgent care after 5 p.m.*
Sat– Sun 9 a.m. to 5 p.m., *urgent care only*

Bloomington Lake Clinic Ltd
7901 Xerxes Ave S., Suite 116
Bloomington, MN 55431
952-888-2024
Mon–Fri 7:30 a.m. to 5 p.m.
Sat 8 a.m. to noon, *urgent care only*

Fairview Oxboro Clinic
600 W 98th St
Bloomington, MN 55420
952-885-6150
Mon, Wed, Thu, Fri 8 a.m. to 5 p.m.
Tue 8 a.m. to 8 p.m.

Fairview Urgent Care–Oxboro
600 W 98th St
Bloomington, MN 55420
952-885-6060
Mon–Fri 9 a.m. to 8:30 p.m., *urgent care only*
Sat 9 a.m. to 7:30 p.m., *urgent care only*
Sun noon to 7:30 p.m., *urgent care only*

BROOKLYN CENTER

Hennepin Care North
6601 Shingle Creek Pkwy, Suite 400
Brooklyn Center, MN 55430
612-873-8800
Mon–Wed, Fri 8 a.m. to 5 p.m.
Thu 8 a.m. to 8 p.m., *only urgent care after 5 p.m.*

BROOKLYN PARK

CPMG–Brooklyn Park Clinic
10000 Zane Ave N
Brooklyn Park, MN 55443
763-572-5700
Mon–Thu 7:30 a.m. to 6 p.m.
Fri 7:30 a.m. to 5 p.m.
Sat 9 a.m. to 1 p.m., *urgent care only*

NMC–Brooklyn Park Family Physicians
8559 Edinbrook Pkwy, Suite 100
Brooklyn Park, MN 55443
763-425-1888
Mon–Tue, Thu 8 a.m. to 8 p.m.
Wed, Fri 8 a.m. to 5 p.m.
Sat 8 a.m. to noon

CHAMPLIN

Allina Medical Clinic–Champlin
11269 Jefferson Hwy N
Champlin, MN 55316
763-236-0600
Mon–Thu 7:30 a.m. to 8 p.m.
Fri 7:30 a.m. to 5 p.m.
Sat 9 a.m. to noon, *urgent care only*

CRYSTAL

Crystal Gallery Urgent Care offered by Northwest Family Physicians
5502 W Broadway Ave, 2nd floor
Crystal, MN 55428
763-504-6599
Mon–Fri 5 p.m. to 9 p.m., *urgent care only*
Sat–Sun 10 a.m. to 6 p.m., *urgent care only*
Holidays 10 a.m. to 6 p.m., *urgent care only*

Northwest Family Physicians
5502 W Broadway Ave
Crystal, MN 55428
763-504-6500
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 5 p.m.
Sat 9 a.m. to 1 p.m., by appointment only–no C&TCs

EDEN PRAIRIE

All About Children Pediatrics
12200 Middle SE Rd, Suite 100
Eden Prairie, MN 55344
952-943-8200
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 6 p.m.
Sat 9 a.m. to noon, *urgent care only*

The Doctors Office Urgent Care
800 Prairie Center Dr, Suite 120
Eden Prairie, MN 55344
952-942-7337
Mon–Fri 6 p.m. to 9 p.m.
Sat–Sun 1 p.m. to 8:30 p.m., *urgent care only*
Christmas Eve 1 p.m. to 6 p.m., *urgent care only*
All other holidays 1 p.m. to 8:30 p.m., *urgent care only*

EDINA

Allina Medical Clinic–Edina
7500 France Ave S
Edina, MN 55435
952-835-1311
Mon–Thu 7 a.m. to 5 p.m.
Fri 7 a.m. to 4 p.m.

Edina Family Physicians
5301 Vernon Ave S
Edina, MN 55436
952-925-2200
Mon–Fri 8 a.m. to 6 p.m.
Sat 9 a.m. to noon, *urgent care only*

Edina Pediatrics
3250 W 66th St, Suite 210
Edina, MN 55435
952-927-7337
Mon–Thu 8 a.m. to 7 p.m.
Fri 8 a.m. to 6 p.m.
Sat 9 a.m. to noon, *urgent care only*

Metropolitan Pediatric Specialists
6545 France Ave S, Suite 400
Edina, MN 55435
952-920-9191
Mon–Thu 8 a.m. to 7 p.m.
Fri 8 a.m. to 6 p.m.
Sat 9 a.m. to noon

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Southdale Pediatric Associates Ltd
3955 Parklawn Ave, Suite 200
Edina, MN 55435
952-831-4454
Mon–Thu 8 a.m. to 5 p.m. and 6 p.m. to 9 p.m., *urgent care only*
Fri 8 a.m. to 5 p.m.
Sat 8 a.m. to noon, *urgent care only*

EXCELSIOR

Eagle Medical
490 Oak St
Excelsior, MN 55331
952-474-4167
Mon–Fri 9 a.m. to 5 p.m.

GOLDEN VALLEY

NMC–Golden Valley Family Physicians
8301 Golden Valley Rd, Suite 100
Golden Valley, MN 55427
763-520-2200
Mon–Thu 8 a.m. to 6 p.m.
Fri 8 a.m. to 5 p.m.

MAPLE GROVE

Allina Medical Clinic–Maple Grove
7840 Vinewood Lane
Maple Grove, MN 55369
763-236-0200
Mon–Tue, Thu-Fri 7 a.m. to 5 p.m.
Wed 7 a.m. to 7 p.m.
Sat 9 a.m. to noon, *urgent care only*

Fairview Maple Grove Medical Center
14500 99th Ave
Maple Grove, MN 55369
763-898-1000
Mon–Fri 7 a.m. to 8 p.m.
Sat 8 a.m. to 5 p.m., *urgent care only*

Partners In Pediatrics Ltd
12720 Bass Lake Rd
Maple Grove, MN 55369
763-559-2861
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 5 p.m.
Sat–Sun 8:30 a.m. to 12:30 p.m., *urgent care only*

South Lake Pediatrics
12000 Elm Creek Blvd N, Suite 250
Maple Grove, MN 55369
952-401-8300
Mon–Thu 8 a.m. to 5 p.m. and 6 p.m. to 8:30 p.m.
Fri 8 a.m. to 5 p.m.
Sat 9 a.m. to noon, *urgent care only*

MINNEAPOLIS

Allina Medical Clinic–The Doctors Uptown
1221 W Lake St, Suite 201
Minneapolis, MN 55408
612-824-1772
Mon, Thu 8:30 a.m. to 7 p.m.
Tue-Wed 8:30 a.m. to 5 p.m.
Fri 6:30 a.m. to 3 p.m.

Cedar Riverside Peoples Center
425 20th Ave S
Minneapolis, MN 55454
612-332-4973
Mon, Wed, Fri 8:30 a.m. to 5:30 p.m.
Tue, Thu 8 a.m. to 8 p.m.

Central Avenue Clinic
2610 Central Ave NE
Minneapolis, MN 55418
612-781-6816
Mon–Wed, Friday 8 a.m. to 5 p.m.
Thu 8 a.m. to 8 p.m.

Childrens Clinic
2525 Chicago Ave
Minneapolis, MN 55404
612-813-6107
Mon–Fri 8 a.m. to 5 p.m.

Crown Medical Center
1925 1st Ave S
Minneapolis, MN 55403
612-871-4354
Mon–Fri 9 a.m. to 5 p.m.
Sat 10 a.m. to 2 p.m.

Fairview Childrens Clinic
2535 University Ave SE
Minneapolis, MN 55414
612-672-2350
Mon–Fri 7:30 a.m. to 8 p.m.
Sat 8 a.m. to 3 p.m.

Fairview Uptown Clinic
Lake Calhoun Executive Center
3033 Excelsior Blvd, Suite 275
Minneapolis, MN 55416
612-827-4751
Mon–Thu 7:30 a.m. to 6 p.m.
Fri 7:30 a.m. to 5 p.m.

Family Medical Center
5 W Lake St
Minneapolis, MN 55408
612-545-9000
Mon, Wed, Fri 8 a.m. to 5:30 p.m.
Tue, Thu 8 a.m. to 9 p.m.
Sat 8 a.m. to noon

Indian Health Board Clinic
1315 E 24th St
Minneapolis, MN 55404
612-721-9800 clinic
612-721-9829 after hours
Mon, Wed, Fri 9 a.m. to 5 p.m.
Tue, Thu 9 a.m. to 8 p.m.

Native American Community Clinic
1213 E Franklin Ave
Minneapolis, MN 55404
612-872-8086
Mon–Fri 10 a.m. to 6 p.m.
Sat 10 a.m. to 2 p.m., *urgent care only*

North Point Health & Wellness Center
1313 Penn Ave N
Minneapolis, MN 55411
612-543-2500 clinic
612-873-3000 after hours
Mon, Tue, Thu, Fri 8 a.m. to 5 p.m.
Wed 8:30 a.m. to 7 p.m.
Sat 8 a.m. to noon

Northstar Pediatric & Teen Clinic
5851 Duluth St, Suite 317
Minneapolis, MN 55435
763-546-4301
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 4 p.m.

Park Nicollet Clinic–Minneapolis
2001 Blaisdell Ave S
Minneapolis, MN 55404
952-993-8000
Mon–Thu 7 a.m. to 5 p.m.

Pediatric & Adolescent Services
2545 Chicago Ave, Suite 405
Minneapolis, MN 55404
612-871-5511
Mon–Fri 9 a.m. to 3:30 p.m.
Sat 9 a.m. to 11 a.m., *urgent care only*

Sheridan Women & Childrens Clinic
342 13th Ave NE
Minneapolis, MN 55413
612-362-4111
Mon 8 a.m. to 8 p.m.
Wed-Fri 8 a.m. to 5 p.m.

