



May 15, 2015

Ms. Carrie Lindgren
Issuing Officer
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114

RE: Proposal for the Iowa High Quality Healthcare Initiative (RFP #MED-16-009)

Dear Ms. Lindgren:

I submit the enclosed proposal for the Iowa High Quality Healthcare Initiative, RFP#MED-16-009, on behalf of Meridian Health Plan of Iowa Inc. (Meridian). I am authorized to speak to the confidential nature of the information included in this proposal, and as requested, have included my contact information below.

David B. Cotton, M.D.
President and CEO
777 Woodward Avenue, Suite 600
Detroit, MI 48226
Phone: (313) 324-3700
Email: dcotton@mhplan.com

Executive Summary

Meridian is a patient-centered managed care organization committed to improving the quality, value and efficiency of care for the members we serve. The Meridian family of companies currently administers physical, behavioral, and long-term supports and services benefits to the full range of Medicaid enrollees in Michigan and Illinois, and the administers the physical health benefits for TANF and Iowa Wellness Plan members in Iowa. Our reputation for providing high-quality managed care services to Medicaid beneficiaries throughout the Midwest demonstrates our qualification and capability to deliver the services sought after in the Iowa High Quality Health Care Initiative (IHQHI). We pride ourselves in producing successful outcomes and innovative approaches to managing care. Our success is reflected in our rankings. In a nationwide comparison of Medicaid health plans, Meridian Health Plan of Michigan and Meridian Health Plan of Illinois ranked #9 and #10 respectively, and Meridian Health Plan of Iowa ranked #38 in its first year of being eligible for accreditation, according to NCQA's 2014-2015 Rankings. Meridian Health Plan of Michigan earned the highest possible rating of five out of five for Consumer Experience, Prevention, and Treatment. Meridian personalizes member care and understands the complex needs of the Medicaid population. Our mission is to continuously improve the quality of care in a low-resource environment. As a physician-owned and member-focused organization, we blend innovative, proprietary technology, with a commitment to member satisfaction. We embody the "Triple Aim" concept so important to our industry: improve the health of the population, enhance the patient experience of care (including quality, access and reliability), and reduce the per capita cost of care.



The 2015 IHQHI establishes specific goals for quantifying the success and efficacy of the overall initiative. When selected as an IHQHI-contracted managed care organization, Meridian's approach to care delivery will meet the presented goals as follows:

Improve Quality of Care and Health Outcomes for Medicaid and CHIP enrollees while leveraging the strength and success of current DHS initiatives:

Since commencing operations in 2012, Meridian has been committed to improving the health outcomes of our nearly 50,000 Iowa TANF and Wellness beneficiaries. In 2014 alone, Meridian met the 90th percentile for the following Healthcare Effectiveness Data and Information Set (HEDIS[®]) measures:

- Pregnant women received timely prenatal care (92.26%)
- Diabetic members (18-75 years) of age had a HbA1c test during the year (95.16%)
- Children received six or more well child visits in the first 15 months of life (79.37%)
- Women received appropriate postpartum care (74.53%)
- Members had controlled high blood pressure (73.08%)
- Diabetic members received an eye exam (67.74%)

In addition to these critical measures reaching the 90th percentile, Meridian scored four out of five for treatment and prevention in NCQA's 2014-2015 plan rankings. Achieving high quality care requires access to necessary services, well-credentialed in-network providers and member outreach. Meridian's programs produce results and our rankings and quality measures reflect this.

Current initiatives conducted by the Department of Human Services are important to Meridian, particularly those in which Meridian currently participates. In 2014, Meridian Health Plan of Iowa achieved a rate of **45% electronic and remote accessibility** of our member's medical records. Meridian is committed to efficient processes that have a direct effect on the quality of services delivered. Meridian actively participated in the IME's Adult Quality Measures Stakeholder Group, which concluded after 3 years in 2014. Working to collaborate and produce innovative programs to improve maternal health and care coordination, Meridian is currently an active member of the Iowa Maternal Health Task Force. Meridian is also the lead of the Iowa Primary Care Pilot supporting innovative solutions to administer primary care to Iowa's most vulnerable populations. Most recently, Meridian Health Plan of Iowa partnered with the Iowa Department of Public Health, establishing the "Cribs for Kids" program, which reduces opportunity for infant mortality, by providing women delivering babies in four pilot counties a free crib if needed.

Emphasize Member choice, access, safety, independence, and responsibility:

Meridian currently provides services for over 700,000 Medicaid eligible beneficiaries. Providing similar services as outline in this RFP, Meridian's plans provide members with choice, by supporting comprehensive provider networks offering members a full range of primary and specialty care providers. These same network development practices ensure members have proper access to all levels of care when necessary. Meridian has developed, in accordance with industry standards, medical and clinical processes that provided members with safe, medically appropriate services. Our network providers are also held accountable for the safety of our members and credentialed in accordance with industry standards. Meridian's care coordination programs provide members with highly coordinated services that allow members to play an active role in their individual plan of care. This approach allows Meridian members



to maintain their independence and develop a sense of responsibility for their health and wellness, while having the support of Meridian's care coordination team.

Provide High Quality healthcare services in the least restrictive manner appropriate to a member's health and functional status:

Each member's care plan identifies overall goals that reflect their unique needs and identify services and care that meet the member's care goals and connect the member/caregiver with add-on benefits and services. Meridian strives to ensure covered services are provided to beneficiaries in the most cost effective and least restrictive manner as appropriate to the member's health. Our Member Services team interacts with enrollees, both new and existing, to educate and equip members to understand the benefits available to them. Our Care Coordination staff works with members assigned to our care coordination program, engaging members to take responsibility for their health and play an active role in their care. Meridian's intent is to allow the member to be as independent in their care as possible, but more importantly serve as an advocate helping navigate the member through the resources available to them.

Deliver covered benefits, including physical health, behavioral health and long term services and supports (LTSS) in a highly coordinated manner:

Meridian excels at routine and preventive care measures and focuses on the management of chronic conditions prevalent in our populations. Our programs combine a member-centered approach to care with technology, bridging the gaps that can occur in coordination of care. Our focus on individual member needs starts at enrollment. Meridian will perform a Health Risk Assessment (HRA) upon enrollment; Based on member stratification an appropriate interdisciplinary care team (ICT) is assigned to coordinate the member's care. Encompassing medical, behavioral/developmental, long-term services and supports, this proactive approach allows the ICT to quickly identify and implement care coordination activities, resulting in improved member health outcomes. These coordination activities are especially important for high-risk members with multiple chronic medical conditions, often exacerbated by underlying behavioral health conditions. Our propriety managed care system fully supports the populations we serve by allowing Care Coordinators, members, providers, and subcontracted entities, real-time access to health information about a member's care.

Meridian offers the following assurances to the Iowa Department of Human Services:

- Meridian will furnish the services required by members as promptly as is appropriate and that the services provided will meet or exceed the Departments' quality standards.
- Meridian affirms the capitation rates outlined in the Incorporating RFP Amendment 2, published on April 17, 2015, will cover all services required by members. Based on the provided caption rates, Meridian affirms its ability to meet the Medical Loss Ratio requirements of eighty-five percent (85%).
- Meridian understand that failure to perform the requirements of this RFP, may result is liquidated damages as described in Exhibit E of the Scope of Work Attachment 1.
- Meridian acknowledges that this contract is based on performance and understands that incentives and disincentives may apply to Meridian's performance as established in RFP MED-16-009.



Meridian Health Plan of Iowa is committed to fulfilling the responsibilities and goals of this contract in a highly coordinated and fiscally responsible manner. We look forward to working with the Iowa Department of Human Services and to deliver high-quality, individualized services to all Iowa Medicaid beneficiaries.

Very truly yours,

David B. Cotton, M.D.
President and CEO
Meridian Health Plan

3.2.1 Bid Proposal Security

Meridian Health Plan has included bid proposal security made payable to the Agency in the amount of \$100,000.00 with the ORIGINAL version of our proposal for the Iowa High Quality Healthcare Initiative (RFP# MED-16-009).

Meridian acknowledges that the bid proposal security shall be forfeited if Meridian is chosen to receive the contract and withdraws its Bid Proposal after the Agency issues a Notice of Intent to Award, does not honor the terms offered in its Bid Proposal, or does not negotiate contract terms in good faith.

Meridian further acknowledges that the bid proposal security submitted by bidders will be returned, if not forfeited for reasons stated above, when the Bid Proposals expire, are rejected, or the Agency enters into a contract with the successful bidder, whichever is earliest.

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PROPOSAL TABLE OF CONTENTS

Tab 1: Transmittal Letter

Transmittal Letter..... i
Bid Proposal Security v

Tab 2: Proposal Table of Contents

Proposal Table of Contents vii

Tab 3: Bidder’s Approach to Meeting the SOW

INTRODUCTION..... 1
SECTION 1 – RFP PURPOSE AND BACKGROUND 1
 1.4 General Contractor Responsibilities 5
SECTION 2 – ADMINISTRATIVE REQUIREMENTS..... 14
 2.1 Licensure/Accreditation..... 14
 2.2 Subcontracts..... 14
 2.3 Financial Stability 24
 2.4 Maintenance of Records 26
 2.5 Disclosures..... 26
 2.6 Debarred Individuals 28
 2.8 Organizational Structure..... 28
 2.9 Staffing 31
 2.11 Coordination with Other State Agencies and Program Contractors 54
 2.13 Written Policies and Procedures 59
 2.14 Participation in Readiness Review 61
 2.15 Confidentiality of Member Medical Records and Other Information 64
 2.16 Material Change to Operations..... 65
SECTION 3 – SCOPE AND COVERED BENEFITS 67
 3.2.2 Benefit Packages..... 67
 3.2.4 Integrated Care..... 72
 3.2.5 Emergency Services..... 77

| | |
|---|------------|
| 3.2.6 Pharmacy Services..... | 82 |
| 3.2.7 EPSDT Services..... | 89 |
| 3.2.8 Behavioral Health Services..... | 90 |
| 3.2.9 Health Homes | 103 |
| 3.2.10 Chronic Condition Health Homes..... | 105 |
| 3.2.11 1915(i) Habilitation Services and 1915(c) Children’s Mental Health (CMH) Services..... | 106 |
| 3.2.13 Iowa Health and Wellness Plan Benefits | 110 |
| 3.2.14 Value-Added Services | 111 |
| 3.3 Continuity of Care | 123 |
| 3.4 Coordination with Medicare | 125 |
| SECTION 4 – LONG TERM SERVICES AND SUPPORTS | 129 |
| 4.1 General..... | 129 |
| 4.2 Level of Care Assessments | 131 |
| 4.3 Community-Based Case Management Requirements | 136 |
| 4.3.12 Nursing Facilities and ICF/IDs | 147 |
| 4.4 1915(c) HCBS Waivers | 158 |
| SECTION 5 – BILLING AND COLLECTIONS..... | 172 |
| 5.1 General Provisions..... | 172 |
| 5.2 Reserved | 174 |
| 5.3 Copayments | 174 |
| 5.4 Patient Liability | 175 |
| 5.5 IDPH Sliding Scale..... | 176 |
| SECTION 6 – PROVIDER NETWORK REQUIREMENTS | 177 |
| 6.1 General Provisions..... | 177 |
| 6.1.2 Provider Agreements | 179 |
| 6.1.3 Provider Credentialing..... | 184 |
| 6.1.4 Cultural Competence | 190 |
| 6.1.6 Provider Relations and Communications | 197 |
| 6.1.8 Notification of Provider Disenrollment | 200 |
| 6.1.9 Medical Records | 201 |
| 6.1.10 Availability of Services | 203 |
| 6.1.11 Provider Compliance | 204 |
| 6.2 Network Development and Adequacy..... | 208 |

| | |
|---|------------|
| 6.3 Requirements by Provider Type | 211 |
| SECTION 7 – ENROLLMENT | 217 |
| 7.4 Member Disenrollment | 219 |
| SECTION 8 – MEMBER SERVICES | 222 |
| 8.1 Marketing | 222 |
| 8.2 Member Communications | 224 |
| 8.3 Member Services Helpline | 233 |
| 8.4 Nurse Call Line | 238 |
| 8.5 Electronic Communications | 239 |
| 8.6 Member Website | 242 |
| 8.7 Health Education and Initiatives | 244 |
| 8.8 Cost and Quality Information | 246 |
| 8.10 Member Rights | 247 |
| 8.11 Redetermination Assistance | 248 |
| 8.12 Member and Stakeholder Engagement | 249 |
| 8.13 Stakeholder Education | 254 |
| 8.14 Implementation Support | 257 |
| 8.15 Grievances, Appeals, and State Fair Hearings | 257 |
| SECTION 9 – Care Coordination | 264 |
| 9.1 General | 264 |
| 9.1.1 Initial Screening | 266 |
| 9.1.2 Comprehensive Health Risk Assessment | 268 |
| 9.1.3 Care Coordination | 271 |
| 9.1.4 Risk Stratification | 286 |
| 9.1.5 Member Identification | 292 |
| 9.1.6 Care Plan Development | 293 |
| 9.1.7 Tracking and Reporting | 314 |
| 9.1.8 Monitoring | 317 |
| 9.1.9 Reassessments | 318 |
| SECTION 10 – QUALITY MANAGEMENT AND IMPROVEMENT STRATEGIES | 325 |
| 10.1 Contractor Quality Management/Quality Improvement Program | 325 |
| 10.2 State Quality Initiatives | 341 |
| 10.3 Incentive Programs | 344 |

| | |
|---|------------|
| 10.4 Critical Incidents..... | 350 |
| 10.5 Provider Preventable Conditions | 355 |
| SECTION 11 – Utilization Management | 357 |
| 11.1 Utilization Management Programs | 357 |
| 11.2 Prior Authorization | 378 |
| SECTION 12 – Program Integrity | 394 |
| SECTION 13 – Information Technology | 407 |
| 13.1 Information Services & System..... | 407 |
| 13.2 Contingency and Continuity Planning..... | 432 |
| 13.3 Data Exchange | 433 |
| 13.4 Claims Processing..... | 434 |
| 13.5 Encounter Claims Submission..... | 440 |
| 13.6 TPL Processing..... | 441 |
| 13.7 Health Information Technology..... | 445 |
| SECTION 14 – Performance Targets and Reporting Requirements..... | 449 |
| SECTION 15 – Termination | 471 |

Tab 4: Bidder’s Background

| | |
|---|------------|
| 3.2.5.1 Experience. | 475 |
| 3.2.5.1.1 Level of technical experience in providing the types of services sought by the RFP..... | 475 |
| 3.2.5.1.4 Letters of reference | 483 |
| 3.2.5.1.5 Description of experience managing subcontractors | 489 |
| 3.2.5.2 Personnel..... | 493 |
| 3.2.5.2.1 Tables of Organization. | 493 |
| 3.2.5.2.2 Names and Credentials of Key Corporate Personnel..... | 509 |
| 3.2.5.2.3 Information About Key Project Personnel..... | 511 |
| 3.2.5.4 Termination, Litigation, and Investigation..... | 520 |

Tab 5: Attachments

| | |
|--|-----|
| Attachment 1 (Care Coordination/Long Term Care Support & Services Job Descriptions)..... | 523 |
| Attachment 2 (Claims Job Descriptions)..... | 537 |

| | |
|--|-----|
| Attachment 3 (Behavioral & Physical Health Job Descriptions)..... | 545 |
| Attachment 4 (Grievance & Appeals Job Descriptions)..... | 581 |
| Attachment 5 (Information Technologies Job Descriptions)..... | 587 |
| Attachment 6 (Marketing Job Descriptions)..... | 603 |
| Attachment 7 (Member Services Job Descriptions) | 605 |
| Attachment 8 (Network Development & Management Job Descriptions)..... | 611 |
| Attachment 9 (Performance Data Reporting & Encounter Claims Submission Job Descriptions) | 617 |
| Attachment 10 (Pharmacy Job Descriptions) | 625 |
| Attachment 11 (Provider Services & Provider Enrollment Job Descriptions) | 645 |
| Attachment 12 (Quality Management & Improvement Job Descriptions)..... | 659 |
| Attachment 13 (Utilization & Care Management Job Descriptions)..... | 669 |
| Attachment 14 (Key Personnel Job Descriptions) | 701 |
| Attachment 15 (InterRAI Long Term Care Assessment) | 735 |
| Attachment 16 (InterRAI Home Care Assessment) | 743 |
| Attachment 17 (Community Transition Plan Checklist Tool)..... | 751 |
| Attachment 18 (Sample Self-Assessment Tool)..... | 753 |
| Attachment 19 (Informed Consent and Risk Agreement) | 757 |
| Attachment 20 (Provider Communication Sample 1)..... | 759 |
| Attachment 21 (Provider Communication Sample 2) | 761 |
| Attachment 22 (Meridian Health Plan Iowa Member Handbook)..... | 763 |
| Attachment 23 (Sample ID Card Letter)..... | 807 |
| Attachment 24 (Welcome Newsletter Excerpt)..... | 809 |
| Attachment 25 (LTSS Member Handbook Excerpts)..... | 811 |
| Attachment 26 (Self-Directed Care Flyer)..... | 813 |
| Attachment 27 (Sample Member EOB)..... | 815 |
| Attachment 28 (Health Risk Screening Tool)..... | 817 |
| Attachment 29 (QIC Reports)..... | 847 |
| Attachment 30 (Provider Satisfaction Analysis) | 849 |
| Attachment 31 (Quality KPIs) | 863 |
| Attachment 32 (QI Work Plan)..... | 865 |
| Attachment 33 (Operations Report)..... | 873 |
| Attachment 34 (Quality Review Process)..... | 881 |
| Attachment 35 (Sample Provider FWA Report)..... | 883 |

| | |
|---|-----|
| Attachment 36 (Sample Notices of Action)..... | 885 |
| Attachment 37 (Corporate Compliance and Fraud, Waste and Abuse Program) | 891 |
| Attachment 38 (Information Systems Staffing Model) | 909 |
| Attachment 39 (Sample Release Management Plans) | 911 |
| Attachment 40 (Corporate Business Continuity & Disaster Recovery Plan) | 915 |
| Attachment 41 (NCQA HEDIS Compliance Audit)..... | 961 |

Tab 6: RFP Forms, Financial Statements, Resumes, and Contract Lists

| | |
|--|---|
| 3.2.7.1 RFP Forms..... | 971 |
| Exhibit A – Release of Information Form | 971 |
| Exhibit B – Primary Bidder Detail Form & Certification..... | 973 |
| Exhibit C – Subcontractor Disclosure Forms | 977 |
| 3.2.7.2 Financial Statements..... | Bound and labeled separately from proposal |
| 3.2.7.3 Resumes | 1005 |
| Contract Administrator/CEO/COO – Pitera, Raymond D..... | 1005 |
| Medical Director – Smith, C. David..... | 1007 |
| Chief Financial Officer – Torosian, Janice..... | 1009 |
| Compliance Officer – Goldsmith, Jane..... | 1011 |
| Pharmacy Director/Coordinator – Acker, Rene..... | 1015 |
| Grievance & Appeals Manager – Moubadder, Maria..... | 1019 |
| Quality Management Manager – Muhlenbruck, Amy | 1025 |
| Utilization Management Manager – Smith, Catherine | 1029 |
| Behavioral Health Manager – Solky, Mary Clare | 1033 |
| Member Services Manager – Brandon, Christina..... | 1035 |
| Provider Services Manager – West, Candace..... | 1037 |
| Information Systems Manager – Green, Dana..... | 1043 |
| Claims Administrator – Wegner, Bruce | 1045 |
| Care Coordination Manager – Butler, Brandy..... | 1049 |
| Program Integrity Manager – Goldsmith, Jane..... | 1053 |
| Long Term Care Manager – Olver, Kathryne..... | 1057 |
| Director of Operations (Primary Point of Contact with the Agency) – Foltz, Kimberly..... | 1061 |

| | |
|---|-------------|
| 3.2.7.4 Contract Lists | 1063 |
| 3.2.7.4.2 Table | 1063 |
| 3.2.7.4.3 Description of all contracts and projects currently undertaken by the bidder..... | 1137 |
| 3.2.7.5 Select Attachments Not Included in Page Count | 1143 |
| Attachment 42 EQRO Reports | 1143 |
| Attachment 43 Implementation Plan | 1191 |
| Attachment 44 HEDIS Scores | 1247 |
| Attachment 45 Sample Provider Agreements..... | 1249 |

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**State of Iowa
MED-16-009
Iowa High Quality Healthcare Initiative
Required Content of Proposals
Attachment 5 - Technical Proposal Response Form
Incorporating RFP Amendment 2, April 22, 2015**

INTRODUCTION

This document provides questions and prompts for the Bidder to address each section of the Scope of Work. References to “you,” “the bidder,” “bidders,” etc. all refer to the organization that is submitting a proposal in response to this RFP. Bidders should address the entire Scope of Work in their response, including but not limited to the topics below, and number each response according to the Scope of Work. Exhibits or attachments should be clearly labeled for ease of reference and provided as separate documents.

SECTION 1 – RFP PURPOSE AND BACKGROUND

Please explain how you propose to execute Section 1 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience. To the extent that a more detailed description of your qualifications and relevant experience for this section is described in more detail later in your proposal, a brief summary will suffice.

A premier Medicaid managed care plan, Meridian Health Plan of Iowa, Inc. is committed to partnering with the State of Iowa to ensure the Medicaid Modernization efforts improve coordination and quality of care while stabilizing Medicaid spending. The State has demonstrated its ability to adequately manage and oversee the administration of Medicaid benefits to qualifying beneficiaries. In comparison to other states with similar populations, the State of Iowa has made significant efforts to reduce Medicaid expenditures without reducing services. However, the changing tides of government sponsored healthcare programs have resulted in more complex patient caseloads and shrinking Federal match funds. These changes have stretched state budgets and derailed cost containments efforts. It can be assumed that with the changing Medicaid environment, cost containment efforts will continue to become more difficult to accomplish. By integrating managed care entities, the Iowa High Quality Healthcare Initiative (IHQHI) will create an environment consistent with national trends, centered on care coordination, and designed for sustainability.

With over seventeen (17) years of Medicaid managed care experience, Meridian has been delivering high quality, patient-centered services to the full range of Medicaid beneficiaries. Currently ranked the number one (#1) Medicaid HMO in Michigan, Illinois and Iowa (according to the National Committee for Quality Assurance Medicaid Health Insurance Plan Rankings for 2014-2015), Meridian is committed to improving the value, quality, and efficiency of care for the members we serve. Based on these same rankings, nationally the Meridian affiliates in Michigan and Illinois ranked ninth (9th) and tenth (10th), and Iowa ranked thirty-eighth (38th). In addition, our Michigan affiliate earned the highest possible rating of five out of five in composite scores for Consumer Experience, Prevention, and Treatment. Our proven track record of serving Medicaid beneficiaries throughout the Midwest demonstrates our capabilities in delivering successful outcomes and reducing Medicaid program costs for taxpayers. Meridian personalizes member care and understands the complex needs of the Medicaid population.

Our mission is to continuously improve the quality of care in a low-resource environment. As a physician-owned and member-focused organization, we blend innovative proprietary technology with a commitment to premier service. We embody the “Triple Aim” concept vital to our industry:

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce the per capita cost of care

Meridian delivers outstanding quality of care while streamlining the value of care delivery. Our focus on innovative, coordinated programs allows us to tear down traditional healthcare silos. Instead, Meridian emphasizes the patient-focused delivery of services while maximizing the potential for savings. Serving as an established Medicaid managed care plan in the State of Iowa, Meridian is equipped and committed to serving the populations included in the 2015 Iowa High Quality Healthcare Initiative (IHQHI). The 2015 IHQHI establishes specific goals for quantifying the success and efficacy of the overall initiative. Selected contractors are expected to attain these prospective goals. When selected as an IHQHI contracted managed care organization, Meridian intends to achieve the presented goals as follows:

Goal: Improve Quality of Care and Health Outcomes for Medicaid and CHIP members while leveraging the strength and success of current DHS initiatives

Presently, Meridian provides services for both Temporary Assistance for Needy Families (TANF) and Iowa Health and Wellness Plan Medicaid beneficiaries with a combined membership of over 55,000 covered lives. Coordinating and managing care for the current population positions Meridian to seamlessly integrate the new beneficiaries included in the IHQHI. Meridian’s expertise and efficiency in the Medicaid managed care environment will be necessary for a smooth transition. From members to providers, from claims to compliance, quality is Meridian’s top priority, permeating to all facets of our organization. Achieving high quality of care requires available access to the necessary services, well-credentialed in-network providers and member outreach ensuring health literacy. As a Physician-owned and member-focused organization, Meridian’s mission is to continuously improve the quality of care in a low resource environment. We take this pledge seriously.

Keeping in line with our affiliates, Meridian achieved high results after only one year qualifying for measurement. Our HEDIS® trends make evident Meridian’s commitment to best practices in administering high quality benefits for our members. As demonstrated below, Meridian is consistently improving our performance measurements to meet, or exceed, the HEDIS® National ninetieth (90th) Percentiles. In our first year qualifying for measurement in Iowa, our best practices propelled us to reach the ninetieth (90th) percentile in seven critical measures, of which, four (4) are listed below.

| HEDIS® Measure | HEDIS® 2012 (2011 Measurement Year) | | | HEDIS® 2013 (2012 Measurement Year) | | | HEDIS® 2014 (2013 Measurement Year) | | | Quality Compass HEDIS® 2014 National Percentiles | | |
|---|--|--------|----|--|--------|----|--|--------|--------|---|--------|--------|
| | MI | IL | IA | MI | IL | IA | MI | IL | IA | 50th | 75th | 90th |
| Childhood Immunizations - Combo 2 | 79.07% | 87.04% | NR | 81.54% | 84.89% | NR | 85.42% | 85.68% | 79.23% | 75.18% | 79.72% | 83.33% |
| Controlling High Blood Pressure | 69.50% | NR | NR | 76.69% | NR | NR | 76.69% | 78.50% | 73.08% | 56.46% | 63.76% | 69.79% |
| PPC - Postpartum Care | 71.10% | 76.19% | NR | 72.07% | 83.06% | NR | 76.35% | 78.46% | 74.53% | 62.84% | 69.47% | 74.03% |
| PPC - Timeliness of Prenatal Care | 93.94% | 93.88% | NR | 94.13% | 96.37% | NR | 94.13% | 94.03% | 96.26% | 84.30% | 89.62% | 93.10% |
| Well-Child Visits in the First 15 Months of Life (6+) | 77.31% | 82.00% | NR | 77.55% | 92.40% | NR | 78.24% | 90.46% | 79.37% | 62.86% | 69.75% | 76.92% |

Current Initiatives:

Current initiatives conducted by the State are important to Meridian. In 2014, Meridian achieved a rate of forty-five percent (45%) electronic and remote accessibility of member records in Iowa. Meridian is committed to efficient processes that have a direct effect on the quality of services delivered. Our capabilities to electronically access our member records results in timely, detailed, and technologically driven procedures.

Meridian plays a critical role as both a contributor and leader in both advocating and promoting innovations in care. Meridian is an active member of the Iowa Maternal Health Task Force, working to collaborate and produce innovative programs to improve maternal health and care coordination. Meridian is the lead of the Iowa Primary Care Pilot Project working to improve the outcomes and efficacy of primary care to Iowa's most vulnerable populations.

Meridian recently partnered with the Iowa Department of Public Health, establishing the "Cribs for Kids" program, which provides women delivering babies in four (4) pilot counties a free crib if needed. More than half of infants that died of a sleep related cause were bed-sharing at the time of death. Identifying community specific health concerns allows Meridian to develop innovative solutions that address local needs to produce better outcomes.

Goal: Emphasize Member choice, access, safety, independence, and responsibility

Each member has a dedicated team responsible for developing a care plan with Meridian based on the desires of the member and within the guidelines of the Meridian Model of Care, which recently received a score of ninety-one point six-seven percent (91.67%) from CMS. The Model of Care requires Meridian's care coordination teams to constantly communicate with members, their families, caregivers, and providers in order to provide the member with the information necessary to make the most informed choices regarding their own health. Our Member Services and Care Coordination teams assist the member in selecting providers and community based services with whom the member feels comfortable. Every Meridian member has the opportunity to transition to another network provider if unsatisfied with their current provider. Meridian never mandates members to participate in available programs, but rather serves as a resource and guide, supporting members within their level of safety and comfort.

Levels of support vary, but in all cases, the emphasis is on the needs, desires, preferences and goals of the member. Meridian believes in empowering each member to achieve maximum functionality and independence in the community. Ultimately, the beneficiary is responsible for their individual health and wellness. Our goal, as a managed care organization, is to motivate and equip the member to reach their optimal level of health while operating within the limits of a low resources environment.

Goal: Provide High Quality healthcare services in the least restrictive manner appropriate to a member's health and functional status

Each member's care plan identifies overall goals that reflect their unique needs, are realistic and measurable, include a time frame for achievement as appropriate, identify services and care to meet members' care goals, and connect the member/caregiver with add-on benefits and services. Upon completion of the assessment, Meridian's proprietary Managed Care System (MCS) automatically identifies appropriate short-term and long-term goals based on member responses. The Care Coordinator reviews these goals with the member and adds any additional goals identified during discussions with the member. The Care Coordinator works together to rank each short-term goal in order of importance, as well as to establish member confidence in ability to achieve these goals. If the Care Coordinator identifies

barriers that are associated with a goal, the Care Coordinator will document these challenges on the care plan. The care plan is generated within MCS and sent to the member, the medical home, primary care provider (PCP) and specialist (if applicable). It is also present on Meridian’s web portal for easy access by the member and those providers with permitted access.

Through the development of individualized, member-centric care plans the member, caregiver, and all other stakeholders, including providers of Home and Community Based Services (HCBS), are able to plan and address common goals and services related to the care of the member. By sharing a member’s care plan with all of the providers serving the member, a common goal of improved health and team approach is achieved. Engaging the member in self-directed care, together with the support of the care management team, will prevent duplication of services and ensure that the member receives the care and services needed for maintaining health.

All Care Coordinators are responsible for member outreach, assistance, and ensuring the member is receiving needed care in a timely fashion and in an appropriate setting. Where the level of member need is greater, a specialized Care Coordinator known as a Community-Based Case Manager is assigned to the member. The Community-Based Case Managers are charged with engaging in a higher level of interaction and interventions with the member. Interventions include providing support ranging from the completion of daily chores to advocating on the member’s behalf. Community-Based Case Managers conduct regular face-to-face visits with members to monitor their current health status (including hygiene and environmental situation) and to determine the overall health needs based on the members functional status. Community-Based Case Managers, in conjunction with Meridian’s strategic partners, also provide the critical service of accessing and coordinating home and community-based services available to the member so that the member can live as healthy a lifestyle as possible.

Meridian coordinates directly with patients and providers to ensure members receive medically necessary and appropriate care in a timely manner. Meridian reached the National ninetieth (90th) percentile in Iowa for the 2014 HEDIS® measures listed in the table below (Iowa HEDIS® Measures for 2014).

| Meridian Health Plan of Iowa 90th percentile HEDIS® Measures for 2014 (2013 Data Set) | |
|--|--|
| Measure | Score-Meets National 90th Percentile for 2014 |
| Infants were seen by their primary care provider by age 2 | 99.32% |
| Pregnant women received timely prenatal care | 96.26% |
| Diabetic members 18-75 years of age had a HbA1c test during the year | 95.16% |
| Children received six or more well child visits in the first 15 months of life | 79.37% |
| Women received appropriate postpartum care | 74.53% |
| Members had controlled high blood pressure | 73.08% |
| Diabetic members received an eye exam | 67.74% |

Goal: Deliver covered benefits, including physical health, behavioral health and Long-Term Services and Supports (LTSS) in a highly coordinated manner

Meridian excels at routine and preventive care measures while focusing on the management of chronic conditions prevalent in our populations. Our clinical infrastructure identifies high-risk members that are in need of specific care coordination, while managing comorbidities, as well as facilitating a preventive and

proactive delivery of education and treatment. Meridian's development of award-winning software enables predictive analysis with the goal of personalizing member management. The aforementioned technology assists in identifying the right care at the right time for the right member. It results in evidence-based, member-centered care being delivered in the most efficient manner possible.

Meridian understands the challenges associated and has experience with coordinating covered benefits for members who are eligible to receive services outside of physical health services including those needing Long-Term Services and Supports (LTSS). This includes members who require physical, behavioral and long term care services and supports. Meridian addresses the coordination of covered benefits in using a wide range of care coordination techniques.

Our programs combine a member-centered approach to care with technology, bridging the gaps that can occur in coordination of care. Our focus on individual member needs starts at enrollment. Within ninety (90) days of joining our plan, members receive an initial health screening; based on the results, our proprietary Managed Care System (MCS) uses objective data and member interaction to stratify members into the appropriate risk categories. Based on member stratification an appropriate Interdisciplinary Care Team (ICT) is assigned to coordinate the member's care. Encompassing medical, behavioral/developmental, and LTSS, this proactive approach allows the ICT to quickly identify and implement care coordination activities, resulting in improved member health outcomes. These coordination activities are especially important for high risk members with multiple chronic medical conditions, often exacerbated by underlying behavioral health issues.

A key feature of the ICT is member involvement. Members are invited to participate in the team meetings, either by phone or in person. With their caregivers also invited to attend, members are encouraged to learn about their medical conditions and strategies for self-management; this member education not only supports improved health outcomes, but it also empowers members to take an active role in their own health care.

Ability to Execute the Contract

As an existing Medicaid HMO in the State of Iowa, Meridian is prepared to seamlessly execute the responsibilities of the Iowa High Quality Healthcare Initiative in its entirety. Meridian's experience operating similar programs in other markets, also speaks to our capability of administering the services outlined in the IHQHI. Where more expertise may be required in administering specific services such as behavioral health services and long term services and supports, Meridian has developed relationships with qualified subcontractors that specialize in these specific services. Meridian has extensive experience in overseeing and managing subcontractors who specialize in services required by Medicaid populations.

1.4 General Contractor Responsibilities

1. Indicate your ability to comply with all Federal and State Laws and Regulations that may affect this Contract.

Meridian Health Plan will comply with all of the applicable requirements under all Federal and State Laws and regulations including the following:

- Title VI of the Civil Rights Act of 1964

- Title IX of the Education Amendments of 1972 (regarding education programs and activities)
- Age Discrimination Act of 1975
- Rehabilitation Act of 1973
- Americans with Disabilities Act
- Section 1903(m) and 1932 of the Social Security Act
- The implementing regulations set forth in 42 CFR 438, as may be amended

Meridian will observe and comply at all times with all, then and current, Federal and State Law related to or affecting this RFP or the Contract, including any law that may be enacted during the term of this RFP or the Contract.

In addition, Meridian will maintain compliance with all applicable Federal and State Law pertinent to member confidentiality and rights and ensure that its staff, network providers and subcontractors take those rights into account when furnishing services to members. Meridian understands that it is the responsibility of Meridian to remain aware of changes in Federal and State Laws and Regulations as they affect our duties and responsibilities under this RFP or the Contract.

2. Summarize how you are qualified to provide the services listed in Section 1.4.2

Meridian Health Plan currently has full-risk capitated Medicaid contracts in place to provided services similar to those sought by the Iowa High Quality Health Care Initiative (IHQHI) in Illinois, Iowa, and Michigan. In addition to our Medicaid Managed Care Programs, Meridian is contracted with the Centers for Medicare and Medicaid Services (CMS) for two Dual Demonstration programs in conjunction with the Illinois Department of Human and Family Services and the Michigan Department of Health and Human Services (MDHHS). Similar to the services sought by the Iowa High Quality Health Care Initiative (IHQHI) Meridian has been responsible for providing covered services to the full range of Medicaid members including:

- Aged, Blind, and Disabled (ABD)
- Temporary Assistance for Needy Families (TANF)
- Supplemental Security Income (SSI)
- Sixth Omnibus Reconciliation Act (SOBRA)
- Families with Dependent Children (AFDC)
- Children's Health Insurance Plan (CHIP)
- Affordable Care Act (ACA)/Family Health Plan (FHP) Program
- Foster children
- Dual eligible-Special Needs Plan (D-SNP)
- Medicare-Medicaid Alignment Initiative (Michigan/Illinois)
- Medicaid Expansion Eligible (Michigan/Illinois/Iowa)

In 2008, the Illinois Department of Healthcare and Family Services (HFS) chose to partner with Meridian for the specific purpose of increasing quality outcomes. Later that year, Meridian began administering coordination and care management services to eligible recipients in the Illinois AllKids, Family Care, and Moms and Babies programs. Meridian has delivered the significant increases in quality that Illinois was seeking, with over ninety percent (90%) of Meridian's total

enrollment having received all National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) preventive services in a timely manner.

Meridian also has a contract with CMS to operate a Dual Eligible Special Needs Medicare Advantage Plan known as Meridian Advantage Plan (HMO SNP). Meridian coordinates the care of over 2,000 dual-eligible members through its Medicaid contract and is transitioning many of those members into the Meridian Advantage Plan. In January 2011, Meridian successfully implemented the Meridian Advantage Plan (HMO SNP) in Michigan. By targeting enrollment exclusively to dual eligibles, Meridian Advantage Plan succeeded in developing a unique benefit structure and system of healthcare delivery that is population-specific. Through the offering of a single benefit package and network of health care providers, Meridian Advantage Plan has proven successful in offering Medicare and Medicaid services to dual-eligible members with minimal confusion and expedited access to necessary services. Meridian launched identical HMO SNP programs in Illinois in 2013 and in Iowa in 2014.

Meridian also launched a Medicare Advantage Prescription Drug Plan (MAPD) in 2014 in all three (3) states in which we operate. Meridian Prime (HMO) coordinates Medicare Part A, Part B, and Part D benefits for Medicare beneficiaries.

In recognition of the complex and unique needs of the dual eligible population, Meridian Advantage Plan maintains ongoing quality improvement initiatives aimed towards innovative partnerships, member sensitivity and effective relationships with providers. In addition, Meridian Advantage Plan implements strategies outlined in its CMS-approved Model of Care to effectively improve the health outcomes of members. Meridian Advantage Plan utilizes Chronic Care Improvement Programs and Quality Improvement Projects to systematically evaluate, improve and thereby ensure the quality and safety of provided healthcare services.

In 2012, Meridian expanded operations into the State of Iowa. Building on its extensive experience in Michigan and Illinois, Meridian began providing healthcare services to Medicaid beneficiaries based on the State of Iowa Medicaid benefit guidelines under the Temporary Assistance for Needy Families (TANF) program.

Meridian's operations expanded into the State of New Hampshire in 2013, when Meridian began providing services for beneficiaries eligible for New Hampshire Medicaid benefits. Meridian terminated operations in New Hampshire as of July 31, 2014.

Meridian Choice, Meridian's premier health insurance exchange product launched in 2013. Meridian developed an exclusive partnership with Bronson Healthcare to develop a regionally based health insurance exchange product providing access to over 800 medical providers. Meridian coordinates with Bronson Healthcare to provide services for individuals who receive coverage through the healthcare marketplace.

In 2013, Meridian was awarded a contract between CMS and the State of Illinois to administer a Medicare-Medicaid Alignment Initiative (MMAI), known as Meridian Complete. This product provides services for members who are entitled to Medicare Part A, enrolled under Medicare Part B, receive full Medicaid benefits, and live within a specified service area. Meridian Complete provides complex or vulnerable members with highly coordinated benefits, individualized care plans, and person-centered services. This program also encompasses physical health services, behavioral health services, and Long-Term Services and Supports (LTSS). Meridian began managing the care of this specific population in March of 2014. Nearly a year later, as of

March 31, 2015, Meridian serves an MMAI population of over 9,000 beneficiaries in Illinois. Meridian Complete aligns members' benefits to ensure beneficiaries are provided services in a fully integrated and highly coordinated setting.

In 2014, Meridian expanded its Meridian Complete program in Michigan to include members eligible for the Michigan Integrated Care Demonstration program in March of 2015. The program, MI Health Link, is a program available for very sick and frail individuals in great need of coordinated care. Meridian is responsible for managing a wide range of services for this population including pharmacy, dental, LTSS, Home and Community Based-Services (HCBS) and Personal care Attendant Services.

Meridian currently provides services for over 725,000 Medicaid-eligible beneficiaries. Meridian has experience administering physical health, behavioral health, and Long-Term Services and Supports (LTSS) for the full range of Medicaid members. Providing similar services as outlined in this RFP, Meridian's current programs achieve the goals as set forth in the Iowa High Quality Healthcare Initiative (IHQHI).

Meridian's plans provide members with choice, by supporting comprehensive provider networks offering members a full range of primary and specialty care providers. These same network development practices ensure members have proper access to all levels of care when necessary. Meridian has developed, in accordance with industry standards, medical and clinical processes that provide members with safe, medically appropriate services. Our network providers are also held accountable for the safety of our members. Meridian's care coordination programs provide members with highly coordinated services that allow members to play an active role in their care plan. This approach allows members to maintain their independence, with the support of Meridian's care coordination team. Actively participating in the care plan, Meridian members develop a sense of responsibility for their health and wellness.

In accordance with the qualifications outlined in the Scope of Work Section 1.4.2 Meridian has experience and meets the qualification desired by the State of Iowa to provide the services outlined in the 2015 IHQHI:

1.4.2.1 Work with existing and additional provider networks and stakeholders to successfully meet the needs of members with a wide range of physical, social, functional, behavioral and LTSS needs.

Meridian currently manages provider networks in Michigan, Illinois and Iowa. Our networks consist of primary care providers (PCP), specialists, hospitals, behavioral health, Long-Term Services and Supports (LTSS), and ancillary providers. Meridian's established network of Medicaid providers in Iowa offers our members with access to over 2,500 primary care providers, over 5,200 specialists, and eighty-seven (87) hospitals. Our current network provides our members with access to services in forty-nine (49) counties within the State of Iowa. Our focus on quality and partnership is evident in this network and ensures that our members have access to the high quality of care synonymous with our performance in other states. Meridian has not and will not discriminate against providers who serve high risk populations or specialize in conditions that require costly treatment. We instead control costs through coordination, with any and all providers, to identify high risk and high cost members and education to reduce unnecessary costs. Our network has outstanding credentials and we verify that all included are eligible to participate in Federal health care programs. We monitor the

adequacy, accessibility, and availability of our provider network to all members, including those with special needs and cultural considerations.

1.4.2.2 Manage all statewide physical, LTSS and behavioral health services for Iowa residents who meet the eligibility requirements defined in this RFP.

Meridian has developed an administrative structure to accommodate the specific needs associated with the populations we serve. Our organizational structure is designed to ensure an efficient and patient centered process. The coordination of physical and behavioral health, and Long-Term Services and Supports (LTSS) are critical to ensure the patient is treated from a holistic approach. While a member may be in need of certain physical health services, their condition may be complicated due to behavioral or social conditions. We recognize that health is not simply developed based on treatment for physical conditions, but also reliant on behavioral and social stability. Meridian's administrative structure hinges on credentialed personnel, technology, and strong relationships with our subcontracted service providers.

Our programs combine a member-centered approach to care with technology, bridging the gaps that can occur in transitions of care. Our focus on individual member needs starts at enrollment. Within ninety (90) days of joining our plan, members receive an initial health screening; based on the results, Meridian's Managed Care System (MCS) uses objective data and member interaction to stratify members into the appropriate risk categories. Based on member stratification an appropriate Interdisciplinary Care Team (ICT) is assigned to coordinate the member's care. Encompassing medical, behavioral/developmental, Long-Term Services and Supports (LTSS), this proactive approach allows the ICT to quickly identify and implement care coordination activities, resulting in improved member health outcomes. These coordination activities are especially important for dual eligible members with multiple chronic medical conditions, often exacerbated by underlying behavioral health issues.