Southside Community Health Services
4730 Chicago Ave S
Minneapolis, MN 55407
612-822-3186
Mon–Fri 8 a.m. to 5:30 p.m.
Sat one Saturday each month

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TAMS–Teen Age Medical Services
2425 Chicago Ave
Minneapolis, MN 55404
612-813-6125
Mon–Tue, Thu 9 a.m. to 5:30 p.m., ages 10–23 years only
Wed 9 a.m. to 9 p.m., ages 10–23 years only
Fri 9 a.m. to 5 p.m

U of M Physicians–Broadway Family Medicine
1020 W Broadway Ave
Minneapolis, MN 55411
612-302-8200
Mon, Wed 8 a.m. to 8 p.m.
Tues, Thu, Fri 8 a.m. to 5 p.m.
Sat 11 a.m. to 3:30 p.m., *urgent care only*

U of M Physicians–Smiley's Clinic
2020 E 28th St
Minneapolis, MN 55407
612-333-0770
Mon, Wed, Fri 8 a.m. to 5 p.m.
Tue, Thu 8 a.m. to 8 p.m.

MINNETONKA

South Lake Pediatrics
17705 Hutchins Dr, Suite 101
Minnetonka, MN 55345
952-401-8300
Mon–Fri 7:30 a.m. to 5 p.m.
Sat 9 a.m. to noon, *urgent care only*

The Doctors Office Urgent Care
17705 Hutchins Dr, Suite 101
Minnetonka, MN 55345
952-401-8383
Mon–Fri 6 p.m. to 9 p.m., *urgent care only*
Sat–Sun 1 p.m. to 8:30 p.m., *urgent care only*
Christmas Eve 1 p.m. to 6 p.m., *urgent care only*

Urgent Care For Kids
6060 Clearwater Dr, Suite 240
Minnetonka, MN 55343
952-939-4112
Mon–Fri 6 p.m. to 9 p.m., *urgent care only*
Sat– Sun 11 a.m. to 7 p.m., *urgent care only*
Christmas Eve 1 p.m. to 6 p.m., *urgent care only*
Holidays 11 a.m. to 7 p.m., *urgent care only*

PLYMOUTH

Allina Medical Clinic–WestHealth Campus
2855 Campus Dr, Suite 400
Plymouth, MN 55441
763-577-7400
Mon–Fri 6:30 a.m. to 5 p.m.

Northwest Family Physicians
1495 State Hwy 101 N
Plymouth, MN 55447
763-504-6600
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 5 p.m.
Sat 9 a.m. to noon

ROBBINSDALE

Robbinsdale Clinic
3819 W Broadway Ave
Robbinsdale, MN 55422
763-533-2534
Mon, Thu 9 a.m. to 4 p.m.
Tue, Wed, Fri 8 a.m. to 5 p.m.
Sat 7:30 a.m. to noon, *urgent care only*

ROGERS

Northwest Family Physicians
21395 John Milless Dr
Rogers, MN 55374
763-504-6400
Mon, Wed 8 a.m. to 8 p.m.
Tues, Thu-Fri 8 a.m. to 5 p.m.

SAINT LOUIS PARK

Pediatric Services
5111 Minnetonka Blvd
Saint Louis Park, MN 55416
952-922-4200
Mon–Fri 8:30 a.m. to 5 p.m.
Sat 8:30 a.m. to 11 a.m., *urgent care only*

WAYZATA

Wayzata Childrens Clinic
250 Central Ave N, Suite 101
Wayzata, MN 55391
952-473-0211
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 5 p.m.
Sat 8:30 a.m. to 12:30 p.m., *urgent care only*

RAMSEY COUNTY

MAPLEWOOD

Aspen Medical Group–Maplewood
1850 Beam Ave
Maplewood, MN 55109
651-779-2500
Mon–Fri 8 a.m. to 9:45 p.m., *only urgent care after 5 p.m.*
Sat–Sun 9 a.m. to 4:45 p.m., *urgent care only*

Healtheast Maplewood Clinic
3100 Kennard St, Suite 100
Maplewood, MN 55109
651-232-7800
Mon–Thu 7:30 a.m. to 6:30 p.m.
Fri 7:30 a.m. to 5 p.m.
Sat 8:30 a.m. to 11:30 a.m.

ROSEVILLE

MultiCare Associates–Roseville Medical Center
Rosedale Medical Center
1835 County Rd C W
Roseville, MN 55113
763-785-4300
Mon–Fri 7:30 a.m. to 8 p.m.

SAINT PAUL

Aspen Medical Group–Bandana Square
1020 Bandana Blvd W
Saint Paul, MN 55108
651-641-7000 clinic
651-241-9900 urgent care
Mon–Fri 8 a.m. to 10 p.m., *only urgent care after 5 p.m.*
Sat–Sun 9 a.m. to 5 p.m., *urgent care only*

Children's Clinic–St. Paul
347 N Smith Ave, Suite 302
Saint Paul, MN 55102
651-220-6789
Mon–Thu 8 a.m. to 7 p.m
Fri 8 a.m. to 5 p.m.

Fairview Highland Park Clinic
2155 Ford Pkwy
Saint Paul, MN 55116
651-696-5050
Mon–Fri 7 a.m. to 5 p.m

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Fairview Urgent Care–Highland Park Clinic
2155 Ford Pkwy
Saint Paul, MN 55116
651-696-5070
Mon–Fri 6 p.m. to 10 p.m.
Sat 8 a.m. to 10 p.m., *urgent care only*
Sun 10 a.m. to 8 p.m., *urgent care only*

Family Health Services–Highland
1540 Randolph Ave
Saint Paul, MN 55105
651-699-8333
Mon–Fri 8 a.m. to 5 p.m.
Sat 9 a.m. to 5 p.m., *urgent care only*
Sun 9 a.m. to 4 p.m., *urgent care only*

Family Health Services–Maryland
911 E Maryland Ave
Saint Paul, MN 55106
651-776-2719
Mon 8:30 a.m. to 6 p.m.
Tue-Fri 8:30 a.m. to 5 p.m.

HealthPartners–Midway Clinic
451 Dunlap St N
Saint Paul, MN 55104
952-967-7886
Mon–Fri 8 a.m. to 5 p.m.

Open Cities Health Center Inc
409 Dunlap St N
Saint Paul, MN 55104
651-290-9200
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 5 p.m.
Sat 10 a.m. to 2 p.m., *urgent care only*

Open Cities Health Center Inc–Northend Clinic
135 Manitoba Ave
Saint Paul, MN 55117
651-489-8021
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 5 p.m.
Sat 10 a.m. to 2 p.m., *urgent care only*

Pediatric & Young Adult Medicine
233 Grand Ave
Saint Paul, MN 55102
651-227-7806
Mon, Wed, Thu, Fri 8:30 a.m. to 5 p.m.
Tue 8:30 a.m. to 6:30 p.m.
Sat 9 a.m. to noon, *urgent care only*

Priority Pediatrics–St. Paul
1536 Larpenteur Ave W
Saint Paul, MN 55113
651-645-4693
Mon–Fri 5 p.m. to 10 p.m., *urgent care only*
Sat 9 a.m. to 5 p.m., *urgent care only*
Sun noon to 8 p.m., *urgent care only*

United Family Practice Health Center
1026 West 7th St
Saint Paul, MN 55102
651-241-1000
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 5 p.m.

West Side Health Center–La Clinica
153 Cesar Chavez St
Saint Paul, MN 55107
651-222-1816
Mon–Tue, Fri 8 a.m. to 5 p.m.
Wed, Thu 8 a.m. to 8 p.m.
Sat 8 a.m. to noon, *urgent care only*

SHOREVIEW

Allina Medical Clinic–Shoreview
4194 Lexington Ave N
Shoreview, MN 55126
651-483-5461
Mon–Fri 8 a.m. to 9:30 p.m.
Sat 10 a.m. to 5 p.m.
Sun noon to 6 p.m.

Silver Lake Clinic
4625 Churchill St
Shoreview, MN 55126
651-766-3900
Mon–Thu 7 a.m. to 8 p.m.
Fri 7 a.m. to 5 p.m.
Sat 8 a.m. to 11 a.m.

VADNAIS HEIGHTS

Northeast Pediatric Clinic
4520 Centerville Rd
Vadnais Heights, MN 55127
651-426-1141
Mon, Thu 8 a.m. to 8 p.m.
Tue-Wed, Fri 8 a.m. to 6 p.m.
Sat 9 a.m. to 11 a.m., *urgent care only*

WHITE BEAR LAKE

Northern Lights Pediatric and Adolescent Medicine
3555 Willow Lake Blvd, Suite 140
White Bear Lake, MN 55110
651-770-2124
Mon–Friday 7:30 a.m. to 7:30 p.m.
Sat 8 a.m. to noon, *urgent care only*
Sun 2 p.m. to 5 p.m., *urgent care only*

SCOTT COUNTY

BELLE PLAINE

Southern Metro Medical Clinics–Belle Plaine
700 W Prairie St
Belle Plaine, MN 56011
952-873-2276
Mon–Fri 8 a.m. to 5 p.m.

NEW PRAGUE

Parkview Medical Clinic
1400 1st St NE
New Prague, MN 56071
952-758-2535
Mon– Fri 8:30 a.m. to 5 p.m.
Sat 8:30 a.m. to noon, *urgent care only*

PRIOR LAKE

Allina Medical Clinic–Crossroads Prior Lake
14033 Commerce Ave NE
Prior Lake, MN 55372
952-447-1700
Mon–Fri 8 a.m. to 6 p.m.

Fairview RidgeValley Clinic
4151 Willowwood St SE
Prior Lake, MN 55372
952-226-2600
Mon–Fri 8 a.m. to 5 p.m.
Sat 8:30 a.m. to noon, *urgent care only*

SHAKOPEE

Allina Medical Clinic–Crossroads Shakopee
4201 Dean Lakes Blvd, Suite 120
Shakopee, MN 55379
952-496-6700
Mon–Fri 8 a.m. to 6 p.m.

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Allina Medical Clinic–Shakopee
1601 Saint Francis Ave, Suite 100
Shakopee, MN 55379
952-403-3535
Mon–Thu 7 a.m. to 5 p.m.
Fri 8 a.m. to 5 p.m.

Park Nicollet Clinic–Shakopee
1455 Saint Francis Ave
Shakopee, MN 55379
952-993-7750
Mon–Fri 8 a.m. to 5 p.m. and 6 p.m to 10 p.m., *only urgent care after 6 p.m.*
Sat–Sun 1 p.m. to 10 p.m., *urgent care only*

WASHINGTON COUNTY

COTTAGE GROVE

Allina Medical Clinic–Cottage Grove
8611 West Point Douglas Rd S
Cottage Grove, MN 55016
951-458-1884
Mon–Thu 8 a.m. to 8 p.m.
Fri 8 a.m. to 5 p.m.

Regina Medical Group
8451 East Point Douglas Rd S, Suite 100
Cottage Grove, MN 55016
951-459-6654
Mon–Thu 8 a.m. to 8 p.m., *only urgent care after 5 p.m.*
Fri 8 a.m. to 6 p.m., *only urgent care after 5 p.m.*

FOREST LAKE

Allina Medical Clinic–Forest Lake
1540 Lake St S
Forest Lake, MN 55025
651-464-7100
Mon–Thu 8 a.m. to 6 p.m.
Fri 8 a.m. to 5 p.m.
Sat 9 a.m. to noon, *urgent care only*

HUGO

Fairview Hugo Clinic
14663 Mercantile Dr N
Hugo, MN 55038
651-466-1900
Mon 7:30 a.m. to 5 p.m., every other Monday open until 7 p.m.
Tue-Fri 7:30 a.m. to 5 p.m.

OAKDALE

Healtheast Oakdale Clinic
1099 Helmo Ave N, Suite 100
Oakdale, MN 55128
651-326-5300
Mon–Fri 7 a.m. to 5 p.m.

STILLWATER

Stillwater Medical Group
1500 Curve Crest Blvd W
Stillwater, MN 55082
651-439-1234
Mon–Fri 7:30 a.m. to 8:30 p.m., *only urgent care after 5:30 p.m.*
Sat–Sun 8 a.m. to 11:30 a.m., *urgent care only*

WOODBURY

Allina Medical Clinic–Woodbury
8675 Valley Creek Rd
Woodbury, MN 55125
651-241-3000 clinic
651-241-3414 after hours care
Mon–Fri 7 a.m. to 5 p.m.
Mon–Fri 3 p.m. to 10 p.m., *urgent care services available*
Sat–Sun 9 a.m. to 4 p.m., *urgent care only*

Family Health Services–Woodbury
8325 City Centre Dr
Woodbury, MN 55125
651-731-0859
Mon–Thu 7 a.m. to 7 p.m.
Fri 7 a.m. to 5 p.m.

Priority Pediatrics–Woodbury
7801 Afton Rd
Woodbury, MN 55125
651-738-9494
Mon–Fri 5 p.m. to 10 p.m., *urgent care only*
Sat 9 a.m. to 5 p.m., *urgent care only*
Sun noon to 8 p.m., *urgent care only*

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Member Tip:

Provider Appointment Sheet

Use this form to prepare for your provider appointment and to record any notes after the visit.

Provider Appointment Sheet

Date of appointment	Time
Provider name	
Clinic name	
Clinic address	
Clinic telephone number	

Concerns or problems I want to tell the provider

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Questions I have for the provider

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Notes from the visit

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Important Medica Telephone Numbers

Medica Customer Service
Monday through Thursday 8 a.m. – 5 p.m.; Friday 9 a.m. – 5 p.m. Closed daily from 12 p.m. – 12:30 p.m.

Twin Cities metro area **952-992-2322**
Toll-free **1-800-373-8335**
TTY users (please call the National Relay Center and ask for the number above) **1-800-855-2880**

Transportation/Provide-A-Ride℠
Monday through Thursday 8 a.m. – 5 p.m.; Friday 9 a.m. – 5 p.m. Closed daily from 12 p.m. – 12:30 p.m.

Twin Cities metro area **952-992-2292**
Toll-free **1-800-601-1805**
TTY users (please call the National Relay Center and ask for the number above) **1-800-855-2880**

Language Lines
Monday through Thursday 7:30 a.m. – 5 p.m.; Friday 9 a.m. – 5 p.m. Closed daily from 12 p.m. – 12:30 p.m.

Hmong (Lus Hmoob) **952-992-2296**
Russian (Русскнй). **952-992-2294**
Somali (Soomaali) **952-992-2260**
Spanish (Español) **952-992-2297**
Vietnamese (Tiếng Việt). **952-992-2295**
Other languages. **1-800-373-8335**

Social Services
Monday through Thursday 8 a.m. – 4:30 pm.; Friday 9 a.m. – 4:30 p..m. Closed daily from 12 p.m. – 12:30 p.m.

Twin Cities metro area **952-992-3535**
Toll-free **1-800-373-8335**
TTY users (please call the National Relay Center and ask for the number above) **1-800-855-2880**

Mental Health and Chemical Dependency Services
Monday through Friday 8 a.m. – 5 p.m. Crisis services 24/7/365

Toll-free **1-800-848-8327**
TTY users (please call the National Relay Center and ask for the number above) **1-800-855-2880**

National Violence Hotline
Anytime, 24 hours a day, seven days a week

Toll-free **1-800-799-7233**

Dental Services
Monday through Friday 8 a.m. – 5 p.m.

Twin Cities metro area **651-406-5919**
Toll-free **1-800-459-8574**
TTY users **1-800-916-9514**

Nurse Line – Medica CallLink®
Anytime, 24 hours a day, seven days a week

Toll-free **1-866-715-0915**
TTY users (please call the National Relay Center and ask for the number above) **1-800-855-2880**

Health Coaching Program
Monday through Friday 7 a.m. – 8 p.m.; Saturday 9 a.m. – 5 p.m.

Toll-free **1-866-905-7430**
TTY users (please call the National Relay Center and ask for the number above) **1-800-855-2880**

Healthy Pregnancy Program
Monday through Friday 8 a.m. – 5 p.m.

Toll-free **1-888-906-8958**
TTY users (please call the National Relay Center and ask for the number above) **1-800-855-2880**

At Medica, you're not just part of a health plan.

You're part of a community that believes in better health for all.

Benefits that reward good health

- **My Health Rewards:** Earn gift cards for going to the doctor. Look inside for reward vouchers.
- **Health and wellness programs:** Work with a health coach to set personal health goals.

Easy access to healthcare services

- **Dental care:** Access to Delta Dental's CivicSmiles℠ large network of providers.
- **Mental health and chemical dependency services:** Get help 24/7.
- **Language support:** Our call center staff can speak English, Hmong, Russian, Somali and Spanish. We will arrange interpreters for all other languages.

Visit us at medica.com or call the Customer Service number listed inside.

PO Box 9310, Minneapolis, MN 55440-9310

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Dear Medica Choice Care℠ member:

Thank you for choosing Medica for your health plan coverage!

Enclosed you will find all of your 2015 Medica Choice Care℠ member materials, along with your 2014-2015 Evidence of Coverage (EOC) information, your 2015 Provider Directory and your 2015 Member Handbook.

Your EOC describes what health care services are covered with your health plan and what your share of the cost may be for certain services or procedures. Enclosed in your EOC you will find your Privacy Notice, information on Advanced Directives, How Medica Pays Providers, Breast Reconstruction Notice and what your Rights and Responsibilities are as a Medica member.

Your Medica ID card should have been sent ahead of this letter as well. Please remember to bring this card with you to all of your health care appointments. If you have not received your Medica ID card, please call us at one of the numbers listed below.

There is no action you need to take at this time; we simply want to welcome you to Medica! As a Medica Choice Care℠ member we value your business and work hard to provide the benefits and services you need to live a happy and healthy life.

If you have any questions or concerns about your plan after reviewing this packet, please contact us. You can reach Medica Customer Service at **952-992-2322** or **1-800-373-8335** (toll-free). TTY users, call the National Relay Center at **1-800-855-2880** (toll-free) and ask for **1-800-373-8335** (toll-free). We are here to help Monday – Thursday 8 a.m. to 5 p.m., and Friday 9 a.m. to 5 p.m. *Please note our Customer Service phone lines are closed daily from 12 p.m. to 12:30 p.m.*

Once again, thank you for your membership and we look forward to serving you!

Sincerely,

Stephanie Kelly
Director, Customer Service Operations

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An equal opportunity employer

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Medica Choice Care℠ (MA) and Medica MinnesotaCare members
Call Medica Customer Service at 952-992-2322 or 1-800-373-8335 (toll-free)

Medica AccessAbility Solution® (SNBC), Medica DUAL Solution® (MSHO) and Medica Choice Care MSC+ members
Call Medica Customer Service at 952-992-2580 or 1-888-347-3630 (toll-free)

Attention. If you need free help interpreting this document, call the above number.

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LB3-0016 (3-13)

SPP1113

This information is available in other forms to people with disabilities by calling the above number, or through the National Relay Center toll free at 1-800-855-2880 (TTY/TDD), or 7-1-1, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

You can’t always avoid germs,
but you can fight them.

Get health answers fast with Medica CallLink®.

You have a lot going on. The last thing you need is to deal with an illness. Let Medica CallLink handle it. Contact our nurses for easy, quick answers to questions such as:

- Should I treat symptoms myself or go to my clinic, urgent care or the ER?
- Is it too late to get a flu shot?
- What can I do to keep myself and my family healthy all year long?

CallLink nurses can help you stay relatively germ-free.

This service should not be used for emergency needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for information purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law.

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Call any time. Your call and any CallLink services provided are kept confidential. This service is available at no additional cost.

24/7 Medica CallLink® Nurse Line

1-866-715-0915 (toll-free)

medica.com

TTY callers, please call the National Relay Center at 1-800-855-2880 (toll-free) and ask for the number above.

MEDICA®

Getting Care After Your Baby Arrives

Congratulations on the birth of your baby! To provide the best care for your baby, remember to take good care of yourself.

Schedule a visit with your provider 3 to 8 weeks after the birth of your baby to make sure you are recovering well. Your provider may want to see you sooner depending on your needs.

Topics you may want to discuss at your visit:

PHYSICAL HEALTH

- Symptoms such as pain, vaginal bleeding/discharge or trouble going to the bathroom
- Health conditions including diabetes, high blood pressure or anemia
- Trouble caring for yourself or your baby

EMOTIONAL HEALTH

- Feelings of sadness, doubt or helplessness
- Anxiety or panic attacks
- Thoughts of hurting your baby or yourself

SEXUAL HEALTH AND BIRTH CONTROL

- When it is safe to have sex again
- Birth control options

HEALTHY WEIGHT AND NUTRITION

- Your healthy weight
- Eating a healthy diet and taking vitamins
- Unusual diet changes

EXERCISE

- Safe exercises

FEEDING YOUR BABY

- Breastfeeding

Write down other thoughts you have before your visit so that you remember to talk about them.