1.4.2.3 Operate in a manner that results in eligible individuals receiving services that are timely and effective in reducing problems and symptoms and how proposed operations will maximize member functioning and quality of life.

Meridian's focus on key care coordination and utilization management process ensures that members receive care in the manner and timeframe that best suits the member's needs. Meridian is committed to authorizing care at the least restrictive and most medically appropriate levels. This commitment results in high quality of care and improved member autonomy, provider satisfaction and effectively controlling costs. The prior authorization process ensures that members receive services consistent with their plans of care, covered services, medically necessary, appropriate, timely, and cost efficient. In addition, prior authorization supports patient safety and cost control by minimizing or eliminating the occurrence of medication errors, duplication of services and inappropriate service delivery. Meridian identifies services and procedures requiring prior authorization through an annual and ongoing analysis of utilization data. These are generally high-volume, high-cost services where review of medical necessity and/or benefits would be helpful.

1.4.2.4 Establish a comprehensive, accessible provider network that offers a choice of providers in all areas of the state.

Meridian’s plans provide members with choice, by supporting comprehensive provider networks offering members a full range of primary and specialty care providers. These same network development practices ensure members have proper access to all levels of care when necessary. Meridian has developed, in accordance with industry standards, medical and clinical processes that provide members with safe, medically appropriate services. Our network providers are also held accountable for the safety of our members. Meridian’s care coordination programs provide members with highly coordinated services that allow members to play an active role in their care plan. This approach allows members to maintain their independence, with the support of Meridian’s care coordination team. Actively participating in the care plan, Meridian members develop a sense of responsibility for their health and wellness.

1.4.2.5 Offer a coordinated array of services to eligible individuals.

Meridian knows that effective healthcare services must extend beyond the doors of a provider’s office. With a focus on care management and intensive preventive health outreach, member outreach and education efforts play a critical role in our operations. Meridian is committed to providing members with information and outreach in multiple formats, from phone calls and mailings to online resources, chat, and social media. Social media allows us to reach our members in new ways, providing additional opportunities to educate. By increasing access to health information, Meridian empowers members to optimize their individual healthcare outcomes. Meridian’s Member Services Department is trained to turn every member contact into a preventive health education opportunity. We provide a range of ongoing member outreach activities, including:

- Telephonic Outreach
- Mailings (monthly, seasonally, condition-specific, or as needed based on members contact)
- Website, Live Chat, and Other Technology
- Community Events and Activities

1.4.2.6 Improve the quality of care provided to members.

Quality Improvement initiatives are embedded in the culture and daily functions of Meridian. Our enterprise goals consistently emphasize the criticality of providing high quality healthcare and the importance of longitudinal planning in ensuring quality improvement throughout periods of growth. Experience, including established community partnerships, is essential in determining which interventions are successful long-term, and positively impact member health. Long-term planning is the key to a stable and successful Quality Improvement Program (QIP). Meridian embraces this process and is confident current planning efforts exceed the expectations of the State. The Meridian Quality Improvement Program operates using a continuous strategic planning cycle. State-specific plans are evaluated annually along with an accompanying work plan. The annual plan contains goals and measureable objectives which are tracked using key performance indicators (KPIs). Progress reporting on KPIs occurs weekly and helps identify areas needing focus or programmatic adjustment.

1.4.2.7 Improve outcomes across the healthcare delivery system.

Meridian is committed to improving outcomes through the engagement of providers. An expansive, engaged Network Development Department strives to accomplish regular, trusted interaction with providers through numerous efforts. Provider Network Development Representatives visit every in-network primary care provider (PCP) office monthly to reinforce clinical practice guidelines, review opportunities for improving patient access to routine and preventive services, and timely and accurate claims submission. Provider educational materials are developed with consideration for seasonal patient patterns (e.g. well child visits are encouraged in summer). Quarterly provider newsletters reinforce disease management concepts, encourage provider feedback, and detail how to maximize interactions with members.

1.4.2.8 Ensure the delivery of services to members that are readily accessible and provided in the least restrictive environment likely to result in the desired outcomes.

Meridian currently provides services for over 725,000 Medicaid beneficiaries. In accordance with the goals outlined within the Iowa High Quality Healthcare Initiative, Meridian strives to ensure benefits are provided to beneficiaries in the most cost effective and least restrictive manner possible. Meridian has experience maintaining individuals in the least restrictive settings such as those members in the HCBS waiver programs and those members receiving care at home with personal care attendants. Our Member Services team interacts with members, both new and existing to educate and equip members on the benefits available to them. Our Care Coordination staff collaborates with members to encourage active engagement in self-care. Meridian's intent is to allow the member to be as independent in their care as possible, but more importantly serve as an advocate helping navigate the member through the resources available to them. Each member that is enrolled in Meridian's care coordination program works with our care team to develop individual goals. These goals are continuously revisited by members, providers, and care managers. This process allows members to achieve their desired health outcomes and measure their individual progress.

1.4.2.9 Provide all covered benefits and administrative functions as required in the RFP.

Meridian will provide all administrative functions as described in this RFP. Meridian will provide all benefits and services deemed medically necessary that are covered under the contract with the State. Meridian will deliver services in accordance with 42 CFR 438.210 (a) (3). Meridian will furnish these covered benefits in the amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. Referencing our clinical practice guidelines, Meridian does not arbitrarily deny, or reduce the amount, duration, and scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. Through our Utilization Management procedures, Meridian may potentially place appropriate limits on services based on medical necessity criteria for the purpose of utilization control, in accordance with the overarching goals of the Iowa High Quality Healthcare Initiative (IHQHI). Meridian intends to leverage our current relationships with our comprehensive network of providers, to deliver covered services. As the sole Medicaid managed care organization currently operating in the State of Iowa, Meridian's established and growing provider network will provide members, to the extent possible and appropriate, adequate choice in selecting his or her health professional.

1.4.2.10 Operate in a manner that promotes efficiency in the service delivery system while offering the highest quality services.

Meridian has a custom-built Managed Care System (MCS) that encompasses all functions of Meridian and has been in use at Meridian's Michigan affiliate since 2003. MCS provides a best practices approach to the design and development of healthcare systems and data environments. The end result is an integrated member/provider profile that focuses on delivering a high quality of care with streamlined efficiency while being highly available. Meridian's integrated system is used to:

- Manage member and provider data
- Submit, approve, deny, and appeal authorizations
- Process claims
- Process, track, and report on member grievances and provider appeals
- Initiate, investigate, and route fraud, waste and abuse cases
- Manage members in case management and disease management programs
- Perform health risk screenings and assessments on all members

Additionally, MCS allows many employees to manage their daily workflow through online work list screens, providing a single point to initiate and assign work while also helping to automatically push work to the appropriate destination. MCS is an integral part of all Meridian functions. Its customizable functionality is a significant factor in the continued success of Meridian as a whole. Meridian's information technologies offer the following advantages:

- **Quality Workflow and Efficiency** – Meridian's vision is to be the number one Medicare/Medicaid Health Plan in Iowa based on quality, innovative technology, and service to members. This commitment to using technology to deliver high quality of care drives a best practices approach to designing and delivering systems and applications. Additionally, Meridian's ability to automate the routing of processes ensures consistent quality and rapid turnaround times. Meridian's attention to member, provider, and end-user needs assures that applications continuously improve, while also being flexible to meet the needs of unique State requirements. The ability to customize Meridian's MCS system to meet State-specific requirements or changing demands provides a notable advantage in the marketplace. Finally, Meridian's focus on HEDIS® allows Meridian to continuously set the bar for excellence in the healthcare industry.
- **Integration** – Meridian's focus on streamlining information flows through open connections with partner platforms provides a tremendous advantage when sharing information. Meridian has set the standard for linking applications between the health plan, State, and outside vendors. As evidence, the State of Michigan uses Meridian's Michigan affiliate as a testing site when it implements new requirements, regulations, procedures, and systems. The resulting common data formats, definitions, and types allow Meridian to act as a responsible data steward when working with State agencies.
- **Reliability and Security** – Meridian's commitment to providing highly available services reassures that the advantages of these systems and applications are

accessible. Meridian's focus on securely delivering content means that members and providers can rest assured that their data is used to better the overall quality of care.

- **Analytics and Business Intelligence** – Meridian's focus on effective decision making allows the organization to identify opportunities and issues with our member and provider relationships. This furthers Meridian's ability to deliver high quality service while also delivering cost savings efficiencies. Meridian's reporting goes far beyond monthly statements and statutory reports. To truly improve health outcomes and manage costs in a low resource environment, information must be analyzed and dissected with extreme efficiency. Meridian invests heavily in data analytics to provide the most accurate, cutting edge, and up-to-date metrics available in the healthcare industry.

1.4.2.11 Coordinate, integrate and be accountable for all services proposed

Meridian offers more than the traditional managed care organization. With a belief in integrative care models, we partner with providers and subcontracted entities to streamline the delivery of care, while ensuring that appropriate care is delivered at the appropriate time. Meridian's innovative programs are supported by our Managed Care System (MCS), our award winning proprietary software platform. Meridian is unique in that our system is an integrated enterprise-wide solution that encompasses all aspects of our operations. Our system also allows online accessibility for providers through our secure Provider Portal, accessible through the internet, which allows providers to view member eligibility, enter authorizations, verify claims status, request direct assistance from Case Management and Member Services and review member health history, including previous utilization from other health plans; MCS allows Meridian to provide coordinated, comprehensive, collaborative and continuous care to members. The ability to access all aspects of a member's care under one software system allows information to be integrated and shared with other parties involved in managing member needs. Members with mental illness, substance use disorders and chronic disorders such as HIV require care from a large number of settings. Meridian staff utilizes MCS as well as interfaces with provider systems to acquire the full picture of a member's medical needs and use of services to coordinate high quality care across settings. Meridian has extensive experience in managing the delivery of services and holding providers and subcontractors accountable to the same standards and requirements to which Meridian is held to through contractual obligations.

1.5 Effects of the Federal Waiver

Meridian Health Plan will comply with any modifications to this RFP and subsequent Contract resulting from the CMS waiver approval process. Meridian acknowledges that in the event that CMS denies the waiver request(s) prior to Contract award or signature, the State will be under no obligation to award a contract as a result of this RFP. Meridian further acknowledges that in the event that CMS denies the waiver request(s) following Contract award and signature, the State may terminate the Contract immediately in writing without penalty. In the event of this type of termination, Meridian will not hold the State liable or require the State to compensate Meridian for any work performed or expenses incurred prior to termination.

SECTION 2 – ADMINISTRATIVE REQUIREMENTS

Please explain how you propose to execute Section 2 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

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.**

Meridian Health Plan is currently licensed and in good standing in the State of Iowa as a Health Maintenance Organization (HMO) in accordance with Administrative code 191 Chapter 40.

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

Meridian Health Plan is not currently certified as a qualified health plan (QHP) by the Iowa Health Insurance Exchange, as defined at 45 CFR 155.20. To facilitate continuity of care for members who may move between Medicaid and premium tax credit eligibility Meridian will apply for this certification once awarded a contract under this Request for Proposal (RFP).

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

Meridian Health Plan of Iowa was awarded an NCQA accreditation status of Commendable for Medicaid HMO product and Accredited for Exchange product in 2014. Meridian will maintain NCQA accreditation throughout the life of the contract.

“Achieving an accreditation status of Commendable from NCQA is a sign that a health plan is serious about quality,” stated Margaret E. O’Kane, President of NCQA. “It is awarded to plans whose service and clinical quality meet or exceed NCQA’s rigorous requirements for consumer protection and quality improvement.”

2.2 Subcontracts

- 1. Summarize your proposed subcontracts, including any with parent companies, and key work to be delegated under the subcontracted relationship.**

Meridian Health Plan’s experience in overseeing subcontracting relationships allows us to ensure beneficiaries receive the highest quality of services in the most accommodating and individualized manner. In accordance with 42 CFR 438.230 Meridian will be accountable for any functions and responsibilities that are delegated to a subcontractor, and will certify and warrant all subcontractor work. Prior to delegation Meridian will evaluate the prospective subcontractor’s ability to perform the activities to be delegated, including firm and staff qualifications. All subcontracts will be supported by a written agreement that specifies the activities and reporting

responsibilities delegated to the subcontractor and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. Meridian will ensure all written subcontracts meet the requirements of 42 CFR 434.6 and shall incorporate by reference the applicable terms and conditions of the contract. Meridian will notify the State in writing of all subcontracts relating to Deliverables to be provided under this Contract prior to the time the subcontract(s) become effective. Meridian will submit for State review and approval subcontractor agreements for any subcontractor whose payments are equal to or greater than five percent (5%) of capitation payments under the Contract.

Meridian intends to subcontract with the following entities to adhere to our contractual obligations in Iowa and function in the most efficient manner possible.

Administrative Services

Meridian engages Caidan Management Company, LLC (CMC) to perform an array of administrative services which will allow Meridian to provide the services described in the Scope of Work. CMC shares the same parent organization as Meridian, Caidan Enterprise, Inc., and thus benefits from efficiencies through integration.

Pursuant to an Administrative Services contract, CMC will perform the following delegated work:

- Claims processing and adjudication
- Member enrollment and eligibility verification
- Medical management
- Behavioral health
- Quality improvement activities
- Authorizations, denials, and appeals
- Complaints and grievances
- Provider recruitment and education
- Support staff for credentialing activities
- Member services/Call center operations
- Member compliance program
- Risk management
- Administrative, technical, and day-to-day operational duties
- Information technology and management services
- Banking, accounting, and financial matters
- Support staff for compliance and fraud, waste and abuse activities

CMC has been providing the described services for over seventeen (17) years to Medicaid and Medicare plans in Michigan, Illinois and Iowa. CMC hires locally-based personnel in each of the states in which it operates and shall do the same for the 2015 Iowa High Quality Healthcare Initiative.

After-Hours Call Services

Meridian intends to contract with Tri-Hospital EMS doing business as (DBA) Med-Connection for delegation of after-hours call center services. Med-Connection was founded in 2001 and provides high-quality, customizable call center services to healthcare organizations. Med-

Connection maintains stringent hiring guidelines and employs a comprehensive and continuous training program based on health plan needs and requirements. Med-Connection dedicates staff to a single account in order to provide the maximum level of attention to callers. Their focus is on resolving issues in a single call and to the satisfaction of the caller 100 percent of the time.

Translation Services

Meridian intends to subcontract with Pan American Languages & Services International (PALS) to provide foreign language translation services. PALS is a woman-owned business in operation since 1983. PALS provides written translation services in more than 170 languages, including Spanish, French, German, English, Arabic, Chinese, Japanese, Korean, Italian, Polish, Russian, Portuguese, and Hmong. PALS also provides immediate twenty-four (24) hours a day, seven (7) days a week access to more than 170 languages supported by over 1,000 professional, certified linguists within an average connect time of thirty (30) seconds. Using state-of-the-art technology with high-quality, professional linguists, PALS is capable of producing unique oral interpretation services of extraordinary speed and reliability. PALS is a current subcontractor of Meridian and has provided multiple years of exceptional service.

Behavioral Health Services

Meridian intends to subcontract with Beacon Health Options for the oversight and delegation of behavioral health services. Beacon Health Options is a premier partner in providing behavioral health solutions to large regional and specialty health plans, employers and labor organizations of all sizes, as well as Federal, State and local governments. Founded through a strategic merger between Beacon Health Strategies and ValueOptions—two unmatched leaders in the behavioral health services sector—Beacon Health Options delivers best-in-class care to forty-five (45) million individuals across all fifty (50) states and the United Kingdom. Beacon will provide and maintain an adequate network of behavioral health providers responsible for providing appropriate behavioral health services to our members in the following ways:

- Reviewing service requests and clinical information against Medicaid medical necessity criteria to ensure approval of the least restrictive and clinically appropriate service
- Developing a unified care plan that incorporates mental health, substance use, physical health, and pharmacy needs and data into a single individual record available to all participating in the member's care team
- Implementing a three (3)-tiered, Intensive Care Management program designed to improve health outcomes and achieve behavioral and physical health cost savings
- Supporting utilization management activities that focus on the member's own recovery goals and connections to community resources, including housing and employment
- Working with all inpatient providers to provide discharge information that will allow us to assist individuals' follow-up with aftercare and in tracking and monitoring care transitions for members in the community
- Utilizing innovative clinical and quality management programs to ensure that services meet quality standards and enhance outcomes for members
- Encouraging providers to involve members in the development of their recovery goals and care plans

Pharmacy Benefit Management

Meridian will engage MeridianRx, LLC (MeridianRx), to perform pharmacy benefit management services for its membership. MeridianRx shares the same parent organization as Meridian and Caidan Management Company, which results in superior alignment of information and extensive integration of service provision. MeridianRx maintains a comprehensive national pharmacy network covering all fifty (50) States, the District of Columbia, the United States Virgin Islands, American Samoa, the Northern Mariana Islands, Puerto Rico and Guam. The expanse of the MeridianRx network ensures convenient access to prescriptions at deeply discounted rates.

MeridianRx employs a variety of tools to ensure the best clinical outcomes for patients. Robust programs such as frequent drug utilization review, medication therapy management, and assessment for appropriate medication use within disease management populations are examples of existing mechanisms used to support optimum health outcomes. Member education materials are provided in numerous formats including a user-friendly member portal, direct mailings, email newsletters, and through live communication conducted in the MeridianRx call center. MeridianRx utilizes highly-qualified, independent physicians, pharmacists and other clinical experts in the development of formularies encouraging clinically-appropriate and cost-effective prescribing. MeridianRx encourages but does not require or incentivize the use of efficient mail-service pharmacies. E-prescribing technology provides physicians with real-time clinical and cost information on prescription options and empowers providers to counsel patients on the safest and most affordable medication choices. MeridianRx supports a twenty-four (24) hours a day, seven (7) days a week toll-free hotline with access to pharmacy service representatives, provider service representatives and pharmacists to address any client or patient related issues.

Non-Emergency Medical Transportation

Meridian intends to subcontract with LogistiCare to provide non-emergency medical transportation (NEMT) services to our members. These services include transportation or gas reimbursement for traveling to and from medical appointments. LogistiCare brokers non-emergency transportation services for commercial health plans, government entities (such as State Medicaid agencies), and hospitals throughout the US. Using its nearly twenty (20) call centers and a network of some 1,500 independent, contracted transportation providers, the company coordinates the medical-related travel arrangements of its clients' members. In addition, it contracts with local school boards to coordinate transportation for special needs students. The company provides more than twenty-six (26) million trips each year for clients in some forty (40) states. Meridian's contract with LogistiCare outlines the types of trips approved by Meridian, but also requires reporting of members attempting to take trips for unapproved reasons in an effort to monitor inappropriate use or identify the need for expanded trip types.

Claims Recovery Services

Meridian intends to subcontract with First Recovery Group (FRG) for claims recovery services. FRG is the largest independent healthcare cost management company focused solely on subrogation claims recovery. FRG represents health maintenance organizations, third party administrators, insurance companies, self-insured corporations, physician hospital organizations, independent physicians associations, and management service organizations covering more than six (6) million lives nationwide.

FRG receives a data feed of all paid claims from a healthcare payor and using its exclusive SubroMAX® system analyzes ICD-9 and ICD-10 codes, CPT codes and episodes of care to identify cases with recovery potential. They are also able to search court records, insurance databases, and workers compensation records. FRG will work in conjunction with Meridian's claims team to ensure claims processing integrity and proper subrogation practices.

Coordination of Third Party Benefits

Meridian intends to subcontract with Emdeon for assistance with coordination of benefits and third-party recoveries. Emdeon is a leading provider of revenue and payment cycle management and clinical information exchange solutions, connecting payers, providers and patients in the U.S. healthcare system. Emdeon's offerings integrate and automate key business and administrative functions of its payer and provider customers throughout the patient encounter. Through the use of Emdeon's comprehensive suite of solutions, which are designed to easily integrate with existing technology infrastructures, customers are able to improve efficiency, reduce costs, increase cash flow and more efficiently manage the complex revenue and payment cycle and clinical information exchange processes.

Long-Term Services and Supports (LTSS)

Meridian intends to subcontract with Independent Living Systems (ILS) for Long-Term Services and Supports (LTSS). ILS is a health-services company that develops, delivers and manages community-based services and nutritional support for millions of America's Medicaid, Medicare, dual eligible, and Special Needs populations – including the blind, developmentally disabled, and children – through financial re-alignment programs such as:

- Dual eligible demonstrations
- Managed long-term services and support
- Managed Medicaid
- Special needs plans (SNPs)
- Developmentally disabled
- Accountable care organizations (ACOs)

In partnership with health plans; providers; hospitals; and pharmaceutical and medical device companies, ILS provides managed long-term support services aimed at improving health outcomes while rebalancing costs. The Company's integrated offering, powered by eCare Central, ILS' award winning technology platform, provides assistance beyond the clinical realm at every stage of care – from acute hospitalization through experiences with chronic illness, to personalized care management for the long term including nutritional support.

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

As stated in section 2.2.1 of the Scope of Work, Meridian Health Plan submits subcontractor agreements whose payments are equal or greater to five percent (5%) of capitation payments under this contract for review and approval by the State. Meridian expects the subcontractor agreements listed below to be worth at least five percent (5%) of capitation payments under the contract.

- Caidan Management Company, LLC (CMC)
- MeridianRx, LLC (MeridianRx)
- Beacon Health Options
- Independent Living Services (ILS)

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

Meridian Health Plan assumes accountability for the performance of its subcontractors. Pre-delegation, ongoing monitoring and oversight obligations are taken seriously. Subcontractors and delegates are held to the same standards and requirements as Meridian, and compliance is routinely monitored. Meridian selects subcontractors that prioritize quality outcomes and whose program goals align with Meridian. Subcontractors are expected to meet or exceed contractual requirements, State and Federal regulations and NCQA standards, when applicable. Delegates are assessed similarly to subcontractors. Delegates are assessed through reference checks, review of industry standard/publicly available reports and reputation. Underperforming subcontractors or delegates are placed on corrective action plans. If unwilling or unable to meet the expectations of the corrective action plan within the time period specific in the CAP, contract termination may occur.

Prior to approval, delegates are required to submit to a pre-delegation evaluation including an audit of policies and procedures, template forms, member-directed materials (including those needing state approval), staff qualifications, credentials and training records, reporting capabilities and the results of any audits conducted by regulatory or accrediting bodies. Subcontractors are required to submit personnel documentation including designated personnel resumes and job descriptions.

Documents are reviewed against the metrics and requirements of the Contract, Contract statement of work and NCQA accreditation standards.

Examples of metrics required of subcontractors are:

- For all subcontractors with delegated activities:
 - All staff must complete contractually required trainings prior to implementation; all newly hired staff must complete trainings upon hire and quarterly or annually thereafter depending in the specific requirement
 - All staff must be checked against the List of Excluded Individuals/Entities (LEIE) and General Service Administration's System for Award Management (SAM) systems
- For subcontractors with a customer service call center:
 - Eighty percent (80%) of incoming calls answered within thirty (30) seconds
 - Less than five percent (5%) abandonment rate for all incoming calls
- For subcontractors with credentialing activities:
 - All primary source verifications are conducted not more than 180 days prior to approval date
- For subcontractors handling requests for services:

- All notice of actions are provided to members for standard authorization decisions within a timeframe not more than seven (7) calendar days after the request for services
- For subcontractors handling grievances:
 - All grievances were resolved within a timeframe not more than thirty (30) calendar days after the grievance was filed
- For subcontractors providing transportation services:
 - The monthly ratio of one way trips for Meridian members to Meridian member complaints must be less than one percent (1%)
 - The monthly ratio of telephone calls from Meridian members to Meridian member complaints must be less than one percent (1%)
- For subcontractors providing direct services to members
 - Metrics include quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors

Meridian verifies provider subcontractors against the State, Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) every thirty (30) calendar days. Meridian also verifies with the State the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the Medicare Exclusion Database (the MED) and any other such databases as the Secretary of the State may prescribe. Upon request by the State, Meridian will terminate its relationship with any provider identified as in continued violation of Law by the State.

In addition, actual records such as provider credentialing files, case management cases files, or request for service denials are reviewed to validate the metrics and verify requirements are met in the contractor's day to day operations. For new subcontractors, file reviews occurring in the first thirty (30) to ninety (90) days of implementation are often used to determine that operational activities are meeting expectations and if not, corrections or adjustments needed for compliance can be addressed as early in the implementation as possible.

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

Once approved to provide subcontracted services and an agreement is executed, Meridian Health Plan requires its subcontractors or delegates to provide ongoing reports and documentation to demonstrate compliance with Meridian, Centers for Medicare and Medicaid Services (CMS), regulatory agencies and contractual requirements. Meridian constantly monitors and oversees its subcontractors and other delegated entities. To ensure confidentiality during information exchange, business associate agreements are executed in advance of any formal discussion of contractual work.

The Compliance Department is responsible for auditing and monitoring of subcontractors and delegated entities. The department maintains tracking lists of all non-provider subcontractors and delegated entities and associated reports and documentation that the delegates and subcontractors are required to submit to Meridian. Depending on the contract, Meridian requires reporting on a monthly, quarterly and annual basis. Meridian monitors these report submissions including whether they are received timely and all information is provided. Consistent, regular communication is maintained with the subcontractor to obtain needed information. Compliance staff reviews the reports and complete an ongoing monitoring tracking grid for the specific

performance metrics that are required. Formal reviews of metrics and report submissions occur on a quarterly basis. Feedback is provided if the formal reviews indicate substandard performance and the performance is further reviewed by the Compliance Officer and compliance staff to determine if the substandard performance warrants the implementation of a corrective action plan (CAP).

Meridian will monitor the financial stability of subcontractor(s) whose payments are equal to or greater than five percent (5%) of premium/revenue. Meridian will obtain the following information from the subcontractor at least quarterly and use it to monitor the subcontractor's performance: (i) a statement of revenues and expenses; (ii) a balance sheet; (iii) cash flows and changes in equity/fund balance; and (iv) incurred but not received (IBNR) estimates. Additional financial reporting will be obtained from the subcontractor as needed and upon request of the State.

In addition to quarterly formal reviews, an annual in-depth performance review is conducted to further assess the delegate's ability to perform functions. The annual review includes review of staff qualifications, credentialing and training, and operations activities supporting the delegated functions. Documentation collected from the delegate or subcontractor and reviewed by Meridian includes personnel documentation, actual case file review and any template forms or policies and procedures related to the delegated function.

Subcontractor performance is summarized and reviewed by the Compliance Officer and Meridian's Compliance Committee on an ongoing basis and after the aforementioned quarterly and annual performance reviews. If the Compliance Officer determines the subcontractor failed to meet performance requirements and has the potential to adversely impact member services, the subcontractor is placed on a CAP immediately. If the findings illustrate serious concerns of non-compliance, the Compliance Officer may convene an ad-hoc Compliance Committee to review the findings. The Compliance Committee will determine if remedial or corrective actions necessary outside of a CAP, or whether the subcontract issue warrants termination. The subcontractor is notified of the actions required and must submit a plan addressing the deficiencies to Meridian for approval within a predetermined time period. The State is currently and will continue to be informed of performance monitoring and reviews as required and will be notified any time a subcontractor is placed on corrective action.

The compliance staff monitors the implementation of any and all CAPs to ensure the subcontractor is meeting all requirements within the communicated timeframe. Upon completion of the duration of the CAP, the compliance staff prepares a report summarizing the activities performed by the subcontractor and whether the subcontractor has met the terms of the CAP. If the subcontractor has adequately met the terms of the CAP, the Compliance Officer prepares the appropriate documentation to store with the subcontractor's file.

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

Meridian Health Plan utilizes corrective action plans (CAP), financial remedies and termination to enforce non-performance by subcontractors. All enforcement protocols are included in a subcontractor's agreement clearly documenting the timelines for remedy and recourse for non-performance.

Through our compliance and reporting requirements if a potential issue is identified Meridian will assess and notify the subcontractor of the issue with the expected timeline for CAP submission. The compliance staff reviews and approves the terms of the CAP and ensures that the subcontractor is addressing the deficiencies in performance. Upon completion of the activities described within the CAP, the compliance staff will prepare a report summarizing the activities performed by the subcontractor and whether the subcontractor has met the terms of the CAP. If the subcontractor has satisfactorily met the terms of the CAP, the Compliance Officer will prepare the appropriate documentation to store with the subcontractor's file and provide an update to the Compliance Committee.

If the subcontractor has not satisfactorily met the terms of the CAP, the compliance officer will present a report to the compliance committee. The compliance committee will make a determination on whether to extend the CAP or to terminate the agreement. If the compliance committee determines that other actions should be taken, the Compliance Officer will be responsible for carrying out the Committee's request. Additional required actions may include but are not limited to regular subcontractor performance metric reporting, periodic site visits, repeat audits of policies and procedures and additional financial reporting and assurances to verify the viability of the subcontractor. Ongoing full and complete investigation of all complaints or grievances related to a subcontractor would continue.

For example, if a delegate demonstrates that member grievances are not being resolved completely or in a timely fashion, the delegate would be required to identify the for the deficiencies, such as newly hired staff need additional training and internal monitoring. The delegate would then be required to develop a corrective action plan and documentation to address the issues, such as staff needing the training session, a schedule of trainings, and training content. Meridian would review the CAP and the materials supporting the plan, such as the training agenda, any additional content to be added to the CAP to make the CAP acceptable.

For example, if a subcontractor, failed to maintain financial stability as described by disproportionate expenses compared to revenues or changes in cash flow and incurred but not received (IBNR) estimates, a CAP may include provision of additional financial reporting and assurances to verify the viability of the subcontractor to continue to handle Meridian functions.

Prior to considering the CAP resolved, the delegate would be required to provide documentation indicated the CAP activities had been completed, such as the staff attendance records. Meridian would monitor the performance metrics, such as the grievances timeliness reports and the content of the grievances resolutions to ensure the CAP has improved the performance of the subcontractor. A summary of the outcome of the CAP and the ongoing monitoring of the subcontractor would be reviewed by compliance committee.

In the rare event that Meridian must exercise its right to terminate its agreement with a subcontractor that is failing to provide services to members, a transition plan is put in place to ensure that a member's services transition without interruption to another qualified subcontractor. Members are notified of the inability to obtain services from the subcontractor and offered alternatives for services. Meridian's Member Services and Care Coordination contact information is provided to the members and these teams also assist members with identifying and transitioning to another provider. For example, if a homecare services provider fails to provide the care as prescribed for the member, and fails to sufficiently implement a corrective action plan, an alternative homecare service provider is identified and the member is notified of the alternatives and offered a choice of those providers available. The members assigned Care

Coordinator or Care Manager reaches out to both the member and the State to facilitate the transitions of care including authorizing services as needed. The State would be informed of the initial CAP that was implemented and the outcome of the failed corrective action plan.

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

Meridian Health Plan will work with subcontractors where greater expertise is needed to deliver the highest level of service in accordance with our contractual obligations to the State. Whether affiliated or not, Meridian takes all measures necessary to extract the best performance possible from its subcontractors. This includes but is not limited to developing integrated systems to deliver information in real-time to Meridian, subcontractors, providers, members, care-givers and those actively involved in the continuum of care. The goal is to create one seamless experience for both members and providers.

Seamless Experience for Members

In alignment with the goals of the Iowa High Quality Healthcare Initiative, Meridian has established processes for seamless integration of care. For example, Meridian subcontracts non-emergent medical transportation (NEMT) to remove transportation as a barrier to accessing health services. Meridian's care coordination program is designed to allow members to actively participate in their care. The NEMT subcontractor staff is trained to conduct three-way calls with Meridian staff or complete a warm transfer when moving the member to Meridian Member Services or Care Coordination. This type of integration with subcontracted services is critical to ensuring the most complete and least disruptive service for Meridian members.

Meridian is experienced in working with multiple, diverse populations of varying ethnic and cultural backgrounds. The use of a Pan American Languages & Services (PALS) provides unparalleled access to translational services. In an effort to track and monitor cultural diversity, Meridian analyzes PALS usage on an annual basis for all state contracts. The analysis helps inform cultural competency training and drives Network Development efforts to secure providers to match the ethnic and cultural backgrounds of members. Additionally, all staff is trained on the subject of cultural competency. This competency enhances staff ability to be culturally sensitive to members. Meridian's Managed Care System (MCS) tracks the use of translational services allowing seamless transition to use of the member's preferred language, when known. Care Coordinators and other Meridian staff utilizes translation services for printed materials as well as assistance with interpretation when contacting a provider.

As previously mentioned, Meridian will be using Tri-Hospital EMS for after-hours call center member needs. This and all subcontractors will be trained by Meridian to effectively respond to the needs of Meridian members. Meridian staff follows-up on issues that arise and move quickly toward remediation. Performance reports containing detailed call information are included in Meridian's MCS.

For the timely and thorough provision of behavioral health services, Beacon Health Options will be used. As previously stated, Meridian will assume responsibility and accountability for all subcontractors for a quality, coordinated service experience. Rigorous selection and pre-approval processes assure competent subcontractors are secured for the best level of integrated care. Continuous subcontractor compliance is monitored and corrected when needed.

Seamless Experience for Providers

The goal of the Meridian provider experience is to maximize the provision of quality health care and manage the confusion and frustration among network providers. Monthly in-person visits to provider offices allow direct connections between Provider Services representatives and provider offices. This approach maximizes relationship-building opportunities and creates lasting partnerships within Iowa communities. Meridian promotes the use of the online provider portal, which interfaces with Meridian's management care system. This exceptional example of integration allows secure, real-time information display of attributed member information, including relevant medical history potentially used in care management.

The contracting of Long-Term Services and Supports (LTSS) with Independent Living Systems (ILS) is a prime example of the prioritization of seamless provider experience with Meridian. Meridian again supplies training and educational tools, but more importantly access to the provider portal for the review and documentation of member visit details. Meridian supports secure, monitored information sharing, when conducive to better patient care. ILS is then equipped with knowledge of the patient's entire spectrum of care and may build on existing services.

Some of Meridian's administrative responsibilities may be subcontracted to reduce or eliminate confusion among provider networks. Meridian shares extensive information with providers including reference lists to inform providers of required procedures and processes needed when interacting with subcontractors. The Meridian provider manual supplies all necessary information regarding claims submission, contact information, clinical practice guidelines and much more. Meridian's Provider Services Department is also available to assist providers to resolve any questions or concerns providers may have. Meridian continuously evaluates our subcontracting relationships to improve our processes to make the subcontractor relationship as seamless as possible for our providers.

2.3 Financial Stability

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

Meridian Health Plan maintains good standing with the State of Iowa as a licensed health maintenance organization in accordance with Iowa Administrative Code 191 Chapter 40 and complies with all applicable insurance regulations. Meridian does comply with the deposit requirements set forth in the Iowa Administrative Code 191 Chapter 40.12(514B). In addition, Meridian exceeds the amount required to transact business in the State of Iowa and has made all necessary payments to satisfy solvency requirements of the State. Annually, Meridian files a report covering the preceding year in accordance with statutory accounting practices in the form designated by the National Association of Insurance Commissioners to the commissioner of insurance in compliance with Iowa Administrative Code 191 Chapter 40.14(514B). Meridian will comply with all financial reporting requirements of the Department of Human Services and copy them on all filings required by Iowa Insurance Division.

Meridian will maintain a fiscally solvent operation as demonstrated in our fiscal 2014 filing in accordance with Federal requirements and Iowa Insurance Division requirements for minimum net worth. Meridian's ultimate controlling parent will guarantee to provide financial resources to

Meridian should it be needed to maintain a 200 percent or higher RBC as defined by NAIC. Meridian 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.

Meridian maintains a reinsurance contracts with third party reinsurers for its Iowa business which meets the requirements set forth in the Iowa Administrative Code r. 191 Chapter 40.17(514B). Meridian will provide to the State the risk analysis, assumptions, cost estimates and rationale supporting its proposed reinsurance arrangements.

Meridian will support the State in their risk adjustment program which is based on the relative morbidity of their enrolled members to the statewide population.

Meridian will deliver long-term services and supports (LTSS) to the Elderly population in the least restrictive environment and encourage entry into institutions.

Meridian will support the State's process for applying a system of assigning severity to the individuals enrolled in the non-LTSS population to develop a risk score for each program contractor.

Meridian will submit an annual audited financial report that specifies Meridian's financial activities under the Contract within six (6) months following the end of each calendar year. The report, prepared using Statutory Accounting Principles as designated by the NAIC, must be prepared by an independent Certified Public Accountant included on the Iowa Insurance Division's list of approved auditors on a calendar year basis. While the final format is yet to be determined Meridian will at a minimum provide:

- Third party liability payments made by other third-party payers;
- Receipts received from other insurers
- A breakdown of the costs of service provision, administrative support functions, plan management and profit
- Assessment of Meridian's compliance with financial requirements of the Contract including compliance with requirements for insolvency protection, surplus funds, working capital, and any additional requirements established in Administrative Rules for organizations licensed as HMOs
- A separate letter from the independent Certified Public Accountant addressing non-material findings, if any

Meridian will submit to the State copies of the quarterly NAIC financial reports.

Meridian will comply and incorporate General Terms for Service Contracts as described in Section 2.8 of Exhibit E: Sample Contract.

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

Meridian Health Plan will maintain a series of reinsurance contracts that optimizes coverage for large claims which meets the requirements set forth in the Iowa Administrative Code r. 191 Chapter 40.17(514B). Meridian will maintain reinsurance contracts with multiple vendors,

including a captive reinsurer. Use of multiple reinsurance providers for different claim values ensures maximum coverage while maintaining reasonable premiums. All contracts will be submitted for approval before they are finalized, and Meridian will report all claims paid by its reinsurance contracts during the applicable reporting periods.

Meridian does not intend to submit a plan of self-insurance for this product line.

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.

Financial records are retained longer than seven (7) years after the termination of the contract if there were outstanding audit questions or ongoing litigation. Our policies define how long certain documents should be retained and by what methods and how to properly dispose of them once they are no longer needed.

Meridian Health Plan currently complies with the Maintenance of Records requirements for Financial and Medical Records as detailed in the Scope of Work. We have reviewed our current practices and have determined that in all cases listed, we retain records for the required length of time or longer. Meridian will provide copies of the requested records to the State, OIG or MFCU within ten (10) business days from the date of the request

Meridian's policies and procedures provide for the systematic review, retention, and destruction of documents based on industry standard guidelines from organizations such as American Health Information Management Association (AHIMA); State and Federal requirements, and the needs of our unique approach to patient care. Based on this information, we choose to retain each class of data for the longest time period required. For example, some events are "lifetime" events, (e.g. wisdom teeth extraction) and should be retained for the life of the member, while others, such as a claim for a routine office visit can be discarded after (seven) 7 years. Meridian's proprietary Managed Care System (MCS) stores the records including documentation received from providers, pertaining to the care provided to the member. MCS attaches the medical records to the members file.

2.5 Disclosures

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

Meridian will furnish to the State 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.

Meridian will provide full disclosure of significant business transactions as set forth in 42 CFR 455.105. Meridian will submit, within thirty-five (35) days of a request made by the State, full and complete information about:

- The ownership of any subcontractor with whom Meridian has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of the request
- Any significant business transactions between Meridian and any wholly owned supplier, or between the Meridian and any subcontractor, during the five (5) year period ending on the date of the request

Meridian shall make full disclosure of ownership, management and control information, any subcontracting entities or providers as required by 42 CFR 455.100 through 455.106. This information shall be delivered to the State with the proposal, upon Contract execution and within thirty-five (35) days after any change in ownership. Meridian will submit financial statements for any individuals or corporations with five percent (5%) or more of ownership or controlling interest.

Meridian will report to the State all transactions with a party in interest. Federally qualified HMOs, as defined in 42 USC sec. 300gg-91(b) (3), are exempt from this requirement.

Meridian will disclose the following types of transaction:

- Any sale, exchange or lease of any property between the HMO and a party in interest
- Any lending of money or other extension of credit between the HMO and a party in interest
- Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest

Meridian will disclose all financial terms and arrangements for remuneration of any kind that apply between Meridian 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.

Meridian will disclose the following information in the transaction between Meridian and a party in interest as defined in Section 2.5.4.1:

- 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

If required, Meridian will submit a consolidated financial statement for itself and the party in interest. As this RFP is intended to renew an existing contract, Meridian will disclose information on business transactions which occurred during the prior contract period.

2.6 Debarred Individuals

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

Meridian Health Plan collects all necessary information from employees, subcontractors, and providers to perform routine monthly checks of Federal exclusion databases. For employees, initial checks are performed at the commencement of employment. Initial checks for subcontractors are performed at the onset of the contract. Providers, including owners and managing employees of provider practices, are first checked against the databases during credentialing. Thereafter, Meridian receives a monthly report from each database that it then verifies against existing rosters to ensure that there are no matches for new names added to each database.

Meridian immediately terminates its relationship with any person or entity it finds on an exclusion database.

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.

Meridian Health Plan currently employs eighteen (18) full-time individuals in Iowa. Once the State selects Meridian as a partner to serve the population, local hiring will commence immediately. Corporate personnel will be used during onboarding of new staff, pre-implementation, and as a source of long-term support for the Iowa team.

Current clinical staff consists of thoroughly trained, licensed, registered nurses with experience in utilization review, case management and quality improvement programs. Clinical staff also consists of at least one physician with experience in family practice, specialty or subspecialty care. Additionally, Meridian will rely on pharmacists to review a suitable formulary for the State and approve the appropriate use of pharmaceutical therapies, both retail and specialty.

Meridian's model with regard to customer service staff is to provide an entry-level training environment for college graduates with interest in the healthcare industry, or more specifically the managed care industry. Meridian values the talents and abilities college graduates bring to the Meridian culture. Realizing that college graduates are the leaders of tomorrow, Meridian provides an opportunity for early careerists to gain hands on experience in the managed care environment by working directly with members participating in our benefit programs. Meridian's customer service centers are unparalleled in both their quality and the customer service experience provided to the member.

The following operational areas will be conducted in Iowa:

- Care Coordination/Long Term Care Support & Services (Field Based)
- Behavioral and Physical Health
- Provider Network Development and Management
- Quality Management and Improvement

- Utilization and Care Management
- Compliance

The following operational areas will be conducted at our affiliated offices out-of-state:

- Administrative and Fiscal Management
- Care Coordination (Virtual)
- Member Services
- Provider Enrollment
- Provider Services
- Marketing
- Information Technologies (Information Systems)
- Performance Data Reporting and Encounter Claims Submission
- Claims Payments
- Grievance and Appeals
- Pharmacy

The following operational areas will receive out-of-state support:

- Utilization and Care Management
- Quality Management and Improvement
- Compliance

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

Meridian Health Plan has developed an administrative structure to accommodate the unique needs associated with the populations we serve. Our organizational structure is designed to ensure an efficient and patient centered process. The coordination of physical and behavioral health and Long-Term Services and Supports (LTSS) are critical to ensure the patient is treated from a holistic approach. While a member may be in need of certain physical health services, their condition may be complicated due to behavioral or social conditions. We recognize that health is not simply developed based on treatment for physical conditions, but also reliant on behavioral and social stability. Meridian's administrative structure hinges on credentialed personnel, technology, and strong relationships with our subcontracted service providers.

Our programs combine a member-centered approach to care with technology, bridging the gaps that can occur in transitions of care. Our focus on individual member needs starts at enrollment. Within ninety (90) days of joining our plan, members receive an initial health screening; based on the results, Meridian's Managed Care System (MCS) then uses the initial health screening data and member encounters to stratify members into the appropriate risk categories. For members in higher stratifications, an appropriate Interdisciplinary Care Team (ICT) is assigned to coordinate the member's care. ICTs may encompass medical, behavioral/developmental, Long-Term Services and Supports (LTSS). This proactive approach allows the ICT to quickly identify and implement care coordination activities with the goal of improved member health outcomes. Coordinated activities are especially important for dual eligible members with multiple chronic medical conditions, whose conditions often exacerbated by underlying behavioral health issues.

Meridian uses advanced, custom technological processes to allow contracted providers and waiver service providers to notify our staff when a referral for additional services outside of physical health services may be necessary. Providers have direct, real-time, access to Meridian's provider portal. Providers may submit a referral for authorization of additional services aside from physical health services. Whether behavioral or long-term support services, our utilization management team is notified that a provider has requested additional services for a member. Meridian's utilization team then collaborates with the Care Coordination Department to identify appropriate service providers to meet the member's needs as prescribed by the physical health providers. Providers are always permitted to submit referrals and suggestions outside of the provider portal by utilizing appropriate channels.

Meridian has experience in coordinating Long-Term Services and Supports (LTSS). Meridian's network in Iowa will include acute and long term support service providers with the ability to offer the continuum of care required to meet our member's medical needs. LTSS providers will deliver a continuum of care and assistance ranging from in-home and community based services for elderly people and persons with disabilities who need assistance in maintaining their independence, to institutional care for those who require that level of support, seeking to maintain independence for individuals while providing the support required. Meridian's LTSS programs include adult day care, adult foster care, home delivered meals, home health services, home modifications, home therapy, personal attendant services, residential care and respite care services. Personal Care Services will also be available to members including assistance with the performance of the activities of daily living and household chores necessary to maintain the home in a clean, sanitary, and safe environment. The level of assistance provided is determined by the member's needs for assistance and the plans of care. These services include assistance with activities related to the care of the member's physical health such as bathing, dressing, preparing meals, and feeding, as well as home management (i.e. house cleaning, changing bed linens, shopping, etc.). Meridian's care coordination team will work oversee the coordination of these services and work with both the provider and member to determine the appropriate services.

Meridian intends to subcontract with Beacon Health Options for providing behavioral health services; however, Meridian will retain the overall coordination of each members care. Meridian is ultimately responsible for the delegate's performance and will conduct oversight and monitoring of delegate of behavioral health services. Meridian's Care Coordination program is designed to foster collaboration between the member, and all of the member's providers. The integration of physical, behavioral, and LTSS providers ensures the member receives appropriate treatment based on the collaboration of all involved providers. As a contracted provider, Beacon will have real time access to Meridian's provider portal allowing for the integration of care between Meridian's care coordination team and Beacon's provider network.

The delivery of high quality LTSS is critical to a member's ability to preserve their utmost level of independence. In order to provide high quality, cost effective LTSS services with the greatest level of skill and expertise, Meridian intends to partner with Independent Living Solutions (ILS), a national provider of LTSS services. ILS will provide Meridian members with individualized services that qualify as benefits under the LTSS covered benefits, while Meridian coordinates the overall care plan for the member from an administrative standpoint. ILS servicing providers will have real time access to Meridian's Managed Care System (MCS), by way of the provider portal. MCS allows for seamless integration between our network of providers, and our care coordination staff. Members benefit from Meridians integration of provider partnerships, by receiving highly coordinated and streamlined services.

Meridian's experience in administering care for vulnerable populations relates to our primary purpose of improving access to medical, mental and social services, the improvement of access to affordable care, coordination of care, seamless transitions across healthcare settings, and access to preventive health services. Other objectives include appropriate utilization of services, improvement of reducing hospitalizations and nursing facility placements, as well as improved health outcomes.

MCS fully supports the full range of Medicaid populations by allowing Care Managers, members, medical and behavioral health provider's real-time access to health information about member care.

2.9 Staffing

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

Meridian's Talent Acquisition Team actively and continuously recruits for talented individuals in operating markets and across the country. Effective recruitment for our teams involves continual action to identify both active and passive candidates in the market place, ensuring selection of top performers across the market space.

To ensure efficient hiring processes, the Talent Acquisition Team uses an applicant tracking system. This tool allows management of communication with candidates, a source for capturing interviewer feedback, candidate documentation, as well as the ability to identify appropriate skill sets for aligned with Meridian positions.

Meridian's successful hiring model is accomplished by addressing five (5) key areas of recruitment, each listed below with corresponding detail to the activities contained with each category.

Collegiate Recruitment

Meridian works with universities and colleges to identify recent graduates, internship candidates, and attend position appropriate career fairs. Primarily, these career fairs focus on clinical staff roles, such as Nursing, Behavioral Health, Public Health, and Social Work. Collegiate career fairs are traditionally scheduled in both fall and spring semesters. Meridian's comprehensive internship program includes over fifty (50) summer interns of varying educational background placed throughout the organization learning, collaborating, and creating.

In Iowa, Meridian serves as an experiential learning site for Drake University Health Sciences students. Meridian has hosted student collegiate interns from Iowa State University and Drake University. Iowa-based Meridian staff has strong relationships with Iowa academic institutions including:

- University of Iowa
- Iowa State University
- University of Northern Iowa
- Drake University
- Des Moines University

- Grandview University
- Simpson University

Database Mining

Meridian holds active agreements with the below institutions to access their respective resume databases and display appropriate position advertisements.

- American's Health Insurance Plans (AHIP)
- American Health Quality Association (AHQA)
- Career Builder (including partner boards through Solo Gig, Miracle Workers, Career Rookie, and Finance Jobs)
- InsuranceJobs.com
- The Ladders
- LinkedIn
- National Association of Social Workers – Iowa Chapter
- Previously mentioned universities and colleges

The Talent Acquisition Team reviews potential candidates who have created profiles within these databases. The team has received extensive training on effective searching and talent identification processes from Career Builder and LinkedIn. Candidates meeting skill and experience needs are contacted to discuss career goals and determine how Meridian can be a part of this process.

Mass Media

Meridian routinely engages in mass media communication to reach candidates. Social media outlets, like Twitter, LinkedIn, and Bullhorn Reach, all provide candidates a consistent message about opportunities within the organization. With the launch of our selected Applicant Tracking System, these social media activities will become integrated into the candidate experience and automated. This enhancement improves consistency and message delivery.

Recruitment Events

Meridian regularly hosts recruitment events in our operating markets to process a large volume of candidates. The events, often called Interview Fairs, are an invitation-only process, where qualified candidates are able to meet with both Human Resources and the specific hiring department.

Previous interview fairs have focused on Community Care Coordination, Utilization Management, Complex Case Management, internships, and Behavioral Health positions within our operating states. Interview fairs have an interview-to-placement success ratio of over forty percent (40%). Interview fairs provide an effective, scalable way to quickly select large volumes of candidates.

To support the needs of our Iowa operations, Meridian conducts in-person interview fairs in Des Moines. Additional fairs are planned to occur in the communities with the highest concentration of members, including those currently receiving Home Based Community Services. These structured interview events take place with the support of local conference spaces and hotels. By

engaging local resources and recruiting directly from the area we are supporting, Meridian is able to find a dedicated and engaged talent pool.

Referrals

Meridian has launched an on-going referral program designed to encourage high performing employees to identify and submit potential candidates from their personal networks. The program is structured to incentivize initial placement and long-term retention within the company. To date, Meridian has received referrals for Community-Based Case Managers and Utilization Management professionals. Internal participation in the Employee Referral Program has increased to a volume of over forty-three (43) candidates per week in 2015.

In addition to Meridian’s internal recruitment activities defined above, Meridian also holds active vendor partnership agreements with ten (10) staffing companies and maintains on-going relationships with over fifteen (15) additional staffing services vendors. Staffing services are engaged on an as needed basis and utilization of these services is then integrated into the staffing plan. Typically, Meridian engages in a “direct placement” model. A direct placement model encourages our staffing vendors to provide for review of talented candidates with potential for permanent hire. If selected, each candidate follows the rigorous hiring expectations associated with the Meridian process. After ensuring candidates are aligned with Meridian’s vision and mission, candidates are then hired as permanent employees of Meridian.

Meridian’s recruitment success is based on a methodical process of analysis, planning, and execution across these six (6) key areas and effective partnerships across the business landscape. This dynamic model allows the recruitment team to adjust strategies quickly, shifting time, energy, and focus to the activities yielding the greatest recruitment results. The on-going dedication to the process ensures that as candidates promote within the organization, teammates leave the organization, or new positions are developed, an ample flow of talent is readily available to move into these recently opened positions.

The expected staffing model for Meridian is based on membership of 150,000. The specific staffing levels for each functional area are as follows, and will be adjusted accordingly should membership numbers change.

Care Coordination/Long Term Care Support & Services

The primary responsibility of these operational areas is to ensure that member needs are met, manages resources effectively, and ensures member’s health, safety, and welfare are met. These operational areas also assist the members in gaining access to appropriate resources.

| Care Coordination/Long-Term Services and Supports Expected Staffing Levels | |
|---|------------------------|
| Position | Number of Staff |
| Care Coordinator | 40.00 |
| Care Coordination Team Lead | 8.00 |
| Virtual Manager of Care Coordination | 1.00 |
| Manager of Community Care Coordination | 1.00 |
| Community-Based Case Manager | 20.00 |
| Community Health Outreach Worker | 12.00 |

| Care Coordination/Long-Term Services and Supports Expected Staffing Levels | |
|---|------|
| Community Care Coordination Team Lead | 3.00 |

Claims

The primary responsibility of this operational area is to ensure timely and accurate processing of claims.

| Claims Expected Staffing Levels | |
|--|------------------------|
| Position | Number of Staff |
| Claims Coder | 1.00 |
| Claims Examiner | 13.00 |
| Manager of Claims | 1.00 |
| Scanner Operator | 1.00 |
| Quality Assurance Auditor | 1.00 |
| Vertexer | 4.00 |

Behavioral & Physical Health

Meridian is committed to providing comprehensive behavioral health services to Iowa Medicaid members. Integration of medical and behavioral health services is critical to ensure access to the full spectrum of necessary services. Effective delivery of behavioral health care services relies on engaging individuals with their own health management process and recovery, encompassing all of their physical, behavioral and social needs. Meridian has partnered with Beacon Health Options (Beacon) to deliver superior mental health and substance abuse disorder services to Medicaid, CHIP, and IDHP populations across the State.

| Behavioral & Physical Health Expected Staffing Levels | |
|--|------------------------|
| Position | Number of Staff |
| Program Director | 1.00 |
| Inter-Agency Liaison | 1.00 |
| Business Analyst | 1.25 |
| Database Developer | 1.00 |
| Claims/Encounter Processing | 1.50 |
| Case Manager | 2.35 |
| Manager - Utilization Review | 0.50 |
| Manager - Case Management | 0.25 |
| Utilization Review Clinician | 4.00 |
| AfterCare Coordinator | 2.15 |
| After Hours Clinician | 0.60 |
| Community Based Support Coordinator | 5.00 |
| Peer Support Specialist | 3.00 |
| RN- Hot Line Clinician | 0.35 |
| Practice Transitioning Coach | 1.00 |

| Behavioral & Physical Health Expected Staffing Levels | |
|--|------------------------|
| Position | Number of Staff |
| Clinical Learning Specialist | 0.50 |
| Integrated Care Nurse | 2.00 |
| Financial Reporting Analyst | 0.25 |
| Human Resources Specialist | 0.50 |
| Manager - Information Systems | 0.25 |
| Fraud & Abuse Investigator | 0.50 |
| Member Services Representative | 1.50 |
| BH Medical Director | 1.00 |
| Credentialing and Data Specialist | 12.00 |
| Manager - Network | 0.25 |
| Manager - Provider Relations | 0.25 |
| Provider Relations Specialist | 2.50 |
| Network Contract Manager | 1.00 |
| Manager - Provider Partnerships | 3.00 |
| Grievance and Appeals Coordinator | 0.50 |
| Manager - Quality | 0.25 |
| Quality Analysts | 1.00 |
| Quality Improvement Coordinator | 1.00 |
| Data Analyst | 1.00 |
| Help Desk Analyst | 1.00 |

Grievance & Appeals

The primary responsibility of this operational area is to manage the grievance and appeals process while ensuring compliance with timeline and policy and procedure adherence.

| Grievance & Appeals Expected Staffing Levels | |
|---|------------------------|
| Position | Number of Staff |
| Appeals Coordinator | 1.00 |
| Grievance Coordinator | 2.00 |
| Grievance & Appeals Team Lead | 1.00 |

Information Technologies (Information Systems)

Meridian uses a variety of dedicated resources to maintain an effective and collaborative Information Technologies (IT) Department. This operational area is broken into various high level sub-groups comprised of Security, Infrastructure and Networking, EDI and Release Management, and Application and Technical Delivery. This operational area also houses a variety of Director-level staff members overseeing the sub-groups previously stated. Each individual maintains their allocated areas of IT to resolve technical issues, troubleshoot system issues, monitor data exchange activities, and implement corrective actions for Meridian staff, members and business affiliates. Meridian maintains a dedicated EDI team including an EDI help desk to

monitor data exchange activities, coordinate corrective actions for failed records or transactions, and support trading partners and business associates.

| Information Technologies (Information Systems) Expected Staffing Levels | |
|--|------------------------|
| Position | Number of Staff |
| Infrastructure Engineer | 2.00 |
| Service Desk Team Lead | 2.00 |
| IT Service Desk Analyst | 2.00 |
| Technical Delivery Lead | 7.00 |
| Quality Assurance Analyst | 1.00 |
| Sr. Application Developer | 1.00 |
| Application Developer | 1.00 |
| Technical Business Analyst | 2.00 |

Marketing

The primary responsibility of this operational area is to manage marketing and outreach efforts. Meridian believes that Medicaid dollars should be utilized to enhance the quality of member health care. Meridian prefers community-oriented marketing focused on providing health and wellness education to the general community and potential members. Community-oriented marketing includes hosting and/or participating in health and wellness fairs, providing information on healthy living to all members of the community who attend these events, and sponsoring activities and organizations that promote the well-being of Iowa communities.

| Marketing Expected Staffing Levels | |
|---|------------------------|
| Position | Number of Staff |
| Marketing Coordinator | 1.00 |

Member Services

The primary responsibility of this operational area is to respond to member inquiries. Members and providers have access to Member Services Representatives through a toll-free phone number, Live Chat (online messaging), and email.

| Member Services Expected Staffing Levels | |
|---|------------------------|
| Position | Number of Staff |
| Member Services Manager | 1.00 |
| Member Services Representative Team Lead | 1.00 |
| Member Benefit Coordinator | 15.00 |

Network Development & Management

The primary responsibility of this operational area is to adequately serve the expected enrollment, offer an appropriate range of services and access to medically necessary, preventive and primary care services for the population expected to be enrolled. The Provider Network Development Representatives make monthly in-person visits to primary care provider (PCP) offices, establishing a personal relationship with every office in our network. At each visit, our representatives educate PCPs, Specialists, and their staff about the latest policies and procedures, including wellness standards, HEDIS®, medical home guidelines, evidence-based practice guidelines, monthly education sheets, and provider portal education and instruction. The representatives also provide a customized report of assigned members still needing necessary preventive health services, and the potential bonuses that can be earned for completing these services.

| Network Development & Management Expected Staffing Levels | |
|--|------------------------|
| Position | Number of Staff |
| Director of Network Development | 1.00 |
| Manager of Network Development | 1.00 |
| Provider Network Development Representative | 6.00 |

Performance Data Reporting & Encounter Claims Submission

The primary responsibility of this operational area is to ensure timely and accurate reporting and analytics needed to meet the requirements of the Contract.

| Performance Data Reporting & Encounter Claims Submission Expected Staffing Levels | |
|--|------------------------|
| Position | Number of Staff |
| Manager of Provider Data Analytics | 1.00 |
| Corporate Provider Services Analyst | 1.00 |
| Manager of Enrollment | 1.00 |
| Encounter Specialist | 2.00 |

Pharmacy

Meridian fully utilizes the experience of its affiliate, MeridianRx, for its pharmacy benefit management needs. Consistent with our focus on integration, Meridian operates as an interdisciplinary team that draws on our knowledge and expertise covering the care spectrum while relying on integrative technology that ensures comprehensive care for our members by our providers and pharmacies. MeridianRx offers an unparalleled client-focused service model, with seamless implementation processes and excellence in day-to-day service.

| Pharmacy Expected Staffing Levels | |
|--|------------------------|
| Position | Number of Staff |
| Pharmacy Analyst | 1.00 |
| Behavioral Health Care Coordinator | 1.00 |
| Pharmacy Care Coordinator | 2.00 |
| Claims Reviewer | 1.00 |
| Pharmacy Data Entry Specialist | 1.00 |
| Pharmacy Operations Trainer | 1.00 |
| Outreach Coordinator | 2.00 |
| Pharmacy Technician | 7.00 |
| Pharmacist | 2.00 |
| Specialty Pharmacy Technician | 1.00 |

Provider Services & Provider Enrollment

The primary responsibility of this operational area is to respond to provider inquiries and disputes and provide outreach on provider policies and procedures. Meridian also fully credentials all networked providers to verify that each holds the proper licenses, certifications, and are enrolled as an Iowa Medicaid provider. Meridian ensures that our network meets all current and future State and Federal eligibility criteria, reporting requirements, and any other applicable rules or contractual regulations. All of our credentialing is performed in house by our credentialing specialists.

| Provider Services & Provider Enrollment Expected Staffing Levels | |
|---|------------------------|
| Position | Number of Staff |
| Manager, Corporate Provider Services | 1.00 |
| Sr. Corporate Provider Services Representative | 1.00 |
| Corporate Provider Services Representative | 10.00 |
| Manager of Credentialing | 1.00 |
| Credentialing Specialist | 8.00 |
| Manager, Delegated Credentialing | 1.00 |
| Delegated Credentialing Coordinator | 1.00 |

Quality Management & Improvement

The primary responsibility of this operational area is to perform quality management and improvement activities. The Quality Management & Improvement Department has a staffing structure designed to respond to changes in population composition and/or health while sustaining the highest level of quality care.

| Quality Management & Improvement Expected Staffing Levels | |
|---|------------------------|
| Position | Number of Staff |
| Quality Management Director (in place of Quality Management Manager required in Section 2.9.3.7 of the Scope of Work) | 1.00 |
| Quality Coordinator | 2.00 |
| Quality Analyst | 1.00 |
| Medical Record Data Abstractor | 2.00 |
| Outreach Specialist | 1.50 |

Utilization & Care Management

The primary responsibility of this operational area is to authorize requests for services and conduct inpatient concurrent review. Meridian’s Utilization Management (UM) Program is designed to monitor, evaluate, and ensure the delivery of high quality, cost-effective health care services to our members at the right time and in the right setting.

| Utilization & Care Management Expected Staffing Levels | |
|---|------------------------|
| Position | Number of Staff |
| Denials Nurse | 1.00 |
| Denials Specialist | 1.00 |
| Denials Team Lead | 1.00 |
| Director of Utilization Management | 1.00 |
| Inpatient Review Nurse | 9.00 |
| Inpatient Review Nurse Team Lead | 1.00 |
| Manager of Utilization Management | 1.00 |
| Nurse Educator | 1.00 |
| Pre-Service Review Nurse | 3.00 |
| Transitional Care Coordinator | 2.00 |
| Transitional Case Manager | 2.00 |
| Transplant Care Coordinator | 1.00 |
| Utilization Management Care Coordinator | 6.00 |
| Utilization Management Operational Lead | 1.00 |
| Utilization Management Trainer | 1.00 |

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 for the positions proposed in Meridian’s staffing plan (indicated in the response to Question 2.9.1 above) are included in Tab 5 as follows:

Attachment 1 (Care Coordination/Long-Term Services and Supports Job Descriptions)

- Care Coordinator

- Care Coordination Team Lead
- Virtual Manager of Care Coordination
- Manager of Community Care Coordination
- Community-Based Case Manager
- Community Health Outreach Worker
- Community Care Coordination Team Lead

Attachment 2 (Claims Job Descriptions)

- Claims Coder
- Claims Examiner
- Manager of Claims
- Scanner Operator
- Quality Assurance Auditor
- Vertexer

Attachment 3 (Behavioral & Physical Health Job Descriptions)

- Program Director
- Inter-Agency Liaison
- Business Analyst
- Database Developer
- Claims/Encounter Processing
- Case Manager
- Manager - Utilization Review
- Manager - Case Management
- Utilization Review Clinician
- AfterCare Coordinator
- After Hours Clinician
- Community Based Support Coordinator
- Peer Support Specialist
- RN- Hot Line Clinician
- Practice Transitioning Coach
- Clinical Learning Specialist
- Integrated Care Nurse
- Financial Reporting Analyst
- Human Resources Specialist
- Manager - Information Systems
- Fraud & Abuse Investigator
- Member Services Representative
- BH Medical Director
- Credentialing and Data Specialist
- Manager - Network
- Manager - Provider Relations
- Provider Relations Specialist
- Network Contract Manager
- Manager - Provider Partnerships

- Grievance and Appeals Coordinator
- Manager - Quality
- Quality Analysts
- Quality Improvement Coordinator
- Data Analyst
- Help Desk Analyst

Attachment 4 (Grievance & Appeals Job Descriptions)

- Appeals Coordinator
- Grievance Coordinator
- Grievance & Appeals Team Lead

Attachment 5 (Information Technologies Job Descriptions)

- Infrastructure Engineer
- Service Desk Team Lead
- IT Service Desk Analyst
- Technical Delivery Lead
- Quality Assurance Analyst
- Sr. Application Developer
- Application Developer
- Technical Business Analyst

Attachment 6 (Marketing Job Descriptions)

- Marketing Coordinator

Attachment 7 (Member Services Job Descriptions)

- Member Services Manager
- Member Services Representative Team Lead
- Member Benefit Coordinator

Attachment 8 (Network Development & Management Job Descriptions)

- Director of Network Development
- Manager of Network Development
- Provider Network Development Representative

Attachment 9 (Performance Data Reporting & Encounter Claims Submission Job Descriptions)

- Manager of Provider Data Analytics
- Corporate Provider Services Analyst
- Manager of Enrollment
- Encounter Specialist

Attachment 10 (Pharmacy Job Descriptions)

- Pharmacy Analyst
- Behavioral Health Care Coordinator
- Pharmacy Care Coordinator
- Claims Reviewer
- Pharmacy Data Entry Specialist
- Pharmacy Operations Trainer
- Outreach Coordinator
- Pharmacy Technician
- Pharmacist
- Specialty Pharmacy Technician

Attachment 11 (Provider Services & Provider Enrollment Job Descriptions)

- Manager, Corporate Provider Services
- Sr. Corporate Provider Services Representative
- Corporate Provider Services Representative
- Manager of Credentialing
- Credentialing Specialist
- Manager, Delegated Credentialing
- Delegated Credentialing Coordinator

Attachment 12 (Quality Management & Improvement Job Descriptions)

- Quality Management Director (in place of Quality Management Manager required in Section 2.9.3.7 of the Scope of Work)
- Quality Coordinator
- Quality Analyst
- Medical Record Data Abstractor
- Outreach Specialist

Attachment 13 (Utilization & Care Management Job Descriptions)

- Denials Nurse
- Denials Specialist
- Denials Team Lead
- Director of Utilization Management
- Inpatient Review Nurse
- Inpatient Review Nurse Team Lead
- Manager of Utilization Management
- Nurse Educator
- Pre-Service Review Nurse
- Transitional Care Coordinator
- Transitional Case Manager
- Transplant Care Coordinator
- Utilization Management Care Coordinator
- Utilization Management Operational Lead

- Utilization Management Trainer

Attachment 14 (Key Personnel Job Descriptions)

- Contract Administrator/CEO/COO
- Medical Director
- Chief Financial Officer
- Compliance Officer
- Pharmacy Director/Coordinator
- Grievance & Appeals Manager
- Quality Management Director (in place of Quality Management Manager required in Section 2.9.3.7 of the Scope of Work)
- Utilization Management Manager
- Behavioral Health Manager
- Member Services Manager
- Provider Services Manager
- Information Systems Manager
- Claims Administrator
- Care Coordination Manager
- Program Integrity Manager
- Long Term Care Manager
- Director of Operations (Primary Point of Contact with the Agency as defined in Section 2.9.3.17 of the Scope of Work)

3. Confirm that a final staffing plan, including a resume for each Key Personnel member, will be delivered within ten (10) calendar days after notice of award.

Meridian Health Plan shall provide a final staffing plan and the resumes of Key Personnel within the ten (10) day time frame.

The resumes of Key Personnel indicated in Section 2.9.3 of the Scope of Work are provided in Tab 6 as “3.2.7.3 Resumes”.

- Contract Administrator/CEO/COO
- Medical Director
- Chief Financial Officer
- Compliance Officer
- Pharmacy Director/Coordinator
- Grievance & Appeals Manager
- Quality Management Director
- Utilization Management Manager
- Behavioral Health Manager
- Member Services Manager
- Provider Services Manager
- Information Systems Manager
- Claims Administrator
- Care Coordination Manager

- Program Integrity Manager
- Long Term Care Manager
- Director of Operations

In addition to management positions above, Meridian shall designate a primary point of contact with the State for delivery system reform activities, including managing a specific project plan and reporting on activity and progress towards identified goals. In matters related to healthcare delivery system transformation described in SIM, the point person will also serve as the liaison between Meridian and various State agencies, leaders from the healthcare delivery system, other payers, stakeholders, and Federal agencies.

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.

In the event of a loss of Key Personnel, Meridian Health Plan will appoint a qualified internal employee on an interim basis. This individual will be responsible for maintaining the functional responsibilities of the vacant position, ensuring contractual obligations are sustained. The efforts of the Talent Acquisition Team will also be activated. The Talent Acquisition Team consists of eleven (11) individuals dedicated strictly to the identification, development, and hiring of the right resources. The team is an internal, Meridian function. As a result, the team is uniquely adept at identifying the right organizational and skill based fits for the company.

By combining activities in each of the recruitment categories (Collegiate Recruitment; Database Mining; Mass Media; Networking; Recruitment Events; and Referrals), Meridian is able to generate a continual flow of qualified candidates. Weekly, Meridian receives over 1,800 applications in response to position openings.

In response to an open position, the team develops an individualized recruitment plan that is defined by the position vacated. Thorough understanding of contractual requirements and position duties helps to shape the direction of the staffing plan and dictates where positions are posted and what candidates are targeted. For example, positions requiring licensure will include affiliation with appropriate professional organizations, educational programs, and networking opportunities targeted specifically to this licensure requirement.

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

In addition to the internal efforts of the Talent Acquisition Team, Meridian Health Plan has identified key staffing partners to augment and support recruitment strategies. Meridian engages in direct hire and contract-to-hire methodologies with over ten (10) staffing vendors, and maintains relationships with an additional fifteen (15) staffing vendors. As appropriate, services are engaged to ensure that all positions receive the best qualified candidates available. Vendor partners are chosen for their ability to understand

Meridian's unique approach and requirements, ability to deliver quality candidates, and willingness to form a healthy business partnership.

Further, Meridian works to prevent internal information silos and firmly believes that knowledge is empowerment. By cross-training resources and activating a centralized corporate strategy, staff members are able to assist in the event of a loss of Key Personnel or others. By identifying secondary support resources, Meridian can continue normal operations and guarantee there is no loss of care delivery, customer service, or contract execution for both members and providers. Effective cross training is essential to maintaining compliance with performance standards in a fluctuating employment dynamic.

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

Meridian Health Plan is dedicated to meeting all contractual requirements for key personnel. In the event of the need to replace staff that holds key qualifications, Meridian will implement a multifaceted approach to identifying and replacing these employees with candidates holding similar qualifications and experience.

This approach involves:

- Meridian will implement an individualized recruitment plan defined by the position vacated. If the position requires specific licensure, this plan will include a targeted approach to focus specifically on the credentials needed to meet contractual requirements. As previously outlined, Meridian is engaged in an on-going requirement effort to ensure an adequate candidate pool in the event of such staffing changes.
- Meridian will identify internal corporate employees with the credentials and qualifications required to assist with immediate need situations. Meridian employs professionals with licensure across states and provides cross training across operating states. These professionals operate with the high Meridian standards, with a commitment to the Meridian operating philosophies. If appropriate, this will include state specific licensure. These professionals may provide assistance during an immediate need.
- In the event that Meridian does not have an internal employee with appropriate credentials or qualifications available to assist, Meridian will engage one of our staffing partners to assist. The selected staffing partner may provide either temporary or short term contract assistance with a qualified professional to meet the staffing need.

d. The time frame necessary for obtaining replacements.

The amount of time necessary to fill vacated positions will vary based on role. On average, a newly vacated position will take between five (5) and thirty-three (33) business days to replace. Recruitment standards and timelines are measured using the

applicant tracking system. This tool also helps ensure that each candidate follows a consistent and rigorous hiring process including multiple interviews, detailed skill and aptitude based assessments, and contractually required background screening.

Recruiters are incentivized to both quickly place and retain talent long term, eliminating a desire to simply select people to fill vacancies. Meridian Health Plan is dedicated to finding the right employees to execute our passionate approach to member care and has structured our entire process around a thorough, systematic process. We strive to select the top talent in each market and view the retention of this top talent as a long term investment into the organization.

Meridian will notify the State, in writing, when changes to key staffing occur, including changes in the Key Personnel and other management and supervisory level staff at least five (5) business days prior to the last date the employee is employed to the extent possible. Meridian will provide written notification to the State at least thirty (30) calendar days in advance of any plans to change, hire, or re-assign designated Key Personnel. At that time, Meridian will present an interim plan to cover the responsibilities created by the Key Personnel vacancy. Meridian will also submit the name and resume of the candidate filling a Key Personnel vacancy within ten (10) business days after a candidate's acceptance to fill a Key Personnel position or ten (10) business days prior to the candidate's start date, whichever occurs first. Meridian will ensure that knowledge is transferred from an employee leaving a position to a new employee to the extent possible. All Key Personnel positions will be filled within sixty (60) calendar days of departure, unless a different time frame is approved by the State.

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

Upon identifying qualified replacement personnel, Meridian Health Plan requires replacements and additions to complete necessary training in order to ensure a seamless transition. To ensure that employees can provide comprehensive support, training includes overviews of each functional department, emphasizing areas of specific interest for members and providers. Employees who are either new to the organization, or assume a different role, meet with department directors and key managerial staff to establish a cross functional understanding of the organization and position requirements. Meridian will utilize the expertise of our training staff to organize and monitor the completion of the training program. Regardless of the level of the position, Meridian requires all employees to complete the necessary training as outlined within our contract and to ensure compliance with industry standards.

Meridian's compliance and program integrity staff is responsible for keeping record of, and disseminating any modifications to our program contracts. Our compliance team works in conjunction with our training and development staff to create training modules and educational plans to ensure any updates and addendums to contracts are distributed to the appropriate personnel. Meridian provides the resources necessary to ensure our staff is confident and well-informed to deliver the highest level of customer service to our beneficiaries.

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

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.

Iowa-based staff members located in the Des Moines, Iowa office are the subject matter experts on the Iowa contract requirements as well as the needs of the Iowa membership. Currently Meridian Health Plan has provider representatives, operations staff, quality improvement staff, contract compliance staff, complex case management staff, and utilization management staff working in the Des Moines office. Meridian will maintain all appropriate staff in the Iowa office as required by the contract and as warranted to meet quality and access to care objectives.

While corporate out-of-state functions are needed to realize economies of scale, Iowa based staff provide feedback on a daily basis to ensure those corporate operations are implemented and managed congruent with contract requirements. Production monitoring reports such as customer service calls received and claims processed are compiled for the Iowa contract and monitored against Iowa specific contract requirements. These reports are reviewed by both local and out-of-state operations staff. Coordination and collaboration between state and corporate operations is facilitated with daily interactions, weekly and monthly state-specific operational oversight meetings. Ultimate oversight and direction for all staff serving the Iowa population rests with the local plan President.

Commingling of local and out-of-state staff is facilitated through video conferencing and periodic travel between local and corporate offices. State specific and corporate trainings are provided to all local and out-of-state staff throughout the year to ensure an ongoing understanding of the operations that are conducted related to the Iowa plan.

Iowa staff works in collaboration with our corporate Training and Development Department to develop and implement all training materials and sessions specific to the Iowa contract. State specific and corporate trainings are provided to all local and out-of-state staff throughout the year to ensure ongoing competency and compliance with the Iowa contract.

Local people know their communities, and as a result, Meridian is committed to hiring locally in Iowa. Further, Meridian has always believed that local personnel are best equipped to assist and serve the local population. Meridian immerses itself in the communities in which it operates, which involves hiring individuals from those communities who are familiar with the cultural nuances of the region. These activities have increased access to care and have resulted in a dramatic increase in health outcomes of members and overall quality of care.

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

The location of the Iowa office from which key staff members will perform their duties and responsibilities is 666 Grand Avenue, 14th Floor, Des Moines, IA 50309.

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

Meridian Health Plan's Hiring Policy provides expectations for ensuring that professional staff holds and maintains appropriate licensure needed for their designated roles throughout the candidate selection process and upon hire. This policy provides a standardized hiring process that ensures compliance with contract and accreditation agencies.

Prior to candidate application and candidate identification, all job descriptions include clearly marked expectations of licensure. Once candidates have been provided the employment application and an interview scheduled, professional licensure verification is completed. Licensure verification source is dependent upon the type of professional licensure held.

Status of licensure is validated prior to hiring decision and offer being extended. Licensure verification is tracked within the Applicant Tracking System and is maintained within the candidate's electronic record throughout their employment. Once a candidate is selected, a paper version of the verification is printed for the employee's paper record. Both paper and electronic versions of the document clearly define primary source verification and date verification was completed.

For subcontracted and delegated functions, staff must identify staff proposed to perform the functions related to the Meridian subcontract. These staff qualifications are reviewed included trainings, licenses and required databased verifications. Documentation must be provided by the subcontractor delegate that illustrates the staff has completed trainings and that the licenses and database checks were completed. The requirements must be met both at initial contracting review and during the annual compliance review.

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

Meridian develops and maintains written policies and procedures for each functional area. Written guidelines are maintained for developing, reviewing and approving all policies and procedures. All policies and procedures are reviewed at least annually in conjunction with compliance and department leadership. Policies reflect state contractual requirements, activities needed to sustain accreditation, and functions necessary to maintain compliance.

All Meridian Iowa policies and procedures are available to all employees on Meridian's intranet. Throughout our New Employee Orientation (NEO) program, quarterly and annual training, the Iowa staff is shown where to locate all policies and procedures.

Staff members are required to complete function-specific trainings related to the state-specific operations that they are assigned to perform. Meridian team leads, managers and directors and the staff located in the Iowa office are subject matter experts, well versed in Iowa specific requirements and policies. These subject matter experts are responsible for initial training, testing, monitoring and maintaining ongoing communication with their teams that are performing the Iowa specific functions. Any updates and addendums to existing policies and procedures are distributed to the personnel responsible for the Iowa specific functions. Day to day operations are monitored and feedback provided to staff to ensure requirements are fulfilled. All medical and

quality management policies are reviewed, approved and dated by Meridian's Medical Directors. Policy changes for most functional areas must go through the quality improvement committee and state board of directors for approval. In addition, each department has a department liaison or trainer that reviews state-specific policies and job aids with the department staff. The departments train employees on Iowa specific policies and provide team specific training. All training is documented and tracked. Meridian houses all mandatory e-Learning training modules on the Learning Management System (LMS). Modules are updated as needed (at least annually) and comprehensive reports can be pulled at any time. Meridian provides the resources necessary to ensure our staff is confident and well-informed to deliver the highest level of service to our members.

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

Meridian Health Plan's staffing plan includes preparation and execution of trainings specified in Section 2.9.7 of the Scope of Work and subsequent contract including state-specific requirements regarding utilization management, required training topics, Long-Term Services and Supports (LTSS) and care coordination and other requirements. Meridian has an interdepartmental process to ensure training content meets the contractual requirements and is accurate. To prepare for the training, Meridian's Training Department will compile training materials based on contractual requirements. The Training Department engages the subject matter expert and the Compliance Department to review and approve the content of the training to ensure all staff are trained in managing the components of the Contract.

Initial trainings related to the specific program requirements related to this RFP will occur between the time of the RFP award and the effective date of the contract to ensure readiness to meet the contract requirements and ongoing thereafter to ensure adequate, trained staffing is available to meet the contractual obligations.

Meridian ensures on an ongoing basis that all staff has the appropriate credentials, education, experience and orientation to fulfill the requirements of their position. All training aids are housed on Meridian's internal SharePoint site, Meridian University. Training is updated on a regular basis to reflect any program changes. Meridian maintains documentation in a Learning Management System (LMS) to confirm staff training, curriculum, schedules, attendance and scoring. At any time, training documentation can be reviewed.

Subcontractors will also be expected to complete policy-related training. Meridian expects its subcontractors to provide the highest quality care to our members and our comprehensive training curriculum supports that expectation. During pre-delegation reviews and early subcontracting implementation, Meridian works with its subcontractor or delegate to deliver and document required trainings are completed to the same level of competency that Meridian requires of its internal staff. The training materials used by the subcontractor or delegate are reviewed by Meridian to ensure the content includes complete and accurate content compliant with the state-specific contractual requirements.

New Employee Orientation

Upon hire, staff will attend a three (3) day, comprehensive New Employee Orientation (NEO) which includes an overview of the company and completion of mandatory modules within first

week of hire. During this time, all new employees are asked to complete the following mandatory modules:

- HIPAA
- Model of Care
- URAC
- NCQA
- Fraud, Waste, Abuse & False Claims Act
- Cultural Competency/Sensitivity Training
- CAHPS®
- Policies and Procedures- located on Meridian's Intranet and discussed during NEO
- HEDIS® 101
- Disaster Recovery

New employees, whose job functions are state-specific, receive state-specific training in addition to these modules.

Ongoing Training

Annually, all staff (including contractors) is asked to complete the above annual training modules on Meridian's Learning Management System (LMS). These mandatory modules are sent throughout the year and are available at any time for staff and contractors to re-take. In collaboration with the Compliance Department, the training and development team completes quarterly audits to ensure employee completion.

Each department is responsible for training on Iowa specific orientation to ensure a seamless transition upon go-live by following contract requirements and State and Federal requirements specific to job functions, in accordance with 42 CFR 422.128, which includes training on advance directives. Department specific training will be conducted by the appropriate business unit. Many departments have at least one department training liaison responsible for providing department-specific training, including pertinent assessments, reviews of policies and procedures, training regarding handling of quality of care concerns and clinical protocol training for clinical staff. Each department has their own schedule and curriculum, but shares Meridian corporate training resources which include, Meridian University and the LMS.

Contract Requirements and State and Federal Requirements Specific to Job Functions

Upon hire, all staff is educated on the contract requirements and State and Federal requirements specific to their job functions. Relevant State or Federal contracts are available for all staff to review. In addition, training or job aids are available to all staff and contractors on Meridian's SharePoint page, Meridian University. Meridian's Plan President is responsible for disseminating any updates or changes to the contract requirements, including those that result in updates to training materials. The compliance team will validate that resulting training changes have been made and monitor the training progress in conjunction with Meridian's Training and Development staff.

Training on Policies and Procedures on Advanced Directives

Training on Meridian's policy and procedure on advance directives will be provided to all staff and contractors. All staff has ongoing access to this training on Meridian's intranet.

Initial and Ongoing Training on Identifying and Handling Quality of Care Concerns

Meridian is committed to the timely identification, investigation and reporting of quality of care (QOC) concerns. QOC issues are found through member interactions, claims and utilization reviews, provider reporting and other sources. Staff is trained to identify comments or events that may be described to them that are indicative of quality of care concerns. For example, if a member were to describe that a clinic staff did not close a door to the exam room, did not wash their hands, or did not take their blood pressure even though the appointment was to address the member's high blood pressure. Meridian provides resources for members to report quality concerns such as these should they occur. In addition, clinical staff is trained to identify increased lengths of stay, unusual procedures or nosocomial infections that could be an indicator of inappropriate, unusual or poor quality of care.

When a quality of care concern is identified, Meridian's medical directors and other medical management staff reviews the concern, request records as needed, and determine what additional information or actions are needed. A site visit to the clinic or facility may be conducted if that visit could shed light on the issue, such as how the patient care areas are situated, cleanliness of the site, etc.

Once the information regarding the concern has been gathered and based on the content of the concern, the appropriate staff such as medical directors, quality improvement staff, provider services, legal and compliance staff and review the concern. If the concern has substance, the team will determine what remedial or corrective actions will be required of the provider. Depending on the severity of the issue, the quality improvement committee, physician advisory committee, credentialing committee and Compliance Committee can review the information before actions are taken and committees are informed of the concerns, investigation outcomes and actions taken on all quality of care concerns that are identified. Actions taken against providers may include a corrective action plan addressing in clinic or facility staff need for training, clinic or facility upkeep or maintenance, or based on the severity, reporting to the appropriate regulatory entity.

Cultural Sensitivity Training

Upon hire and annually, all staff and contractors are required to take Cultural Competency training, which includes components on cultural sensitivity, via an e-Learning module, which includes cultural sensitivity curriculum and other important strategies to achieving optimum care. Meridian developed this comprehensive module through a partnership with Brilljent, a company with deep experience providing cultural competency learning curriculum. This module is available to all staff to take at any time throughout the year.

Meridian's Cultural Competency Plan has the following goals:

- To improve communication for members who have cultural and/or linguistic issues
- Decrease healthcare disparities in the populations that we serve

- Improve employee understanding and appreciation to the cultural diversity among the populations that we service and within our plan
- Ensure access and availability to culturally appropriate services to meet the needs of our diverse population

In addition to cultural sensitivity training for Meridian staff, Meridian's network providers will receive initial in-service training upon contracting as well as ongoing cultural competency training, which will be provided through web-based cultural competency training sessions. The training is free for any Meridian contracted physician who requests to take it and the completion results are tracked in Meridian's Managed Care System (MCS). Meridian will use the annual regional provider meetings to provide competency training updates.

Training on Fraud and Abuse and the False Claims Act

Upon hire and annually, all staff and contractors are required to take the Fraud, Waste & Abuse e-Learning module that includes information regarding the False Claims Act. The module was created by the Centers for Medicare and Medicaid Services (CMS) and is maintained on Meridian's LMS for staff to take at any time throughout the year. Meridian's Compliance Officer will be responsible for working with our Training and Development staff to further develop out fraud, waste and abuse education materials, in accordance with CMS and legislative requirements.

HIPAA Training

Upon hire and annually, all staff and contractors are required to take the Health Insurance Portability and Accountability Act (HIPAA) training. This module is updated as necessary (at least annually) and is available on Meridian's LMS for staff to take at any time throughout the year. In addition, a quarterly HIPAA newsletter is sent to all staff to remind them of HIPAA basics.

Clinical Protocol Training for all Clinical Staff

Clinical protocol training for clinical staff is taken very seriously at Meridian and includes training on clinical practice guidelines, medical management policies and InterQual® clinical decision-making criteria. Upon hire, all initial cases are reviewed by the team lead or manager until the new clinician passes the initial protocols. Training and testing protocols include use of case studies, job shadowing and over-reading of review decisions. Once initial protocols are met, the new clinician will then be able to work independently. Quarterly audits are in place to verify that correct decisions are being made and they are applying learned information appropriately. Inter Rater Reliability (IRR) testing is used to ensure consistent decision making is maintained between reviewers. The IRR is conducted to all physicians and nurses on a quarterly basis.