_____

_____

_____

_____

YOUR ONGOING CARE

It is important to return for visits with your provider as scheduled. He or she can keep track of your progress and help answer any questions you have.

Sometimes it is hard to cope after having a baby. Get help right away if you are:

- Feeling anxious all the time
- Having trouble caring for yourself or your baby
- Thinking about hurting yourself or your baby

Call your provider, Medica Behavioral Health **(1-800-848-8327, toll-free)** or 911 for help. You can also call Medical CallLink nurse line 24/7 at **1-866-715-0915 (toll-free)**. TTY users please call **1-800-855-2880 (toll-free)** and ask for the number above.

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LB3-0016 (3-13)

SPP0613

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HMGSPP10578-1-00115 (A)

It's Your Health™

Spring 2015

You belong.

MEDICA®

'Home' is where your care is

Having a health care "home" is good for you! Studies show that people who have regular visits with their primary care provider are healthier than those who don't. It is important for you to select a primary care provider (PCP) for your care.

Your primary care provider can help with all of your routine care, such as:

- Annual checkups, vaccines and other care to help you stay well
- Treatment when you have a minor injury or illness, such as a sore throat or stomachache
- Helping you find care from a specialist, if needed

Getting to know you

Having a health care "home" helps your doctor get to know you. Your doctor will understand your health history and your current health status. This means you get the care you need to stay as healthy as can be.

Your doctor also can talk with you about any concerns you have about your health, such as maintaining a healthy weight, or help with mental health or substance abuse.

Having a primary care provider means your doctor will be ready to help you when you are sick or hurt. Many people would rather receive care from a doctor that they know and trust, instead of one that they have never seen before.

Check your Medica ID card

Medica ID cards for Medica MinnesotaCare and Medica Choice Care℠ members now show the name of your primary care provider, or PCP. **You can and should choose your PCP.** You can use our Primary Care Network Listing in print or online at **medica.com** to find a PCP. Please notify Medica of your selection. If you do not choose a PCP, we will pick one for you based on your address and claims history.

We encourage you to visit your primary care provider to coordinate all your health care needs. To have your chosen PCP listed on your Medica ID card or if you need to change your designated PCP, please call Customer Service at **952-992-2232** or **1-800-373-8335** (toll-free).

It's important to us that you have the best health care possible. We know it's important for you to see doctors and specialists in our network without a referral or notifying Medica. You will still be able to visit any personal care provider within the network and have those network services covered, regardless of the primary care provider designation on your ID card.

Building trust

The more information you share with your doctor, the better your doctor will be able to provide the best care for you.

You'll want to tell your doctor about all medications you take. This includes vitamins, over-the-counter drugs or other supplements you use.

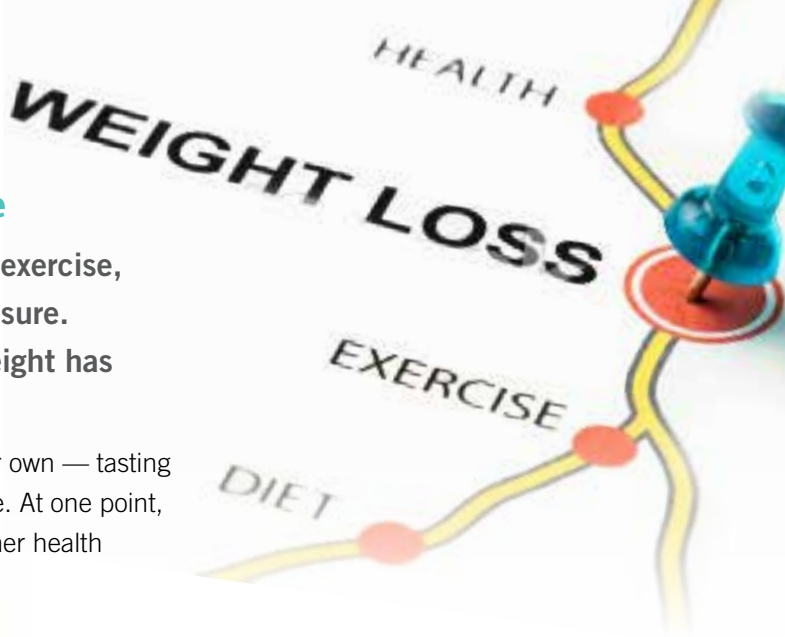
Your doctor also should know about care you receive from other providers.

Your doctor may not know you are experiencing symptoms such as pain, hearing loss or side effects of a medication. It's important for you to share that information with your primary care provider.

Don't be ashamed to tell your doctor about anything that affects your health. It's very important for your doctor to know about any medical conditions or health concerns you have.

Ruth's story

How one member is creating a healthy lifestyle



Ruth is on a mission to achieve better health through exercise, healthy eating and weight loss. It's a battle, that's for sure. Obesity and heart disease run in her family. Ruth's weight has been a challenge for most of her adult life.

She added the pounds slowly while raising her son, Everest, on her own — tasting food at her catering jobs and dealing with the stress of everyday life. At one point, she weighed more than 250 pounds. The excess pounds made other health problems worse.

But Ruth is fighting back with motivation and determination.

It seemed like bad luck when Ruth was in a wreck and her car was totaled. But she turned the event into a way to lose weight. Instead of buying a new car, she started walking many places she needed to go.

"Sometimes I walk home from my catering job," Ruth said. "It's five miles and takes about two hours, but it's really helped me to lose weight."

Healthy Savings help

Ruth has also found inspiration to eat more nutritious foods with the Medica Healthy Savings program. She signed up and received a special card to take to the grocery store with her.

"I print out the Healthy Savings deals so I can get what's being offered when I shop," she said. "I eat a lot of salmon, chicken and lean meats, so it's perfect for that."

Each week, new savings on healthy foods are added to her card automatically. She saves up to $50 a week on her groceries.

Results and rewards

So far, Ruth has lost more than 50 pounds and is almost to her goal. As soon as she gets there, she will reward herself with a special purchase.

"I've had my eye on a navy blue North Face® jacket for a long time. I used to wear a size 2X, but now I fit into a large," she said.

GET IN ON THE SAVINGS

Like Ruth, you can **save up to $50 each week** on groceries when you join the Medica Healthy Savings program. Sign up is free. Each week, new savings on healthy foods will be added to your card automatically.

When you are ready to go shopping:

- Visit Cub Foods, Lunds or Byerly's.
- Buy the week's featured foods.
- Scan your card at checkout.
- Count the savings.

Go to **medicahealthysavings.com** to sign up. Or call Customer Service and say you want to sign up for Medica Healthy Savings.

Stress: It's not all in your head

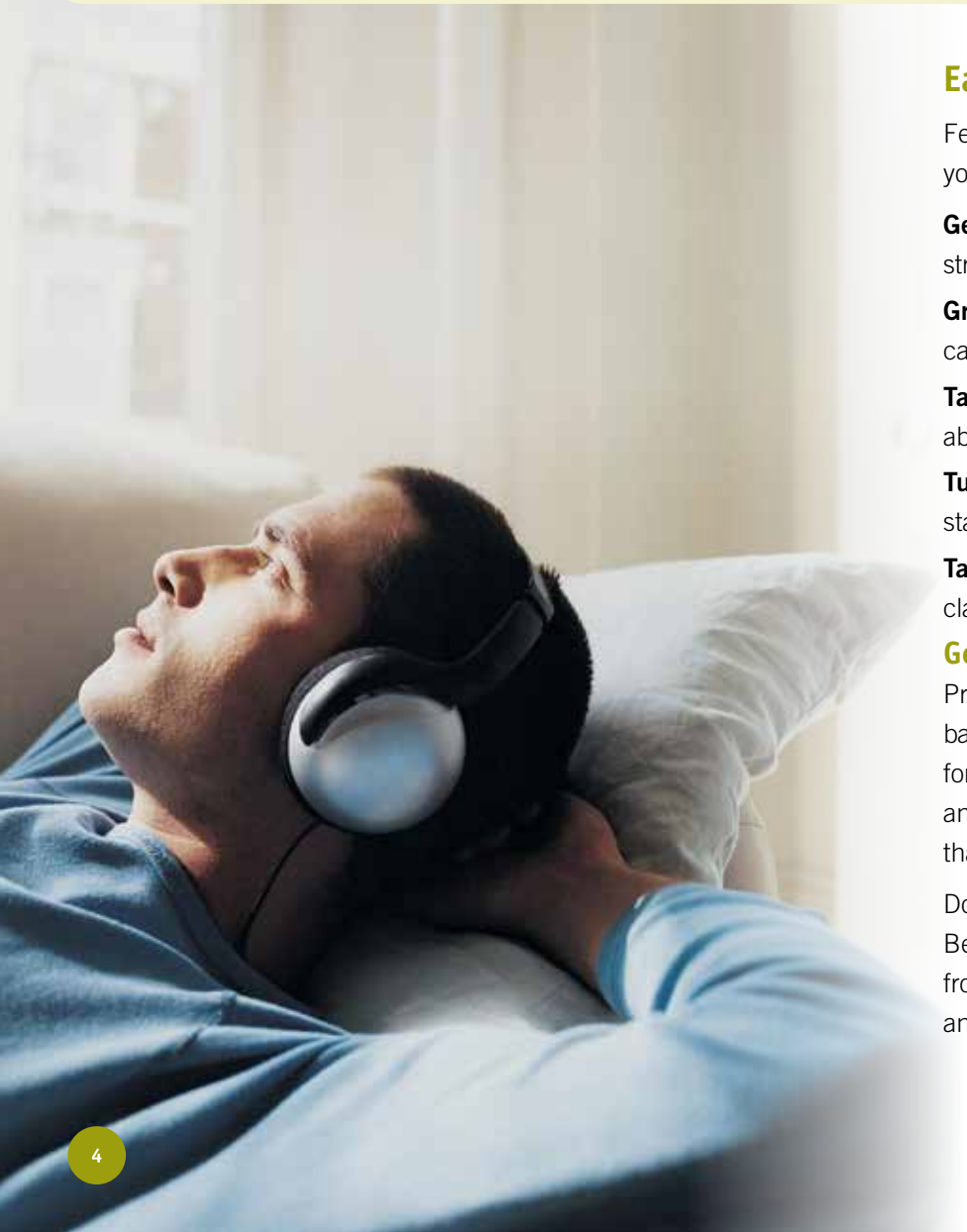
For many people, stress is a part of each day. But too much stress can be bad for your health. This is especially true of long-term stress caused by events like the death of a loved one or a major illness.