The Utilization Management Department employs two (2) nurse educators who oversee the clinical training of all licensed employees. Both nurse educators are McKesson Certified InterQual® trainers. They conduct hands on/classroom training, online modules and weekly written testing for a minimum of six (6) weeks. The nurse educators also work with Meridian's Auditing and Remediation team to conduct clinical audits and develop training modules based on those results.

Utilization Management

Initial and ongoing training, at least quarterly regarding application of utilization management guidelines for all utilization management staff will be scheduled. These training sessions will be a combination of live training sessions and e-Learning modules located in the LMS for all employees to access. The Utilization Management Department is administering the Inter Rater Reliability Test (IRR) to the physicians and nurses on a quarterly basis. InterQual® tips will be shared with clinical staff on a weekly basis via email, with discussion and case presentation of that specific information during the morning huddle calls. Monthly staff meetings will be held to discuss a summary of the month's updates and provide re-training for all clinical disciplines. The Utilization Management Department employs two (2) full-time nurse educators that oversee the clinical training of all licensed employees. The nurse educators conduct training in a variety of ways including, live classroom training, e-learning modules and weekly written testing for a minimum of six (6) weeks. Meridian will have two (2) Utilization Management Trainers to implement the developed training curriculum for non-clinical staff. In conjunction with the Corporate Training Department, utilization management will continue to partner to train and evaluate new corporate initiatives applicable to the utilization management team.

Assessment Processes

A variety of assessments is housed within Meridian's Managed Care System (MCS) and is given to members to identify person-centered planning. Meridian Care Coordinators perform an initial health screening upon enrollment to identify medical and behavioral health needs. This information is incorporated into a member's individualized care plan (ICP) and used to determine needed appointments with their primary care provider (PCP), specialist providers, and behavioral health providers. The ICP is developed with the member after completion of the appropriate initial health screenings and includes agreed upon goals determined by the member and Care Coordinator. If a member is not available to participate or cannot participate, an authorized member representative can participate on behalf of the member in the creation of the care plan with the Care Coordinator. Upon completion of the initial health screening, the Care Coordinator communicates with the member, obtains additional information by completing additional medical status assessments, discusses the results of the initial health screening and stratification level, explains the stratification level, and utilizes all information available to develop the care plan.

The above information is all included in the Care Coordination curriculum and is provided to all staff upon starting their position. The training is conducted in collaboration of classroom and e-Learning modules and tracked for completion. Ongoing training is a necessity and the team collaborates with weekly emails and huddles. The Care Coordination Department employs two (2) full-time Care Coordination Trainers, one (1) Care Coordination Support Specialist Trainer and one (1) Community Care Coordination Trainer. Feedback is provided as needed as a result of significant oversight of the administration of these processes. All training sessions are tracked for completion.

Abuse, Neglect, Exploitation and Prevention

Upon hire and annually, all staff and contractors are required to take Abuse & Neglect training. This module is updated as necessary (at least annually) and is available on Meridian's LMS for staff to take at any time throughout the year. This module includes the detection, reporting, investigation and remediation procedure and requirements.

Policies & Procedures

As described earlier, Meridian provides all policies and procedures to all staff throughout our training programs. Policies and procedures are updated at least annually or when significant changes to our contract occur. The training material will be updated on a regular basis to reflect any program changes. Currently, all staff is given the Human Resources handbook upon hire and it is available on Meridian's intranet. The Human Resources handbook is derived from policies and procedures.

Documentation

All training courses are tracked electronically in the LMS or tracked via sign-in sheet and can be uploaded into the LMS via historical data upload. Reports can be pulled at any time in the event that the State would like to review training documentation and compliance.

The Agency Meeting Requirements

Meridian will comply with all meeting requirements established by the Agency, including, but not limited to, preparation, attendance, participation and documentation. Meridian recognizes that expenses for attendance at all meetings are considered to be included in the total bid price and shall be at no additional cost to the Agency.

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.

Meridian Health Plan will cooperate and work with other program contractors in areas including, but not limited to, the development of policies, processes, and initiatives identified by the State intended to improve quality outcomes in the program or streamline provider and member processes. Meridian partners with many other managed care plans through the Michigan Association of Health Plans (MAHP) to promote and advocate for high quality, affordable, and accessible health care for the individuals we serve. This partnership allows us to work collaboratively on the changes that are occurring at the State and Federal level. Meridian will continue to form partnerships such as this in order to facilitate collaboration among other plans.

Meridian has entered into subcontractor relationships with physical, behavioral, and community-based providers for the purpose of network participation and the provision of covered services and other services. Meridian's subcontractors will be bound by the terms and conditions of this Contract appropriate to the services they have been delegated, including the record keeping and audit provisions of the Contract. Subcontractors are notified in their contracts that Meridian has a legal responsibility to uphold its obligations to the Centers for Medicare and Medicaid Services (CMS), the State, and the Department of Insurance.

Providers, provider groups, and hospitals are subject to an extensive credentialing process upon receipt of their executed contract. Meridian runs the National Data Bank Report to check all current provider sanctions, as well compare providers to the lists available in the Medicare Exclusions Database and the State Licensure websites to ensure that eligible professionals continue to meet State licensing requirements. Meridian checks and monitors all contractors,

subcontractors and third-party representatives through employing database checks of eligible professionals, owners, authorized officials, delegated officials, managing employees, medical directors, and supervising physicians (at Independent Diagnostic Testing Facilities and Laboratories) as part of the Medicare provider and supplier enrollment process. These include database checks with the Social Security Administration, the National Plan and Provider Enumeration System to verify the National Provider Identifier of an eligible professional, and State licensing board checks to determine if an eligible professional is appropriately licensed to furnish medical services within a given state. These checks also include reviewing against the HHS OIG LEIE and GSA SAM systems.

Meridian has developed many strong relationships and partnerships with the State agencies and we anticipate continuing and expanding the partnerships, ensuring we meet or exceed compliance with the requirements outlined within the RFP. Meridian currently works with Iowa Department of Public Health (IDPH) with demonstrated success in multiple programs. Examples of our current participation in programs with IDPH include the Maternal Health Task Force, Chlamydia Coalition, Bureau of Family Health-Title V program, Title X program, LARC project, Cribs for Kids, and the Iowa Health Information Network.

Meridian has partnered with education departments and agencies to promote and support efforts to improve child health. In Michigan, Meridian works with the school health network to promote immunizations, well child and adolescent well child visits, and lead screening. Due in part to these efforts, Meridian has consistently scored the highest of all Medicaid health plans in Michigan. Meridian will take the same approach in Iowa. Meridian has worked with the Linn County Community School District to obtain member information and encourage preventive services for children. Meridian will outreach to the Department of Education to explore opportunities to better serve Iowa's children. Meridian will continue to work closely with the Iowa Department of Education. Meridian will also work with the DHS Division of Mental Health and Disability Services (MHDS).

Meridian recognizes that children in juvenile child protection systems, juvenile justice systems, foster homes, group homes, and residential placement settings are in serious need of care coordination. Meridian strongly believes that children in these settings have the same rights to care as children in more typical settings. In 2010, the State of Michigan began the transition of foster care children into Medicaid Health Plans. An important component of the statute mandating this transition was to ensure that medical exams for foster children occurred within thirty (30) days of enrollment into foster care, as well as ongoing EPSDT and preventive health services. As a result, Meridian initiated a comprehensive foster care children initiative to ensure smooth enrollment transition. Managed Care System (MCS) alerts staff and displays contact information ensuring appropriate communication and coordination occurs between the plan, provider, parent/guardian, foster care parents and child's case worker.

Meridian's use of technology has resulted in a smooth enrollment transition, improved care coordination, and promotion of medical assessment/preventive care. After just seven (7) months, approximately thirty-five percent (35%) of newly enrolled foster care members received an office visit within thirty (30) days of joining Meridian. Seventy-one point one percent (71.1%) of foster care children continuously enrolled with Meridian had an office visit during that period. As recognition of our successful implementation, we received a Pinnacle Award from MAHP.

Meridian's foster care programs can be easily adapted to serve children and youth involved in the child protection and/or juvenile justice systems. We recognize the importance of key players in

the children's lives emphasizing the engagement of families/guardians. Meridian will coordinate with the DHS Division of Adult, Family, and Children Services (ADFS) to meet goals for safety, permanency, and well-being of the child and will authorize appropriate healthcare services to complement the child's welfare/juvenile justice services upon request from State field workers or juvenile court officers. Meridian recognizes the need to support the specialized health needs of children who have been adopted from Iowa's foster care system and will collaborate with the State and the Iowa Foster and Adoptive Parents Association to develop programs to meet these needs. Meridian's Vice President of Quality serves on Iowa's Child Death Review Team as the insurance industry representative alongside staff from MHDS and ADFS. Recommendations identified by the Team exemplify work extending beyond the purview of a typical managed care organization and have resulted in changes in law enforcement practice, child protective services processes, and legislative action leading to the protection of children.

Meridian works closely with many community based agencies. Examples of such are outlined as follows:

Maternal Health Task Force

Stakeholders: Iowa Medicaid Enterprise (lead), Iowa Department of Public Health, Meridian Health Plan

Description: This group meets quarterly to discuss issues affecting maternal, infant and child health. Past topics have included a research project defining factors contributing to perinatal complications, premature birth, and low birth weight, long-action reproductive contraception, and prenatal screening assessment.

Chlamydia Coalition

Stakeholders: Meridian Health Plan (lead), Iowa Department of Public Health (IDPH) Bureau of Hepatitis C, HIV, and STDs, State Hygienic Laboratory, Iowa Primary Care Association

Description: This Meridian-initiated effort began in 2014 in response to a need to improve chlamydia screening rates in Iowa. Disease incidence has increased every year for more than ten years in a target group of female young adults. The project focused on evaluating existing data, including completeness of billing and reporting for tests performed by the State Hygienic Laboratory. The group continues to explore ways to improve testing through provider education, member incentives, and support for Title X clinics.

Iowa Department of Public Health, Bureau of Family Health- Title V program, Title X program, LARC project

Stakeholders: Meridian Health Plan (co-lead), Iowa Department of Public Health (co-lead)

Description: Several active partnerships exist with the Bureau of Family Health. Meridian works with the Bureau to provide regular service area maps, assist with maternal or child health clinic billing issues, communication of member incentives and education programs, and general support for Meridian member access to maternal and child health programs.

Recently, Meridian began working with the Bureau on a project to evaluate provision of long-acting reproductive contraception at the time of delivery.

Cribs for Kids

Stakeholders: Meridian Health Plan (lead), Iowa Department of Public Health Bureau of Family Health, Allen Hospital, Great River Medical Center, Covenant Medical Center, Mercy Clinton, Iowa Maternal, Infant, and Early Child Home Visitation Program

Description: Meridian leads this exceptional project focused on reducing infant mortality associated with unsafe sleep environments. Following an analysis of sleep-associated infant mortality, it was determined parents in high-incidence counties with significant racial disparity were in need of cribs. Meridian assisted with securing funding and provided supplemental funds for the purchase of more than 2,000 cribs being distributed at five Iowa hospitals. The outcomes of this project are being tracked through home visitation occurring in pilot and comparison counties. This project is the first in the nation to assess the impact of crib provision on sleep-related infant mortality.

Improving Access to Care

Stakeholders: Meridian (lead), Primary Health Care (PHC)

Description: In the summer of 2014, Meridian launched a pilot project with an Iowa federally-qualified health center, PHC, in an effort to improve access to care and establishing care. Meridian outreached to members assigned to PHC and assisted with appointment scheduling.

State Hygienic Laboratory

Stakeholders: Meridian Health Plan (lead), State Hygienic Laboratory (SHL)

Description: Meridian has been working with SHL to assess completeness of laboratory reporting, potential expanded use of the laboratory, and a study of prenatal screening.

Iowa Health Information Network

Stakeholders: Iowa Department of Public Health (IDPH), Meridian Health Plan

Description: Meridian and IDPH have an ongoing collaboration to promote the expansion and adoption of Iowa's Health Information Network. The partnership recognizes the value of involving third party payers in health information exchange development, as coordinated care through secure information sharing results in better patient outcomes.

University of Iowa Public Policy Center (PPC)

Stakeholders: University of Iowa, Meridian Health Plan

Description: The PPC has provided statistical services and managed research projects for Iowa Medicaid Enterprise (IME) for several years, including studies of HEDIS® measure performance comparison between Fee for Service, MediPass, and managed care. Meridian engaged in interactions with PPC in 2014 with the goal of supporting comprehensive projects focused on the Iowa Medicaid population.

Iowa Child Death Review Team (ICDRT)

Stakeholders: Several state agencies, education and child advocacy organizations, law enforcement, insurance (Meridian serves as state representative)

Description: The ICDRT is charged with the review of selected cases of child death in an effort to identify opportunities for intervention and prevention of future deaths. Meridian's Vice

President of Quality serves as the insurance representative and statistician for the production of annual reports.

American Cancer Society

Stakeholders: American Cancer Society (ACS), Meridian Health Plan

Description: ACS and Meridian have a regional relationship focused on education of members on cancer screening and detection. ACS provided educational member mailing materials for co-branding recently adopted for use in reminding members about cancer screenings. Co-branded mailings are used in all three (3) Meridian Medicaid states, though a more comprehensive campaign is underway in Michigan.

Drake University Health Sciences Program Experiential Learning Site

Stakeholders: Drake University, Meridian Health Plan

Description: Meridian has an ongoing engagement with Drake University. Meridian hosts Drake Health Sciences students as interns, and will serve as a capstone experiential learning site in 2015.

Healthiest State Initiative

Stakeholders: Healthiest State Initiative, Meridian Health Plan

Description: Meridian recently requested to participate on the Initiative's planning committees and committed support for the Initiative's annual conference in June. Significant opportunity exists between Meridian and the Healthiest State Initiative and Meridian is excited to join the effort to improve the health of Iowans.

Meridian will work closely and collaboratively with the state Ombudsman's office to ensure the satisfaction and safety of members; resolution of conflicts, complaints, and grievances; and transition of member during facility or provider closure. Meridian will also work closely with the Iowa Department of Education, The Agency Child Welfare and Juvenile Justice Services, Iowa Department of Inspection and Appeals (DIA).

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

Meridian Health Plan currently works with the Iowa Department of Public Health (IDPH) on a number of services and initiatives, with demonstrated success in programs such as Cribs for Kids, collaborations on data exchanges (immunizations), a chlamydia screening initiative, and more. We anticipate and expect to collaborate successfully with IDPH related to the delivery of and administration of funded substance abuse services throughout the State.

Seamless transfer of information is critical to successful program integration with IDPH-funded substance abuse services. Meridian is familiar with the current program administration structure; the use of a State-provided EMR for some behavioral health providers and warehousing of clinical and claims data is a valuable asset to the Department. Meridian has an active exchange with the Iowa Immunization Registry Information System (IRIS), where Meridian supplies identification of members to IRIS and immunization records are extracted to Meridian for upload into Meridian's Managed Care System (MCS). The timely and complete receipt of records

resulted in the most accurate immunization data on Meridian pediatric members since Meridian's launch into Iowa in 2012. This data exchange also allowed Meridian Quality staff an up-to-date picture of member immunization status necessary for targeted outreach. At multiple times throughout 2014, Meridian was able to outreach to members and/or the parents of members who were in need of a vaccination to encourage a preventive service visit. As demonstrated by the IRIS data exchange, Meridian strives to achieve coordinated program management and information sharing and will continue to do so with IDPH.

Meridian will not provide to the media or give media interviews without the express consent of the State. Any contacts by the media or other entity or individual not directly related to the program shall be referred to the State.

2.13 Written Policies and Procedures

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

Meridian Health Plan has a formal process for the creation, editing, and securing of policies and procedures, as well as their annual review and approval. This process addresses the following areas of responsibility: (1) implementation of the process, (2) ownership and security, (3) creating or editing policies and procedures, (4) approving policies and procedures, and (5) auditing and reviewing policies and procedures.

The Meridian Board of Directors has delegated its power to approve policies and procedures to various corporate committees, depending on the subject matter of the policy and procedure. A report of all policies and procedures modified within the past calendar year are brought to the Board annually for their review and are available at all times to board members for individual review.

Overall Implementation

Overall implementation and monitoring of this policy is the responsibility of the Vice President of Regulatory Compliance and Accreditation, through delegation to staff in the Compliance Department. The Compliance Department will be responsible for:

- Configuring and maintaining libraries and permissions of these documents on the employee intranet
- Monitoring necessary dates, timeframes, and approvals for policies and procedures as they move through the process
- Performing audits

Development and Revision of Policies

Development of new policies and necessary revisions to existing policies will be performed by subject matter experts within the relevant department. Policies and procedures are not to be downloaded or edited outside of the Policy and Procedures library on the employee intranet.

Review and Approval

When a draft version of a policy and procedure is deemed complete by the department subject matter expert, the approval process begins. The draft version of the policy is uploaded to Compliance Department library on the employee intranet by the relevant department however is only viewable by permission. The policy must be submitted to the appropriate committee for comment and/or approval. Upon committee approval or executive signature, the policy becomes a final, approved version in the Policy and Procedures library on the employee intranet and is viewable by all staff.

Based on the functional area, the development, revision, reviews and approvals work flows may follow slightly different processes. For example, medical directors and clinical staff provide input into utilization management and medical management policies impacting handling of requests for services or clinical decision making. Whereas, if the policy addresses specialized care, clinicians of with credentials and experience related to the specialized care would be solicited for input. This clinical type of policy would then be reviewed by the applicable committees with clinician members such as the utilization management committee, the physician advisory committee and the quality improvement committee.

If a policy was being developed or updated which addressed the reporting of suspected fraud, waste and abuse then the compliance staff and legal team would review the policy to ensure that the policy addresses all legal and regulatory requirements as well as industry standards of practice. Once drafted this policy would be reviewed and approved by the fraud, waste and abuse committee.

If a policy was being developed or updated regarding credentialing of the provider network, then provider services staff, compliance staff and accreditation staff may provide input into the policy to ensure that the policy addressed all the contractual and accreditation standards. This type of policy would be reviewed and approved by the credentialing committee and the quality improvement committee.

Security and Ownership

The policies and procedures will be stored on a Compliance Department SharePoint site on the employee intranet and contained within separate libraries. The Compliance Department will retain ownership of the site and will be responsible for ongoing monitoring and maintenance. Each department will be able to access policies and procedures contained within the library or libraries necessary to perform their daily job functions and are responsible for maintained the content of the policy and procedure to reflect current operational practices.

Audits and Monitoring

The Compliance Department is responsible for receiving notifications about a policy as it moves through the approval process, and monitoring the progress of all policies under active revision. Compliance is additionally responsible for performing routine audits of the development and approval process.

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.**

Meridian Health Plan will meet an operational effective date of January 1, 2016. To ensure the delivery of an integrated care system, Meridian believes in open collaboration with the Agency during the implementation period. The plan will provide all of the necessary components for a successful partnership prior to go-live (Contract effective date).

Meridian has a turnkey information management system with its proprietary Managed Care System (MCS), an integrated, enterprise-wide care management system. All Meridian functions are found within this single platform for healthcare optimization. Consistent with our belief in partnership, our talented team of technologists will identify and implement any custom changes needed for Iowa. Additional details about our award winning information systems can be found in our response to Section 13. A sample detailed implementation plan, successfully implemented with a previous Medicaid program, is provided in Tab 6 as Attachment 43 (Implementation Plan).

a. Tasks;

Operational success requires that the implementation team and permanent staff work together to coordinate programs, training, technology and report obligations. The overlap between the implementation team and permanent staff occurs for approximately six (6) months but can extend longer if there is value in doing so. Prior to the go-live date the focus is on preparedness, ensuring that Meridian delivers a care system to match the needs of the State. Post implementation analysis includes a thorough contract review and lessons learned to ensure that all requirements are in place and operating without issue. This analysis is the final step before a full transition to permanent staff and ensures that they are equipped to operate without the aid of the implementation team. A detailed task list (schedule) for a previous client of ours is provided in Tab 6 as Attachment 43 (Implementation Plan).

b. Staff responsibilities;

Meridian has a fully contracted and credentialed provider network ready to meet the needs of Iowa's Medicaid Program upon the effective date of the Contract. Prior to January 1, 2016, we will provide orientation and training for our providers to ensure a seamless transition upon go-live. Meridian is poised to execute an effective member outreach strategy that builds personal relationships and connects members with providers. Using all available communication mediums, we take pride in working with members using their preferred communication methods, in their communities, to best meet their individual health needs.

Our plan incorporates the planning and delivery of appropriate staffing, onboarding activities and training. The staff responsible for the oversight of this implementation will include but not be limited to:

- Contract Administrator/CEO/COO, Meridian Health Plan of Iowa
- Director of the Project Management Office (PMO) and an assigned project manager
- Director of Operations
- Director of Information Technology (IT)
- Director of Network Development
- Director of Human Resources (HR)

In addition to the leadership identified above, our detailed planning and execution personnel will include staff from the following departments; PMO, Operations, IT, Network Development, HR, Training, Care Coordination, Utilization Management, Quality Improvement, Medical Management, Behavioral Health, Provider Services, Member Services and Communications.

Utilizing a team approach, the implementation focus teams include:

- Project Management Team – responsible for the overall implementation, managing to a detailed timeline, providing status updates and meeting contractual obligations
- Information Technologies (IT) Team – tasked with integrating data and files with the State while ensuring that the necessary hardware/software development, testing and deployment is performed to specification
- Clinical Team – charged with the implementation and execution of all care management programs in line with Iowa's requirements
- Client Support Team – to assist with any questions/needs from the State

c. Timelines; and

The implementation team, consisting of personnel from project management, information technology, clinical and customer support staff, are involved with the project through the early implementation phase. The high level timeline implementation plan can be seen in the following graphic.

| Item | Major Task | MHP of IA - MED16009 Implementation Schedule (Aug 2015 - June 2016) | | | | | | | | | | | |
|----------|---|---|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|--|
| | | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
| 1 | Start Up | [Gantt bar from Aug to Jan] | | | | | | | | | | | |
| 1.1 | Assign PM & Team Members | [Gantt bar from Aug to Sep] | | | | | | | | | | | |
| 1.2 | Document Project Charter/Scope | [Gantt bar from Sep to Jan] | | | | | | | | | | | |
| 2 | Planning | [Gantt bars for 2.1-2.4] | | | | | | | | | | | |
| 2.1 | Identify All Needed Systems Changes | [Gantt bar from Sep to Oct] | | | | | | | | | | | |
| 2.2 | Document Partner Roles & Responsibilities | [Gantt bar from Oct to Nov] | | | | | | | | | | | |
| 2.3 | Create the "As Is" and the "To Be" operational states | [Gantt bar from Nov to Dec] | | | | | | | | | | | |
| 2.4 | Create Detailed Plans | [Gantt bar from Dec to Jan] | | | | | | | | | | | |
| 3 | Execution | [Gantt bars for 3.1-3.5] | | | | | | | | | | | |
| 3.1 | Conduct Staffing & Training | [Gantt bar from Oct to Mar] | | | | | | | | | | | |
| 3.2 | Develop & Test Required System Changes | [Gantt bar from Nov to Feb] | | | | | | | | | | | |
| 3.2.1 | MHP Systems | [Gantt bar from Dec to Jan] | | | | | | | | | | | |
| 3.2.2 | Partner System Integrations | [Gantt bar from Jan to Feb] | | | | | | | | | | | |
| 3.3 | Conduct IA State Readiness Review | [Gantt bar from Nov to Dec] | | | | | | | | | | | |
| 3.4 | Ensure SLA / Reporting Capabilities | [Gantt bar from Dec to Jan] | | | | | | | | | | | |
| 3.5 | Transition to Operations | [Gantt bar from Jan to Apr] | | | | | | | | | | | |
| 4 | Project Close Down | [Gantt bars for 4.1-4.3] | | | | | | | | | | | |
| 4.1 | Update Subcontracts as Needed | [Gantt bar from Apr to May] | | | | | | | | | | | |
| 4.2 | Conduct Lessons Learned | [Gantt bar from May to Jun] | | | | | | | | | | | |
| 4.3 | Archive all Project Materials | [Gantt bar from Jun to Jun] | | | | | | | | | | | |

Note: Detailed plans include: Training, Staffing, Communications, Facilities, Mailings & Materials, N/W Development Expansion, Project Schedule

A sample detailed implementation plan, successfully implemented with a previous Medicaid program, is provided in Tab 6 as Attachment 43 (Implementation Plan).

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

There is a transition and evaluation process that determines when functions will transition from the implementation team to the operations team. We will follow our internal quality control process to ensure that systems related changes are thoroughly tested prior to their release into production. We will also follow our internal hiring and training processes to ensure staffing and education is timely. We will also ensure that we update our policies and procedures for compliance purposes.

The project team will meet regularly to monitor the progress of the implementation. There will be acceptance criteria and gate reviews included in the plan to ensure milestones and deliverables are met. We will follow the State’s requests for project status and readiness reviews. Finally, we will ensure that we follow our communications processes for external and internal communications, which align with requirements outlined in Section 8 and Section 2.12 of the Scope of Work.

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

The Director of Meridian Health Plan’s Project Management Office (PMO) and the PMO team are directly engaged in the development, monitoring and control of the implementation plan. The PMO will make necessary revisions to the plan and keep the plan updated throughout the readiness review process and through the transition to operations. Meridian is currently delivering

managed care services in the State and understands the importance of project planning and delivering services.

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.

Meridian Health Plan maintains comprehensive written policies and procedures for the privacy and confidentiality of member health information in accordance with State and Federal law (i.e. 42 CFR 438.224 and Iowa Code §228). This includes protecting and maintaining the confidentiality of mental health information and substance use disorder information, for which Meridian will implement policies for staff and through contract terms with network providers.

As a covered entity under HIPAA, Meridian is keenly aware of its responsibilities regarding the protection of member information. Meridian educates its employees and requires them to be cognizant of the requirements of HIPAA, implementing regulations, and other State and Federal privacy laws at all times in the performance of their job functions. Meridian fosters an environment of open communication in order to learn of privacy or security incidents and respond to them quickly and appropriately.

Meridian has designated a Privacy Officer, a Security Officer and a Privacy and Security Committee that meets quarterly and as often as necessary to develop, implement, maintain, and modify as necessary Privacy and Security policies and procedures that are compliant with Federal, State, and government agency laws, regulations and guidelines. The Privacy and Security Officers are readily available to Meridian staff. Their contact information is circulated on a regular basis through various communication tools including training, handbooks and newsletters so as to eliminate employee confusion or hesitation in the event they have questions related to their responsibilities or need to report a privacy incident as required by Meridian policy. All Meridian employees are trained upon hire and then annually thereafter regarding HIPAA, HITECH, and all relevant privacy regulations and guidelines.

Meridian has implemented administrative and technical safeguards in compliance with Federal and State regulations including the following:

- All documents containing protected health information (PHI) are shredded prior to disposal
- All doors to areas that house records containing PHI (or to file cabinets housing such records) remain locked at all times when not actively supervised by authorized personnel
- A key, pass-code or swipe card is required to gain entry into all areas that house records containing PHI, or to file cabinets housing such records
- Personnel with access to areas that house records containing PHI, or to file cabinets housing such records, is limited to only those who need such access to effectively carry out Meridian operations
- User access to systems containing PHI is determined by the department managers and directors, in consultation with the Privacy Officer
- Personal computers require a Personal Identification Number

- Personal faxes are paperless and arrive via email accessible only by two-tier access on personal computers
- Departmental faxes are also paperless, arriving in a queue only visible to authorized personnel
- Any email sent outside of Meridian is automatically flagged and the employee is prompted to send the information in an encrypted, secure format. The system is also capable of recognizing keywords commonly associated with PHI and automatically encrypting certain emails
- The Security Officer reviews and approves each employee's access to physical and electronic information upon hire, annually thereafter, and immediately upon changes in employment
- After-hours faxes received by Meridian are maintained in a queue until authorized personnel access them using their swipe card and private PIN
- The Privacy Officer reviews and signs off on each request for disclosure of PHI for purposes other than treatment, payment, or health care operations
- Randomized, unannounced audits of employee workstations to ensure proper security of PHI and other sensitive information

Violations of Meridian's policies and procedures are immediately reported to the Privacy and/or Security Officer, as appropriate. These violations are investigated and thoroughly documented. Corrective action is taken as appropriate, and reports are made to the Privacy and Security Committee. In compliance with Federal and State laws, any incidents that constitute a breach are reported by the Privacy Officer to the State within one (1) day.

2.16 Material Change to Operations

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

Meridian Health Plan will provide advance notice of any material changes to its operations through the submission of documentation to DHS, prior to implementing material changes. Meridian will describe in this documentation the nature of the change, rationale for the change, and the impact of the change on the members. A material change is a change to a policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of the Meridian's membership or provider network.

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.

Meridian Health Plan confirms 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.

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.

Meridian Health Plan confirms that members and providers will be notified of material changes at least thirty (30) days prior to the effective date of material changes. Meridian notifies members by letter of material changes specifically impacting them such as primary care provider (PCP) terminations. The letter describes for the members how they are impacted by the change and what action they need to take and what will occur if they take no action. Providers are notified of material changes through provider newsletters and updates to the electronic provider manual. All communications regarding material changes describe the nature of the change, the rationale for the change, and the impact of the change on the members.

Response to State Inquiries & Requests for Information

Upon request for financial or other information from the State, Meridian Health Plan will fully disclose all financial or other information requested. Information may be designated as confidential but will not be withheld from the State as proprietary. If the Meridian believes the requested information is confidential and may not be disclosed to third parties, Meridian will provide a detailed legal analysis to the State, setting forth the specific reasons why the information is confidential and describing the specific harm or injury that would result from disclosure.

Meridian will comply with requests for information that is in response to inquiries and complaints from external entities. Responses will be provided in the timeframe specified by the State when the inquiry or complaint is forwarded to the Meridian for resolution.

Dissemination of Information

Upon request of the State, the Meridian Health Plan will distribute information prepared by the State or the Federal government to its members and provider network as appropriate.

DHS Ongoing Monitoring

Meridian Health Plan will cooperate with the State's ongoing monitoring to ensure compliance with Contract requirements and performance standards. The method and frequency of monitoring is at the discretion of the State and may include, but is not limited to, both scheduled and unannounced onsite visits, review of policies and procedures, and performance reporting. In preparation for planned onsite reviews, the Meridian will cooperate with the State by forwarding in advance policies, procedures, job descriptions, contracts, records, logs, and other material upon request. Documents not requested in advance will be made available during the course of the review. Meridian will be available at all times during review activities. Meridian will have available work space and access to staff and systems for the State staff while onsite.

Future Program Guidance

Meridian Health Plan will comply with the Policies and Procedures Manual provided by the State and will operate in compliance with future program manuals, guidance, and policies and procedures, as well as any amendments at no additional cost to the State. Meridian understands that future modifications that have a significant impact on Meridian's responsibilities, as set forth in this RFP, will be made through the Contract amendment process.

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.

Meridian Health Plan will enroll all eligible Medicaid and Children’s Health Insurance Program (CHIP) members as designated. In addition to covering Medicaid and CHIP members, Meridian will provide substance use disorder services, as described in Exhibit D, to members meeting the eligibility criteria to receive Iowa Department of Public Health (IDPH)-funded substance use disorder services (“IDPH Participants”). Meridian will provide services to a minimum number of IDPH Participants annually, based on requirements established by IDPH and subject to annual adjustments at the discretion of IDPH.

Meridian recognizes that the following populations are excluded from the contract: (i) undocumented immigrants receiving time-limited coverage of certain emergency medical conditions; (ii) beneficiaries that have a Medicaid eligibility period that is retroactive; (iii) persons eligible for the Program of All-Inclusive Care for the Elderly (PACE) program who voluntarily elect PACE coverage; (iv) persons enrolled in the Health Insurance Premium Payment (HIPP) program; and (v) persons eligible only for the Medicare Savings Program. Alaskan Native and American Indian populations will be enrolled voluntarily.

Meridian understands that assignments to Meridian and changes to the members’ aid type will be made on a prospective basis. Meridian is not responsible for covering retroactive Medicaid eligibility periods, with the exception of babies born to Medicaid-enrolled women who are retroactively eligible to the month of birth.

Meridian will provide statewide coverage to the State of Iowa eligible membership.

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.

Meridian Health Plan has a streamlined enrollment process to ensure members receive the covered benefits included within their eligibility group. These eligibility groups include;

- Iowa Health and Wellness Plan
- Family Planning Network
- Presumptively Eligible Pregnant Women
- Children’s Health Insurance Plan (CHIP) and hawk-i
- Other Eligibility Group

In accordance with 42 CFR 431.51(b)(2), members will not be restricted in freedom of choice of providers of family planning services. Therefore, members will be permitted to self-refer to any State Medicaid provider for the provision of family planning services, including those not in Meridian’s network.

Meridian uses a custom-developed, proprietary Managed Care System (MCS), which allows quick adaptation to accommodate state and Federal requirements. The current Medicaid

enrollment process involves the receipt of files from states of operation in Health Insurance Portability and Accountability Act (HIPAA) compliant, 834 format. File loads are automated, the member's eligibility is updated as well as other member data fields contained in the file. Updated fields may include member name, date of birth, gender, case number, third party liability data fields, member eligibility group, and primary care provider (PCP) history. Members may also be identified as terminated effective retrospectively to the last day of the current month. Daily and in some cases weekly enrollment files further append member information. Meridian anticipates receipt of enrollment files from the State similar to the current process. Upon file receipt, each will be loaded into MCS to update member eligibility. Provider data are also populated along with third party liability and provider history information.

MCS contains multiple screens able to display, manage, and store data received from enrollment files on both active and inactive members. MCS is a critical business tool for nearly all Meridian functional units including:

- Member demographics, including responsible party and guardian information
- Care Management
- Authorizations
- HEDIS® measure status
- Eligibility and PCP history
- Current and historical medical and pharmacy claims
- Health risk assessment data
- Coordination of benefits
- A record of all communication between the member and the health plan

Benefits Delivery

Staff tracks utilization of services through Meridian's Managed Care System (MCS). Claims data are synchronized with a continuously updated "Member Service Counts" module. This module includes visit tracking of chiropractic, vision, and behavioral health services, as well as physical/occupational therapy, inpatient days, and skilled nursing facility days. Meridian staff keeps members and providers updated on the amounts remaining of those services that are limited.

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

Meridian Health Plan has a streamlined enrollment process to ensure members receive the most appropriate benefits included within their eligibility group. Meridian uses a custom-developed, proprietary Managed Care System (MCS), which allows quick adaptation to accommodate State and Federal requirements. The current Medicaid enrollment process involves the receipt of files from states of operation in HIPAA compliant, 834 format. File loads are automated, the member's eligibility is updated as well as other member data fields contained in the file. Updated fields may include member name, date of birth, gender, case number, third party liability data fields, member eligibility and primary care provider (PCP) history. Members may also be identified as terminated effective retrospectively to the last day of the current month. Daily and in some cases weekly enrollment files further append member information. Meridian anticipates receipt of enrollment files from the Iowa Medicaid Enterprise similar to the current process. Upon

file receipt, each will be loaded into MCS to update member eligibility. Provider data are also populated along with third party liability and provider history information.

MCS contains multiple screens able to display, manage, and store data received from enrollment files on both active and inactive members. MCS is a critical business tool for nearly all Meridian functional units including:

- Member demographics, including responsible party and guardian information
- Care Management
- Demographic information
- Authorizations
- HEDIS® measure status
- Eligibility and PCP history
- Current and historical medical and pharmacy claims
- Health risk assessment data
- Coordination of benefits
- A record of all communication between the member and the health plan

Member Alerts and Notifications

When a member's profile is accessed in MCS, the necessary information to verify his or her identity in accordance with HIPAA guidelines is immediately visible. Following confirmation of identity, users review member alerts to guide their member interaction.

[REDACTED]

These alerts appear in red letters on the "Member" and "Authorization" screens in MCS, although full descriptions are used in certain instances.

[REDACTED]

[REDACTED]

In addition to member alerts, an automated notification system has been incorporated into MCS. This mechanism allows notices to be sent to the Member Services, Case Management, Disease Management, and Behavioral Health Departments from users external to these departments and off-site providers with access to the MCS Provider Portal.

Benefits Delivery

Staff tracks utilization of services through Meridian's Managed Care System (MCS). Claims data are synchronized with a continuously updated "Member Service Counts" module. This module includes visit tracking of chiropractic, vision, and behavioral health services, as well as physical/occupational therapy, inpatient days, and skilled nursing facility days. Meridian staff

keeps members and providers updated on the amounts remaining of those services that are limited.

Meridian will provide all benefits and services deemed medically necessary that are covered under the contract with the state. Meridian will deliver services in accordance with 42 CFR 438.210 (a) (3). Meridian will furnish covered benefits in the amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished. Referencing our clinical practice guidelines, Meridian does not arbitrarily deny or reduce the amount, duration, and scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. Through our Utilization Management procedures, Meridian may place appropriate limits on services based on medical necessity criteria, in accordance with the overarching goals of the Iowa High Quality Healthcare Initiative (IHQHI). Meridian intends to leverage current relationships with our comprehensive network of providers to deliver covered services. As the sole Medicaid managed care organization currently operating in the State of Iowa, Meridian's established and growing provider network will provide members, to the extent possible and appropriate, adequate choice in selecting their health professionals.

The Meridian Family of Companies currently has full-risk capitated Medicaid contracts in place to provide services to beneficiaries in Iowa, Illinois and Michigan. Meridian has a wide range of experience delivering and managing services for the full range of Medicaid members, including:

- Aged, Blind, and Disabled (ABD)
- Temporary Assistance for Needy Families (TANF)
- Supplemental Security Income (SSI)
- Sixth Omnibus Reconciliation Act (SOBRA)
- Families with Dependent Children (AFDC)
- Children's Health Insurance Plan (CHIP)
- Affordable Care Act (ACA)/Medicaid expansion
- Iowa Health and Wellness Plan
- Foster children
- Dual eligible

As the only managed care company operating in Iowa since 2012, Meridian has experience administering the care of both the Temporary Assistance for Needy Families (TANF) and Iowa Wellness Plan beneficiaries. Successive years of established care provision Iowa, Illinois and Michigan has equipped Meridian with the most appropriate experience for administering the benefits of the IHQHI.

Iowa Health and Wellness Plan Benefits

Meridian currently administers benefits for beneficiaries eligible through the Iowa Health and Wellness Plan, through an expansive network of Iowa providers. Meridian also manages benefits for Medicaid expansion-eligible beneficiaries in Michigan through the Healthy Michigan Plan and to the ACA-eligible population in Illinois. Meridian has experience delivering benefit packages for Medicaid expansion eligible beneficiaries. Our propriety Managed Care System (MCS) is designed to manage and organize members based on their plan enrollment. MCS allows Meridian to deliver benefit packages as required by the contract with the State.

Family Planning Network Benefits

Meridian administers family planning benefits in nearly all of our current programs. We are experienced in coordinating with members and providers to ensure members receive family planning benefits available to them and administered in the appropriate setting. Family planning services are private and Meridian Care Coordinators will work with members and providers to ensure that members are actively involved in coordinating their family planning services. Members have the utmost independence and choice in determining appropriate family planning services.

Presumptively Eligible Pregnant Women Benefits

Meridian will provide ambulatory prenatal care to pregnant women during the presumptive eligibility period. Meridian will work internally, through the use of our Managed Care System (MCS) and enrollment staff, to identify members and new members who are eligible for pregnant women benefits.

Children's' Health Insurance Plan (CHIP) and hawk-i

Meridian has experience administering services for populations identical to the CHIP and hawk-i populations outlined within the IHQHI. Meridian's enrollment team will work with the selected enrollment agencies to identify members who are entitled to CHIP and hawk-i benefits. Because of the age range of CHIP and hawk-i eligible beneficiaries, Meridian's Member Services and Care Coordination teams will work with members' custodial parent or advocate ensuring members receive the services covered within their benefit package.

Other Program Plans

Meridian is experienced in working with members who may not fall into specific benefit categories as listed in Section 3.2.2.1 through 3.2.2.4 of the Scope of Work. These members are eligible for all medically necessary covered benefits in Iowa's State Plan Amendment and all waivers approved by CMS. Upon identifying these members, Meridian's Member Services and Care Coordination teams will work on educating members on benefits available to them.

Meridian currently provides services for over 725,000 Medicaid beneficiaries in three (3) states. Meridian strives to ensure benefits are provided to beneficiaries in the most cost effective and least restrictive manner possible while recognizing the unique needs of every member. Our Member Services team interacts with members, both new and existing to educate and equip members on the benefits available to them. Our Care Coordination staff works with members to engage members to take responsibility for their health and play an active role in their care. Meridian's intent is to allow the members to be as independent in their care as possible, but more importantly serve as an advocate helping navigate members through the resources available to them.

3.2.4 Integrated Care

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

Meridian Health Plan will continue seamless integration of services to members and providers across the healthcare delivery system. As part of this expanded high quality healthcare initiative, Independent Living Services (ILS), our Long-Term Services and Supports (LTSS) subcontractor, and Beacon Health Options (Beacon), our behavioral health subcontractor, are partners dedicated to optimizing the member and provider experience spanning physical, behavioral, and oral health services. Meridian will assure members are receiving appropriate care in the right setting by constant engagement with subcontractors and healthcare partners. Meridian will promote and utilize health homes using an interdisciplinary care management approach resulting in comprehensive coordination of care through all aspects of care management and LTSS. Through the interdisciplinary team, the member's care will be managed and coordinated. We will ensure that members receive comprehensive care management, care coordination, health promotion, transitional care and follow-up, individual and family support, and referrals to community and social support services. We will utilize evidence-based practices and flexibility that applies a "no wrong door" approach to individuals where the full spectrum of healthcare needs, regardless of their point of entry, is delivered.

Meridian recognizes communication is vital to the integration of care between medical homes and other aspects of care. Care coordination and communication among the many members of the medical care team is one of the greatest challenges facing providers. Communication to integrate care among all team members, including physical, behavioral, and oral health providers, is critical to maintaining the quality of care for members.

Meridian requires the timely exchange of member information amongst all practitioners. A corporate communication policy outlining guidelines for the exchange of information includes the following:

- The timely exchange of pertinent member information within thirty (30) days for routine and non-urgent visits and one (1) business day for urgent and emergent visits
- The exchange of pertinent member information among all practitioners, regardless of referral method or lack of, is required:
 - After the initial consult/evaluation
 - If the member has been seen on an ongoing basis twelve (12) months or greater
 - If the member has had significant changes in clinical presentation or treatment

Acceptable forms of communication that represent the flow of information and promote continuity of care include, but are not limited to, office notes or summaries (inclusive of diagnostic reports), treatment plans, and discharge summaries from facilities. It is important that any communication sent or received on behalf of our members be documented in the medical record. The communication should include the date the report was sent/received and evidence that the report was reviewed by the practitioner.

Adherence to the practice of communication among practitioners is monitored through annual audits of medical records as specified in the Quality Management "Evaluating Continuity and Coordination of Care" policy as well as through medical record audits conducted during the

credentialing process. Facilities scoring less than ninety percent (90%) on the audit will be required to submit plans for improving communication with the primary care provider (PCP).

Behavioral health specialists (including psychiatrists, psychiatric nurse practitioners, psychologists, neuropsychologists, social workers, mental health clinics, and chemical dependency clinics) are expected to communicate pertinent clinical information to the members' PCP by the completion of the third visit, when medications are changed, or when the treatment plan is modified.

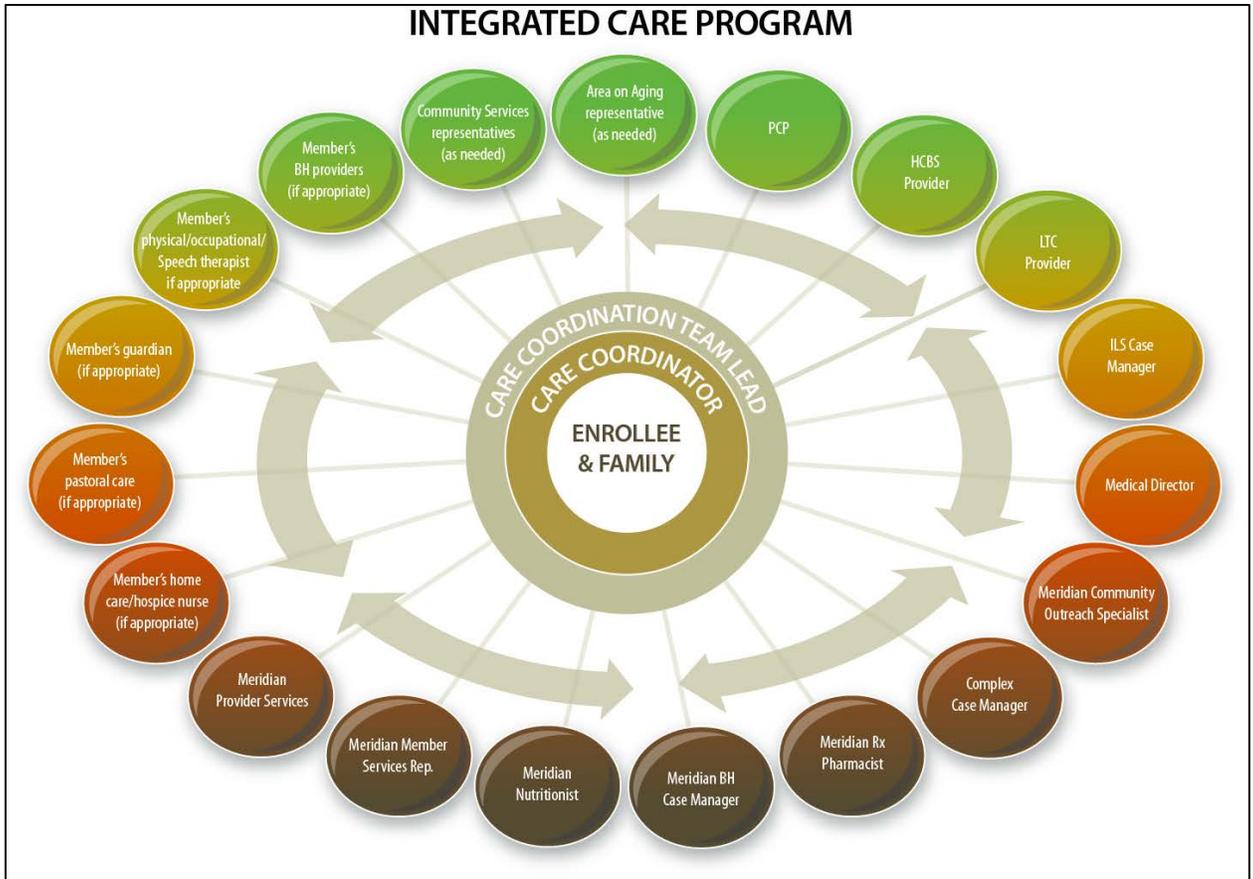
In accordance with corporate policies, a behavioral health specialist must have a valid, HIPAA-compliant consent form signed by the member in order to share clinical information with a member's PCP. Behavioral health specialists may use any type of confidential written or verbal communication to share information with the PCP. All communication efforts must be documented in the members' medical record. It must also be documented if the member refused to sign the consent form to release clinical information.

Adherence to this policy is monitored through an annual audit of medical records, as specified in the Quality Management "Evaluating Continuity and Coordination of Care" policy. High volume outpatient specialists, facilities, and community based programs will be audited.

While practitioners consistently verbalize communication among treating providers, office practice patterns may not always support it. Meridian improves communication efforts by incorporating regular updates of the members' most current PCP within the current office systems, securing a member. Communication between the PCP and Meridian is also coordinated through our Provider Portal, where PCPs work in conjunction with the Care Coordinator to share results of scheduled appointments, medication updates, lab results, and to arrange needed services. The MCS Provider Portal is a secure, proprietary software program that offers unmatched flexibility and efficiency for our network providers. Free of charge to all participating Meridian providers, the Provider Portal allows providers to verify eligibility, view and submit claims, enter prior authorizations, detailed member data and reports, enrollment lists, HEDIS® bonus information, self-reporting, and much more.

The Role of the Interdisciplinary Care Team in Ensuring the Integration of Care

Please see the following pages for more information about the role of the Interdisciplinary Care Team in ensuring the integration of care.



Composition and Team Membership

Meridian believes its team-based approach to care coordination leverages the collective expertise to provide outstanding care to our members. The following roles are active in this process:

Medical Director – Meridian’s Medical Directors are responsible for the quality of care and services that members receive. The Medical Directors’ role in the Care Coordination team is to provide consultation to staff and practitioners regarding program components and member-specific interventions, such as Integrated Care and Chronic Care Improvement. Meridian’s Medical Directors are Board Certified and hold years of clinical experience.

Utilization Management (UM) Director– This position ensures alignment of various care coordination functions (Utilization Management, Care Coordination, Disease Management) with organizational strategic direction, goals, measures, and initiatives. Cost-effective and appropriate use of healthcare services is assured by planning, designing, implementing, and evaluating continuity of care programs.

Care Coordination Team Lead – Care Coordination Team Leads oversee the Care Coordinators and the Care Coordination Teams to ensure balance of cases by acuity level. They provide front-line assistance in the development and implementation of the care plan. They are responsible for providing ongoing clinical training and education for the Care Coordination Team and coordinate training schedules with the Care Coordination Trainers and Managers. They are also essential in

identifying potential cases that are appropriate for team case conference with other team resources, such as the nutrition, behavioral health, pharmacy, compliance and medical management staff.

Care Coordinators – Maintain ongoing tracking and appropriate documentation of referrals to promote team awareness and ensure member safety. Care Coordinators conduct complete, timely, and accurate Health Risk Assessments (HRA) telephonically, including current member demographic information. Based on the HRA, information is compiled concerning member's clinical background. The Care Coordinator identifies needed referrals, and per referral guidelines, provides appropriate clinical information to the member's primary care provider (PCP) and specialist providers in a timely manner. Care Coordinators assist members in solving potential issues related to access to health, such as need for transportation, interpreters, cultural resources, and community resources. Serving as the point-of-contact for members and families, Care Coordinators function as the system navigator. Members and families have direct access to Care Coordinators to ask questions and raise concerns.

Community Health Outreach Workers (CHOW) – Community Health Outreach Workers are responsible for the face-to-face interactions with members in the community. CHOWs work as a member advocate and community liaisons. CHOWs are trained in fundamentals of chronic disease standards of care and have strong communication skills and the ability to engage and motivate members to take charge of their chronic condition. Using a multifaceted, intense approach that includes interventions in homes, schools, churches, and community centers, each CHOW is responsible for a targeted geographic area. The CHOW improves access to care for members by linking them with PCPs, arranging transportation, promoting appointment compliance, and connecting members to community resources. Health literacy among the targeted population will improve by using educational materials written at an appropriate reading level, using Meridian's language line for translations, encouraging members to attend educational classes and community events, and referring members to case management, if needed.

Community Care Coordinator (CCC) – As the member's direct point of contact, the Community Care Coordinator is responsible for contacting the member's nursing facility case manager or nurse to set up appointments to complete the initial health risk screening, or comprehensive Health Risk Assessment, and any ongoing contractual visits. During ongoing case management, the CCC communicates any pertinent information via phone contact or face-to-face visit with the nursing facility and assist with completing any transitions with the Transitional Case Manager.

Transitional Case Managers – Transitional Case Managers are licensed practical nurses and/or registered nurses with current licenses without restriction. This position is responsible for the safe and effective transition of care for members transitioning from one acute care setting to another, as the member's health status changes. Responsibilities include, but are not limited to, ensuring authorization requests for skilled nursing facility placement and processing inpatient acute rehabilitation placements.

Behavioral Health Case Managers – Care Coordinators work in conjunction with Behavioral Health (BH) Case Managers to assist members with psychosocial issues, such as chemical and substance abuse, coordination of counseling for members with depression, schizophrenia, and bipolar disease. The BH Case Managers also address care needs, including shelter, utilities, food, and clothing. These case managers connect members to community resources that address a

myriad of needs and concerns in the community. Depending on the unique needs of the member, the BH Case Manager may be assigned as the member's primary Care Coordinator.

Clinical Pharmacist – The Clinical Pharmacist conducts medication profile reviews and monitors for persistent medications, drug interactions, and drugs to avoid in the elderly. Based on analysis, Clinical Pharmacists reach out to members identified for the Medication Therapy Management (MTM) program. The Clinical Pharmacist also provides education to the staff regarding certain pharmaceuticals.

Nutrition Team – The Nutrition Team is an on-going resource to the Care Coordination Team with regard to developing the care plan. They are important in the development of self-management goals related to control of congestive heart failure, hypertension, diabetes, and weight management. They assist in identifying nutrition barriers for members, education, and resources to address their needs.

Utilization Management (UM) Staff – Medicare Care Coordinators, Medicare Specialists and UM Specialists review and assess services requiring prior authorization, ensuring that established indicators and criteria are met before determinations are made. Requests that do not meet medical necessity criteria are reviewed by the Medical Directors for determination.

Primary Care Provider Team – The member's PCP will be notified on all transitions of care or major medical issues as needed. In addition, the member's PCP is invited to participate in the Interdisciplinary Care Team (ICT) meeting and will be provided a full spectrum of care management resources to support the needs of the member.

Integrating Innovative Programs and Methods throughout the System

Meridian creates innovative programs that support transformational change within the healthcare system:

- Meridian offers more than the traditional managed care organization. With a belief in integrative care models, we partner with providers to streamline the delivery of care while ensuring that appropriate care is delivered at the appropriate time.
- Meridian's innovative programs are supported by our Managed Care System (MCS), our award winning proprietary software platform. Meridian is unique in that our system is an integrated, enterprise-wide solution that encompasses all aspects of our operations. Backed by an in-house team of technologists, we are able to customize applications specific to the State's needs, integrating those applications with State systems to enhance collaboration and shared decision-making, and creating a single source of data regarding member care. Our system also allows online accessibility for providers through our secure Provider Portal, which allows providers to view member eligibility, enter authorizations, verify claims status, request direct assistance from Case Management and Member Services, and review member health history, including previous utilization from other health plans.
- Meridian received the Chief Information Officer (CIO) 100 Award from the editors of *CIO Magazine* in 2007, 2008, 2010, 2012 and 2013 for innovations in our use of technology to integrate data to improve the quality of member health.

MCS allows Meridian to provide coordinated, comprehensive, collaborative, and continuous care to members. The ability to access all aspects of a member's care under one software system

allows information to be integrated and shared with other parties involved in managing member needs and will be leveraged to provide unified, flawless care with our partners, Beacon and Independent Living Services (ILS). Members with mental illness, substance use disorders and chronic disorders, such as HIV, require care from a large number of settings. We will interface with provider systems to acquire the full picture of a member's medical needs and use of services to coordinate high quality care across settings.

Meridian partners with hospitals in the sharing of Electronic Medical Record (EMR) access. This bidirectional sharing of information between MCS and hospital EMRs leads to greater efficiency in the coordination of healthcare services. Meridian's Quality and Performance Improvement Department is involved in many initiatives aimed at the improvement of information sharing in the managed care setting. Partnerships in Iowa have resulted in remote EMR access or electronic data exchange involving more than 40,000 member records. Meridian purports a strong relationship with the Iowa Health Information Exchange and envisions continuing that relationship for years to come.

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.

Meridian Health Plan complies with 42 CFR 438.114, and covers emergency services without the need for prior authorization and does not limit reimbursement to in-network providers. Medical screening examination, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations, provided to a member who presents to an emergency room with an emergency medical condition is also covered. Emergency services are available twenty-four (24) hours a day, seven (7) days a week. Meridian will not deny payment for treatment obtained under either of the following circumstances:

- The member had an emergency medical condition, defined as a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses 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
 - Serious impairment to bodily functions
 - Serious dysfunction of any bodily organ or part. This includes cases in which the absence of immediate medical attention would not have resulted in such impairment or dysfunction
- A representative of Meridian instructs the member to seek emergency services

Meridian recognizes that some members regularly seek routine, non-emergent care in an emergency room setting. This behavior is detrimental to continuity of care and undermines the Medical Home concept. It is also inefficient and very expensive. In response to this problem, Meridian has developed a multi-faceted approach to reduce unnecessary emergency room visits and educate members about the importance of creating and maintaining a relationship with their Medical Home.

Meridian's process for managing emergency room utilization is directed at the management of members who incur visits for primary care provider (PCP) treatable, non-emergent conditions. Claims for members who incur ER visits for chronic or ambulatory sensitive conditions are included in Meridian's predictive model program and are forwarded to one of Meridian's care coordination programs for management.

Meridian uses the NYU ED algorithm (developed by the NYU Center for Health and Public Service Research) to identify members who have visited the emergency room for a PCP-treatable or non-emergent condition. We send these members an educational letter regarding appropriate use of emergency room services after the first emergency room visit. After the second visit, Meridian's High-ER team follows up with the member to conduct a post-emergency room assessment. The assessment identifies the reason for the emergency room utilization. During the assessment, the High-ER Care Coordinator informs the member of their transportation benefit, assists the member in selecting another PCP if indicated, and educates the member on his or her preventive healthcare needs. If indicated, the High-ER Care Coordinator will refer the member to meet behavioral health or medical case management needs.

Members incurring additional emergency room visits for PCP-treatable, non-emergent conditions continue to be monitored and contacted by the High-ER Care Coordination staff. Members identified as potential narcotic abusers are referred to the pharmacy lock program.

Collaboration Initiative

Meridian has collaborated with several high volume facilities and Physician Hospital Organizations (PHO) in an effort to reduce unnecessary emergency room utilization. The following is an example of a successful collaboration intervention.

Review of emergency room utilization at a collaborative high volume facility revealed that a large percentage of the members were assigned to a specific large-volume provider. Upon investigation, it was identified that the office saw members on a walk-in basis as opposed to scheduled appointments. The reason stated by the office was that they had to resort to this type of process due to a large number of appointment "no-shows."

Meridian Provider Services and Utilization Management staff worked together with the staff from the emergency room facility and met with the physician staff and the PHO. Together, they developed a plan where the office staff agreed to work more closely with the members who were high emergency room utilizers by providing more education, developing an emergency room letter, which they could send directly to the members with high emergency room utilization, and agreeing to schedule appointments with members within seven (7) days of the emergency room visit. The facility emergency room case manager scheduled the appointment for the member and reinforced the importance of attending the appointment. Transportation was also arranged.

Outcomes of the Collaborative Initiative

Another large network PHO has developed an education program for members identified as High-ER utilizers to teach them about health plan resources, their responsibilities, the Patient-Centered Medical Home (PCMH) concept, emergent situations versus non-emergent situations, and how to handle those situations. Meridian follows up with members who have had no-show appointments at their PCP office and educates them on the importance of the PCP visit as well as identifies barriers to them getting to the doctor. Provider access issues are identified through

receipt of monthly reports that highlight providers with higher than normal utilization in the emergency room. Meridian also meets with PCPs who do not have appointments readily available and discusses strategies for improving access.

- Meridian’s chronic obstructive pulmonary disease (COPD) Home Program successfully decreased the average rate of admission and emergency room visits per member from over three point three (3.3) to approximately zero point two (0.2) admits per member. Members in this program also received intensive smoking cessation education and support. Of the members who completed the program, sixty-six percent (66%) successfully quit smoking.

| Meridian COPD Home Program Results | | |
|---|-------------------|---------------------|
| Members Completed | Admissions | Admit/Member |
| Admissions/Observations 2 Months Prior to Program | | |
| 82 | 277 | 3.37 |
| Admission/Observations After Program Enrollment to 2 Months | | |
| 82 | 19 | 0.23 |

As a compliment to targeted programs, Meridian has successfully implemented a High-ER Care Coordination Team. Meridian proactively investigates all cases of suspected narcotics abuse and excessive emergency room utilization as such behavior is indicative of members who do not understand the most effective manner in which to utilize their healthcare benefits. Information received from Meridian providers, prescribers, and other contracted entities, as well as from Meridian staff, is forwarded to the Care Coordination High-ER Manager to initiate the process for the member’s referral to the High-ER Care Coordination Team. This team works, through the investigation of referred cases, to educate members displaying non-compliant behavior while providing the tools and resources necessary for members to effectively manage their healthcare.

The High-ER Care Coordination Team provides members with the opportunity to work one-on-one with a High-ER Care Coordinator who is assigned to their case. By assigning each member a specific Care Coordinator, Meridian ensures the member’s access to the Meridian staff member who is most knowledgeable of their medical conditions and healthcare history. The High-ER Care Coordinator engages the member’s primary care provider (PCP) as well as other specialty providers the member has seen.

The High-ER Care Coordinator works with the member to schedule PCP appointments, as well as specialty provider appointments, as recommended by the member’s PCP and/or specialty provider. Transportation and gas reimbursement arrangements are also scheduled by the member’s Care Coordinator in an effort to decrease barriers prohibiting the member’s compliance with managing their healthcare. In addition to scheduling provider appointments and transportation, the Care Coordinator provides reminder notices prior to and conducts follow-up after all member interaction with the entities responsible for managing the member’s healthcare needs. Additional follow-up may include the distribution of informational packets specific to the member’s condition(s) (i.e. coping with stress, substance abuse, pain management, etc.), as well as personalized letters to the member reinforcing concerns that were discussed telephonically.

The High-ER team has shown quantifiable success in decreasing abusive emergency room utilization by Meridian members, while increasing member utilization of PCP/Medical Home services. In addition, Meridian has discovered (through the successful implementation of this

team) that members, when provided the education and resources necessary, are receptive to the idea of working with Care Coordinators to most effectively manage their health care. Through the analysis of member claims data, former members of the High-ER coordination program have shown both measurable (and positive) changes in behavior as it relates to utilizing the appropriate channels when receiving healthcare services.

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.

Through our utilization management processes, hospitals will make and document all post-stabilization authorization inquiries by telephone call to Meridian Health Plan. Meridian will return all post-stabilization inquiries within one (1) hour of receipt of the telephone call from the hospital and the hospital shall not be required to make more than one (1) call, provided that the call included clinical information. Authorization for admission and additional services shall be automatic should Meridian fail to respond within one (1) hour. The hospital agrees to provide Meridian with the requested information obtained from a “medical screening examination,” provided in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA), in order to determine the emergent status for payment approval, prior to treatment and after stabilization. Meridian shall provide twenty-four (24) hours a day, seven (7) days a week availability for post-stabilization authorization requests.

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

Emergency services access is detected through review of claims for the presence of diagnostic codes based on the “Emergency Diagnosis Code” list provided by the State of Iowa. Meridian Health Plan may also be notified of these services by phone, fax, or Provider Portal when requesting additional services, other than the emergency services. Prior authorization (PA) is another key component in tracking a member’s presentation for services, more specifically presentation for emergency services. Meridian is committed to authorizing care at the least restrictive and most medically appropriate levels. This commitment results in high quality of care and improved member autonomy, provider satisfaction, and effectiveness of controlling costs. The PA process ensures that members receive services consistent with their care plan, including covered services that are medically necessary, appropriate, timely and cost-efficient. In addition, PA supports patient safety and cost control by minimizing or eliminating the occurrence of medication errors, duplication of services, and inappropriate service delivery.

Meridian’s staff will track emergency services request through Meridian’s Managed Care System (MCS). Corporate authorization requests are entered into MCS by the attending provider at presentation or the facility and sent to Meridian electronically, through Meridian’s online Provider Portal. The MCS online Provider Portal is a secure, proprietary software program that offers unmatched flexibility and efficiency for our network providers. Accessible to all participating Meridian providers, the Provider Portal allows providers to verify eligibility, enter prior authorizations, review detailed member data and reports, and much more. The Provider Portal interfaces with MCS in real time in order to provide timely notification of requests for services. Requests can also be faxed to Meridian on a standard referral form, which is then entered into MCS by a Utilization Management (UM) Specialist. All requests should be

accompanied by documentation of medical necessity. Services requiring corporate prior authorization are evaluated on the basis of medical necessity.

Meridian has processes in place to ensure appropriate service and coverage to members as well as to address opportunities for improvement. Meridian continuously monitors data to detect potential under- and over-utilization and takes steps to correct the variance.

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

Meridian Health Plan's claims system is currently configured to recognize emergency room-related diagnosis (DX) codes based on the "Emergency Diagnosis Code" list provided by the State of Iowa. When the diagnosis code is entered on the initial screen, there is a field available that identifies the DX code as emergency room with a "Yes" or "No" response. When double-clicking on the individually highlighted diagnosis code line, an additional screen reflects a full description of the code along with an indicator flag that can be checked when the code should be identified as emergent. Our claims system has the capability to recognize and reduce payments for non-emergent diagnosis codes. This reflects and supports the functionality within our system to accurately identify and reimburse payments for valid emergency room services based on the "Emergency Diagnosis Code" list published on the IME site.

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

Emergency services do not require prior authorization. Members who have an emergency medical condition are not liable for payment of subsequent screening needed to diagnose the specific condition or stabilize the member, regardless of who refers them for the emergency service. Our claims processing system has the capability to recognize and reimburse claims based on the status of the referring provider (e.g. whether the referring provider is an in-network versus out-of-network provider). If the referring provider is a primary care provider (PCP) or network provider, Meridian Health Plan has the ability to program the system to allow payment of claims based on multiple variables, including, but not limited to, emergency room services.

Post-Stabilization Services

In accordance with CFR 438.114(e) and 42 CFR 422.113(c), Meridian covers post-stabilization services. Post-stabilization services are covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition. This includes all medical and behavioral health services that may be necessary to assure, within reasonable medical probability, that no material deterioration of the member's condition is likely to result from, or occur during, discharge of the member or transfer of the member to another facility.

Meridian is financially responsible for post-stabilization services obtained within or outside the network that are pre-approved by a plan provider or Meridian's representative. Meridian is also financially responsible for post-stabilization services that are not pre-approved but administered to a member to maintain the stabilized condition within one (1) hour of the request to Meridian for pre-approval of further post-stabilization services. Meridian will reimburse for post-

stabilization services if: (i) we do not respond within one (1) hour to a request for pre-approval; (ii) we cannot be contacted; or (iii) Meridian and treating physician cannot reach an agreement concerning the member's care and a Meridian physician is not available for consultation. In this situation, Meridian will give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with the care of the patient until a plan physician is reached or one of the following conditions is met pursuant to 42 CFR 422.113(c)(3): (i) a plan physician with privileges at the treating hospital assumes responsibility for the member's care; (ii) a Meridian representative and the treating physician reach an agreement concerning the member's care; or (iii) the member is discharged. If there is a disagreement between the treating facility and Meridian concerning whether the member is stable enough for discharge or transfer, or whether the medical benefits of an un-stabilized transfer outweigh the risks, the judgment of the attending provider(s) caring for the member at the treating facility prevails and is binding on Meridian.

3.2.6 Pharmacy Services

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

Meridian Health Plan fully utilizes the experience of its affiliate, MeridianRx, for its pharmacy benefit management needs. MeridianRx currently covers and/or reimburses prescription drugs for applicable Meridian Medicaid program affiliates (in accordance with Section 1927 of the Social Security Act, Payment for Covered Outpatient Drugs, and all applicable State and Federal Law). Consistent with our focus on integration, Meridian operates as an interdisciplinary team fully capable of delivering pharmacy benefits for this Contract. We draw on our expertise covering the full spectrum of care while relying on integrative technology to ensure comprehensive care for our members. MeridianRx offers an unparalleled, client-focused service model and excellence in day-to-day service.

MeridianRx's implementation plan includes a seamless transition for new members by honoring prior authorizations for the first ninety (90) days of enrollment. We provide necessary support to our members and providers by informing them of the transition timeframe, formulary alternatives, and the prior authorization process. MeridianRx works to ensure members are informed of their covered services to promote continued care. MeridianRx also examines up to twenty-four (24) months of administrative data, from both fee-for-service (FFS) and managed care organizations (MCOs), to support its rebate billing process and apply evidence-based guidelines to determine prescribing appropriateness. Our point of service (POS) system allows for quick and effective adjudication of pharmacy claims and in accordance with the National Council for Prescription Drug Programs (NCPDP), has a ninety-five percent (95%) POS transaction completion rate of less than one (1) second.

MeridianRx provides coverage for all classes of drugs including over-the-counter, to the extent and manner they are covered by the Medicaid FFS pharmacy benefit. Additional over-the-counter products and outpatient drugs self-administered by the member shall also be reviewed for coverage. Over-the-counter drugs dispensed in a nursing facility, PMIC, or ICF/ID shall be included in the per diem rate.

MeridianRx will follow and enforce the Preferred Drug List (PDL) and Recommended Drug List (RDL) under the Medicaid FFS Pharmacy benefit with prior authorization (PA) criteria, including quantity limits and day's supply limitations. MeridianRx shall restrict access to prescription drugs through the use of the PDL with prior authorization. Providers will be notified at a minimum of thirty (30) days prior to the implementation of PDL and PA criteria changes. MeridianRx shall provide continuity of care contingencies upon the implementation of PDL or PA revisions. Consistent with all applicable laws, MeridianRx will require PA to ensure the appropriate use of medication therapies. Pursuant to Iowa Code 249A.20A, drugs prescribed for the treatment of human immunodeficiency virus or acquired immune deficiency syndrome, transplantation and cancer are excluded from inclusion on the PDL. MeridianRx will utilize the RDL that was developed by the State for these drugs including Antihemophilic Agents.

Meridian is able to dispense and reimburse for at least a seventy-two (72) hour supply of a covered outpatient prescription drug that requires prior authorization in an emergency situation as required in 42 U.S.C 1396r- 8(d)(5)(B).

Aside from the twenty-four (24) hour, seven (7) day a week, fully operational call center, MeridianRx currently offers our existing provider community the ability to automate the prior authorization process through a HIPAA-compliant transaction formats using the most current standard (NCPDP D.0), web-based provider portal, which at a minimum, is capable of minimizing burden on the provider community while driving appropriate utilization and supplying access to electronic health records through a secure login process. The Provider Portal also gives authorized users access to their members' patient profile information, prescriber information, PA history, real-time approval and denial outcomes, and gives providers the ability to attach applicable medical record data to PA submissions.

MeridianRx will also ensure that all 340B Covered Entities adhere to the following: use drugs, vaccines, and diabetic supplies for all Iowa Medicaid managed care members; inform HRSA at the time of 340B enrollment; intends to purchase and dispense 340B drugs for Medicaid managed care members; will not bill MeridianRx for 340B drugs for Medicaid managed care members nor for 340B acquired drugs and products if the entity's NPI is not on the HRSA Medicaid Exclusion File; purchase all drugs and other products billed to MeridianRx under 340B unless the product is not eligible for 340B pricing; submit pharmacy claims for 340B acquired drugs to Meridian at the entity's AAC with values of "08" in Basis of Cost Determination field 423-DN, OR in Compound Ingredient Basis of Cost Determination field 490-UE, AND insert "20" in the Submission Clarification Code field 420-DK; and submit vaccines and diabetic supply claims for 340B acquired products to MeridianRx at the entities 340B AAC on the UB04 or CMS1500 claim forms.

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

Meridian Health Plan has the ability and experience to obtain and report on all rebates utilized under both the Pharmacy and Medical Benefit. Meridian has performed this function for other Medicaid Programs, including proper rebate claims adjudication, enforcement of rebate protocol, data collection, rebate claims investigation, and rebate reporting. MeridianRx works diligently with the drug manufacturers to validate that all drug utilization submissions are timely and accurate to ensure maximum rebate dollar retention.

Meridian will cover all medications which are rebated by the pharmaceutical manufacturer, in accordance with section 1927 of the Social Security Act, with the exception of drugs subject to restriction as outlined in Section 1927 (d)(2) of the Act. Meridian will enforce to contracted providers and pharmacies, the rebate requirement, including physician administered drugs, and to provide coverage at a minimum, for the same categories in the excluded/restricted category, to the same extent they are covered by the Medicaid FFS pharmacy benefit.

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

The mechanisms in place for tracking, accounting, and paying rebates include providing manufacturers with applicable source data directly from MeridianRx, Meridian Health Plan's affiliate pharmacy benefit manager, in each usage data submission file. Each claim can be tied back to the member and associated with each client. A rebate invoice per manufacturer per client will be generated for each quarterly submission. Upon receipt of the rebate payment, the claims that were eligible for rebates are bumped up against the submission file to determine outliers. The outliers are further scrubbed for possible re-submission in the run-out file or identified as non-rebate eligible. The final payment file to the client will contain all claims that were originally submitted and those that received a rebate payment. MeridianRx has a process for rebate dispute investigation and resolution. Meridian receives notification of a rebate dispute and employs the proper protocol for resolution. This includes dedicated staff to make outbound inquiries to providers and return documentation to all parties.

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.

For any drugs with prior authorization (PA) criteria, consistent with all applicable laws, MeridianRx will enforce and require prior authorization to ensure the appropriateness of its use. Once received, all prior authorization requests are reviewed and decisions are rendered within twenty-four (24) hours. Once a decision is made, MeridianRx will provide a response to the submitter by telephone or other telecommunication device within twenty-four (24) hours of the request's resolution. MeridianRx will communicate clearly and quickly with the member and provider by generating and distributing PA denial and/or approval letters. MeridianRx is a fully operational twenty-four (24) hours a day, and seven (7) days a week organization. In emergency situations, MeridianRx allows medication overrides for medications and dispenses a minimum of a seventy-two (72) hour supply. MeridianRx also provides the capability to utilize a prescriber's specialty code when rendering an automated PA determination to reduce barriers and expedite treatment.

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

The MERLIN (MeridianRx Live Integrated Network) pharmacy benefit management system offered by MeridianRx (MRx) is a twenty-four (24) hours a day, seven (7) days a week system for processing pharmacy claims for client healthcare companies. The system consists of a powerfully integrated network of membership, physician, pharmacy, and drug information built

around a comprehensive, rules-based adjudication engine. The combination of these elements working together within a state-of-the-art, integrated platform allows the MERLIN system to:

- Accurately adjudicate member pharmacy claims
- Quickly deliberate prior authorization and step therapy requests
- Manage drug coverage and formulary rules
- Configure member copays and cost sharing
- Supply business optimization reporting to improve efficiencies and reduce costs
- Provide timely invoicing and payment to clients and member pharmacies

In addition, MeridianRx has classified its drug utilization review (DUR) program into two (2) primary categories: soft edits and hard edits. The functions of DUR allow automated processing of claims while confirming appropriate utilization.

Meridian Health Plan will also report prospective and retrospective DUR activities and educational initiatives to the State or its designee quarterly and assist in data collection and reporting to the State the data necessary to complete the Centers for Medicare and Medicaid Services (CMS) DUR annual report. MeridianRx employs a series of real-time hard edits at the point of sale through its proprietary claims processing system. Every pharmacy claim submitted to MeridianRx must pass edit prior to payment, meaning that all pharmacies who submit a claim to MeridianRx are audited. These DUR activities include quantity limitations, duplicate prescriptions or claims, early refills, number of refills authorized, invalid refills, sanctioned prescriber, prescriber lock, and pharmacy lock. With the advanced DUR edits, MeridianRx maintains dedicated staff analysts for the purpose of performing prospective and retrospective review in order to identify any outliers in various categories. MeridianRx analysts are able (based on client requirements) to conduct investigations consisting of reviewing medical records maintained by prescribers to verify medical necessity and performing member outreach and intervention designed to curb inappropriate utilization. All DUR activities are monitored for quality and training purposes and can be processed on a daily, weekly, monthly, or quarterly basis as designated by the State.

MeridianRx also uses a prior authorization process to promote appropriate, safe, and effective utilization of drugs through the establishment of clinical guidelines. Along with a customizable prior authorization criteria process, MeridianRx holds a utilization management program which includes prospective, concurrent, and retrospective utilization review. MeridianRx's prospective review encourages appropriate prescribing in accordance to State and CMS guidelines. The use of prior authorization, step therapy, and medical criteria help ensure that members consistently receive the appropriate medications.

Soft Edits: These messages are meant to alert the pharmacist of potential interactions that are considered mild to severe in nature based on the information received in the claim. MERLIN allows the dispensing pharmacist to override the soft edit by providing confirmation back to MeridianRx through a designated National Council for Prescription Drug Programs (NCPDP) field. This confirmation will allow the claim to adjudicate completely without requiring MeridianRx involvement.

Soft Edits include:

- Drug-Drug Interaction

- Duplicate Therapy (DUP)
- Therapeutic Appropriateness (Duration, Diagnosis, Age Appropriateness)
- Over- or Under-Utilization
- Drug-Disease Contraindications
- Drug-Drug or Drug-Allergy Interactions
- Drug-Dosage
- Duration of Treatment
- Clinical Abuse or Misuse (Retrospective)
- Drug-Gender Precautions

Depending on the severity of the interaction, MeridianRx either sends an “Alert” or a “Reject” response to the pharmacy that submitted the claim.

An example of a Drug-Drug Interaction soft edit that would adjudicate completely without requiring MRx intervention would be two (2) anxiolytic benzodiazepines. More than one (1) benzodiazepine may be prescribed to a member due to a seizure disorder diagnosis along with a psychiatric diagnosis (anxiety, panic disorder, insomnia, etc.). The DUR rejection alerts the pharmacist that two (2) medications in the same therapeutic class are being prescribed and it is at the discretion of the retail pharmacist to dispense the medication.

Hard Edits: These are messages that only MeridianRx pharmacy staff can override. Hard edits require that the pharmacy contact MeridianRx to resolve the issue and provide the member with needed medication.

Hard Edits include:

- Eligibility – member not found
- Age-related rejections
- Prescriber sanctions
- Pharmacy sanctions or out-of-network
- Maximum cost exceeded
- Drug not covered
- Step Therapy DUR rejections
- Quantity limits
- Dispense as written (DAW) rejections
- Allowed number of fills exceeded
- Specialty medication
- Days’ supply limit exceeded
- Refill too soon (pharmacy is provided with upcoming refill date)

An example of an age-related hard edit that would require intervention from MeridianRx would be Azithromycin 200 mg/five (5) ml suspension. This medication has maximum age criteria of eight (8). In the event a member is over the maximum age and is unable to swallow the tablet or capsule form of the medication, MRx can place a courtesy override to ensure medication is dispensed and there is no delay in member’s treatment.

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.

The MeridianRx Live Integrated Network (MERLIN) adjudication system employed by MeridianRx (MRx) routinely checks incoming claim submissions for indications of fraudulent activity including, but not limited to:

- Multiple fills of narcotic medications
- Identical fills from different pharmacies for same patient
- Identical medications from different prescribers for same patient
- Extraordinary quantities in relation to days' supply
- Pharmacies with high rates of brand or narcotic dispensing

The analysis of the utilization data includes identification of patterns that may indicate inappropriate utilization by members, physicians, and pharmacies. Identifying patterns of fraud, abuse, and/or gross overuse can be identified by any of the above processes with the ability to drill down to the specific member, physician, and even claim level to determine the appropriateness. Meridian completes provider and member profiling on a monthly basis. The Finance Department provides the provider report, which renders detailed utilization patterns by all Meridian providers. Analysis of the report is completed on a monthly basis by the Meridian Medical Director, and quarterly by the corporate Quality Improvement Committee. This analysis includes investigation of outliers in pharmacy utilization patterns in a specialty specific manner, by cost, and type of medication prescribed.

Meridian's process for identifying member fraud, abuse, or gross over use is the responsibility of the MeridianRx Narcotic Monitoring Coordinator. A monthly report is pulled to capture our Medicaid population that have three (3) or more narcotic claims, from three (3) or more different prescribers, and filled at three (3) or more different pharmacies. The parameters of this report can be adjusted to meet contractual agreements. Once a member has been identified as narcotic seeking, a request for lock agreement is sent to the member's primary care provider (PCP). Once the lock agreement is complete and returned to MRx, the overall approval comes from a MRx pharmacist. This process restricts members to only obtain prescriptions from their PCP. In the event a provider is unwilling to contract, the member is placed in a pharmacy lock that limits them to filling prescriptions from one (1) pharmacy. Once the locks are approved by the MRx pharmacist, status updates are sent to all previous prescribers informing them of the applied lock.

In addition, MeridianRx has contracted the services of an outside vendor to fully sweep and analyze all paid claims over thirty-five dollars (\$35) (post-adjudication) for potential fraudulent activity. MeridianRx provides claim files to its vendor each week and a response is returned that identifies claims for further review and/or executive action. Through review of MRx's data, this vendor will review claims for things such as quantity limits, invalid or outdated prescriptions, prescriptions filled at certain times of the day, repackaged scripts, and reversed questionable claims returned to MeridianRx in the response file, which are further reviewed for erroneous submittals, inaccurate prescription fills, over/under payment, and other potentially fraudulent, wasteful or abusive practices. If fraud, waste, or abuse (FWA) is identified, MRx staff will submit a referral to the FWA team.

MeridianRx offers a complete portfolio of reports designed to detect and identify potential FWA activity by members, prescribers, and pharmacies. These reports are readily available in an ad-hoc format and provide ample input filtering criteria to allow users to target specific elements or activities.

Enhanced Member Health Outcomes While Monitoring the Value of Care

Recently, Meridian's trend management reports showed that the prescription pain medication, OxyContin, was being over-utilized by members. In some cases, pain medications do not address root problems of pain, only act to hide symptoms, and should not be used for ongoing care. As members were taking OxyContin, many required a higher dosage and frequency to mask their symptoms, and in some cases became dependent. In response to this challenge, Meridian developed a policy that required members taking OxyContin to visit a pain management specialist to assess their condition and set an appropriate care plan. This policy reduced the member's dependency on OxyContin. Since 2009, the number of members filling prescriptions for OxyContin has decreased by seventy-six percent (76%) and decreased cost while improving the member's care.

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.

Pending state approval, Meridian Health Plan will engage MeridianRx, LLC (MeridianRx), to function as the full-service pharmacy benefits manager (PBM) for this initiative and to perform pharmacy benefit management services for its membership. MeridianRx is a subsidiary of our parent organization, Caidan Enterprises, Inc. Meridian incorporated the care management synergies of its in-house pharmacy benefit manager, MeridianRx in the beginning of 2011. One of our key motivating factors in creating MeridianRx was to ensure that we could develop unique features that seamlessly integrate the needs of our members, providers, and pharmacies. As affiliates, Meridian and MeridianRx offer a shared commitment and culture to improving the quality of care.

Meridian will develop a plan for oversight of the MeridianRx performance, including, but not limited to, handling of provider issues and submit it to the State for review within ten (10) days of the execution of the contract. The plan will include the steps to be taken, a timeline with target completion dates. If changes are requested by the State, Meridian will submit the revised plan with thirty (30) days after the first submission of the plan and will execute the State-approved plan. Meridian will maintain a current, updated version of the plan and any subsequent changes to the plan will be submitted to the State for approval.

Meridian's systems, such as our Managed Care System (MCS), are highly integrated with MeridianRx systems. This real time, electronic synthesis of all of a member's health information streamlines and strengthens our ability to effectively conduct monitoring and oversight of subcontractor activities. It also maximizes effective communications, increasing Meridian's ability to implement changes to improve performance quickly and efficiently. This also provides Meridian with unequalled access to member information in real time, which allows us to provide the highest level of care coordination and overall service to our members, providers, and DHHS. For example, claims information maintained by MeridianRx, will be fed directly into Meridian's proprietary MCS platform, providing compliance, case managers, member services personnel, and other staff who have direct contact with members and their providers, with a comprehensive

snapshot of a member’s medical profile at their fingertips. MeridianRx maintains a comprehensive national network that covers all fifty (50) states, the District of Columbia, the United States Virgin Islands, American Samoa, the Northern Mariana Islands, Puerto Rico, and Guam. The breadth of the MeridianRx network ensures convenient access to prescriptions at deeply discounted rates.

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.

Meridian Health Plan prioritizes the health and well-being of members ages twenty-one (21) years and younger. Per the current contract with the Iowa Department of Human Services (IDHS), Meridian is required to promote the completion of early and periodic screening, diagnostic, and treatment (EPSDT) in accordance with recommendations from the American Academy of Pediatrics periodicity schedule.

As stated below, Meridian uses several approaches to ensure the completion of EPSDT screens including member and provider outreach, incentives, and education. Meridian monitors pediatric members in need of preventive or routine screening on a real-time basis using the Healthcare Effectiveness Data and Information Set (HEDIS®). At certain points in the year, Meridian individually engages members needing care. This approach has resulted in successful annual screening rates. In the baseline year of measurement, Iowa EPSDT rates only reached twenty-one percent (21%); however, in 2013, rates for infants through six (6) year olds reached eighty percent (80%) and the adolescent screening rate was nearly sixty percent (60%). Data for the 2014 reporting year will not be available until June 2015.

| Measure | Numerator | Denominator | Rate | Goal |
|------------------------|-----------|-------------|--------|---------|
| Well-child 0-15 months | 100 | 126 | 79.37% | Not Met |
| Well-child 3-6 years | 348 | 431 | 80.74% | Met |
| Adolescent well-care | 254 | 431 | 58.7% | Not Met |

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

Meridian will ensure that all requested records, including medical and peer review records, shall be available for inspection by State or Federal personnel or their representatives. Meridian will record health screenings and examination related activities and will report those findings in a State approved format at DHS required frequency.

Numerous efforts to secure routine, periodic screening are in place for Iowa children including targeted member outreach, where Quality Improvement or Member Services Representatives contact members and caregivers to provide reminders of the need for a preventive visit or assist in scheduling. Member incentives are used to promote the importance of well-child visits, particularly the first six (6) recommended from ages zero (0) to fifteen (15) months. Call campaigns are periodically employed to reach a large population. Clinical practice guidelines, including the EPSDT schedule and forms are provided to Meridian Health Plan providers. Completion of routine, preventive screenings are promoted through provider education and

incentives. Additionally, Care Coordinators and Community-Based Case Managers provide reminders about needed EPSDT follow-up and assist with appointment scheduling as needed.

External partnerships are critical to achieving continued success in EPSDT screenings. In the summer of 2014, Meridian met with the Maternal and Child Health program staff at the Iowa Department of Public Health (IDPH) to ensure appropriate guidelines were being promoted among Meridian providers, and alignment between Meridian and Child Health programs was occurring. Meridian stays in regular contact with IDPH staff providing service area maps monthly, updates to incentive programs, and in partnering on special projects.

Three (3) measures within the Healthcare Effectiveness Data and Information Set (HEDIS®) are used to calculate annual screening rates for EPSDT, including well-child visits in the first fifteen (15) months of life, well-child visits in the third, fourth, fifth and sixth years of life, and adolescent well-care visits. Additional measures indicating primary care provider (PCP) interaction and aspects of EPSDT include access to care, lead screening, and immunizations. These measures account for visits occurring between ages zero (0) and twenty-one (21) years of age. The data for these measures is refreshed daily for real-time tracking of member activity.

If selected to continue providing care in Iowa, Meridian will sustain existing efforts. Meridian will work to strengthen and streamline outreach activities to providers and members through the partnership with IDPH. Meridian anticipates meeting or exceeding screening rates for 2014 and will continue the goal of incremental gain in 2015.