Stress can cause headaches, make you feel very tired and give you an upset stomach. Stress can make it harder for you to get a good night's sleep.

Stress may affect your body's ability to fight illness. For example, people with chronic stress tend to get colds more often and with more severe symptoms.

In addition, stress can affect your mental health. Stress can make you feel sad or angry. As you fight stress, you might be short-tempered, restless and unable to concentrate.

Often, people turn to unhealthy behaviors to get through stressful times. Eating a lot of food, especially so-called "comfort" foods, is common. Other people use drugs or alcohol in an effort to cope.



Easy ways to beat stress

Feeling stressed out? Try these easy tips for relaxing your mind and your body:

Get physical. Take a walk or do some basic stretches. You'll feel your mood and outlook improve.

Grab a healthy snack. Reach for an apple or some carrot sticks, rather than chips or a candy bar.

Talk it out. Tell a trusted friend or family member about your problem. Often, just talking can be a relief.

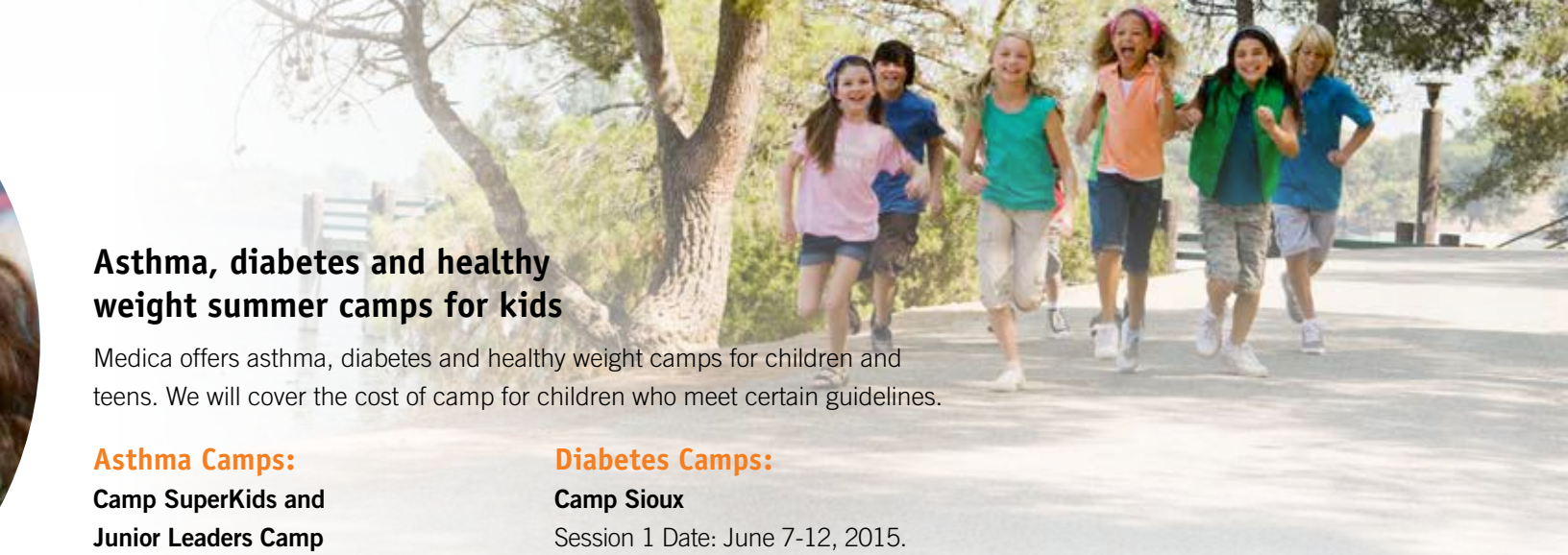
Turn it up. Listen to your favorite songs or radio station. Music can be a great way to relax.

Take a class. Your local community center may offer classes in relaxation techniques, yoga or meditation.

Get help

Professional help may be a key to getting yourself back on track if stress is affecting your life. Treatment for stress can include therapy, lifestyle changes, and perhaps — medicine. If stress becomes more than you can handle, call your doctor.

Don't let stress control you. For help, call Medica Behavioral Health at **1-800-848-8327** (toll-free) from 8 a.m.-5 p.m., Monday through Friday. In an emergency, call **911**.



Asthma, diabetes and healthy weight summer camps for kids

Medica offers asthma, diabetes and healthy weight camps for children and teens. We will cover the cost of camp for children who meet certain guidelines.

Asthma Camps:

Camp SuperKids and Junior Leaders Camp
Date: June 28-July 3, 2015.
Eligibility: Any child, ages 7-15, who has moderate to severe asthma. Junior Leaders Camp is for children 14-15 years old who have gone to Camp SuperKids.

Camp We-No-Wheeze
Date: August 15-17, 2015.
Eligibility: Any child, ages 7-15, who has moderate to severe asthma.

Healthy Weight Camp:

Date: June 14-19, 2015.
Eligibility: Any child, ages 10-14 – weight in the 85 percentile for age and gender.

Diabetes Camps:

Camp Sioux
Session 1 Date: June 7-12, 2015.
Session 2 Date: June 14-19, 2015.
Eligibility: Kids 8-15 years old who have been diagnosed with diabetes.

Camp Needlepoint
Session 1 Date: August 16-22, 2015.
Session 2 Date: August 23-29, 2015.
Eligibility: Kids 8-16 years old who have been diagnosed with diabetes

Camp Daypoint
Date: August 17-21, 2015.
Eligibility: Kids 5-9 years old who have been diagnosed with diabetes

For information, call **952-992-3535** or **1-800-373-8335** (toll-free) and choose option 4. TTY users, call **1-800-855-2880** (toll-free) and ask for the number above. Please call during Medica Social Services hours listed on page 7.

Your child's asthma: Five facts you need to know

1. Asthma is a disease that makes it hard to breathe. Asthma is especially dangerous for children.
2. Lots of things can "trigger" asthma. Allergies, cigarette smoke, cold air, the flu and colds are common triggers.
3. An asthma attack occurs when symptoms get really bad. Medicine can give fast relief from an asthma attack.
4. Avoiding asthma triggers and following an asthma action plan can help control your child's asthma.
5. An asthma action plan can save your child's life. Ask your child's doctor to help you make an asthma action plan. Be sure to review the plan often so it is always up to date.

6 steps to give your child a healthier future

It's a fact! Obese children are more likely to be obese as adults. This means they will have a higher risk of Type 2 diabetes, heart disease and other serious health conditions.

Small things like these can make a big difference in your child's weight and healthy future:

1. Serve more water and less or no soda and fruit juice.
2. Give your child orange slices or a banana instead of cookies for a snack.
3. Enjoy meals as a family. You will probably eat less food and eat it slower.
4. Let your child stop eating when he or she is full.
5. Encourage your child to play a sport at school or in the community.
6. Be active. Kids ages 6-17 years need at least 60 minutes of physical fun each day. You can join in, too!

Changes to My Health Rewards by Medica

My Health Rewards by Medica® helps you make healthy choices for you and your family. With this program, you can:

- Earn gift cards for going to the doctor
- Receive a car seat for kids

We are making some changes to My Health Rewards, starting June 1, 2015:

Blood lead testing

- The $50 gift card for blood lead testing will no longer be available. Any voucher for a blood lead test done through May 31, 2015 will be honored if it is submitted within 90 days of the test date.

New and updated My Health Rewards vouchers:

- A new gift card is available to members with Type 1 or Type 2 diabetes. You may earn a $25 gift card (one per calendar year) for having the following three tests: A1C, LDL cholesterol, urine microalbumin OR positive urine macroalbumin.
- The gift card amount for prenatal and postnatal checkups is increasing to $150. You may earn $50 for your first prenatal visit. Earn up to $50 based on the total number of prenatal visits. And, earn $50 for having a postpartum visit.
- The gift card amount for yearly Child and Teen Checkups visits 15 months-20 years is increasing from $10 to $25.

Making a difference in your community's health

Access to dental care is a top health issue for many of our members. In 2014, the Medica Foundation funded five programs in Minnesota and North Dakota so thousands of children and adults could learn about and get dental care.

The foundation also gave almost $1.4 million in grants to other nonprofit groups to support:

- Behavioral health
- Early childhood health
- Core mission support for smaller nonprofits
- General health

The foundation funds programs that support Medica members and the community. These programs help to improve health and remove barriers to health care.

More information: **medicafoundation.org**

Car Seats

Our car seat program is expanding. We will provide car seats to women who are at least six months pregnant and for children up to eight years of age. Booster seats are now available!

To get your car seat:

- Call Medica's car seat request line at **1-866-455-7426** (toll-free).
- Have your Medica ID number available and follow the prompts.
- Watch your mail for a letter that explains where to pick up your car seat.
- Attend your car seat education session to receive your car seat and learn how to install the seat.

My Health Rewards continues to offer gift cards for:

- Child and Teen Checkups visits from birth-14 months — up to $75
- Yearly breast cancer screening (mammogram) — $15
- Yearly cervical cancer screening (pap test) — $15
- Yearly colorectal cancer screening — $15
- Yearly chlamydia screening — $15

My Health Rewards vouchers are available at **medica.com/earnrewards** or by contacting Customer Service at **952-992-2322** or **1-800-373-8335** (toll-free). If you have questions about My Health Rewards, please call us.

Find us where you 'like' us

It's easy for you to get the latest news about your Medica plan. Just visit us on Facebook and YouTube.

"Medica-You Belong" is our Facebook page where you can:

- Tell us how we can help you
- Find out about Medica events happening near you
- Learn how to get the most out of your health plan

Find us at "Medica4Me" on YouTube. You can watch videos that will help you manage your health plan and learn how to take care of your health.

Medica cares about you. Visit us at:

Facebook: **www.facebook.com/MedicaYouBelong**

YouTube: **www.youtube.com/user/Medica4Me**

Medica Choice Care (MA) and MinnesotaCare members
Call Medica Customer Service at 952-992-2322 or 1-800-373-8335 (toll-free)

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយ ឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB3-0016 (3-13)

SPP0613

This information is available in other forms to people with disabilities by calling the above number, or through the National Relay Center toll-free at 1-800-855-2880 (TTY/TDD), or 7-1-1, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older, this includes Elderly Waiver services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your Medica primary care provider prior to the referral.

HELPFUL NUMBERS

TTY users, call the National Relay Center at **1-800-855-2880** (toll-free) during the hours listed below and ask to connect with the specific department you need.

Medica Choice Care and Medica MinnesotaCare Customer Service
M-Th 8 a.m.–5 p.m.;
F 9 a.m.–5 p.m.
Closed noon–12:30 p.m. daily
Metro: **952-992-2322**
1-800-373-8335 (toll-free)

Medica CallLink® Nurse Line
24 hours, 7 days a week
To speak with a nurse, call **1-866-715-0915** (toll-free).

Medica's Fraud Hotline
24 hours, 7 days a week
English **952-992-2237**
All languages:
1-866-821-1331 (toll-free)

Delta Dental of Minnesota
M-F 8 a.m.–5 p.m.
Metro: **651-406-5916**
1-800-459-8574 (toll-free)

Medica Behavioral Health
M-F 8 a.m.–5 p.m.
To find a mental health or substance abuse provider, call **1-800-848-8327** (toll-free).

Medica Social Services
M-F 8 a.m.–4:30 p.m.
(closed 12–12:30 p.m.)
Metro: **952-992-3535**
1-800-373-8335 (toll-free)
(option 4)

Visit us at **medica.com.**

It's Your Health

Medica
Mail Route CW104
PO Box 9310
Minneapolis, MN 55440-9310
medica.com

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Editor: Jim Williams

WE'RE LISTENING.

Tell us how we can make *It's Your Health* more helpful to you. Send an email with your comments to **NewsletterFeedback@medica.com**.

ASK CUSTOMER SERVICE

Q: Can Medica help me pay for a new pair of glasses?

A: Yes. One pair of glasses (frames and lenses) is covered every 24 months.

Covered lenses can be single vision, lined bifocals or lined trifocals. Ask your network eye care provider about frames you can choose as part of your Medica benefits. We offer about 100 different frames in styles for men, women and children.

Your network eye care provider may have a selection of the Medica frames on hand. However, you may have even more choices through a catalog of all the frames that Medica covers. Tell the provider that you would like to look at the catalog so you can choose the frames you like best.

These frames are available as part of your benefits only at our network providers. Providers include some large chain stores, as well as many small and independent eye care centers.

ASK THE PHARMACIST

Q: Sometimes my young son doesn't want to take his medicine. Do you have any tips to make it easier?

A: Giving medicine to a child who does not feel well can be hard. So, stay calm and smile. This may help your son relax. Try to explain to your child that the medicine will help him feel better.

If your son still won't take his medicine, ask why. If he doesn't like the taste, offer to give him something to help the bad taste go away. Or have your son hold his nose to block the smell and taste while he swallows the medicine.

Many children don't like liquid medicines. So ask the doctor if these medicines are available in another form, such as a pill that your son can chew.

Note: Check with the doctor before you mix your son's medicine with applesauce or other food.

P6424028002

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201410283315

TEST

Return Service Requested

Have more questions? Visit medicamember.com for all your claim and benefit information or contact Customer Service at 888-592-8211 or email your claims questions to IFBClaims2@Medica.com

1 OF 4

ENV 1

SINGLE PIECE

1 0.8502 SP 0.480

Subscriber E2E007MNR001
1216 104TH AVE W
DULUTH, MN 55808-1723

1

October 14, 2014

Patient Information
Patient Name: Subscriber
ID: 037115772500
Group/Policy #: IFB-037115772500

Explanation of Benefits Statement
This is not a Bill

Claims Summary

For more information refer to the following pages.

Total Charges:	$12,000.00	This is the total amount your provider(s) billed for your visit. (This is called "Charges" on Claim Detail Page 2)
Discounted Balance:	$120.00	Medica negotiates discounts with doctors, hospitals and other health care providers. (This is called "Allowed Amount" on Claim Detail Page 2)
Medica Paid:	$0.00	Medica paid this amount either to you or your provider. (This is called "Paid Amount" on Claim Detail Page 2)
What You Owe:**	$120.00	People may owe because they have coinsurance (cost sharing), deductibles, copays, or received services not covered by their policy. (This is called "Total Amount You Owe" on Claim Detail Page 2) ** "What You Owe" assumes you received services from an in network health care provider. If you received services from an out-of-network health care provider(s) you may owe the difference between the "Total Charges" and what "Medica Paid." If you have any questions, please call Medica at 888-592-8211.

When we receive a claim for you, we provide an Explanation of Benefits (EOB) to you and your provider. It describes how the services you received were covered. It also shows any amount you owe. Use your EOB to review the charges on any bill you receive from your provider that is associated with this claim. If you notice differences between the EOB and your bill, contact customer service or your provider's office to get help reconciling them.

This Claim Summary Page gives you an overview of how your claim was handled, and may help you interpret the information on the following Claim Detail page. The Detail page is provided to you based on requirements established in state law.

VOID

P642402802

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WHITE STOCK

October 14, 2014

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Claim Detail *for Subscriber E2E007_MN_R001*

Patient Control Number:

Provider: Marilyn Meierhofer

Claim Number: 00000234213

Date(s) of Service	Description	Notes ID*	Charges	Provider Responsibility	Allowed Amount	Paid Amount	Your Itemized Responsibility to Provider**				Amount You Owe*
							Deductible	Copay	Coinsurance	Patient Non Covered Amount	
2014-10-01	OFFICE VISIT	25	$12,000.00	$11,880.00	$120.00	$0.00	$120.00	$0.00	$0.00	$0.00	$120.00
Claim Total			**$12,000.00**	**$11880.00**	**$120.00**	**$0.00**	**$120.00**	**$0.00**	**$0.00**	**$0.00**	**$120.00**

**** This total does not reflect any payments / copays you made at the time of service.**
**** If you received services from an out-of-network health care provider(s) you may owe the difference between the "Total Charges" and the "Paid Amount."**

TEST

Total Amount You Owe	$120.00

NOTES*

25 -These charges apply to the annual deductible. Please pay your health care provider.

Have questions or want more information about the diagnosis or treatment codes used for the services you received?
Call the number included in this document, or listed on the back of your ID card.

If you disagree with our decision, you have options to file an appeal. We have outlined these options on the attached pages. If you need help with your appeal, please contact us to assist you. Because we know this is important to you, we also offer you additional help. You can work with an independent Health Advocate who will assist you in working with Medica to make an appeal. Health Advocates are available any time at 866-668-6548. They can also help you understand your claims and benefits.

VOID

Information Related to this Decision

If you have any questions related to this claim, please refer to your Policy or contact Medica Customer Service at the phone numbers or address listed below.

WHITE STOCK

First Level of Review

TEST

If you are dissatisfied with Medica's decision, you can call or write us at the phone numbers and address below to request a review. You may designate a representative to act on your behalf at any time during the review process or external review process. If you do so, contact Medica to obtain a Release of Information form, which will allow Medica to discuss your case with your designated representative. We will review any testimony, explanation, or other information we receive from you, Medica staff members, providers, or others.

At any time, you also have the right to file a complaint with the Minnesota Department of Commerce at 651-539-1600 or 1-800-657-3602 (outside of metro area only).

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and/or
- Any other document or information related to this review.

If you need diagnosis and/or treatment code information regarding the services referenced in this document, contact Medica at the numbers listed below.

To request a review, additional information or assistance, please contact Medica at the following address and telephone numbers:

Mail: Medica Customer Service, Route CW295IFB, PO Box 9310, Minneapolis MN 55440-9310

Telephone: Minnesota: 1-888-592-8211
TTY users, call the National Relay Center at 1-800-855-2880, and ask them to dial 1-888-592-8211.

Procedures for complaints that do not involve a medical determination:

1. If you contact Medica to express a complaint verbally, Medica will send you our decision within 10 calendar days from when we received your complaint. If you remain dissatisfied with Medica's decision, Medica will provide you with a complaint form to submit your complaint in writing. If you need assistance completing the complaint form, Medica will help you. The complaint form can be mailed to the address above.

2. If you submit your complaint in writing, Medica will send you our decision within 30 calendar days. If you remain dissatisfied with Medica's decision, you have the right to submit a request for external review.

Procedures for complaints that require a medical determination:

1. If this decision was based on medical necessity, you have one year from the date of the decision to file an appeal. You can call or write us at the phone numbers and address above to request a first level review. Your appeal will be completed no later than 30 calendar days from when we received your request. Your attending provider may request an expedited, 72 –hour appeal review, if they believe it is warranted. You also may request an expedited review if waiting the standard 30-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting. In such cases, you also may have the right to request an external review while your first level review is being conducted.

External Review

You may choose to have your case reviewed by an external review organization. This process is coordinated by the Minnesota Department of Commerce and you must submit your written request for external review within six months from the date of Medica's decision. The Minnesota Department of Commerce can be reached locally at 651-539-1600 or their toll free number 1-800-657-3602. You may submit additional information to be reviewed by the external review organization. You will be notified of the review organization's decision within 45 days. If an expedited review is requested and approved, a decision will be provided within 72 hours.

VOID

The external review organization's decision is not binding on you, but it is binding on Medica. Medica may seek judicial review on grounds that the decision was arbitrary and capricious or involved an abuse of discretion. To request an external review, contact the Minnesota Department of Commerce at the numbers above. You must include a $25.00 filing fee at the time of the request. This amount may be waived in cases of financial hardship.

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October 14, 2014

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P642402802

Definitions

Deductible: The amount you pay before your insurance starts to pay.

Copay: A set amount that you pay up front for some services or prescriptions. Copays may or may not count toward your out-of-pocket maximum - check your policy.

Coinsurance: Your share of the costs after you've paid your deductible. Coinsurance is a percentage of the charges for the service.

Patient Non-Covered Amount: Your share of coinsurance (cost sharing), deductibles, copays, or services not covered by their policy.

In-Network: These are the clinics, doctors, pharmacies and hospitals that Medica has available to you for your health care needs.