3.2.8 Behavioral Health Services

Meridian Health Plan will offer comprehensive mental health services to members in accordance with the Iowa Administrative Health Code 441, Chapter 78; the Iowa Medicaid State Plan; and waivers. Mental health services will meet the members' medical necessity whether or not they are court ordered or are provided to children in need of assistance or an adjudicated delinquent. In addition, the following services will be covered:

- Outpatient therapy provided by a licensed qualified provider including family therapy and in-home family therapy as medically necessary to address the needs of the child or other members in the family
- Medication management provided by a professional licensed to prescribe medication;
- Inpatient hospital psychiatric services including, except as limited, services in the state mental health institutes
- Services that meet the concurrent substance use disorder and mental health needs of individuals with co-occurring condition
- Community-based and facility based sub-acute services
- Crisis Services including, but not limited to:
 - Twenty-four (24) hour crisis response
 - Mobile crisis services
 - Crisis assessment and evaluation
 - Non-hospital facility based crisis services
 - Twenty-three (23) hour observation in a twenty-four (24) hour treatment facility
- Care consultation by a psychiatric physician to a non-psychiatric physician
- Integrated health home mental health services and supports

- Intensive psychiatric rehabilitation services
- Peer support services for persons with serious mental illness
- 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 relationship
 - 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
- Habilitation program services
- Children's mental health waiver services
- Stabilization services
- In-home behavioral management services
- Behavioral interventions with child and with family including behavioral health intervention services (BHIS) and both Medicaid and non-Medicaid funded applied behavior analysis (ABA) services for children with autism
- Psychiatric Medical Institutions for Children (PMIC)

Meridian will ensure, arrange, monitor, and reimburse for comprehensive substance use disorder treatment services in accordance with Iowa Code, Chapter 125; Iowa Administrative Rules 641-155; and the latest version of the American Society of Addiction Medicine Criteria. Additionally, multilevel treatment will be provided, including specialized services for IDPH Participants, as specified in Exhibit D, Table D4 of the Scope of Work. The following substance use disorder services will be covered:

- Outpatient treatment
- Ambulatory detoxification
- Intensive outpatient
- Partial hospitalization (day treatment)
- Clinically managed low intensity residential treatment
- Clinically managed residential detoxification
- Clinically managed medium intensity residential treatment
- Clinically managed high intensity residential treatment
- Medically monitored intensive inpatient treatment
- Medically monitored inpatient detoxification
- Medically managed intensive inpatient services
- Detoxification services including such services by a provider licensed under chapter 135B
- Peer support and peer counseling
- PMIC substance use disorder services consisting of treatment provided by a substance use disorder licensed PMIC and consistent with the nature of care provided by a PMIC as described in Iowa Code chapter 135H
- Emergency services for substance use disorder conditions
- Ambulance services for substance use disorder conditions
- Intake, assessment and diagnosis services, including appropriate physical examinations, urine screening and all necessary medical testing to determine a substance use disorder

diagnosis, identification of medical or health problems, and screening for contagious diseases

- Evaluation, treatment planning and service coordination
- Substance use disorder counseling services when provided by approved opioid treatment programs that are licensed under Iowa Code Chapter 125
- Substance use disorder treatment services determined necessary subsequent to an EPSDT screening
- Substance use disorder 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
- Court-ordered evaluation for substance use disorder
- Court-ordered testing for alcohol and drugs
- Court-ordered treatment which meets criteria for treatment services
- 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

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

Meridian Health Plan is committed to providing comprehensive behavioral health services to Iowa Medicaid members. Integration of medical and behavioral health services is critical to ensure access to the full spectrum of necessary services. Effective delivery of behavioral health care services relies on engaging individuals with their own health management process and recovery, encompassing all of their physical, behavioral and social needs. In this way, members take ownership of their wellbeing and are empowered to strive toward overall wellness. In keeping with the State's commitment for the delivery of high-quality healthcare services for the Iowa Medicaid, Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i) programs, we have partnered with Beacon Health Options (Beacon) to deliver superior mental health and substance abuse disorder services to Medicaid, CHIP, and IDHP populations across the State. Additionally, we are positioned for alignment with the Regional Mental Health Redesign that is underway for mental health and disability services. As such, we will collaborate with the Iowa Department of Mental Health and Disability Services' (MHDS) fifteen (15) Regional Medical Directors, the Iowa Association of Community Providers, National Alliance on Mental Illness (NAMI) of Iowa, and the Iowa Primary Care Association to ensure our members continue to and have increased access to the quality providers of their choice. This will help ensure each member's continuity of care, choice of provider, and active engagement in his or her individual person-centered treatment with the array of needed supports.

Beacon is a Managed Behavioral Healthcare Organization (MBHO) serving more than 45,000,000 individuals across the country and in the United Kingdom, including more than 13,000,000 Medicaid beneficiaries. Beacon is an NCQA-accredited MBHO that specializes in the treatment of mental health and substance use needs on a fully integrated basis. Beacon staff will be co-located within Meridian to ensure unified services to members and providers. Meridian will provide delegation oversight, monitoring, policy and procedure review, and formal quarterly reviews of all Beacon operations, including financial stability if payments are equal to or greater than five percent (5%) of premium revenue. Together, we will deliver a seamless experience for

our members and providers leveraging state-of-the-art technology along with our shared commitment to quality and integration. We will deploy a “whole-person” philosophy of behavioral health care management that assists individuals in integrating all health care and recovery goals. Behavioral Health Case Managers will work with members, providers, and Interdisciplinary Care Team (ICT) members to ensure development of a person-centered care plan that addresses needs and establishes goals, such as those related to behavioral and physical health, housing, employment, family engagement, and peer support. We will collaborate with the State, local, and community organizations to meet the needs of individuals and provide a tailored triage and needs assessment appropriate to the individual’s presenting issues at each point of entry into the behavioral health system. We will utilize our innovative services that deliver customized, recovery-based and community-based treatment solutions, promote the use of certified peer supports, engage non-medical services and supports as necessary, and provide holistic care focused on whole-health wellness, long-term independence and skills building for Medicaid individuals.

2. Describe how your proposed approach will incorporate the values outlined in Section 3.2.8.1.

Our clinical philosophy is grounded in the provision of an understanding, compassionate environment in which the unique clinical and social needs of each individual are addressed in the context of hope, recovery, resiliency, and independence. We know that health recovery is a deeply personal, unique, and self-determined journey through which an individual strives to reach his or her full potential in society. Individuals in recovery improve their health and wellbeing by taking responsibility in pursuing a fulfilling and contributing life while embracing the difficulties one has faced.

Recovery from mental illness requires many elements, including developing hope, forging a new ability to self-manage, fostering supportive relationships, and pursuing meaningful life activities all while eliminating the stigma and discrimination associated with receiving treatment. Our collaborative Stamp Out Stigma (S.O.S.) outreach program educates members on the importance of seeking needed care. S.O.S. is promoted through numerous media outlets, including social media, reaching millions potentially suffering from mental illness. Meridian Behavioral Health staff and programs purport the development of strengths, importance of recovery, and achieving the highest quality of life. Involving member family and supportive individuals are critical to a successful treatment process.

Meridian’s approach to the provision of recovery-oriented mental health and substance use disorder treatment embraces the tenets of recovery and resiliency, beginning with Person-Centered Care and a strengths-based approach to care planning that:

- Encourages that the belief that personal recovery is possible
- Promotes member learning and self-determination
- Empowers members to form supportive relationships with others
- Promotes members achieving a meaningful and productive role in society
- Fosters dignity and respect by reducing and eliminating stigma and discrimination surrounding mental illness
- Uses Certified Peer Specialists to provide “lived experience” and to encourage individuals throughout recovery process

- Incorporates the strengths of individual strengths, aspirations and values as well as those of their families
- Strives to align services in the member's community of choice
- Promotes a "no force first approach" to crisis planning
- Promotes personal responsibility and member-directed recovery goals

Meridian is aware that members are more likely to access services and remain engaged in treatment when they feel their priority needs are understood and being addressed and met. As such, Meridian embraces accountability through policies and procedures assuring members:

- Choose their own behavioral health provider and care team, to the fullest extent possible and appropriate
- Participate in their treatment regarding decisions about services provided to meet the member's behavioral health needs
- Remain engaged in treatment, focusing especially on members with a history of inconsistent involvement, through proven outreach and engagement strategies
- Receive services that are focused on maintaining individuals in their home environment and promote recovery. For example, we provide parents and caregivers of children with serious emotional disturbance (SED) with educational materials to assist and encourage them in care for the child. In addition, we assist adults with serious mental illness (SMI) in obtaining and maintaining meaningful employment through vocational rehabilitation programs and community-based LTSS organizations
- Feel safe by appropriately assisting parents and caregivers of children to develop and maintain a stable environment the child
- Have unencumbered access to needed providers, supports and services via emerging, less restrictive and innovative resources, such as telehealth, to expand access to needed services. This is particularly necessary to facilitate extending mental health and substances use disorder services to rural areas of the State
- Receive coordinated, holistic services by collaborating with providers and other stakeholders to eliminate gaps and duplication of services to the extent possible

By focusing on resilience, strength, and individual goals, Meridian provides members with practical, concrete tools and the opportunity to use them. Meridian understands empowering individuals to design and direct their own recovery and resiliency increases their participation, which positively impacts their overall health and leads to more positive outcomes.

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.

Meridian Health Plan and Beacon Health Options (Beacon)'s collaborative care and recovery model rests on two (2) main principles: empowerment of the individual through engagement of their families and natural supports and person-centered care planning accompanied by a strong network of providers, advocacy organizations and community-based services and supports. Together, Meridian and Beacon will deliver these services to facilitate recovery and resiliency through the application of managed care principles, including disease management and recovery-oriented utilization review. Through effective care management, services are tailored to the individual's needs and not to those of the healthcare delivery system, resulting in a treatment

program that promotes ongoing engagement, increased levels of independence, and sustained results.

Meridian and Beacon weave this approach throughout all of our behavioral healthcare planning and delivery process—from program components, to innovative alternatives for individuals and their families, to our own corporate culture. Our commitment as champions of hope and recovery goes beyond managing clinical care. We will engage families to promote recovery by reducing the risk of noncompliance with treatment plans. One way to diminish this risk is to incorporate the individual's family into the treatment, intervention, and resolution plans.

Another approach that we will utilize engages providers and community stakeholders in the delivery of behavioral health services. Meridian and Beacon will directly engage the local provider community, including advocacy groups and associations to garner community support. Our process for introducing ourselves is as follows:

- Meridian and Beacon meet directly with professional associations, governmental organizations, and advocacy organizations. These groups understand the local system of care, especially the publicly funded mental health services, community health centers and social service agencies, all of which primarily serve lower income, uninsured and often individuals affected by serious mental illnesses. This dialogue establishes mutual trust and respect, and decreases any apprehension over managed care.
- Meridian and Beacon also engage directly with individuals or groups that represent the State. This engagement allows us to quickly uncover local issues, politically sensitive areas, and learn the historical context. In addition, we would ask to be included in any forums or advisory committees to gather additional input.
- Meridian participates in key conversations or facilitates introductions with stakeholders, works with relevant state agencies communicating intent before action, and informing the state of lessons learned from stakeholder engagement. Meridian anticipates feedback from the State of Iowa.

4. Describe your proposed peer support/counseling program.

In partnership with Beacon Health Options (Beacon), Meridian Health Plan will provide members with access to a peer support/counseling program in the State of Iowa. The primary goal of this initiative is to assist the individuals we serve to begin or regain active roles in their communities by taking ownership of their behavioral health needs and recovery. Our hope is that such a program will speed up the recovery process and provide opportunities for members to strengthen their own recovery by supporting others in their recovery efforts.

Beacon's Peer Support and Family Support Specialists undergo formal training in Motivational Interviewing, Wellness Recovery Action Planning® (WRAP®) and our own Health Promoter® Training. The Health Promoter® program is the centerpiece of our peer curriculum and philosophy. Consistent with our strength-based, person-centered values, Health Promoter® empowers individuals to pursue and maintain their own recovery as they define it. Course content includes stage-of-change evaluation, motivational interviewing, total health and wellbeing, role playing, and a number of physical wellness modules addressing weight management, smoking cessation and exercise.

A two-day, hands-on staff course is supplemented by eight (8) hours of online training in Living Well with specific chronic conditions, such as diabetes, coronary artery disease and asthma. In this way, Health Promoter® supports emphasis on the integration of behavioral and physical health management in maintaining wellness and recovery.

When members speak with a Peer Support Specialist on the phone or face-to-face, they are connecting with someone who provides emotional support, averts personal crises and helps the member cope with behavioral health challenges. These specialists excel at engaging members by sharing their own stories of recovery from mental health and substance use disorders. Our Peer Support Specialists have:

- Lived experience and achieved a significant level of personal recovery
- The insight and maturity to be a guide and mentor
- A passion for advocacy and empowerment

Specific to the State of Iowa, Peer Support Specialists will reach out to all recently discharged individuals to assist in their transition, support them to adhere to any follow-up appointments, and help them leverage their own strengths. Beacon and Meridian will also work with each member in transition to ensure he or she has a crisis prevention plan that is created by the member with support from their provider(s) and natural supports. This plan will outline resources, contact information, and strategies to help the person work through a potential crisis. Rather than being passive participants to their recovery, this program will give members the tools to become more active and engaged in their care.

5. Describe your services for prevention and early intervention.

Meridian Health Plan and Beacon Health Options (Beacon) support a philosophy of medical care based on prevention and early intervention through outreach, engagement, education, and peer support. We are aware of and attentive to the member's total life situation, including illness, social needs, strengths, and resources available that promote recovery and resiliency and foster independence. Our thorough intervention program fosters better health and financial wellbeing by avoiding more intensive treatment and/or services, and by preventing further deterioration. Supports and services that promote prevention and early intervention include:

- **Peer Support:** Peer Support Specialists with lived experience are able to empathize with individuals to provide concrete proof that people can, and do, achieve success beyond their behavioral health issues.
- **Education and Information Resources:** We provide educational and information resources through multiple modalities, such as electronically, by mail, and through providers.
- **Medication Alerts and Appointment Reminders:** Our Health Alert application is an outreach tool developed to facilitate and ensure timely and effective continuity of care for individuals. Health Alert is a component of our integrated technology platform that automates appointment reminders to increase compliance with scheduled appointments. Members can access Health Alert to set up and manage all of their appointments. Additionally, providers can also set up reminders for individuals through the provider web portal.

- **Telehealth:** Our telehealth solution connects individuals with timely and convenient access to behavioral health services, thus improving access to care and prevention, while helping to control delivery costs. This is a two-way, interactive web- and smartphone-based audiovisual platform that brings providers and members, residing in remote locations, into the same clinical space.
- **Screening, Brief Intervention, and Referral to Treatment (SBIRT):** SBIRT is a comprehensive, integrated, public health approach used to deliver early intervention and treatment services for persons with substance use disorders as well as those who are at risk of developing these disorders.
- **Physician Consult Line:** We provide a toll-free Physician Consult Line staffed by our Board-Certified Psychiatrists. These psychiatrists are available for telephonic consultation regarding all aspects of mental health and substance use disorder treatment, including medications. This one-on-one communication assists individuals receive the benefit of expert behavioral health care through their PCP for the evaluation of depression, anxiety, and substance use disorders.
- **Depression Screening for Youth:** Beacon developed a screening program aimed at assisting primary care providers (PCPs) with appropriate screenings for early identification of mental illness, suicide prevention in youth, and linking those in need with appropriate services. The program provides all parents the opportunity for their teens to receive a voluntary mental health check-up at the doctor's office, online, or telephonically. Using standardized screening tools, youth aged eleven (11) to eighteen (18) are assessed for behavioral and psychosocial problems in just ten (10) minutes. Parents of youth scoring positive on the screening questionnaires are provided with a referral recommendation to network providers for further evaluation or treatment as indicated.

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

Together with Beacon Health Options (Beacon), Meridian Health Plan will collaborate with providers to make certain Iowa Department of Public Health (IDPH) members receive needed care. Our provider engagement strategy includes regularly scheduled office visits and web-based training, formulating goals, thorough auditing and monitoring processes, as well as educational programs that prepare providers and address the specific needs of the substance user population. We will share data with providers that will formulate the key performance indicators (KPI) within the provider profile, offering technical assistance as needed, and periodically validating internal performance improvement via onsite audits.

Tools shared with providers focused on outreach to IV drug users may include motivational interviewing. Through motivational interviewing, outreach workers encourage members who use IV drugs to undergo treatment and provide awareness information about the relationship between IV drug use and communicable diseases such as HIV/AIDS. Meridian and Beacon will ensure that emergency room and primary care provider (PCP) personnel have a clear understanding of program resources, how to access them, and the services available to proactively facilitate connecting individuals with substance use disorders or co-occurring psychiatric and substance use disorders providers during the early stages of medical management.

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

Meridian Health Plan and Beacon Health Options (Beacon) commit to supporting Iowa Department of Public Health (IDPH)-funded Women and Children services. Once families affected by substance use disorder identified and selected for intensive case management, we will begin targeted intervention strategies, especially those with women and children. Similar intensive case management strategies will be utilized for the HIV/AIDS service delivery.

Our model for delivering clinical services for pregnant women who have substance use disorder is focused on early identification so that the member is assigned a priority status designation. We will work with IDPH to identify ways to enhance early identification and encourage follow through for women who have substance use disorders and are pregnant. We also work with PCPs and physical health services and supports to replicate the same degree of coordination and cooperation.

The Meridian and Beacon service delivery model for women with substance use disorders who have dependent children assesses and supports treatment for women from a holistic, family-centered perspective, and includes:

- Parenting education and support services such as child care services and family therapy
- Life skill training (e.g., budgeting, household management) that maximizes the member's ability to provide a safe, clean environment for herself and her children
- Focus on gender-specific issues, such as addressing emotional, physical and/or sexual abuse in the member and her children
- Comprehensive services for children, including a basic assessment, educational opportunities, and physical/medical evaluation with review of immunizations and childhood diseases, and referral if necessary
- Child development and prevention services, including an assessment of each child's level of functioning
- Alcohol and other drug education for children, including age-specific groups to discuss these issues and improve coping skills

Existing relationships between Meridian and IDPH Women and Children service programs will be leveraged to identify areas for improved member support and ongoing best practices. Such collaboration is critical to reaching members in rural or difficult to reach areas, or who may be served by local public health agencies.

Outcome reviews from Beacon's HIV/AIDS service delivery model revealed that individuals with HIV/AIDS were often not receiving adequate services, which was attributed to scarcity of medical facilities providing specialized HIV/AIDS treatment. Beacon and Meridian's combined strategy for ensuring the most appropriate level of care to these members includes the following components:

- Coordination of care through intensive case management care managers to ensure a comprehensive overview of services provided to the member
- Community-based resources to support members through the treatment phase and assisting them and their families in coping with potential dual issues of HIV infection and substance use disorders

- Coordination of services with the State and/or local programs to offer assistance, especially physical interventions (e.g., respite care) for members with HIV/AIDS
- If providers determine additional needs in training for the recognition and treating of HIV/AIDS, we will collaborate with IDPH to ensure providers have all of the necessary information so that they can provide the best treatment possible for individuals diagnosed with HIV/AIDS

Meridian is aware of IDPH Women and Children programs focused on HIV/AIDS service delivery and will again work with such programs to provide universal, appropriate care.

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.

Meridian Health Plan and Beacon Health Options (Beacon) will use the Child and Adolescent Needs and Strengths (CANS) screening tool to screen children with serious behavioral health conditions. This tool, which was developed using industry standards for the detection of behavioral health conditions, includes the level of care and the plan of service recommended, and allows for monitoring of outcomes for services. The CANS promotes the linkage between the assessment process and the creation of individualized care plans. This tool works towards suggesting meaningful pathways for planning and the provision of appropriate treatment services.

While Meridian and Beacon have specific protocols and guidelines in place for children with serious behavioral health conditions, both entities will collaborate with child welfare and juvenile justice agencies and providers to develop effective trainings, interventions, and supports to respond effectively to needs of children with behavioral health issues. This “knowledge exchange” drives system of care transformations that improves outcomes, promotes recovery, and encourages efficient use of State resources.

Specific treatment protocols include emergency stabilization in emergency rooms and time-sensitive response to crisis situations through mobile team within one (1)-two (2) hours of identified need. Mobile response services may be provided in the emergency room, in natural environment, or by phone. Meridian and Beacon also employ on-site mental health counseling, follow-up with a child’s family, identification and mobilization of community resources, and referral to community mental health agencies. Other protocols Beacon has used in their Medicaid contracts across the country, included:

- **Family-Based Mental Health (FBMH) Services:** FBMH incorporates intensive home therapy, casework services, family support services, and twenty-four (24) hours a day, seven (7) days a week availability for crisis stabilization with the goal of integrating mental health treatment, family support services and casework so that families may continue to care for their children at home. The needs of all the children within a family, not just the child in response to who services were initiated, are actively considered and included as part of the treatment process. FBMH is guided by the recognition of the normal growth and development of children at different ages, and supports family caretaking and functioning through collaborative, joint family meetings. These meetings can include different combinations of family members and community members.

- **Multi-Systemic Therapy (MST):** The prime directive of MST is to keep adolescents who have exhibited serious clinical problems—substance use, violence, severe emotional disturbance—at home, in school, and out of trouble. Because MST is not a “learn it and do it for the rest of your life” approach, the continuing support that MST services provide is crucial to success. Therapists working with these very challenging youths and families receive constant feedback, coaching, and training.

Meridian and Beacon will work closely with area school systems to coordinate prevention, screening and early identification programs and to ensure information and recommendations for continued care in the individual education plan are incorporated in each child’s individualized treatment plan. Meridian and Beacon will coordinate the primary care provider’s involvement in developing the child’s individual treatment plan to ensure that the most appropriate, least restrictive behavioral health services are recommended. Both entities ensure that those plans include educational needs along with collaboration with the school psychologist/counselor.

Meridian and Beacon also establish linkages throughout the continuum of care. Additionally, transitional planning is coordinated with the school prior to and after the child’s discharge from any out-of-home placement to the local school authority. Staff clinicians work with the schools to ensure these activities are occurring. Alongside local school systems, Meridian and Beacon identify available community resources serving youth and work to identify and develop services to meet additional service requirements.

Meridian and Beacon will establish linkages throughout the continuum of care for youth. Education will be offered for school personnel and local educational authority personnel to ensure that they have a solid understanding of the issues that children and adolescents with mental health and/or substance abuse issues face.

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

Meridian Health Plan and Beacon Health Options (Beacon) will employ a mutually cooperative, integrated approach to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAWA) guidelines, and the Final Rule. Meridian and Beacon will create a unified utilization management program that will share guidelines, policies and procedures. Meridian’s Utilization Management and Quality Improvement Committees will include Beacon membership. Meridian will design a comprehensive monitoring and oversight program. Regular audits will ensure:

- 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 than are applied to medical and surgical benefits
- Compliance with MHPAWA for any benefits offered by Meridian to members beyond those specified in the State of Iowa’s Medicaid plan
- Criteria for medical necessity determinations for mental health or substance use disorder benefits are available to any current or potential member, or contracting provider upon request
- Provision of reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members

- Provision of out-of-network coverage for mental health or substance use disorder benefits when 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.

Meridian Health Plan and Beacon Health Options (Beacon) define integration as a continuum of care. Care solutions must be tailored to member needs, and we have a proven track record of successfully working within practice and state-level parameters. For those members that access their care through Iowa Mental Health and Disability Services (MDHS) regional facilities and Iowa Community Health Centers, Meridian and Beacon will work with these providers to ensure each member continues to receive care at their medical home and facilitate the exchange of information to avoid any breaks in treatment. Meridian's policies and procedures ensure collaboration and the exchange of health information (with appropriate member approval) between all providers involved in the member's care plan in order to coordinate services for mental health diagnosis, substance use, and physical illness.

The goal of Meridian and Beacon's integrated care approach is to improve the overall health of individuals who have significant behavioral health needs by providing a delivery system built on the functional integration of mental health care, treatment for addiction, physical health care, and social supports. The foundational elements of this vision are:

- A medical home for all members who are not enrolled in an Integrated Health Home
- A wellness-based approach, wherein all people deserve and receive quality physical and behavioral health care
- A focus on prevention that keeps individuals from moving into higher, more costly levels of care
- A well-trained behavioral health workforce prepared to work effectively with and in primary care
- A system of care that leverages the expertise of clinical providers and the effectiveness of social supports like government agencies, community-based organizations and peer-based recovery resources
- Participation on Meridian's Interdisciplinary Care Team (ICT) in order to develop the member's care plan for all members affected by co-morbid medical and behavioral health conditions

In order for integration between treating providers to be successful, Meridian and Beacon will collaborate with the member's primary care provider (PCP), as this is critical to the member's care, by providing them with behavioral health screening tools. Meridian and Beacon will also provide PCPs with educational resources, individual training services, as well as a Physician Consult Line. The Physician Consult Line is toll-free line which is staffed by our board-certified psychiatrists who provide one-on-one consultation regarding all aspects of mental health and substance use disorder treatment, including medications.

To evaluate and monitor the effectiveness of our integration approach, policies, and procedures, Meridian and Beacon will utilize our newly created Integrated Practice Assessment Tool© (IPAT©). This assessment tool will assist with accurately determining our integration level. The

IPAT enables us to better measure integration both within and across healthcare settings and the provider network.

This web-accessible tool can be used to assess and compare integration abilities by practice type, or between healthcare networks and geographic regions. Additionally, the data collected can help evaluate network readiness for integration, tailor products and services to emerging state partner needs and even establish thresholds for payment structures, offering financial incentives for movement along the integration continuum. Meridian and Beacon also use IPAT to determine the association between integration level and clinical, cost, and utilization outcomes.

Through thorough review processes, quality improvement initiatives, and outcomes monitoring for best practices, we evaluate and monitor the effectiveness of our physical health, substance use disorder, and mental health coordination programs, policies, and procedures. In this way we continually develop and implement mechanisms to improve coordination and continuity of care.

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.

Effective communication is key to achieving integration between behavioral health and medical providers. Beacon Health Options (Beacon) and Meridian Health Plan have developed numerous care coordination initiatives to facilitate improved communication between MCOs, physical and behavioral health practitioners, and facility staff. By measuring behavioral health practitioner compliance through our PCP and behavioral health practitioner communication tools and standards, we continually monitor the continuity of care between physical and behavioral health providers.

Additionally, Beacon and Meridian analyze the exchange of information between behavioral health providers and other mental health and substance use disorder providers through chart review and survey methodologies. Both entities do so through a joint annual review of a significant sample of outpatient medical records. Furthermore, our utilization review clinicians ask their hospital contacts if individuals' PCPs and other behavioral health providers are contacted for each individual admitted to the facility under review.

Integration between behavioral health providers and PCPs is also a key component of Beacon's contracting strategy, as the behavioral health network is contractually required to coordinate care with individuals' PCPs. Additionally, the direct support we provide PCPs streamlines their communication process with behavioral health providers. Many PCPs lack both the training and time to address behavioral health conditions that may emerge during an individual PCP visit. Therefore, Beacon and Meridian will work with the State to educate PCPs about behavioral health treatment and achieve the clinical cultural shift needed to "normalize" the inclusion of behavioral health practices as described within this RFP.

Co-location at the provider level is also key to effectively coordinate service delivery across the continuum of care. Meridian and Beacon will work with the State to identify high-volume primary care sites that will benefit from the co-location of behavioral health services. In other markets, we recently collaborated with some of our state partners to build behavioral health services into several newly formed Patient-Centered Medical Homes. The presence of our clinicians working alongside network providers creates the foundation for care coordination and

integration. As the individual’s care plan is developed and implemented, all providers along the care continuum must communicate with the individual’s PCP and we will serve as an effective facilitator and guarantor that this communication is occurring.

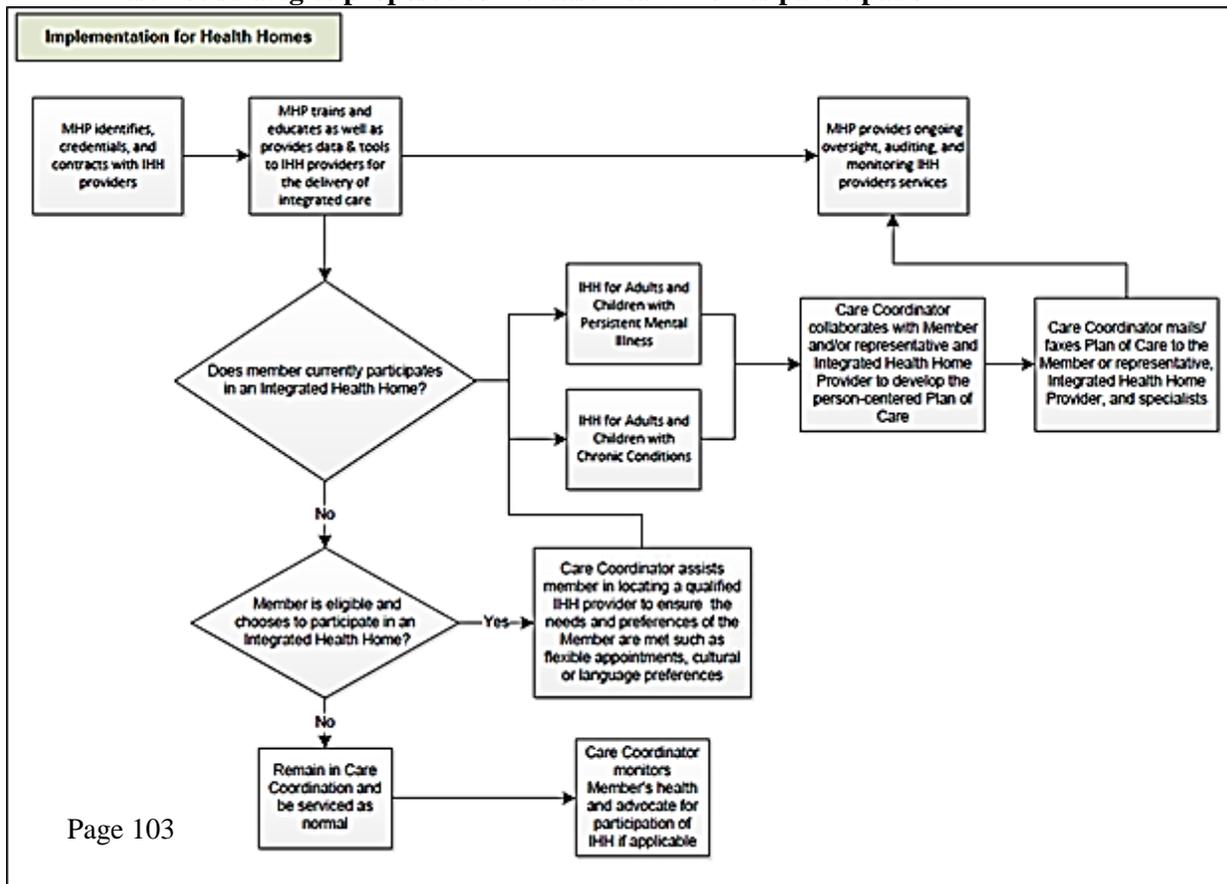
3.2.9 Health Homes

1. Describe your proposed approach for implementing health homes.

Meridian Health Plan will administer and fund integrated health home programs, and will also promote and encourage the participation of applicable members, especially in areas of the State where participation has been historically low. Care Coordinators are responsible for assisting members who are eligible with selecting a provider and establishing care with an Integrated Health Home (IHH). The Care Coordinator takes into consideration the needs and preferences of the member such as flexible appointments, cultural or language preferences when suggesting a provider. It is also imperative that the Care Coordinator establish a relationship with the member’s IHH to ensure implementation and provider input into the care plan.

Provider offices are encouraged to employ electronic tools (including registries), incorporate evidence-based guidelines for targeted chronic conditions, and incorporate team-based care into their operations. Provider practices receive technical assistance and funding to support project implementation. Meridian also provides assistance to PCPs in the meaningful use process and to providers in obtaining national patient-centered medical home (PCMH) certification through Utilization Review Accreditation Commission, National Committee on Quality Assurance, Accreditation Association for Ambulatory Health Care and Joint Commission on Accreditation of Healthcare Organizations. Meridian offers enhanced payments to PCMH-recognized practices through the payment of new billing codes (such as after-hours care), bonus payments based on HEDIS® scores, and a tiered administrative bonus payment based on practice performance.

2. Describe strategies proposed to increase health homes participation.



Meridian Health Plan proposes to implement the following strategies to promote the increase in health homes participation:

- Integration of health home education and benefits in care coordination process for eligible members
- Screening members for potential health home eligibility and participation during initial Comprehensive Assessment and care plan development. Identify, encourage involvement, and enroll individuals eligible for participation
- Utilize a “no wrong door” philosophy where the full spectrum of healthcare needs for all people, regardless of their point of entry, is assessed and met in the most available, most appropriate, and least restrictive treatment settings
- Develop the Health Home network and ensure that each Health Home meets the requirements established in the State Plan Amendment
- Provide training, technical assistance, expertise and oversight of Health Homes;
- Perform data analysis at the individual level and program-wide to ensure continuous quality improvement
- Reimburse providers as approved by the State
- Develop an incentive payment structure, for State review and approval that rewards based on quality and outcomes

3. Describe your proposed reimbursement structure for health homes.

Meridian Health Plan recognizes that practices need up-front financial resources in order to implement technology, evaluate and change work flows, and move from an episodic care model to one that provides care management and coordination at the point of service. Meridian provides a per member/per month (PMPM) payment ranging from one (1) dollar to three (3) dollars PMPM to those eligible.

| Meridian PCP PCMH Bronze | |
|--|---|
| <p><i>Qualifications</i></p> <ul style="list-style-type: none"> • Contracted – Fee-for-Service • Open to and accepting new Meridian members • Meridian membership of 100+ • Level 1 NCQA recognition or score of 35-59 on Baseline Self-Assessment Tool (Passing all Must Pass Elements) | <p><i>Administrative Payment</i></p> <ul style="list-style-type: none"> • \$1 PMPM • Meridian HEDIS® Bonus Program <p>*\$10,000 annual cap per provider</p> |
| Meridian PCP PCMH Silver | |
| <p><i>Qualifications</i></p> <ul style="list-style-type: none"> • Contracted – Fee-for-Service • Open to and accepting new Meridian members • Meridian membership of 100+ • Level 2 NCQA recognition or a score of 60-84 on the Baseline Self-Assessment Tool (Passing all Must Pass Elements) | <p><i>Administrative Payment</i></p> <ul style="list-style-type: none"> • \$2 PMPM • Meridian HEDIS® Bonus Program <p>*\$10,000 annual cap per provider</p> |
| Meridian PCP PCMH Gold | |

| | |
|--|---|
| <p><i>Qualifications</i></p> <ul style="list-style-type: none"> • Contracted – Fee-for-Service • Open to and accepting new Meridian members • Meridian membership of 100+ ▪ PCMH recognition by Joint Commission, URAC or AAAHC and/or level 3 NCQA recognition or score of 85-100 on the Baseline Self-Assessment Tool (Passing all Must Pass Elements) | <p><i>Administrative Payment</i></p> <ul style="list-style-type: none"> • \$3 PMPM • Meridian HEDIS® Bonus Program <p>*\$10,000 annual cap per provider</p> |
|--|---|

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

To ensure non-duplication of payment for similar services offered through the 1915(c) HCBS Waivers or other forms of case management, Meridian Health Plan will utilize our current prior authorization and claims processes.

3.2.10 Chronic Condition Health Homes

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

Part of our mission as experts in healthcare integration is to assist our State partners in implementing their vision for a chronic condition health home. Meridian Health Plan will ensure that individuals with two (2) or more chronic conditions, or with one (1) chronic condition and at risk of developing another, receive coordinated care in an Integrated Health Home (IHH) that facilitates better access to physical and behavioral health care, improves health outcomes, and best meets the needs of individuals.

Our integrated approach allows us to manage programs and networks for Medicaid and low-income populations, as well as dual eligible and persons with complex health issues, through our clinical expertise serving the needs of the local community. Coordination among individuals, providers, and other stakeholders occurs resulting in maximization of efficiency, effectiveness, and overall benefits of a chronic condition health home.

The IHH model is designed around the use of patient-centered medical homes (PCMH) to coordinate care for individuals most in need, particularly those in transition. The model also leverages emerging technologies that accelerate the integration of primary care and behavioral health, and enable effective outreach and individual engagement. Finally, the model enhances chronic disease management by improving adherence to treatment protocols by physicians and to prescribed medications by individuals.

To ensure satisfactory implementation Meridian will:

- Develop the Health Home network and ensure that each Health Home meets the requirements established in the State Plan Amendment (SPA)
- Provide training, technical assistance, expertise, and oversight
- Identify, encourage involvement, and enroll individuals eligible participation

- Perform data analysis at the individual level and program-wide to ensure continuous quality improvement
- Reimburse providers according to our proposed reimbursement methodology as approved by the State
- Develop an incentive payment structure, for State review and approval, that rewards Health Homes for performance based on quality and outcomes

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.

Meridian Health Plan, Beacon Health Options (Beacon), and Independent Living Systems (ILS) will ensure the assessment of needs-based eligibility, recruitment and training of qualified providers, service plan review and authorization, delivery and monitoring of services, and payment related to the (i) Habilitation Services and 1915(c) Children’s Mental Health (CMH) programs. We will optimize the use of all benefits for which a member qualifies. These services include:

- Case Management – When the individual does not qualify for targeted case management
- Home-based Habilitation
- Day Habilitation
- Prevocational Skills
- Supported Employment
- Environmental Modifications and Adaptive Devices
- Family and Community Support Services
- In Home Family Therapy
- Respite

The initial step of the comprehensive care coordination process is to investigate and ensure that members have been authorized by the State to receive these services. On an ongoing basis, Meridian and subcontractors will assist the State with reporting eligibility issues as needed. The next phase for completing the assessment of needs-based eligibility for both programs encompasses an initial face-to-face Health Risk Assessment (InterRAI), care plan collaboration, service level plan development, and connection of members to social, community, and health resources. The InterRAI is programmed into Meridian’s system which allows for triggered risk responses to automatically populate into the Care plan. This allows the Community-Based Case Manager to address the triggered problems and goals with the member in addition to creation of expressed personalized goals. The development of the care plan allows targeted needs and goals to be identified and addressed in the creation or adjustment of the service level plan (conditions for adjustment are outlined in Section 4) within guidelines of the service cost maximum set forth by the applicable state agency. The member has complete autonomy and works with the CCC to self-direct his or her services.

Meridian and ILS understand the complex needs of these populations, and thus the CCC ensures that within the service plan, the back-up plan is also completed in the case that the member’s first self-directed worker is unable to execute services. Once the assessments, care plan, and service level plan has been completed, then authorizations will be placed on file for approved services as discussed with the member. To ensure that the provider has started services for the member, the

CCC will follow up with the member within five (5) days after the initial start date of services as well as conduct ongoing face-to-face and phone contacts. Ongoing contact with the member is crucial since this gives the CCC the opportunity to address investigation of claims and authorization trends and see what risk areas to focus resources on. The CCC must complete the InterRAI Comprehensive Assessment and updates to the service level plan at least annually to ensure services are appropriate, compliant, and adequate. To facilitate compliance with CMS, the State, and Meridian's fraud, waste, and abuse standards and policies, Meridian understands the importance of transparency and communication with providers and members. Meridian will ensure that providers are given the training, tools, and information in order to better provide services to our members. Our Provider Services Representatives complete training with the providers on our web-based portal and designated provider phone queues where providers are able to easily access allowable member information, submit claims, technical assistance, training materials, and other resources.

2. Describe your experience serving similar populations, if any

Meridian Health Plan, Beacon Health Options (Beacon), and Independent Living Systems (ILS) have developed a deep expertise in the managed long term care business. Collectively we have over thirty-three (33) years of experience, in ten (10) states, working with long-term care (LTC) and home and community-based services (HCBS) providers.

The collective experience of Meridian and subcontractor management teams offer demonstrated results in service coordination. These teams have served populations consisting of frail and elder members and the disabled, managed care dual-eligible/enrolled Medicare/Medicaid, and fee-for-service Medicare and/or Medicaid members.

Although the eligibility criteria and service offering varies across each state and waiver program, the one constant attribute across all of our HCBS programs is the goal to sustain member presence in their homes and communities, with appropriate social supports, wherever possible.

In addition to managing HCBS delivery in various Medicaid contracts throughout the United States, Meridian and subcontractors have also collaborated with State agencies to do the following:

- Determine whether selected CMS 1915(c) and CMS 1915(i) waivers would benefit subsets of their Medicaid population
- Manage HCBS eligibility for State- and CMS-funded programs
- Develop and administer assessment tools
- Develop person-centered care plans
- Conduct reviews and quality audits on them

Waiver participants are eligible to receive enhanced mental health services, including:

- **Expressive Behavioral Services:** Art, drama, dance, equine, music, and horticultural therapies
- **Caregiver Peer-to-Peer Support:** Provided by current or previous caregivers of a child or youth with emotional, behavioral, or mental health challenges

- **Youth Peer-to-Peer Support:** Provided by a youth eighteen (18) to twenty-six (26) who has or had emotional and/or behavioral health challenges
- **Family and Youth Training:** Provided by either a parent or youth with experience in the system
- **Crisis and Stabilization:** Mobile supports to youth/families in psychiatric crisis
- **In-Home Respite Care:** Provided where the youth resides or in the community
- **Out-of-Home Respite Care:** Provided in the community overnight

Meridian Highlights

A seventeen (17) year old Illinois Medicaid member became effective with Meridian Health Plan on May 1, 2014. Later that month on May 22, 2014, the member's mother called in to inquire about coverage for in-home services; she informed Meridian that her daughter was severely disabled and required twenty-four (24) hour supervision. The mother had been previously receiving services through a program that lost funding and was at risk for losing services immediately. The Meridian Community Care Coordination Manager spoke with the member's mother and scheduled for a Community-Based Case Manager to go to the member's home the next morning to complete a Comprehensive Assessment.

On May 23, 2014, the Meridian Community Care Coordination Manager communicated urgent follow-up needs with a Case Manager at the Division of Rehabilitation Services to refer the member for a functional assessment. The State sent a Case Manager out that day to complete the functional assessment with the member receiving a qualifying score. The Community-Based Case Manager created a service level plan by the end of the day and an authorization was entered and faxed to the homemaker agency to continue servicing the member. The member's assigned Community-Based Case Manager continues to work with the member and family, and supporting the member's care plan. The member received behavioral health services; the member's family actively participated in counseling programs and began looking for community options that will allow for more independence in the member's life.

Meridian will use the InterRAI assessment for both the Children Mental Health 1915 (C) and Habilitation waivers 1915(i) within sixty (60) days of enrollment. Using this streamlined conflict free approach of assessments delivery will assist in determining the appropriate level of care for members in these populations. Meridian will identify members that may potentially be eligible for long-term care supports and services by using:

- Predictive modeling through claims history
- Screening using the Johnson and Johnson's screening tool to identify high risk members
- Self-referred members
- Provider notification and referrals
- Members identified through Transitions of Care
- Significant Change in Condition

Members with potential waiver eligibility will be screened with the InterRAI tool within thirty (30) days of referral to long-term services and supports (LTSS). Members in these risk groups will be assessed at least annually to track and ensure that appropriate supports and services are in place. If Meridian becomes aware that a members functional status has changed than a reassessment will occur before that timeframe. Once the InterRAI assessment is completed,

Meridian will submit the level of care or functional eligibility assessment to the State as prescribed. Meridian will work within the State waived budget caps in the development of a service level plan for eligible members. All documentation and assessments will be available at the state's request, and Meridian will report all criteria in the state prescribed format.