Out-of-Network: These are the clinics, doctors, pharmacies and hospitals that are not in Medica's network.

Note: You can view your year-to-date deductible and account balance at medicamember.com on your personal computer, smartphone or tablet.

TEST

For assistance, call the number included in this document or on the back of your ID card.

IFB0413

Dine k'ehji shich'i' hadoodzih ninizingo, beesh bee hane'e binumber naaltsoos bikaahigii bich'i' hodiilnih ei doodaii bee neehozin biniiye nanitinigii bine'dee bikaa doo aldo'.

若需要中文协助，请拨打本文件内或您会员卡背面的电话号码。

Para sa tulong sa Tagalog, tawagan ang numerong kabilang sa dokumentong ito o sa likod ng iyong ID card.

Para obtener asistencia en español, llame al número de teléfono que se incluye en este documento o al dorso de su tarjeta de identificatión.

VOID

P6424028002

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201410283315

TEST

Return Service Requested

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1 OF 4

ENV 2

SINGLE PIECE

2 0.8502 SP 0.480

Subscriber E2E007MNR003
548 PORTLAND AVE
SAINT PAUL, MN 55102-2219

1

October 14, 2014

Patient Information
Patient Name: Subscriber
ID: 000361674600
Group/Policy #: IFB-000361674600

Explanation of Benefits Statement
This is not a Bill

Claims Summary

For more information refer to the following pages.

Total Charges:	$6,000.00	This is the total amount your provider(s) billed for your visit. (This is called "Charges" on Claim Detail Page 2)
Discounted Balance:	$60.00	Medica negotiates discounts with doctors, hospitals and other health care providers. (This is called "Allowed Amount" on Claim Detail Page 2)
Medica Paid:	$0.00	Medica paid this amount either to you or your provider. (This is called "Paid Amount" on Claim Detail Page 2)
What You Owe:**	$60.00	People may owe because they have coinsurance (cost sharing), deductibles, copays, or received services not covered by their policy. (This is called "Total Amount You Owe" on Claim Detail Page 2) ** "What You Owe" assumes you received services from an in network health care provider. If you received services from an out-of-network health care provider(s) you may owe the difference between the "Total Charges" and what "Medica Paid." If you have any questions, please call Medica at 888-592-8211.

When we receive a claim for you, we provide an Explanation of Benefits (EOB) to you and your provider. It describes how the services you received were covered. It also shows any amount you owe. Use your EOB to review the charges on any bill you receive from your provider that is associated with this claim. If you notice differences between the EOB and your bill, contact customer service or your provider's office to get help reconciling them.

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October 14, 2014

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Claim Detail *for Subscriber E2E007_MN_R003*

Patient Control Number:

Provider: Marilyn Meierhofer

Claim Number: 00000234214

Date(s) of Service	Description	Notes ID*	Charges	Provider Responsibility	Allowed Amount	Paid Amount	Your Itemized Responsibility to Provider**				Amount You Owe*
							Deductible	Copay	Coinsurance	Patient Non Covered Amount	
2014-10-01	OFFICE VISIT	25	$6,000.00	$5,940.00	$60.00	$0.00	$60.00	$0.00	$0.00	$0.00	$60.00
Claim Total			**$6,000.00**	**$5940.00**	**$60.00**	**$0.00**	**$60.00**	**$0.00**	**$0.00**	**$0.00**	**$60.00**

**** This total does not reflect any payments / copays you made at the time of service.**
**** If you received services from an out-of-network health care provider(s) you may owe the difference between the "Total Charges" and the "Paid Amount."**

TEST

Total Amount You Owe	$60.00

NOTES*

25 -These charges apply to the annual deductible. Please pay your health care provider.

Have questions or want more information about the diagnosis or treatment codes used for the services you received?
Call the number included in this document, or listed on the back of your ID card.

If you disagree with our decision, you have options to file an appeal. We have outlined these options on the attached pages. If you need help with your appeal, please contact us to assist you. Because we know this is important to you, we also offer you additional help. You can work with an independent Health Advocate who will assist you in working with Medica to make an appeal. Health Advocates are available any time at 866-668-6548. They can also help you understand your claims and benefits.

VOID

Information Related to this Decision

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WHITE STOCK

First Level of Review

TEST

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October 14, 2014

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Definitions

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Patient Non-Covered Amount: Your share of coinsurance (cost sharing), deductibles, copays, or services not covered by their policy.

In-Network: These are the clinics, doctors, pharmacies and hospitals that Medica has available to you for your health care needs.

Out-of-Network: These are the clinics, doctors, pharmacies and hospitals that are not in Medica's network.

Note: You can view your year-to-date deductible and account balance at medicamember.com on your personal computer, smartphone or tablet.

TEST

For assistance, call the number included in this document or on the back of your ID card.

IFB0413

Dine k'ehji shich'i' hadoodzih ninizingo, beesh bee hane'e binumber naaltsoos bikaahigii bich'i' hodiilnih ei doodaii bee neehozin biniiye nanitinigii bine'dee bikaa doo aldo'.

若需要中文协助，请拨打本文件内或您会员卡背面的电话号码。

Para sa tulong sa Tagalog, tawagan ang numerong kabilang sa dokumentong ito o sa likod ng iyong ID card.

Para obtener asistencia en español, llame al número de teléfono que se incluye en este documento o al dorso de su tarjeta de identificatión.

VOID

novu®

LifeScore Health Assessment

Take this assessment to better understand your current health and identify areas where you might improve your health and well-being. Before you start, please have your current weight and waist measurement (or a tape measure) available and, if possible, get a copy of your most recent results for blood pressure, cholesterol panel, blood sugar and any diabetes testing you may have had done.

Estimated time to complete this assessment is 15 minutes.

About You

1. Do you have a vision impairment that requires special reading materials?
    a. Yes
    b. No

2. Do you have a hearing impairment that requires special equipment, other than a hearing aid?
    a. Yes
    b. No

3. Are you fluent in English?
    a. Yes
    b. No
        i. If "No," what language do you prefer to speak? _____

4. What is your date of birth?
    a. _____

5. What is your gender?
    a. Female
    b. Male

6. For women only, are you currently pregnant?
    a. Yes
    b. No

7. How would you best describe your race and ethnic group? (Your racial and ethnic origins may provide information about increased risk for certain conditions.)
    a. White
    b. Hispanic or Latino
    c. Black/African American
    d. Asian
    e. Native Hawaiian or other Pacific Islander
    f. Native American or Alaska Native
    g. Mixed race
    h. Other
    i. I prefer not to answer

Your Weight and Waist Measurement

8. What is your height?
    a. _____ feet _____ inches

9. What is your weight (in pounds)?
    a. _____ pounds

10. What is your waist circumference (in inches)? (Measure your waist at the level of your belly button. Make sure the measuring tape is parallel to the floor and not twisted. Don't hold your breath while measuring.)
    a. _____ inches

Nutrition

11. How many servings of fruit do you eat each day? (A serving of fruit equals one medium piece of fresh fruit, 1/2 cup of sliced fruit, 1/4 cup of dried fruit or 6 ounces of 100% fruit juice. Do NOT count fruit punch, fruit drinks, lemonade or sports drinks.)
    a. 0
    b. 1
    c. 2
    d. 3 or more

12. How many servings of vegetables do you eat each day? (A serving of vegetables equals 1/2 cup of cooked vegetables, 1 cup of raw vegetables or 2 cups of raw leafy greens. Do NOT count french fries, onion rings, potato chips or fried okra.)
    a. 0
    b. 1
    c. 2-3
    d. 4 or more

13. How many servings of sugary foods or drinks do you consume each day? (Examples of sugary foods include candy, cookies, sugar cereal, sugar soda and fruit drinks. Do NOT count fresh or dried fruit.)
    a. 0
    b. 1
    c. 2-3
    d. 4 or more

14. When you eat grains, how often do you choose high fiber/whole grains? (Examples of whole grains include whole grain/high fiber bread and cereals, whole wheat pasta and brown rice.)
    a. Never
    b. Sometimes
    c. Most of the time
    d. Always

15. How often do you limit your intake of unhealthy fats, such as trans fats? (Examples include limiting pastries, chips or deep fried foods.)

a. Never
b. Sometimes
c. Most of the time
d. Always

16. How often do you limit your salt intake? (Examples include choosing low-sodium canned soups, not adding salt to food when cooking or at the table.)

a. Never
b. Sometimes
c. Most of the time
d. Always

Physical Activity

17. Do you currently engage in regular physical activity, such as walking or gardening, for at least 10 minutes at a time?

a. Yes
b. No

18. If not, what is preventing you from getting regular physical activity? (Skip if you exercise regularly.)

a. I am inactive and out of shape.
b. I am temporarily unable to exercise due to an illness or injury.
c. I am unable to exercise due to a medical condition or disability.
d. Because of medical or physical issues, I am not sure what type or amount of exercise I can safely do.

If you do not engage in regular physical activity, please go to question 23.

19. In a typical week, how many minutes do you engage in moderate physical activity? (Moderate activity causes you to breathe faster than normal, but you can still carry on a conversation. Examples include walking and light aerobics.)

a. _____ minutes

20. In a typical week, how many minutes do you engage in vigorous physical activity? (Vigorous activity causes you to breathe much faster than normal, and you can only talk in short phrases. Examples include running and fast cycling.)

a. _____ minutes

21. How often do you engage in flexibility exercises each week? (Examples include calisthenics, stretching or yoga.)

a. 0
b. 1
c. 2-3
d. 4-7

22. How often do you engage in strength conditioning exercises, either at home or at a gym? (Examples include weight training, Pilates, aerobics with weights or working with a trainer.)

a. 0
b. 1
c. 2-3
d. 4-6
e. 7

Tobacco Use

23. Do you smoke or use tobacco every day, some days or not at all?

a. Yes, I currently use tobacco every day.
b. Yes, I currently smoke or use tobacco some days.
c. No, I quit tobacco in the past 6 months.
d. No, I quit tobacco 6-12 months ago.
e. No, I quit tobacco over a year ago.
f. No, I have never used tobacco.

If you have never used tobacco, please go to question 28.