If a member does not meet criteria for waiver eligibility, Meridian will inform members that they do not meet criteria for additional LTSS but will inform our members of their rights to continue the application process and continue if they desire. Meridian will complete the InterRAI and submit the level of care or functional eligibility to the State for determination. Meridian will document all conversation and assessments regarding the members care and decisions to be available if needed to the State.

In the event that a member is eligible for additional services and there is a waitlist for services, Meridian will advise our members at the time of assessment, and provide information on additional supports and services that may be utilized. Meridian will track members waiting on slots and ensure that community supports are in place to assist in supplementing services. The Community-Based Case Manager will assist in a person-centered care plan and create a backup plan to ensure health and safety risks are addressed until additional services through waiver can be obtained.

Members who are eligible for services will have a service level plan developed that will include all services identified in the risk areas of the InterRAI and as identified in the person-centered care plan. The service level plan will be reviewed and revised at minimum at the annual reassessment, when there has been a significant change in condition or at the member's request.

The Person-Centered Planning process will be utilized for each service level plan developed. The Person-Centered Plan will be member driven and member led whenever possible to ensure that a person-centered approach to care is the central focus. Areas of risk identified in the assessment process and areas reported by the member during the pre-planning process will be addressed with the member and their support circle. Meridian will have an established core of professional supports that assist with the review and development of the care plan based on the member's needs and services. The person-centered planning teams is comprised of informal and formal supports including, but not limited to, the member and if appropriate the member's legal representative, family, service providers, and others directly involved in the member's care, including input from the member's primary care provider, specialists, and behavioral health providers, and Meridian's Community Case Manager. These meetings will take place at least annually at the place of the member's or legal representative's choice. Meridian is conscious of members' cultural preferences and will supply materials resources as appropriate to the members' or support team's needs. The person-centered planning process is a pathway to open doors to additional community supports and fosters informed choices that promote well-being and self-direction of services. There will be a record of the service level plan, person-centered care plan developed and records of alternative, such as alternative home and community-based settings. The service level plan will include home setting, hours, and types of services provided by formal paid support staff. If a member lives in a group residential setting, records of type of setting, any restrictions, number of people residing in the setting, individual hours, and maintenance of funds for self-directed services. In addition, the person-centered plan shall develop an emergency backup plan. The emergency backup plan will be housed in the service level plan to identify backup staff to ensure a plan is in place to avoid harm to the member. The emergency backup plan will include the member's assessment, the emergency backup support, and crisis response processes needed.

In the case that a member refuses to sign their service level plan, Meridian will ensure that members are comfortable with their self-directed care plan. Members will be provided the right to appeal their service level plan to escalate for further review and determination. Meridian Community Case Management staff will work with the member to assist to resolve any issues and ensure that members have every opportunity for directing their care plan.

Meridian will monitor waiver eligibility on ongoing bases. Monitoring will include residential monitoring and maintenance of billable services by monitoring over and underutilization of waiver services.

Meridian will notify the State, as prescribed by State, if members are not in compliance with appropriate home and community-based waiver settings or are not meeting the minimum of one (1) billable unit per calendar quarter.

To ensure receipt of services and Community-Based Case Managers will contact waiver members at least every thirty (30) days by phone or face-to-face, but at a minimum, face-to-face in their residence every sixty (60) days. When services have implemented, the Community-Based Case Manager will call the member within five (5) business days of service initiation to ensure services have started and visit the member's home to monitor services within thirty (30) days of initiated services. The Community-Based Case Manager will ensure that the backup plan established in the person-centered plan is adequate and covers any service gaps that may be uncovered. Meridian is diligent in ensuring services are in place; follow-up to providers is conducted by back office staff inputting authorizations of services and Community-Based Case Managers conducts monitoring to ensure appropriate and authorized services are taking place. If services are inadequate, options to the member are discussed which may change service providers or address education needs for self-managing care providers. Member choice and self-direction are utilized; education of service delivery and maintenance for health and safety are paramount to the self-directed delivery system.

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.

Meridian Health Plan acknowledges the State's authority for determining medical exceptions. Medically Exempt individuals are identified through: (i) a Medically Exempt member survey and (ii) Medically Exempt attestation and referral form. Meridian understands that the State maintains responsibility for scoring the member survey and determining if, based on the survey, the member is Medically Exempt. The individuals who are identified as Medically Exempt shall have a choice between the Iowa Wellness Plan and regular Medicaid State Plan benefits, as described in Iowa Admin. Code 441 Chapter 78, which offers more comprehensive coverage. Meridian will remain consistent with 42 CFR §440.315(f), where an individual shall be considered Medically Exempt if he or she has one or more of the following: (i) a disabling mental disorder, including adults with serious mental illness; (ii) chronic substance use disorder; (iii) serious and complex medical condition; (iv) a physical, intellectual or developmental disability that significantly impairs his or her ability to perform one (1) or more activities of daily living; or (v) a disability determination based on Social Security Administration criteria. "Activities of daily living" may include: (i) bathing and showering; (ii) bowel and bladder management; (iii) dressing; (iv) eating; (v) feeding; (vi) functional mobility; (vii) personal device care; (viii) personal hygiene and grooming; and (ix) toilet hygiene.

The State shall communicate the findings from the member survey, attestation, and referral form (described in Section 3.2.13.1.1) to the Meridian and the Meridian shall provide State Plan benefits versus Alternative Benefit Plan benefits to Medically Exempt members. Once a member has been deemed eligible by the State and selects his or her new benefit package, Meridian will receive an updated file indicating this plan benefit change. Upon receipt of this file, Meridian's system will be updated to reflect the change in the member's plan benefit ID. Meridian coordinates all member services including service requests and claims payment based on this plan benefit ID. When a member transitions from the Meridian Wellness Plan to the Meridian Iowa Medicaid Plan under Meridian, the Member Services Department conducts outreach using our outreach software, Presence, to educate members on their new benefit package. At this time, Member Services Representatives are able to gather updated contact information for the member, review his or her benefits, assign a primary care provider (PCP), and assist with scheduling appointments, if needed. In addition, the member will be sent new member materials regarding the change in his or her benefit package.

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

Meridian Health Plan recognizes the importance of ensuring members receive the appropriate level of benefits. For this reason, Meridian utilizes a monthly claims algorithm to identify members who are potentially eligible for medical exception. This algorithm can feed into a Member Services outreach campaign, where members receive calls from Meridian Member Services Representatives to learn about the process to complete the medically exempt form or survey.

In addition, Meridian will submit retrospective claims data supporting a member's medical exemption with explanation of their findings. Once the State of Iowa has determined if a member is or is not medically exempt, we will complete the process described above in response to question 3.2.13.1.

3.2.14 Value-Added Services

1. Describe any proposed Value-Added Services. Include in the description:

Meridian Health Plan provides value-added services through multiple programs. Member-focused incentives tie directly to promoting preventive and routine care services. Provider incentives compliment Meridian's member incentive program and are available for primary and maternity care providers. Meridian monitors the success of member incentives on a per incentive basis by reviewing access trends among those who receive incentives and those who do not respond to incentives.

Primary Care Provider (PCP) Incentive Program

The PCP Incentive Program was created to increase physician adherence to clinical guidelines to enhance the health status of our membership.

Meridian uses multiple formats and forums of communication to ensure providers are aware of Meridian Incentive Programs:

- **Provider Bonus** – Providers are offered bonuses as part of the PCP incentive program for getting their members in for certain preventive visits.
- **HEDIS® Report Cards** – Report cards are sent to providers giving the total number of tests performed for each member and the financial incentive given.
- **Action Plans** – The Disease Management (DM) outreach process was enhanced to include faxing of condition-specific action plans to the member’s PCP and mailing a copy to the member.
- **Provider Education Flyers** – Providers are given an educational flyer each month regarding HEDIS® measures.
- **Clinical Practice Guidelines** – The guidelines are available on the Meridian website and are distributed on the back of provider education materials. Providers are notified of any changes to the guidelines via the website and fax blast.
- **Disease Management (DM) Program Information** – Meridian provides information about DM programs on the plan website and in the provider manual so that providers are aware of the interventions being taken by the health plan and so that they know how to refer a member to the program.

Meridian is committed to ensuring that its members receive quality preventive health care. To encourage contracted providers to meet this goal, Meridian implements bonus programs based on specific HEDIS® measures. Focus areas are tailored to specific member types based on Dual-Eligible Program Codes.

Meridian pays a quality bonus to primary care providers for many types of services. These services are designed to keep members healthy. By providing incentives to those administering preventive care, Meridian lowers costs and improves member health status over the long-term. Formally titled the Physician Incentive Program (PIP), primary care providers are incented above and beyond the usual and customary reimbursement of the Medicaid Fee Screen. Physician assistants, advanced practitioners of nursing, nurse practitioners, and certified nurse managers are all eligible to enroll into the program and receive bonuses if credentialed as primary care providers.

Meridian offers value-added services through the PIP. Our incentive programs not only benefit providers, but also our members. Members who participate by way of their primary care provider receive incentives through participation. Through the Physician Incentive Programs for preventive services, Meridian rewards providers able to demonstrate an ability to provide quality care to members. Meridian programs are modeled on achieving aggregate scores on the National Committee for Quality Assurance seventy-fifth (75th) and ninetieth (90th) percentiles for specified HEDIS® measures. Satisfying these requirements allows providers to progress into various reimbursement models that allow for capitation and shared and/or full risk payment methodologies.

The following table outlines Meridian’s 2014-2015 Provider Incentive Program:

| | | | | | |
|--|--|--|--|--|--|
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| | | | | | |

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| | [REDACTED] | [REDACTED] | [REDACTED] | | |
| | [REDACTED] | [REDACTED] | [REDACTED] | | |
| | [REDACTED] | [REDACTED] | [REDACTED] | | |
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| | [REDACTED] | [REDACTED] | [REDACTED] | | |
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| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
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| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
|------------|------------|------------|------------|------------|------------|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

CONFIDENTIAL

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| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
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| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
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| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
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| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

| [REDACTED] | [REDACTED] | [REDACTED] |
|------------|------------|------------|
| [REDACTED] | [REDACTED] | [REDACTED] |

Member-Focused Programs

Member Incentive Program

Meridian's member incentive program is primarily structured to communicate the need for an essential preventive or routine service, encourage members to seek the recommended service by

providing an incentive if the member takes action, and track member response to mailings as well as visits measured by claims review.

Member valuation of the incentive program is also assessed at focus groups. Acquiring anecdotal evidence of member experiences with incentives has helped Meridian identify which incentives are most valuable, motivating, and therefore effective. Meridian has adjusted incentive programs based on member feedback, switching to different gift card retailers, varying amounts according to extent and significance of service, and allowing members to receive multiple incentives if more than one essential service is completed.

All new members who visit their primary care provider within forty-five (45) days of enrollment are entered into a raffle to receive a gift card. To encourage use of web-based resources, members are placed in a raffle for a gift card when they sign up for Meridian’s secure, online Member Portal. Within this Member Portal, members are able to request a PCP change, view their care plan (if applicable), preventive services and request health and benefit information.

Members needing certain routine or preventive services are automatically sent reminder Call-to-Action tri-fold mailings that are part of the member incentive program. The tri-folds include a tear-off, section for the member to indicate date and time of an appointment, self-addressed and stamped postcard to be returned to Meridian. Once Meridian receives the postcard it is scanned into our Managed Care System (MCS). When a claim is obtained for the needed service and Meridian has received a returned postcard, MCS automatically mails the member incentive. This automated system allows for an efficient and successful incentive program.

Meridian also runs a raffle program to encourage members of all ages to receive preventive services. Some current Medicaid member raffles include:

- Apple iPad for women who receive an annual Pap test
- Gift Card for Breast Cancer Screening
- Gift Card for Cervical Cancer Screening
- Gift Card for Diabetes - HbA1c/LDL Screening
- Quarterly Raffle for a Gift Card for PCP Visit within first forty-five (45) days of enrollment
- Walgreen Gift Card for Diabetic Retinal Exam
- Monthly iPad Raffle for Cervical Cancer Screening

All interactions and incentives are tracked within MCS and the incentive status can be viewed in the member contact record. Gift cards cannot be used towards tobacco or alcohol purchases.

| CONFIDENTIAL | | |
|--------------|----------------|------------|
| Member ID | Incentive Type | Status |
| [REDACTED] | [REDACTED] | [REDACTED] |

conduct bi-weekly phone calls and weekly mailings over the course of twelve (12) weeks. Meridian recognizes the importance of lowering smoking rates in its member population and is committed to continuing to promote smoking cessation in collaboration with the State in future years.

Weight Management

Meridian has a unique program offered to members focused on achieving a healthy weight. Qualifying members will fill out a commitment letter with their provider if interested in enrolling in Weight Watchers™. The member must be within the age range of eighteen (18) to sixty-five (65) and have a body mass index (BMI) of thirty (30) or higher. Members successfully completing a full session of Weight Watchers™ may be eligible for additional sessions, if needed. This program is available to all Medicaid members.

Patient Safety

Meridian is committed to improving the safety of clinical care provided to members in any patient care setting. Meridian actively seeks out opportunities and addresses member safety issues as they arise. Meridian recognizes the role that culture, literacy, and disparities play in the provision of safe and effective health care and focuses programs to reduce the impact of these factors.

A key strategy to improve patient safety for Meridian members is to establish their care with a medical home. This safety strategy begins with the member welcome call with the goals of:

- Ensuring members are aware of the PCP assignment
- Identifying members who have established care with another provider and may require a PCP change
- Assisting in appointment scheduling if needed
- Completion of the Health Risk Assessment to identify members' needs and potential risky behaviors
- Completion of Risk Prenatal Assessment for referral to Maternity Care Coordination program
- Other referrals for health condition management as appropriate

In 2013, 3,839 Meridian members were screened for enrollment into Care Coordination. Of those, 2,293 members were enrolled in Care Coordination. During SFY 2013, Meridian scheduled 2,075 appointments through Care Coordination efforts.

The completion of the HRA triggers referrals to both the Care Coordination and Disease Management programs. Meridian's HRA completion rate for 2013 was forty-two percent (42%). Meridian's safety program continues from the outreach call with appropriate member educational mailings based on HRA responses. The grid below provides the overview of the Member Safety materials mailed during 2013, with the majority of education focused on smoking cessation, asthma and health eating.

| Member Education Mailings | | |
|----------------------------------|--------------|-------------------------|
| Member Education Piece | Count | Percent of Total |
| Smoke | 2,980 | 32.58 |
| Asthma | 2,029 | 22.18 |
| Healthy Eating | 1,272 | 13.91 |
| Depression | 888 | 9.71 |
| Blood Pressure | 468 | 5.12 |
| Exercise | 379 | 4.14 |
| Diabetes | 197 | 2.15 |
| Stress | 175 | 1.91 |
| Alcohol | 171 | 1.87 |
| Kidney Problems | 110 | 1.20 |
| Safe Sex (Self) | 98 | 1.07 |
| Hospitalization | 95 | 1.04 |
| Safe Sex (Child) | 94 | 1.03 |
| Heart Disease | 74 | 0.81 |
| Street Drugs | 41 | 0.45 |
| Seat Belts | 30 | 0.32 |
| Emphysema | 29 | 0.32 |
| CHF | 17 | 0.19 |
| TOTAL | 9,147 | 100% |

a. Any limitations, restrictions, or conditions specific to the Value-Added Services;

Meridian’s Provider Incentive Programs are limited to contracted primary care providers and providers practicing obstetrics, and for HEDIS® preventive measures included in the Meridian annual bonus program brochure. Member incentives are limited to the same preventive measures.

b. The providers responsible for providing the Value-Added Service;

Meridian’s primary care providers (PCPs) play a vital role in administering and delivering services included in our incentive programs. While PCPs are critical to this program, Meridian also extends eligibility to physician assistants, advanced practitioners of nursing, nurse practitioners, and certified nurse managers. All are eligible to enroll into the program and receive bonuses if they are credentialed as primary care providers.

c. How the Value-added Service will be identified in administrative (encounter) data;

The following methods are used to assure timely submission of encounter data:

- The use of fee-for-service reimbursement contracts requiring the submission of a bill prior to payment for the service being rendered;
- The use of capitated reimbursement contracts obligating timely monthly, quarterly, and annual encounter data submission within thirty (30) days of the

close of the applicable month, quarter or year with substantial per claim penalties assessed for lateness and missing information;

- The use of state approved additional incentive bonus monies to reward providers for the timely delivery of HEDIS® preventive and maintenance health services; and
- The withholding of monies to capitated providers for not achieving specific quality measures;

Network providers have the ability to submit claims via hard copy, electronically through an 837 file, using a secure FTP website, or directly to Meridian utilizing the Provider Portal. Out-of-network providers have the ability to submit claims via hard copy or electronically through the submission of an 837 file through one of the regional or national healthcare clearing houses. All encounter data is entered into our Managed Care System (MCS), whether the data is submitted via claims, encounter data reports or cornerstone data extractions.

Each month, the Provider Services Department is responsible for monitoring the receipt of encounter data through collaboration with the Claims Department. In the event the required encounter data is incomplete or missing, the Provider Network Development Representative assigned to the specific physician group, PHO, or other clinic-type organization will follow up with the provider to ascertain why the encounter data was not submitted.

Meridian's provider bonus program provides a monetary incentive to providers to submit encounter data in a timely manner. The bonus program is tied directly to the services rendered by the sub-capitated physicians and while they may not receive fee-for-service payment on the claim itself, the presence of a qualifying code on that encounter would trigger a bonus payment to that PCP, provided the member seen is assigned to him or her. The same motivational factor would work in a group or office setting as the providers typically share bonuses within an office which ensures that all encounters, regardless of PCP affiliation to the member, are submitted in a timely manner.

Meridian makes every attempt to facilitate and assist all of its Providers with the timely submission of Encounter Data. However, in the event, the Provider does not submit the contractually required Encounter Data, Meridian imposes financial penalties upon the Provider in accordance with the terms set forth in their contract. These financial penalties are assessed on a per claim line basis for the missing period whether it be a monthly or quarterly submission period.

d. How and when providers and members will be notified about the availability of such Value-Added Services while still meeting the federal marketing requirements; and

Meridian adheres to the guidelines as set forth in the Federal marketing requirements. Utilizing Meridian's local, community based provider representatives, providers have a single point of contact and receive timely responses to questions and inquiries regarding the incentive programs. Information about the incentive program is also included in Meridian Provider Manual, providing a quick reference for providers inquiring about the program. During our provider orientation programs, providers are presented with information on the incentive programs as well.

Members interested in participating in incentive programs have access to information through multiple channels. Upon enrolling with Meridian, members receive a state approved Member manual that outlines available incentive programs. Presenting incentive information directly to the member allows the member to play an active role in receiving qualifying services. In addition to the manual, Providers participating in the incentive program may encourage members to participate in the program as well. Members who are enrolled in Meridian's Care Coordination program are also informed of available incentive programs. Meridian's Care Coordination Representatives assist the member in determining which incentive programs are medically appropriate for the member.

e. How a member may obtain or access the Value-Added Services.

Meridian members will have access to any value added services or incentives that are available and medically appropriate for the member. Generally, members may receive incentive information following outreach efforts made by Member Services Representatives, contact with Quality staff, or Meridian's Care Coordination team. Meridian supports participating providers in reporting and monitoring members who participate in the programs. Meridian members will receive tri-folds, which are a component of the member state-approved incentive program. The tri-folds include a tear-off, self-addressed and stamped postcard to be returned to Meridian. The postcard is scanned into Meridian's Managed Care System (MCS). When a claim is obtained for the needed service and Meridian received a returned postcard, MCS automatically mails the member incentive. Incentives range from gift cards to a year supply of diapers. All interactions and incentives are tracked within MCS and the incentive status can be viewed in the member contact record.

Members may access special programs through interactions with Member Services, Quality staff, or Care Coordination. Programs are suggested to members based on claims experience, information obtained in an HRA, and at the member's direct request.

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

Over a two (2) year period of time, Meridian Health Plan has seen significant outcomes in regards to members receiving critical HEDIS® tests and services. The graphic below demonstrates a significant increase in preventive and maintenance testing received by members through the implementation of Meridian's HEDIS® bonus program.

Multi-year comparison rankings are provided below for twenty-four (24) key HEDIS® measures.

| Measure | 2012 | | 2013 | | Year to Year Change | | |
|--|-------|------------|-------|------------|---------------------|----------|---------|
| | Rate | Percentile | Rate | Percentile | % Change | χ^2 | p-value |
| Childhood Immunizations – Combo 3 on or before 2nd birthday | 48.3% | <50th | 76.5% | 50th | 28.2% | 30.4 | 0.00* |
| Well Child- First 15 months (6+)* | 53.3% | <50th | 79.4% | 90th | 26.1% | 23.04 | 0.00* |
| Well Child 3-6 years* | 66.1% | <50th | 80.6% | 75th | 14.5% | 34.5 | 0.00* |
| Well Child – Adolescent* | 32.0% | <50th | 58.7% | 75th | 26.8% | 88.68 | 0.00* |
| Children and Adolescents’ Access to Primary Care Practitioners – 12 to 24 months | 94.9% | <50th | 99.3% | 90th | 4.4% | 20.29 | 0.00* |
| Children and Adolescents’ Access to Primary Care Practitioners – 25 months to 6 years | 85.9% | <50th | 94.0% | 90th | 8.1% | 74.12 | 0.00* |
| Children and Adolescents’ Access to Primary Care Practitioners – 7 to 11 years | 82.7% | <50th | 92.0% | N/A | 9.3% | 62.73 | 0.00* |
| Children and Adolescents’ Access to Primary Care Practitioners – 12 to 19 years | 84.3% | <50th | 94.1% | N/A | 9.8% | 77.47 | 0.00* |
| Lead Screening in Children | 74.0% | 50th | 85.8% | 75th | 11.8% | 7.85 | 0.005* |
| Timeliness of Prenatal Care | 90.4% | 75th | 96.3% | 90th | 5.9% | 0.61 | 0.44 |
| Postpartum Care | 67.3% | 75th | 74.4% | 90th | 7.1% | 1.68 | 0.196 |
| Comprehensive Diabetes Care – HbA1c Testing | 77.8% | <50th | 95.2% | 90th | 17.4% | 8.64 | 0.003* |
| Comprehensive Diabetes Care – Diabetic Eye Exam | 55.2% | 50th | 71.0% | 90th | 15.8% | 5.37 | 0.02* |
| CDC LDL Screening* | 62.6% | <50th | 77.4% | 50th | 14.8% | 3.74 | 0.053 |
| Immunizations for Adolescents* | 40.8% | <50th | 62.1% | N/A | 21.4% | 9.41 | 0.002* |
| Adults’ Access to Preventative/Ambulatory Health Services Total* | 81.7% | <50th | 91.5% | 90th | 9.9% | 69.55 | 0.00* |
| Chlamydia Screening* | 64.7% | 90th | 61.2% | 50th | -3.5% | 1.34 | 0.25 |
| Cervical Cancer Screening* | 70.7% | 50th | 76.0% | 75th | 5.3% | 7.66 | 0.0056 |

*p-value<0.05

Notes: Percentiles were taken from NCQA for each reporting year. Chi-square was calculated using the year to year comparison of hits and misses by measure.

Administration of Covered Benefits

Medical Necessity Determinations

Meridian Health Plan will apply utilization management strategies that employ the use of standardized clinical criteria and medical necessity determinations made on a case-by-case basis and in accordance with State and Federal laws and regulations. Meridian will use evidence based strategies to ensure the use of the most appropriate care that is delivered in the appropriate setting. Meridian and its subcontractors do not exercise the use of control guidelines or quantitative coverage limits unless supported by an individualized determination of medical necessity that considers each member's personal medical needs.

Second Opinions

Meridian allows members to seek a second opinion when there is a question regarding the diagnosis or options for surgery or other treatment options for medical conditions when requested by a member, parent, and/or legally-appointed representative. The second opinion is conducted by a contracted qualified health care professional or a non-contracted health professional if a contracted professional is not available.

Cost Sharing and Patient Liability

No cost sharing or patient liability, including charges for missed appointments is permitted by Meridian, providers, or subcontractors for covered services except those allowable under the Law and as described in Section 5.

Physician Administered Drugs

Meridian will provide coverage and reimbursement for physician administered drugs to the same extent as the Medicaid FFS. Billing information will comply with Medicaid FFS billing requirements.

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.**

Transition assistance is a process that allows continuity of care for new members. Meridian coordinates continuity of care for its members by ensuring that both members and providers are cooperatively involved in ongoing healthcare management toward the goal of high quality, cost-effective medical care. Transitions include many touch points and Meridian efficiently guides members through these changes.

Prior Authorizations and Transitions

During year one (1) of the Contract, with the exception of long-term services and supports (LTSS), residential services, and certain services rendered to dual diagnosis populations, Meridian will honor existing authorizations for covered benefits for a minimum of ninety (90) calendar days without regard to whether such services are being provided by contract or non-

contract providers, when a member transitions to Meridian from another source of coverage. Meridian will also honor existing exceptions to policy granted by the Director for the scope and duration designated. Beginning one (1) year from the Contract effective date, Meridian will honor existing authorizations for a minimum of thirty (30) calendar days when a member transitions to Meridian from another source of coverage, without regard to whether services are being provided by contract or non-contract providers.

Meridian has policies and procedures for identifying existing prior authorization decisions at the time of the member's enrollment. Upon initial identification that a member is accessing care from an out-of-network provider, Meridian's Provider Services staff is notified and offers a contract to the provider. If the out-of-network provider declines the offer to contract with Meridian, but agrees to continue providing care and treatment to the member, Meridian will offer the provider a single-case contract to authorize services for the first ninety (90) days. The provider must agree to abide with Meridian's quality and utilization program.

Additionally, when a member transitions to another program contractor, Meridian shall be responsible for providing the receiving entity with information on any current service authorizations, utilization data and other applicable clinical information such as disease management or care coordination notes.

Meridian will coordinate care for members whenever the member disenrollment occurs during an inpatient stay. Acute inpatient hospital services for members who are hospitalized at the time of disenrollment from Meridian shall be paid by Meridian until the member is discharged from acute care or for sixty (60) days after disenrollment, whichever is less, unless the member is no longer eligible for Medicaid. When member disenrollment to another program contractor occurs during an inpatient stay, Meridian will notify the new program contractor of the inpatient status of the member. Meridian will also notify the inpatient hospital of the change in program contractor enrollment, but advise the hospital that the program Meridian maintains financial responsibility.

Long-Term Services and Supports (LTSS)

LTSS will not be reduced, modified or terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification, or termination. Meridian shall ensure members receiving LTSS will be permitted to see all current providers on their approved service plan, when they initially enroll with Meridian, even on a non-network basis, until a service plan is completed and either agreed upon by the member or resolved through the appeals or fair hearing process, and implemented. Meridian will honor existing exceptions to policy granted by the Director for the scope and duration designated. Meridian will extend the authorization of LTSS from a non-contracted provider as necessary to ensure continuity of care pending the provider's contracting with Meridian, or the member's transition to a contract provider. Meridian will facilitate a seamless transition to new services and/or providers, as applicable, in the care plan developed by Meridian without any disruption in services.

Residential Services

During the first year of the Contract, Meridian will permit members using a residential provider at the time of enrollment with Meridian to access the residential provider being utilized at the time of enrollment for up to one (1) year, even on a non-network basis. A residential provider is defined as a: (i) nursing facility; (ii) ICF/ID; and (iii) support for the member to live in a

residential setting either controlled by the member or the provider funded through 1915(i) Habilitation waiver provider or a 1915(c) HCBS waiver.

Effective one (1) year after the Contract effective date, Meridian will not transition members using residential providers, as defined in Section 3.3.5.1, to another residential provider unless the following conditions are met: (i) the member or his/her representative specifically requests to transition; (ii) the member or his/her representative provides written consent to transition based on quality or other concerns raised by Meridian, which shall not include the residential provider's rate of reimbursement; or (iii) the residential provider has chosen not to contract with Meridian.

If the residential provider is a non-contract provider, Meridian will: (i) authorize continuation of the services pending contracting with the provider; (ii) authorize continuation of the services, for at least thirty (30) days pending facilitation of the member's transition to a contracted provider, subject to the member's agreement with such transition; or (iii) continue to reimburse services from the non-contract provider. If a member is transitioned to a contract provider, Meridian will extend the authorization of services with the non-contracted provider beyond the minimum thirty (30) day requirement as necessary to ensure continuity of care and the member's seamless transition to a new provider. Meridian will permit a member with a dual diagnosis of a behavioral health condition and developmental disorder to remain with his/her residential provider for at least one (1) year or with his/her inpatient psychiatric provider, regardless of network status, as long as the services continue to be medically necessary. If, for whatever reason, a member can no longer be served by his/her residential provider, it shall be Meridian's responsibility to find and make available to the member an alternative residential provider that can meet the member's needs so there is no break in services.

Pregnancy Continuity of Care

Meridian provides continuity of care to members who are pregnant at the time of their enrollment with Meridian and are receiving services from an out-of-network provider. To be eligible for continuity of care, the pregnant member must be in her second or third trimester of pregnancy or the postpartum period. Continuity of care services will be provided for the duration of the pregnancy and postpartum period (which is the first six (6) weeks after birth of the child).

Dual Diagnosis Continuity of Care

Meridian will permit members with a dual diagnosis of a behavioral health condition and developmental disorder to remain with their providers, in or out-of-network for all outpatient behavioral health services for a minimum of three (3) months as long as the services continue to be medically necessary. Meridian may elect to shorten this transition time frame only when the provider of services is no longer available to serve the member or when a change in providers is requested in writing by the member or the member's 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).

Meridian Health Plan's unique ability to effectively coordinate the care of the dual-eligible population is a result of our seventeen (17) years of Medicaid experience and our Medicare

Advantage Dual Eligible Special Needs Plan. Meridian is poised to partner with the State to meet the needs of the dual-eligible population. Through operation of our Medicare Advantage Special Needs Plan (SNP), Meridian has received a three (3) year approval for its Model of Care from CMS.

Given our corporate focus on overall integration of care, Meridian already incorporates many elements that build the foundation for successfully managing the Iowa dual-eligible population. Meridian offers an established CMS-approved Model of Care (MOC) which received a score of ninety point six three percent (90.63%). Meridian will provide coverage through a CMS-approved and State-approved, dual-integrated formulary.

Meridian has a proven record of successful partnerships with community, state, and Federal agencies, providing managed care services that improve health outcomes for our most vulnerable populations. Meeting the member in his or her community allows us to gain an accurate picture of their needs to provide personalized services. Our whole person, integrated care plans empower members to make informed decisions regarding their health.

Our programs combine a member-centered approach to care with technology, bridging the gaps that can occur in transitions of care. Our focus on individual member needs starts at enrollment. Within thirty (30) days of joining our dual-eligible plan, members receive a Health Risk Assessment (HRA); based on the HRA results, our Managed Care System (MCS) uses objective data and member interaction to stratify members into the appropriate risk categories. Based on member stratification, an appropriate Interdisciplinary Care Team (ICT) is assigned to coordinate the member's care. Encompassing medical, behavioral/developmental, and Long-Term Services and Supports (LTSS), this proactive approach allows the ICT to quickly identify and implement care coordination activities, resulting in improved member health outcomes. These coordination activities are especially important for dual-eligible members with multiple chronic medical conditions, often exacerbated by underlying behavioral health issues.

Meridian's experience in managing care for dual-eligible members relates to the plan's targeted purpose of improving access to medical, mental and social services, the improvement of access to affordable care, coordination of care, seamless transitions across healthcare settings, and access to preventive health services. Other objectives include appropriate utilization of services, improvement of reducing hospitalizations and nursing facility placements as well as improved health outcomes.

MCS fully supports dual-eligible populations by allowing Care Managers, members, medical and behavioral health providers real-time access to health information about member care.

The dual-eligible population has a high prevalence of behavioral health conditions as well as developmental disabilities. In recognition of the complex and unique needs of the dual-eligible population, Meridian maintains ongoing quality improvement initiatives aimed towards innovative partnerships, beneficiary sensitivity, and effective relationships with providers to ensure the quality and safety of healthcare services received by its high-risk population.

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.

Meridian Health Plan conducts two (2) weeks totaling eighty (80) hours of Care Coordination classroom training and overall dual-eligible member education built into this curriculum. Training includes a combination of Medicare and Medicaid benefits through providing them with comprehensive information on both sets of benefits via multiple information channels. Care Coordinators also complete mandatory on-line trainings on dual-eligible and state-specific requirements.

Meridian coordinates Medicare and Medicaid benefits and services for its members to ensure they receive services for which they are eligible, regardless of payer. Medicare and Medicaid have differing rules and benefit structures which can lead to confusion for both members and providers. Care Coordination staff members act as liaisons between members and providers to help coordinate care as efficiently as possible to ensure the well-being and quality of care for members.

Meridian Care Coordinators are trained to provide coordination of benefits for dual-eligible members by:

- Giving prospective members information about benefits they are eligible to receive from both programs through materials that are specifically designed for dual-eligible members, combining information about both Medicare and Medicaid. This information can be presented both via mail and telephone
- Informing members about maintaining their Medicaid eligibility through referral to State personnel as well as assisting members who have lost their eligibility during the Medicaid re-application process. Meridian staff is able to identify changes in member eligibility by reviewing the coverage codes within MCS. Coverage codes indicate what type of coverage the member has on the specified date. If the staff member notices a change in the member's coverage code, he or she will contact the member to identify reasons for the change and provide guidance for how to change eligibility
- Providing information to members about benefits they are eligible to receive from both programs in the form of a detailed benefit package
- Giving members access to staff, in lieu of written documents, who can advise them on using both Medicare and Medicaid

Care Coordination training staff provide Care Coordinators line of business grids answering benefit questions and are updated regularly for each line of business based upon contractual requirement and changes. Utilization Management houses these grids, which are available to all departments so specific criteria for each line of business can be dictated to the member as appropriate. Trainees also receive guidance through formal training on the most prevalent differences between the line of business and what is/is not covered for the specific line of business.

All staff attends training specific to grievances and appeals. Each line of business is specified within the training and differences pointed out. There are questions directed toward acknowledging these differences included in this training which help to assess the trainee's ability to differentiate between the applications of these materials for each line of business. Job aids are available for reference as well.

Other specialized training for Medicare has been developed and is required training for all staff entering Care Coordination. Trainees are assigned to staff proficient in their line of business and shadow these individuals as well as attend trainings specific to their line of business in order to see the application of materials received during training. During this time, trainees are supervised performing processes and facilitating coordination of care for members prior to engagement with members on their own.

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.

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.**

Meridian Health Plan will ensure all services are provided in a manner that facilitates maximum community placement and participation for members that require LTSS. Meridian is dedicated to serving individuals in the communities of their choice within the resources available and to ensuring full implementation and compliance with the United States Supreme Court's mandate in *Olmstead v. L.C.* Meridian considers individual member choice and community-based alternatives, within available resources, to promote a shared goal of maximum community integration in support and enhancement of member-centered care. When a Meridian member resides in nursing facilities or ICF/IDs, those facilities are primarily responsible for the care and treatment of those individuals, and for addressing health and safety needs; and they receive additional care coordination and quality oversight from Meridian. When Meridian's members with health and long-term care needs live in their own homes or other community-based residential settings, Meridian develops a care plan to address their care and treatment needs, providing assurances for health and safety, which proactively addresses risks inherent in our members' desire to live as independently as possible. Meridian does not, and will not, reduce the staffing resources for our members arbitrarily. For Meridian members who require individualized, enhanced staffing patterns to support them in a less-restrictive setting, staffing levels support the clinical needs as documented by the member's provider records.

Meridian will identify members with disabilities, chronic complex medical needs, serious mental illness, and intellectual/developmental disorders that may require services that will allow them to continue to live in a community setting. We emphasize continuity of care through a core services team, assertive outreach, and individualized and on-going treatment plans. Assertive outreach involves actively going out to meet the member's needs in the community and to avoid placement into facilities. Members with complex medical needs who are at risk for being institutionalized are supported through a team of trained licensed social workers and nurses to advocate and support placement needs, using a multifaceted approach that includes interventions in homes, schools, churches, and community centers. The Community-Based Case Manager, the member's direct point of contact, will improve access to care for members by linking them with primary care providers (PCPs), arranging transportation, promoting appointment compliance, developing Service Level Plans, and connecting members to community resources.

For all defined populations, a series of cascading online care management assessment tools are utilized to identify the need for any health plan covered services, HCBS services, community-based resources and other support services, if necessary. The Community-Based Case Manager focuses on the coordination of additional, supportive services generally considered as components of care management.

Using these online tools, the Community-Based Case Manager conducts the initial assessment with the member and appropriate participants during the initial face-to-face visit upon enrollment with plan. The care management system allows for initial stratification of the member's overall risk, health status and care needs based on an established criteria and algorithms. Responses to assessment questions and other inputs also drive recommended interventions for the member's individualized care plan.

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From the initial Health Risk Assessment the individualized care plan is developed and the ongoing care management is initiated. During the on-going development and delivery of the care plan, the care management team ensures the member's goals and preferences are identified and are documented in the care plan. Items used in development of the individualized care plan include:

- Results from the initial Health Risk Assessment
- Member's medical history
- Member's healthcare preferences
- Member's pharmaceutical profile
- Goals and objectives
- Service schedules
- Service gaps contingency and back-up plan
- Medication management
- Barriers to progress

Individual care and treatment goals are incorporated into the member's individualized care plan. Each member's care plan identifies overall goals that reflect their unique needs, are realistic and measurable, include a time frame for achievement as appropriate, services and care to meet member's care goals, and connects the member/caregiver with Home and Community Based Services (HCBS) as well as "in kind" community resources that are drawn from the plan's database of local community social support providers. The care plan reflects stratified needs that are matched to interventions to address services and benefits so the vulnerable and sickest members receive care proportionate to their needs. Each intervention is developed in a "problem, goal, and intervention" model so that there is a clear link between the problem being addressed, the goal of the outcome, and the specific intervention to address the problem.

Along each step of the way, our systems will offer alternatives that can then be aligned by the care manager with the members documented goals and preferences (for example recommending options for in-home attendant care or adult daycare services depending on member preferences and level of social integration). This care management process ensures the provision of any core services as well as any additional, supportive services as necessary. Additionally, the process ensures that these services are cost-effective, provided in the most appropriate setting, and based on designated contract requirements.

The care plan is revised when appropriate to reflect the member's current needs, based on evaluation of new clinical data, progress towards goals, identification of barriers to progress, response to care and treatment and/or significant changes in the member's status, such as transitions of care settings. The member education process uses an interdisciplinary approach, as appropriate to the care plan. The member's care plan will support member education appropriate to his or her assessed needs, abilities, readiness, and preferences. The care planning process incorporates information from the member's assessment regarding his or her education needs and ensures there is a mechanism for member and family input into the care plan.

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.

Meridian Health Plan utilizes tools which are consistent with the tools designed and used by the State to determine the level of care and support needs for members wishing to access either community supports or facility care. Meridian uses a multi-purpose evaluation approach which provides uniformity and streamlines the documents needed to determine the appropriate level of care, specifically identifying the members' needs and ensuring their provider is able to provide the services and tasks needed. Outreach occurs at the start of enrollment with the appropriate assessment, InterRAI or Supports Intensity Scale, conducted for qualified populations. To ensure assessments are completed within the required timeframes, which include upon initial enrollment, when a change in the member's circumstances becomes known necessitating a new assessment, and at a minimum of annually, data tracking of assessment completion is built into our systems, allowing for transparency in data reporting and tracking of reassessments. Our system allows tracking of populations including, but not limited to, foster care, HCBS Waivers, long term care (LTC) and dual eligibles. In order to address the member's current and future needs, the following occurs: a review of the member's acuity level, updates from the member's Interdisciplinary Care Team (ICT), medical review from the internal Medical Director, and required follow-up tasks and assessments. Triggers and issues with higher acuity levels also

receive peer discussion with the Medical Director, which may result in a reassessment and tracking tools within our system provide daily graphs to monitor progress toward these goals. Reporting metrics include completion rates of assessments, timeframe compliance, and risk stratification. To ensure quality and compliance of timeframe assessment and reassessment, audits of records are conducted regularly.

Meridian acknowledges determining the initial level of care for nursing facility or ICF/ID or 1915(c) HCBS waiver enrollment for individuals who are not already enrolled with the Meridian and are applying for initial Medicaid eligibility is the responsibility of the State or its designee. Meridian will refer all inquiries regarding Medicaid enrollment and initial level of care determinations to the State or its designee as directed by the State.

Meridian’s policies and procedures, subject to State approval, outline the ongoing identification of members who may be eligible for LTSS, which include, at minimum the following processes: (i) processing referrals from a member’s provider(s); (ii) processing member self-referrals; (iii) incorporation of hospital admission notifications; and (iv) ongoing review of claims data. Meridian conducts an assessment using a tool and process prior approved by the State, for members who have been identified through any of these processes as potentially meeting an institutional level of care and in need of institutional placement or 1915(c) HCBS waiver enrollment. Meridian will refer individuals who are identified as potentially eligible for LTSS to the State or its designee for level of care determination, if applicable.

The InterRAI Assessments are provided in Tab 5 as Attachment 15 (InterRAI Long Term Care Assessment) and Attachment 16 (InterRAI Home Care Assessment).

The table below outlines timelines associated with assessments and reassessments.

| Assessment | Completion Timeframes | ICT Meeting Timeframes |
|---|--|---------------------------------------|
| InterRAI completed for 1915(i) Habilitation Programs and 1915(C) Children Mental Health Waivers , AIDS/HIV, Brain Injury, Elderly, Health and Disability, Physical Disability Members and Support and Intensity Scale for members with Intellectual Disability | Within 60 days of enrollment | Within 14 days of InterRAI Completion |
| Johnson & Johnson Screening conducted for all Non-waiver members | Within 90 days of enrollment | Not applicable |
| Health Risk Assessment (HRA) conducted for Non- waiver members referred through predictive model, Johnson & Johnson, or referrals for care coordination services | Within 60 days of Johnson & Johnson screening or referral to Care Coordination | Within 14 days of HRA completion |
| InterRAI for high risk members to determine waiver eligibility | Within 30 days of HRA completion | Within 14 days of InterRAI completion |
| Reassessment of InterRAI and Health Risk Assessment (HRA) | Annual | Within 14 days of reassessment |

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

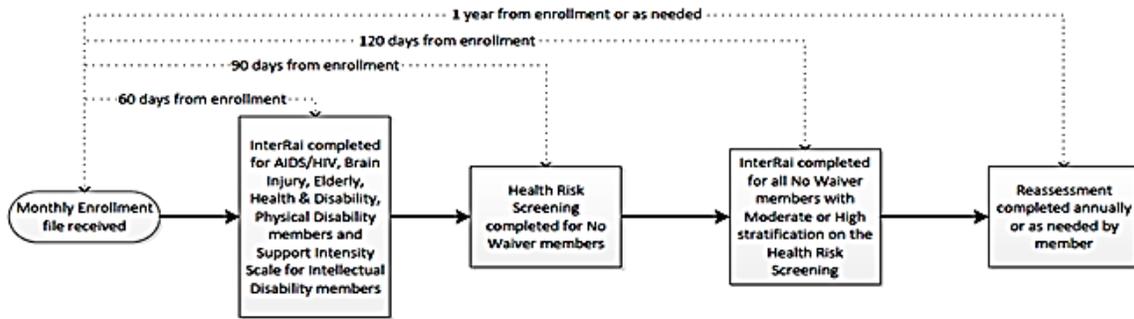
Meridian Health Plan will complete the needs assessments in compliance with the Balancing Incentive Program (BIP). Standardized assessments are crucial for identification of member's needs, risks and outcome measures. Member choice and self-direction as defined in the BIP standards are core facets of the Meridian Care Coordination program. Meridian conducts level of care assessments and reassessments, and will use the State designated tools by population, at least annually, and when we become aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. The level of care and assessment for members potentially eligible for 1915(c) HCBS waiver enrollment includes an assessment of the individual's ability to have his or her needs met safely and effectively in the community and at a cost that does not exceed limits established in each 1915(c) HCBS waiver. If a member does not appear to meet enrollment criteria Meridian complies with the requirements related to the appearance of ineligibility. Meridian tracks the level of care expiration dates to ensure this requirement is met, and this process applies to all members residing in a nursing facility or ICF/ID or eligible under a 1915(c) HCBS waiver. Meridian will adhere to the timelines established by the State to ensure prompt assessment of the member's needs and to ensure member safety.