24. What type of tobacco do you use? If you have quit tobacco, please enter the type of tobacco you used.

a. Cigarettes
b. Cigars
c. Pipe
d. Chewing tobacco

25. How much tobacco do you use in a day? If you have quit tobacco, please enter how much tobacco you used on an average day before you quit.

a. ____ cigarettes per day
b. ____ cigars per day
c. ____ ounces of tobacco per day

26. How many years have you used tobacco? If you have quit tobacco, please enter how many total years you used tobacco.

a. ____ years

27. If you still use tobacco, are you interested in quitting? If you have quit tobacco, please skip this question.

a. Yes, I'm interested in quitting in the next month.
b. Yes, I'm interested in quitting in the next 6 months.
c. No, I'm not interested in quitting at this time.

Alcohol Use

28. On average, how many alcoholic beverages do you drink per week?
    a. None, I don't drink alcohol.
    b. I drink alcohol less often than once a week.
    c. 1-7
    d. 8-14
    e. More than 14

If you do not drink alcohol, please go to question 34.

29. How many drinks containing alcohol do you have on a typical day when you are drinking?
    a. 1-3
    b. 4
    c. 5
    d. 6
    e. 7-9
    f. 10 or more

30. Have you ever felt you should cut down on drinking?
    a. Yes
    b. No

31. Has anyone annoyed you by criticizing your drinking?
    a. Yes
    b. No

32. Have you ever felt bad or guilty about your drinking?
    a. Yes
    b. No

33. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
    a. Yes
    b. No

Family Medical History

34. Has anyone in your immediate biological family (father, mother, sister or brother) had any of the following conditions? Please choose all that apply.
    a. Heart disease
    b. Colorectal cancer
    c. Breast cancer
    d. Ovarian cancer
    e. Prostate cancer
    f. None
    g. I don't know my family medical history.

Personal Medical History

35. Have you ever been diagnosed with any of the following conditions? Please choose all that apply. If so, are you currently being treated for that condition? See Treatment Key below and fill the corresponding letter in the space next to the health condition.

a. Asthma _____
b. COPD, emphysema or chronic bronchitis _____
c. Anxiety _____
d. Depression _____
e. Diabetes type 1 _____
f. Diabetes type 2 _____
g. High blood pressure _____
h. High cholesterol _____
i. Heart disease _____
j. Migraine headaches _____
k. Stroke _____
l. Chronic Back/Neck Pain _____
m. Osteoarthritis _____
n. Rheumatoid arthritis _____
o. Osteoporosis _____
p. Cancer _____
q. Other - Enter _____
r. None

Treatment Key

a. Yes, with prescribed treatment
b. Yes, with lifestyle management
c. Yes, with prescribed treatment and lifestyle management
d. No, the condition has resolved and no longer requires treatment.
e. No, I still have this condition, but am not currently receiving treatment for it.

Health and Well-Being

36. How would your describe your overall health in general?

a. Excellent
b. Very good
c. Good
d. Fair
e. Poor

37. How would you describe the health and condition of your mouth and teeth?

a. Excellent
b. Very good
c. Good
d. Fair
e. Poor

38. In general, how would you rate your overall satisfaction and quality of life?
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor

39. In the past month, how much has your physical and emotional health negatively impacted your usual activities and ability to work, both in and out of the house?
    a. Not at all
    b. A little bit
    c. Moderately
    d. Quite a bit
    e. Extremely

40. How confident are you that you can manage and control most of your health problems?
    a. Very confident
    b. Somewhat confident
    c. Not very confident
    d. Not at all confident
    e. I don't have any health problems.

Pain

41. How much bodily pain have you had during the past 4 weeks?
    a. None
    b. Very mild
    c. Mild
    d. Moderate
    e. Severe
    f. Very severe

42. If you have moderate, severe or very severe pain, is your doctor or nurse aware of the problem? (Skip this question if you have no pain or mild pain.)
    a. Yes
    b. No

Emotional Health

43. In the past two weeks, how often have you felt nervous, anxious or on edge?
    a. Almost never
    b. Some of the time
    c. Most of the time
    d. Almost all of the time

44. In the past two weeks, how often were you not able to stop or control your worrying?
    a. Almost never
    b. Some of the time
    c. Most of the time
    d. Almost all of the time

45. In the past two weeks, how often have you felt down, depressed or hopeless?
    a. Almost never
    b. Some of the time
    c. Most of the time
    d. Almost all of the time

46. In the past two weeks, how often have you felt little interest or pleasure in doing things?
    a. Almost never
    b. Some of the time
    c. Most of the time
    d. Almost all of the time

Sleep Habits

47. On average, how many hours of sleep do you get each night?
    a. More than 9
    b. 7-9
    c. 5-6
    d. Fewer than 5

48. In the past month, how often did you have trouble falling asleep?
    a. Not at all
    b. Less than once a week
    c. Once or twice a week
    d. Three or more times a week

49. In the past month, how often did you have trouble with waking up in the middle of the night or early morning?
    a. Not at all
    b. Less than once a week
    c. Once or twice a week
    d. Three or more times a week

50. During the past month, how would you rate your overall sleep quality?
    a. Very good
    b. Fairly good
    c. Fairly bad
    d. Very bad

51. In the past month, how often did you feel tired or run down?
    a. Almost never
    b. Some of the time
    c. Most of the time
    d. Almost all of the time

Managing Stress

52. How would you rate your current stress level?
    a. Not stressed at all
    b. Somewhat stressed
    c. Moderately stressed
    d. Very stressed

53. Please select the top source of stress in your life. (Skip this question if you are not stressed.)
    a. Personal relationships
    b. Health concerns
    c. Financial concerns
    d. Daily hassles
    e. Too much to do

54. How true is this statement for you: "I know how to manage my stress."
    a. Very true
    b. Somewhat true
    c. Somewhat untrue
    d. Not true

Work Life

55. What is your current employment status?
    a. Employed full time
    b. Employed part time
    c. Unemployed
    d. Stay-at-home parent/caregiver
    e. Student
    f. Retired
    g. Other

If you are not employed full or part time, please go to question 59.

56. In the past 4 weeks, how many days of work did you miss due to personal physical or mental health issues?
    a. _____ days

57. In the past 4 weeks, how many days of work did you miss due to any other reason?
    a. _____ days

58. How would you rate your productivity and job performance at work?
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor

Personal Safety

59. Do you always wear a helmet when riding on a bike or motorcycle?
    a. Yes, always
    b. Yes, sometimes
    c. No
    d. I never ride a bike or motorcycle.

60. Do you always fasten your seatbelt when you are in a car?
    a. Yes, always
    b. Yes, sometimes
    c. No

Support

61. Do you have someone in your life who can help you if you need or want help or support? (For example, if you were sick or lonely, or needed help with chores or taking care of yourself.)
    a. Yes, I have lots of help and support.
    b. Yes, I have some help and support.
    c. Not really, I get very little help or support.
    d. No, I don't have any help or support.

Health Care

62. In general, how easy is it for you to get the health care you need, including the following:
    a. Finding a doctor or provider
        i. Very easy
        ii. Somewhat easy
        iii. Somewhat difficult
        iv. Very difficult

    b. Making an appointment
        i. Very easy
        ii. Somewhat easy
        iii. Somewhat difficult
        iv. Very difficult

c. Getting to your appointment
    i. Very easy
    ii. Somewhat easy
    iii. Somewhat difficult
    iv. Very difficult

d. Getting any medication or other treatment
    i. Very easy
    ii. Somewhat easy
    iii. Somewhat difficult
    iv. Very difficult

e. Paying for care
    i. Very easy
    ii. Somewhat easy
    iii. Somewhat difficult
    iv. Very difficult

Readiness for Change

63. How important is it to make lifestyle changes to improve your health?
    a. Very important
    b. Somewhat important
    c. Not very important
    d. Not at all important

64. How confident are you that you can make healthy changes?
    a. Very confident
    b. Somewhat confident
    c. Not very confident
    d. Not at all confident

65. How ready are you to start making healthy changes?
    a. Very ready
    b. Somewhat ready
    c. Not very ready
    d. Not at all ready
    e. I already have healthy habits, and I plan to continue making healthy choices.

Preventive Health Services and Screenings

66. Have you had a physical exam during the past 12 months?
    a. Yes
    b. No
    c. Unsure

67. Have you had a dental exam during the past 12 months?
    a. Yes
    b. No
    c. Unsure

68. Have you had your blood pressure checked during the past 12 months?
    a. Yes
    b. No
    c. Unsure

69. Have you had a cholesterol blood test during the past 5 years?
    a. Yes
    b. No
    c. Unsure

If you do not have diabetes, please go to question 73 if you are a woman, or to question 75 if you are a man.

70. If you have diabetes, have you had a diabetes blood test (A1C) during the past 12 months?
    a. Yes
    b. No
    c. Unsure

71. If you have diabetes, have you had comprehensive kidney testing during the past 12 months?
    a. Yes
    b. No
    c. Unsure

72. If you have diabetes, have you had a dilated eye exam during the past 12 months?
    a. Yes
    b. No
    c. Unsure

73. For women only, have you had a Pap test and/or HPV test for cervical cancer screening during the past 3 years?
    a. Yes
    b. No
    c. Unsure
    d. Does not apply

74. For women only, have you had a mammogram for breast cancer screening during the past 1-2 years?
    a. Yes
    b. No
    c. Unsure
    d. Does not apply

75. Have you had a flu shot during the past 12 months?
    a. Yes
    b. No
    c. Unsure

76. If you are over age 50, have you had any of the following tests to screen for colorectal cancer:
    a. Colonoscopy during the past 10 years?
        i. Yes
        ii. No
        iii. Unsure

    b. Flexible sigmoidoscopy during the past 4 years?
        i. Yes
        ii. No
        iii. Unsure

    c. Fecal occult blood test during the past 12 months?
        i. Yes
        ii. No
        iii. Unsure

Blood Pressure and Lab Tests *(This section is optional.)*

89. What was your blood pressure the last time it was checked?
    a. _____ / _____

90. What was your cholesterol the last time it was checked?
    a. Total cholesterol _____
    b. HDL _____
    c. LDL _____
    d. Triglycerides _____

91. What was your fasting blood glucose (blood sugar) the last time it was checked?
    a. _____

92. If you have diabetes and/or have had a hemoglobin A1C checked in the past year, what was it the last time it was checked?
    a. _____

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