Once the assessment is completed, Meridian will submit the level of care/support needs assessment to the State, and Meridian acknowledges the State will retain all authority for determining Medicaid categorical, financial and level of care eligibility and enrolling members into a Medicaid eligibility category. Meridian will adhere to the notification from the State when a member has been enrolled in nursing facility or ICF/ID or 1915(c) HCBS waiver eligibility category and apply any applicable patient liability amounts and/or waiver budget caps as identified by the State.

Meridian collaborates with community partners and advocates for our members, and the member's Care Coordination Team facilitates the delivery of appropriate services and streamlines the processes to support members in community-based programs. This is an important process because this ensures cost effective, appropriate services, and compliance with the member's self-directed care choices. To assist the member in health education and autonomy in making health decisions, while also identifying areas of support that are needed when developing a plan of service, uniform assessments that trigger areas of need are utilized. Meridian implements the use of the Support Intensity Scales, Level of Care Utilization System assessments, and the InterRAI to identify placement and support needs that are crucial to the member's care plan.

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

The following Assessment Completion flow outlines the timeframes in which all assessments will be completed.



a. Upon initial enrollment with the Bidder

Upon initial enrollment for non-waiver members, outreach begins with the initial health screening. This initial screening is administered to all eligible members within ninety (90) days of enrollment. The initial health screening, along with predictive modeling member’s health needs, allows Meridian to proactively produce a person-centered care plan for the individual member. The member’s health risk is evaluated and updated throughout the member’s enrollment and at a minimum annually. Claims and other historical data are used to provide a complete picture of members’ needs through predictive modeling. Meridian’s health screenings are built into our systems along with the InterRAI comprehensive assessment. Based on assessment results, members are stratified into low, moderate, high or intensive risk groups. Community-Based Case Managers prioritize caseloads and determine the degree of intervention needed based upon the member’s level of acuity and stratification. The intensity, type, and frequency of member interventions (direct or indirect) are determined by their combined needs and resulting case risk stratification. Moderate and high risk members are screened and assigned to Community-based Case Management staff for waiver determination. The InterRAI assessment tool, which is built into the systems, is used for high risk non-waiver and all waiver members. The InterRAI tool is completed within 120 days of enrollment in the member’s residence. Members who are diagnosed with intellectual disabilities will also be required to have a Supports Intensity Scale Screening (SIS) within sixty (60) days of enrollment to be conducted in the member’s residence. Members who qualify for waiver services will have the InterRAI comprehensive assessment within the sixty (60) days of enrollment. The InterRAI reassessment will be completed at minimum every twelve (12) months for members that are in qualifying populations.

b. When the Bidder becomes aware of a change in the member’s circumstances which necessitates a new assessment

Members that have a self-reported change in condition, or significant changes are triggered through utilization, will have an InterRAI reassessment conducted and a review of services from their Community-Based Case Manager completed. During weekly Interdisciplinary Care Team (ICT) meetings, Meridian monitors utilization for members that are reflecting a significant change in condition.

c. At least every twelve (12) months

At least every twelve (12) months, a reassessment will be completed to ensure members are receiving appropriate services and to detect if there is any change in health status that may require additional services. Every effort is made to maintain a member's ability to live in the community, including additional home visits and routine re-assessments.

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

Meridian Health Plan will submit documentation to the State, in the timeframes described in 3.2.11.2.2 and 4.2.2.2 and in the format determined by the State, for all reassessments which indicate a potential change in the member's level of care. Meridian acknowledges that the State has the responsibility for the final review and maintains the approval authority for any reassessments which indicate a change in the level of care. Any findings determined by the State or its designee will be adhered to by Meridian. If the level of care reassessment indicates no change in level of care, Meridian acknowledges the member is approved to continue at the already established level of care and we will maintain all documentation of the assessment and make it available to the State upon request. Meridian will track and report on level of care reassessment data, including, but not limited to, the date the reassessment was completed, the ability to complete such tracking is built into our current systems. Once the initial assessments are completed the system assigns a due date for the next required assessment using the State guidelines. Triggers and issues with higher severity levels receive peer discussion with the Medical Director, which may result in reassessment. The integrated care plan utilizes a process that defines problems, goals, and interventions which can and will be configured to address the State requirements. Referrals are a part of the care coordination workflow process to ensure timely follow-up and resolution. Our systems include a comprehensive reporting module that allows us to build reports specific to the State requirements. Our inclusive tracking systems allow for transparency in data reporting and tracking of populations including, but not limited to, foster care, HCBS waivers, LTC, and dual-eligible.

At any time, if the member does not appear to meet criteria for LTSS, Meridian will advise the member verbally that he or she does not appear to meet the criteria for enrollment, but we advise the member that he or she has the right to continue the process. At no time does Meridian discontinue the process, unless the decision to discontinue is made by the member or the member's representative. Meridian will not encourage the member or the member's representative to discontinue the process. If the member decides to continue the assessment or reassessment process, Meridian will complete the assessment process, including submission of the level of care assessment to the State. If the member decides to discontinue the assessment or reassessment process, Meridian will document the member's decision to terminate the assessment process, including the member or the member's representative's signature and date. At the State's direction, Meridian will provide the documentation of members who decide to terminate the assessment or reassessment process.

In the event there is a waiting list for a 1915(c) HCBS waiver, at the time of initial assessment, Meridian will advise the member there is a waiting list and that they may choose to receive facility-based services if 1915(c) HCBS waiver enrollment is not immediately available. Meridian will ensure members are receiving additional non-waiver supports and services while on the waiting list. Meridian will work with the State to ensure members are provided slots, when

available, based on date of application. When a member is in a facility and qualifies for a reserved capacity slot, Meridian will work with the State for slot release.

Meridian will work with the State to ensure that the number of members assigned to LTSS is managed in such a way that ensures maximum access, especially for HCBS community integrated services, while controlling overall LTSS costs. Achieving these goals requires effective coordination between Meridian and the State to jointly manage access to LTSS. In order to ensure success, Meridian will provide the State with LTSS utilization information as determined by the State, and participate in regularly scheduled joint LTSS access meetings to collaboratively and effectively manage access to LTSS. Meridian acknowledges we will not add members to LTSS without the State authorization resulting from the regularly scheduled joint LTSS access meetings.

Meridian will ensure we authorize all admissions of members that meet level of care requirements to nursing facilities and ICFs/ID that have a contract in good standing. We will also authorize access to the elderly HCBS waiver for any member that requests such services and meets the level of care requirements when we can adequately demonstrate to the State that we have reduced the corresponding number of nursing facility, ICF/ID, or PMIC beds.

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.

Prior to admission to a nursing facility and any time there is a significant change in status, Meridian Health Plan members will be referred to the State to receive a pre-admission screening and resident review (PASRR) by the State or its designee. Meridian intends to work with the State or its designee responsible for implementing the PASRR process and for oversight by utilizing a member-centric integrated care plan which enables us to easily identify significant changes in the member's status and determine if institutional placement is required. Meridian will ensure members receive specialized services identified by the process. Our referral process will solicit a PASSAR Level I Assessment and once the Level I Assessment is complete, we will address the outcomes of the Assessment and integrate any necessary special services required into the care plan. If the member has had a PASSAR Level II screening and is in an ICF/ID facility, we will ensure that the services of the Facility Care Plan are provided as identified in the Level II screening and incorporated into the integrated care plan. Meridian will pull all members identified as requiring specialized services into our utilization review sample and report the results to the State.

4.3 Community-Based Case Management Requirements

1. Describe your proposed model for delivering LTSS care coordination services.

Meridian Health Plan will provide for the delivery of community-based case management in accordance with the population and activity requirements outlined by the State, including the equivalent of: (i) targeted case management to members who are eighteen (18) years of age or over and have a primary diagnosis of mental retardation or who have a developmental disability as defined in Iowa Admin. Code 441 Chapter 90 whether or not member is receiving LTSS.1; and

(ii) case management to members who are under eighteen (18) years of age and are receiving services under the 1915(c) HCBS waivers and any amendments thereto as a result of this RFP except the 1915(c) HCBS waiver for children with a serious emotional disturbance.

Meridian will assign each member receiving Home and Community-Based LTSS a Community-Based Case Manager who will serve as the member's main point of contact with Meridian and the member's service delivery system. We will ensure each member has ease of access to and responsiveness from their Community-based Case Manager during regular business hours. The Community-Based Case Management staff has the knowledge of the community options, alternatives, and full range of long-term care resources as well as the specialized knowledge of the conditions and functional limitations of the target populations and of the individual members to whom they are assigned, which are served by Meridian. We provide community-based case management services to all members receiving LTSS, and comply with all requirements applicable to members residing in a nursing facility or ICF/ID and members receiving 1915(c) HCBS waivers.

Meridian will ensure that all Community-based Case Management is provided in a conflict free manner that administratively separates the final approval of 1915(c) HCBS waiver plans of care from the approval of funding amount done by Meridian. All community-based case management efforts will be provided in a manner of, and with an emphasis on, avoiding duplication provided within the members' system of care. By centralizing the focus on the member's medical and non-medical community needs, Meridian ensures a person-centered approach to care coordination service delivery. This member-driven approach begins with the initial assessment, open communication and identifying the gap areas in the member's care and needs. The Community-Based Case Manager works with the member to develop an individualized and person-centered care plan which allows for the member to have the tools and resources in place to live safely and make decisions that promote better health outcomes.

Delivery of LTSS Care Coordination

Please see the following pages for information on the delivery of LTSS Care Coordination.



Our Care Coordination approach allows for collaboration with formal and informal providers, and caregivers to ensure transparency and cohesion in coordinating services. Members are assigned to a Community-Based Case Manager based on stratification, waiver eligibility and region, the assigned Community-Based Case Manager will provide case management over the phone and/or face-to-face. After assessment delivery, the care plan is developed with the member to address medical and community needs. Members are encouraged to attend the Interdisciplinary Care Team (ICT) meeting to discuss their care plan with their Meridian and any providers or supports they wish to invite. The ICT meeting is conducted within the first ninety (90) days of enrollment, after a significant change in condition, and annually after each reassessment.

Community-Based Case Managers are highly trained clinical and non-clinical staff with experience in member engagement and coaching. They serve as the primary member contact to ensure that members understand preventive health care and self-management tools and goals.

2. Propose the required qualifications, experience and training requirements for community-based case managers.

Meridian Health Plan acknowledges the qualifications, experience and training of community-based care managers shall meet all of the qualifications and requirements as specified in the Iowa Administrative Code 441 Chapter 90; and are subject to the review and approval of the State, and once approved any changes must be approved prior to implementation. Meridian's Care Coordination Program employs Community-Based Case Manager, non-clinical paraprofessionals with a minimum of a four (4) year college degree; and Care Coordination Team Leads, which are licensed nurses and social workers with a four (4) year college degree. Meridian requires the Community-Based Case Manager's to have previous medical backgrounds including, but not limited to, medical assistants, emergency medical technicians (EMT), licensed social workers, or persons with a bachelor's degree with a concentration in healthcare related courses. Community-based case managers must also have expert computer and mobile knowledge, ability to demonstrate excellent verbal and written communication skills, interpersonal skills, facilitation skills, and ability to adapt to changing environments. The assigned Community-Based Case Managers for members who choose to self-direct services will have specific experience with self-direction and additional training regarding self-direction.

Each Care Coordination Team is led by a licensed nurse or social worker who monitors the Community-Based Case Manager's, activities, and serves as a clinical resource. Community-Based Case Managers are trained and have previous experience in member engagement and coaching.

Community-based Case Management training focuses on skills and strategies to build trust and confidence. The integrated Care Coordination model is designed to support the Community-Based Case Manager in identifying unmet care needs, coordinating services for these needs, facilitating evaluation and monitoring processes to meet these needs, and troubleshooting new issues as they arise.

All Community-Based Case Managers partake in six (6) weeks of training to ensure they understand and are given the tools to effectively identify a member's needs. The training program also teaches Community-Based Case Managers how to communicate the member's needs to the member and/or caregiver, other care team staff, and the member's provider. The training program consists of in person and online training courses, with materials such as PowerPoint presentations and online training courses administered via the Internet with the use of Captivate, an industry-leading eLearning authoring software for rapid creation and management of interactive eLearning content. All training is tracked, after answering a reporting question the training results are sent and stored on a corporate web server and the results are reformatted for reporting purposes. Staff is not allowed to work with members until training is completed. When training is complete, all Community-Based Case Managers have the ability to work with members to identify ongoing medical and behavioral health needs. An example of trainings materials include, but are not limited to:

- Meridian summary of benefits
- System coverage codes
- Medicaid wrap around coverage
- Serving as primary plan contact for Meridian members
- Stratification levels including changing stratifications

- Assessments to be completed
- Problem and goal development including barriers and interventions
- Documentation
- Member correspondence
- Primary care/specialist correspondence
- Integrated documentation when consultants such as behavioral health, registered dietician, pharmacist are consulting on case
- Frequency of member contact
- Appeals and grievance process
- Contracted network
- Health Risk Assessment completion
- Interdisciplinary Care Team (ICT) process
- Advanced directives
- Protected Health Information
- Model of care survey
- Model of care reports including dashboard
- Out-of-network coordination
- Community referral resources such as transportation, shelters, food pantries, utility assistance, area on aging, disability assistance organizations for ramps, etc.
- Cultural competency and interpreter services
- Crisis intervention and escalation procedures
- Health coaching
- Medications to avoid in the elderly
- Discharge planning including ensuring safe transition of care
- Local-coverage decision and national-coverage decision access
- Anticipate, identify and help overcome barriers
- Authorization grid

3. Describe your proposed staffing ratio for community-based case managers to members.

Meridian's staffing ratio for Community-Based Case Managers to members are as follows:

- Community-Based Case Managers to high-risk members identified as needing intensive Care Management services: one (1) to seventy-five (75)
- Community-Based Case Managers to moderate -risk members identified as needing supportive Care Management services: one (1) to 150
- Community-Based Case Managers to low-risk members identified as needing prevention and Wellness Programs: one (1) to 600

4. Describe how care coordination services will include ongoing communications with community and natural supports.

Meridian Health Plan facilitates access to covered benefits and monitors the receipt of services to ensure member's needs are being adequately met. We maintain ongoing communications with a member's community and natural supports to monitor and support their ongoing participation in the member's care. Meridian coordinate's with stakeholders, such as community organizations

rendering non-covered services to the member that are important to the member's health, safety and well-being and/or impact a member's ability to reside in the community. We coordinate and share information with member's service providers across the healthcare delivery system to facilitate a comprehensive, holistic and person-centered approach to care and address issues and concerns as they arise. We ensure there is no duplication of community-based case management for each member, and provide assistance to members in resolving concerns about service delivery or providers. Meridian works with and provides to contracted providers information regarding the role of the Community-Based Case Manager and we educate the providers to notify a Community-Based Case Manager, as expeditiously as warranted by the member's circumstances, of any significant changes in the member's condition or care, hospitalizations, or recommendations for additional services. We have experience and success in ensuring adequate and timely communication with other managed care contractors if a member transitions from one managed care plan to another so there is no interruption or delay in the member's service delivery.

The member's assigned Community-Based Case Manager is responsible for coordinating services and sharing communication with the member's natural supports, Interdisciplinary Care Team (ICT), and other healthcare professionals providing care to the member. The Community-Based Case Manager provides the following information to the member's service delivery system to coordinate care:

- Initial care plan and updates as they are made
- Initial and annual reassessment
- Transitions of care report
- Medication log

All of the information concerning the member including demographic, individual care plan, and services received are recorded in our integrated system which offers a centralized electronic information source for Community-Based Case Managers and other health care providers. Providers can access care summaries in our integrated system through a secure provider portal or they can request information from the Meridian's Community-Based Case Manager. The Community-Based Case Manager provides the member's representatives and member's healthcare providers with a written copy of the member's individual care plan, including short and long-term goals and interventions which ensure consistency in self-management education for the member.

5. Describe how internal operations support communication among departments to ensure community-based case managers are aware of issues related to their assigned membership.

Meridian Health Plan applies multiple approaches and strategies to ensure internal communication among departments is effectively communicated to Community-Based Case Managers and they're adequately aware of issues and opportunities relevant to their assigned member caseload. Examples include, but are not limited to:

- **Integrated health care systems:** Our integrated system allows for all aspects of Care Coordination including assessments, barrier identification, care plan, goal setting, contact follow-ups, and education. The Care Coordination Team Leads view Care Coordination caseloads daily to ensure Community-Based Case Managers are timely with member

contacts and updates to the care plan. The team identifies appropriate educational materials to provide to the member which are reviewed and discussed during the next scheduled contact. Behavioral health services, nutrition, pharmacy, etc. receive alerts when there is a referral that requires their expertise and assistance as well as automatic alerts to the Community-Based Case Manager's case files occur when there is an entry into the care plan or member contact by mail or phone across departments

- **Interdisciplinary Care Team (ICT) Meetings:** The Community-Based Case Manager is supported by the Care Coordination Team Lead and the Care Coordination Team through case round meetings that occur various times per week. The meetings are facilitated by a Clinical Lead and the Medical Director to discuss the treatment plan for challenging or difficult cases. Participants in these rounds also include the Team Lead, Community-Based Case Manager, Pharmacist Consults, Behavioral Health Coordinators, and Nutritionists. The Community-Based Case Manager has the opportunity to learn strategies from other staff that have worked with challenging situations and new community resources may be identified to assist the member

6. Describe strategies to minimize community-based case manager changes and processes to transition care when a member has a change in community-based case managers.

Meridian Health Plan permits members to change to a different Community-Based Case Manager if the member desires and there is an alternative Community-Based Case Manager available. The availability takes into consideration Meridian's need to efficiently deliver community-based case management in accordance with the requirements of the State. In order to ensure quality and continuity of care, Meridian works to minimize the number of changes in a member's Community-Based Case Manager. Examples of when we may initiate a change in Community-Based Case Managers include, but are not limited to, when the Community-Based Case Manager: (i) is no longer employed by Meridian; (ii) has a conflict of interest and cannot serve the member; (iii) is on temporary leave from employment; or (iv) has caseloads that must be adjusted due to the size or intensity of the individual Community-Based Case Managers' caseload.

Meridian has existing policies and procedures, subject to the State review and approval, regarding notice to members of Community-Based Case Manager changes initiated by either Meridian or the member, including advance notice of planned Community-Based Case Manager changes initiated by Meridian. We ensure continuity of care when community-based case manager changes are made, whether initiated by the member or Meridian. We follow industry best practices which include having the newly assigned Community-Based Case Manager attend a face-to-face transition visit with the member and the out-going Community-Based Case Manager when possible. Meridian understands the importance of facilitating member choice in coordinating the member's care which includes the ability for members to change their Community-Based Case Manager. Members who would like to change their current Community-Based Case Manager will have a different Community-Based Case Manager assigned to their case within twenty-four (24) hours. The new Community-Based Case Manager must attempt to complete a home visit within fourteen (14) days of reassignment to ensure a smooth transition of Community-Based Case Managers.

Meridian's goal is to provide seamless, effective transition from the member's Community-Based Case Manager assigned prior to implementation of the managed care contract and any change in community-based case management that Meridian pursues after implementation of the contract.

Meridian will allow the member to retain their current targeted case manager, case manager, Community-Based Case Manager, or integrated health home Care Coordinator during the first six months of transition. We will fully implement the transition plan within one year from the start date of the Contract, which will be reviewed and approved by the State prior to implementation as well as any changes to the plan will be provided to the State for review and approval prior to implementation.

7. Describe your proposed discharge planning process.

Meridian Health Plan ensures Community-Based Case Managers are actively involved in discharge planning when a LTSS recipient is hospitalized or served in any other higher level of care for less than sixty (60) days. Meridian utilizes an internally development Transition of Care program for hospitalized members to meet members needs during the discharge process ensuring those members that require an in-person visit receive a completed needs assessment and update to their care plan. Transitional Care Planning is a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Ongoing consultation with the Community-Based Case Manager and reassessment of the patient's changing medical functional, social and cognitive capabilities assures that the comprehensive needs of the patient are addressed. Patients and families are apprised of the appropriate community resources available and encouraged to participate in all phases of the transitional care planning process. Referral mechanisms with community providers occur in a timely, systematic fashion in order for the patient to gain access to identified resources. The process concludes with the coordination and implementation of services and transition to the least restrictive level of care in keeping with the individual's wishes and with the member able to self-manage their condition(s).

The tenets of the transition of care program include four (4) Pillars:

- Medication self- management
- Dynamic patient centered care plan
- Follow up with PCP and Specialists
- Red Flags/Action Plans

Meridian has a transition of care program based on the Eric Coleman Care Transitions Program and is available to members who are considered to be at “high risk” of readmission, poor outcomes and or high costs due to multiple chronic conditions, impaired self-care skills and or mobility, cognitive issues, homelessness, poor social support, behavioral health and/or substance abuse issues or history of multiple ED visits or admissions. These members require treatment and interventions across a variety of care domains including medical, social, and mental health. Members have the option to accept or decline involvement in the transition of care program; it is not a requirement. This program is provided to members free of charge.

Transition of Care Process for Hospital and Home Visits:

- i. Members are assessed for their risk of readmissions. Members who are at high risk for readmission will be referred for a transition of care visit; and if currently admitted, will have both a hospital and home visit.
- ii. Community-Based Case Manager will acknowledge the referral within one business day and schedule a hospital visit for the member’s inpatient stay prior to discharge.

Community-Based Case Manager will visit the member in the hospital prior to discharge. Items discussed with member in hospital:

- a. Purpose of transition program including providing the member with a program flyer and review as well as observations and documentation of the following: (i) member's physical condition including observations of the member's skin, weight changes and any visible injuries; (ii) member's physical environment; (iii) member's satisfaction with services and care; (iv) member's upcoming appointments; (v) member's mood and emotional well-being; (vi) member's falls and any resulting injuries; (vii) statement by the member regarding any concerns or questions; and (viii) statement from the member's representative or caregiver regarding any concerns or questions (when the representative/caregiver is available).

The Transition of Care program has multiple components, including:

- Collaborative completion of patient-centered care plan and self-management guide to facilitate positive communication during the care transition
- Condition-specific information and/or checklists to empower member's post-discharge activities
- Initial in-home assessment and medication reconciliation
- Telephonic support from Community-Based Case Manager to promote clinical stability and provide continuity

The Transition of Care program is designed to manage the transition from the inpatient setting back into the community. The model is designed to facilitate a safe discharge from the time they are admitted through thirty (30) days post discharge. Using tools such as the discharge checklist, readmission risk evaluation, and medication reconciliation, the Care Coordination Team Lead updates the member's care plan to reflect changes caused by the transition. Once the member is discharged, a home visit is conducted to address six (6) key components associated with transition of care and readmission. These include:

- Medication management
- Nutrition
- Provider follow-up
- Use of personal health records
- Red flags of signs and symptoms
- Home and community-based services

Discrepancies are evaluated with the member and communicated to the member's care team. For thorough follow up, the Community-Based Case Manager also assists the member in scheduling and coordinating services to ensure the member attends the post-discharge primary care provider follow-up visit. This process ensures Meridian identifies, documents, and immediately responds to problems and issues including, but not limited to: (i) service gaps; and (ii) complaints or concerns regarding the quality of care rendered by providers, workers, or community-based case management staff.

Our process ensures a partnership with hospitalist services to ensure seamless transition from inpatient health care settings. Discharge planning begins at the time of admission. Community-Based Case Managers confirm the following is included in the discharge plan:

- Baseline information about the member
 - Current medical and behavioral status
 - Family and community support systems
 - Financial status
 - Decision-making capacity
 - Cultural competence
 - Environmental limitations
- An appropriate medical home
- A continuously updated care plan
- Member-developed short and long-term goals

The Care Coordination Team works with the hospitalist program to ensure discharge instructions are supported and implemented in the care plan. The Care Coordination Team is the communication bridge among members, their family/caregivers, and the hospital team. As needed, the Community-Based Case Manager further supports this seamless transition through face-to-face interactions with the member's, families and significant others for resource education.

If a member needs placement in a nursing facility, ICF/ID or community-based residential alternative setting requested by the member, and the member is unable to be placed, Meridian will meet with the member and/or his or her designated/legal representative, as applicable, to discuss: (i) the reasons why placement is not possible; (ii) available options; and (iii) identification of an alternative facility or community-based residential setting. When Meridian is facilitating a member's admission to a nursing facility, Meridian will ensure all PASRR requirements have been met prior to the member's admission to a nursing facility, including a PASRR level I screening and as applicable, a level II PASRR evaluation. Meridian will ensure members have the option to receive HCBS in more than one (1) residential setting appropriate to their needs and we will educate members on the available settings.

Meridian will not transition nursing facility, ICF/ID, 1915(i) Habilitation or 1915(c) community-based residential alternative residents to another facility or residence unless: (i) the member or his/her representative specifically requests to transition; (ii) the member or his/her representative provides written consent to transition based on quality or other concerns raised by Meridian, which shall not include the residential provider's rate of reimbursement; or (iii) the provider has chosen not to contract with Meridian.

Meridian will establish contractual terms with our contracted providers, subject to approval by the State, which protect an individual from involuntary discharge that may lead to a placement in an inappropriate or more restrictive setting. Meridian shall facilitate a seamless transition whenever a member transitions between facilities or residences.

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.

Meridian Health Plan has a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its community-based care coordination processes. Meridian: (i) immediately remediates all individual findings identified through our monitoring processes; (ii) tracks and trends such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implements strategies to improve community-based case management

processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measures the success of such strategies in addressing identified issues. Meridian monitors the following: community-based care coordination tools and protocols are consistently and objectively applied and outcomes are continuously measured to determine effectiveness and appropriateness of processes; level of care assessments and reassessments occur on schedule; comprehensive needs assessments and reassessment, as applicable, occur on schedule and in compliance with the Contract; care plans are developed and updated on schedule and in compliance with the Contract; care plans reflect needs identified in the comprehensive needs assessment and reassessment process; care plans are appropriate and adequate to address the member's needs; services are delivered as described in the care plan and authorized by Meridian; services are appropriate to address the member's needs; services are delivered in a timely manner; service utilization is appropriate; service gaps are identified and addressed in a timely manner; minimum Community-Based Case Manager contacts are conducted; community-based case manager-to-member ratios are appropriate; and service limits are monitored and appropriate action is taken if a member is nearing or exceeds a service limit.

Specific examples of tools utilized to monitor effective include, but are not limited to:

- Home and Community-Based Surveys:
 - At least annually, Meridian conducts surveys to waiver members in order to monitor satisfaction with services, providers, and the plan
- Annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey Study
 - Meridian contracts with a NCQA-certified vendor and follows the NCQA process for submitting the sample population and conducting the survey. Interim results of the annual CAHPS® survey are tracked weekly and reported in our Operations meetings. Annual results are analyzed and presented to the Quality Improvement Committee and Quality Improvement Annual Evaluation.
- Surveys to assess member satisfaction with our Care Coordination programs
 - Examples of specific surveys include the Complex Case Management survey. This survey is sent to members with complex case management needs to evaluate, and ensure satisfaction with the program, understanding of progress toward goals, and feedback on strategies to improve the program. Based on feedback from this survey, Meridian took the following steps to improve the experience for members:
 - Care plan letters were updated to include a distinct paragraph that identified short-term and long-term goals
 - Measurable goals were updated to include language that was member friendly and understandable
- Annual Disease Management (DM) survey
 - This survey is sent to members that participated in DM programs in the previous year to assess both the member's satisfaction with the type and amount of contact by the plan and the content relevance. This survey has resulted in changes to our mailing and phone outreach program
- Member Advisory Committee (MAC) feedback
 - In order to validate member satisfaction and strategies to exceed expectations, Meridian has designated focus on feedback and strategies to improve the member experience and outcomes

- Tracking member complaints, grievances and appeals as well as Quality of Care concerns to ensure member satisfaction
 - These reports are prepared quarterly and presented to the Quality Improvement Committee (QIC)

9. 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.

In addition to the continuity of care requirements we outlined in Section 3, Meridian Health Plan will ensure a seamless transition of services during program implementation. The table below illustrates the proposed strategy and timeline within which all members receiving LTSS will receive an in-person visit from Meridian staff and an updated assessment and service plan will be completed. Meridian acknowledges understanding that services may not be reduced, modified or terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. Meridian shall adhere to the review and approval requirements of the State prior to implementation of the strategies and timeline and we will not implement any changes without receiving prior approval.

| Case Management Assessments and Contacts for HCBS Waiver Members* | | | | | | | | |
|---|---|---------------------------|-------------------------------|--------------------------|-------------------|---------------|---------------|--|
| Waiver/ Program Type | Initial Enrollment | Ongoing Enrollment | | | | | | Assessments & SLP |
| | Assessments & SLP | High Risk Case Management | Moderate Risk Case Management | Low Risk Case Management | Assessments & SLP | | | |
| | | Phone* | F2F | Phone* | F2F | Phone* | F2F | |
| Health and Disability | F2F CA and/or SIS completed within 60 days of enrollment date and SLP for new waiver created within 14 days | Every 30 days | Every 90 days | Every 30 days | Every 90 days | Every 30 days | Every 90 days | F2F CA and/or SIS re-assessment completed within 1 year of enrollment date and SLP is updated yearly, or as needed due to significant changes in condition or member request SLP updates |
| AIDS/HIV | | Every 30 days | Every 90 days | Every 30 days | Every 90 days | Every 30 days | Every 90 days | |
| Elderly | | Every 30 days | Every 90 days | Every 30 days | Every 90 days | Every 30 days | Every 90 days | |
| Children's Mental Health Waiver | | Every 30 days | Every 90 days | Every 30 days | Every 90 days | Every 30 days | Every 90 days | |
| Brain Injury | | Every 30 days | Every 90 days | Every 30 days | Every 90 days | Every 30 days | Every 90 days | |
| Physical Disability | | Every 30 days | Every 90 days | Every 30 days | Every 90 days | Every 30 days | Every 90 days | |
| Intellectual Disability | | Every 30 days | Every 90 days | Every 30 days | Every 90 days | Every 30 days | Every 90 days | |
| Key | | | | | | | | |
| F2F: Face-to-face CA: Comprehensive assessment SIS: Supports Intensity Scale Screening SLP: Service Level Plan | | | | | | | | |

4.3.12 Nursing Facilities and ICF/IDs

1. Describe proposed strategies for providing care coordination services for residents of nursing facilities and ICF/IDs, including the timelines and frequency of in-person visits.

Meridian Health Plan members that reside in nursing facilities and ICF/ID Facilities will have an InterRAI LTC comprehensive assessment within sixty (60) days of enrollment, face-to-face visits at a minimum of every ninety (90) days, and reassessments on an annual basis or as required by significant changes in condition. The Community Care Coordination Team works with the facility's staff in order to coordinate visits, develop a person-centered care plan, assist in health education, and act as an advocate for the member's needs. The member has not only the

opportunity to be involved in the initial person-centered planning process, but also throughout his or her enrollment with Meridian.

2. Describe processes for working with nursing facilities and ICF/IDs to coordinate care.

Meridian Health Plan seeks to ensure transparency and effective communication with nursing facilities and ICF/IDs in order to coordinate our member's care. We employ internal and external staff members who are responsible for thorough documentation of member's condition, completion of follow up tasks, and coordination of care.

Meridian's protocols and processes outline our work with nursing facilities and ICF/IDs to coordinate the provision of care for our members. We participate, as appropriate and allowed by the member, in the nursing facility and ICF/ID care planning process and we advocate for the member. Meridian continuously evaluates the nursing facility and ICF/ID care plans to determine adequacy and ensure timely discharge planning is addressed and implemented. Our care coordination team develops a care plan for members in a nursing facility or ICF/ID; which incorporates the care plan developed by the facility to supplement the members care plan. Meridian's protocols and processes improve the health, functional and quality of life outcomes of members residing in a nursing facility or ICF/ID.

Our case managers are educated and understand when to escalate and report concerns regarding nursing facility and ICF/ID quality.

Community-Based Case Manager: As the member's direct point of contact, the Community-Based Case Manager is responsible for contacting the member's nursing facility case manager or nurse to set up appointments to complete the initial health risk screening, assessments, and any ongoing contractual visits. During ongoing case management, the Community-Based Case Manager communicates any pertinent information via phone contact or face-to-face with the nursing facilities or ICF/IDs and assists with completing any transitions. The Community-Based Case Manager works together with the rest of the member's facility care team to develop a thorough transition care plan. With every transition, Community-Based Case Manager is responsible for the safe transition from the current to the most appropriate setting for the member's needs.

Meridian contracted providers will:

- Provide consistent and timely comprehensive medical care in the skilled nursing facility (SNF)
- Assist in the management of patients with acute and chronic conditions
- Provide immediate and responsive medical services which lead to positive clinical outcomes
- Upon admission of the patient to the SNF, develop a care plan which includes a discharge plan
- Work closely with the SNF and ancillary staff to assess, treat, and discharge the patient to lower, and less costly level of care
- Work closely with the SNF nursing, and ancillary staff to decrease the average length of stay and readmissions to the hospital

Our providers assess the appropriate care setting for those members that are moving from inpatient settings to a skilled nursing facility. This transition requires individualized care to prevent readmissions for co-morbid populations who are at high risk for relapse. Oversight of members for thirty (30) days leads to better outcomes, and reduction in preventable utilization. When appropriate, Meridian's Case Managers work with our nursing facility members' regarding options counseling and transition activities when a member has been identified through the quarterly screening of MDS Section Q, Participation in assessment and Goal setting, to return to their home and/or community of their choice.

In the event a member residing in a nursing facility or ICF/ID has a patient liability that must be met prior to Medicaid reimbursing for services, and the nursing facility or ICF/ID is considering discharging the member due to non-payment of the patient liability, Meridian will work to find an alternate nursing facility or ICF/ID willing to serve the member and document all related efforts.

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.

The care management model includes a comprehensive Care Coordination Program designed to drive the continuum of care across all care needs. It is based on a Person-Centered Care Coordination Model which empowers the member by promoting a healthy lifestyle, preventing disease, diagnosing disease early, and managing chronic conditions. The continuum of care design allows Meridian Health Plan to proactively identify high-risk members and move members along the continuum as their conditions warrant. The program is built to identify needs, develop individualized care plans, and coordinate services, including long-term care and home and community-based services.

Meridian will use an Interdisciplinary Care Team (ICT) approach to providing each member with an individualized, comprehensive care planning process in order to maximize and maintain every member's functional potential and quality of life. For each member, an individually tailored ICT, led by a Community-Based Case Manager, will ensure the integration of the member's medical, behavioral health, community-based or facility-based long term services and supports (LTSS), and social needs. The ICT will be built on the member's specific preferences and needs. Meridian, through the Community-Based Case Manager and in consultation with the member (and/or the member's Designee and/or Authorized Representative), will identify the individuals who will be on the member's ICT. The ICT members will be identified as soon as possible and identified in the system ICT module designed to schedule and invite attendees, track attendance, document proceedings and provide reports and summaries of ICT meetings. A screenshot of how the Community-Based Case Manager can view a member's ICT information is shown below.

[Continue/View Care Plan](#) [Go to the Documents Store](#) **Attach** **Print**

Member Name: SAM TEST

Subject: ICT Meeting

ICT/IDT Date: 10/30/2013 **ICT/IDT Type:** -- Select IDT Type --

Start Time: 8:00 AM **End Time:** 8:30 AM

CM/Organizer: Joseph Wetzel **ICT/IDT Notes:** -- Select One --

Location: AFCH (Adult Facility Care) **Other:**

Summary/Notes:

Care Plan Updated
 Member/Caregiver Updated
 Provider Updated

Meeting Status: Scheduled

Created by: Joseph Wetzel **Created Date:** 10/30/2013 11:35:42 PM

Modified By: **Modified Date:**

Teleconference Number

- (866) 951-1151 Conference# 274388852
- (866) 951-1151 Conference# 8988020
- (866) 951-1151 Conference# 7965380
- (866) 951-1151 Conference# 661905114
- (866) 951-1151 Conference# 1537484
- (866) 951-1151 Conference# 662297871
- (866) 951-1151 Conference# 2909298
- (866) 951-1151 Conference# 276776566
- (866) 951-1151 Conference# 445058182

Meeting Address

- 112 Charles Street
2nd Floor
New York, NY 10014
- 121-B West 20th Street
1st Floor
New York, NY 10011
- Participant's home

Meeting Minutes **generate documents**

| Name | Role | Title | Attended | Attendance | Action | Action Date |
|-----------------------------|---------------------------------|-------|----------|------------|--------|-------------|
| ILSNY CARE MANAGER 2 TEAM 2 | Care Team ((ILS) Case Manager) | | No | N/A | | |

Leveraging the support of the ICT, the Community-Based Case Manager will work with the member to develop an integrated care plan for each member that will define interventions based on historical data and member self-reported data (assessments) to generate a series of problems, goals and interventions (as well as protocols to support each intervention).

A care plan mapping module is available to allow them to graphically map the following:

- The relationship between singular data elements and specific interventions (e.g. member is diabetic; assign intervention X)
- The relationship between multiple elements and interventions (e.g. member is diabetic AND has behavioral issues AND has had no HbA1C test in six (6) months' assign intervention Y)
- Assign protocol to support each intervention. An intervention defines the “what” (e.g. ensure a member sees a cardiologist each ninety (90) days), while a protocol defines the “how” (i.e. call specialist on member behalf, coordinate transportation etc.)

The screenshot shows a software interface with a 'Client Specific' tab. A dropdown menu for 'Line Of Business' is open, showing options: SNP, PASS, MEALS, LTC, and SPD. Below the menu, there are several rows of checkboxes and text descriptions for various care plan items. The items include:

- PHYSICIAN: Provide member with information to appropriate physician services to address identified physical, medical, behavioral, and mental health issues.
- P: No PCP in past 6 months. G: Member will complete, and maintain regularly scheduled PCP visits. I: PCP visit to coordinate ongoing PCP visits.
- Refer to PCP - Eval & Treatment
- P: Assessment indicates no advanced care planning or advanced directive established. G: Member will have access to available services to address lack of advanced care planning, advanced directive established. I: PCP visit to evaluate and discuss appropriate and related advanced directives services.
- Education Materials - General
- Follow-up on Referral to PCP
- Refer to PCP - Eval & Treatment
- P: Assessment indicates member with low health status, low satisfaction with quality of life or other health goal needs. G: Member will have access to services as appropriate to assist in improved self-rating of overall health status. I: PCP visit to evaluate and coordinate appropriate services to improve or maintain member's overall health status and health goals.
- Follow-up on Referral to PCP
- Refer to PCP - Eval & Treatment
- P: Member is unreachable - Care Plan is generated based on clinical and/or administrative data when available. G: Member will complete Health Risk Assessment and gain access to additional coordination of care as needed. I: PCP visit to encourage member to complete health risk assessment and update demographic information with health plan.
- Send Member Letter - Care Plan per Member Request
- Send Member Letter - Trying To Reach You

Below is an illustration of how the member care plan is integrated showing the behavioral, mental and physical attributes of that member.

| Health Conditions | | |
|--|----------|-------------------------------------|
| Problem: Health Risk Assessment and/or clinical data indicates incontinence. <i>Created On: 8/25/2013 Created By: TAMMY TWENHOFEL Frequency: As Needed</i> | Approved | Agreement Status: Agree |
| Problem: Member assessment indicates recent hospitalization and discharge from an inpatient setting back to member's home and MAY require transition of care services. <i>Created On: 11/20/2014 Created By: JESSICA CLEMENTE Frequency: As Needed</i> | Approved | Agreement Status: Pending |
| Nutrition | | |
| Problem: Potential for nutritional deficit. <i>Created On: 8/25/2013 Created By: TAMMY TWENHOFEL Frequency: As Needed</i> | Approved | Agreement Status: Agree |
| Medication Management | | |
| Problem: Health Risk Assessment and/or clinical data indicate polypharmacy, medication discrepancy, or need for medication reconciliation. <i>Created On: 8/25/2013 Created By: TAMMY TWENHOFEL Frequency: As Needed</i> | Approved | Agreement Status: Agree |
| Environmental & Social Services | | |
| Problem: Health Risk Assessment indicates limited or no access to transportation. <i>Created On: 8/29/2013 Created By: System Frequency: As Needed</i> | Approved | Agreement Status: Agree |
| Functional Status | | |
| Problem: Member requires assistance with ADL's (Activities of Daily Living). <i>Created On: 8/25/2013 Created By: TAMMY TWENHOFEL Frequency: As Needed</i> | Approved | Agreement Status: Agree |
| Problem: Member requires assistance with IADL's (Instrumental Activities of Daily Living) <i>Created On: 8/26/2013 Created By: TAMMY TWENHOFEL Frequency: As Needed</i> | Approved | Agreement Status: Agree |
| Problem: Member requires assistance with meal preparation. <i>Created On: 9/25/2014 Created By: Noelia Moises Frequency: As Needed</i> | Approved | Agreement Status: Agree |

Assessing the Member's Needs

Based upon assessment responses, a review of historical claims and other data, the predictive modeling software allows each Community-Based Case Manager to develop an Individualized Care Plan (ICP) for the member. This ICP will address all member needs, taking into account cultural and linguistic preferences. This process identifies members who suffer from behavioral health conditions, serious mental illness (SMI), substance abuse issues, ESRD, or developmental disabilities. Members are referred to the appropriate Community-Based Case Manager for further condition-specific assessments when necessary. These responses provide consumer direction in ICP development following a problem, goal, and intervention methodology.

Based on outreach, additional risk factors may be identified in which case a referral/consultation may be made to medical, behavioral, nutritional, medication review or smoking cessation programs. Once the acute problems and emergency needs of the member are met, the case can go to the Community-Based Case Manager for continued follow up and monitoring.

The program also includes utilizing the InterRAI tool that addresses a comprehensive assessment of a member's physical, social, development, behavioral, nutritional, environmental and clinical areas. The Community-Based Case Manager is expected to collect the information from the member within sixty (60) days of enrollment. The information obtained through the assessment is shared in the form of a Summary Profile and an Individualized Care Plan that is shared with the member, and/or their caregiver along with the member's medical home. The Care Coordination Team Lead coordinates the services, inclusive of preventive health screenings, together with the member, and/or caregiver, and member's primary care provider and ensures that all appropriate handoffs occur.

During the initial assessment, a complete medication list is recorded for each patient. As a component of the care plan, interventions are designed around evaluating medication compliance, poly-pharmacy, medication education and overall medication management. The Community-Based Case Manager will follow-up with members to verify compliance with medication plans and provide continuous medication alignment. The care management system can be modified to base interventions on any standards or models to ensure proper compliance and management. For example, triggers can be set in the system to apply interventions related to HEDIS® measures such as annual monitoring for patients on persistent medications.

The Community-Based Case Managers are responsible for ensuring that the member's assessment is adequately completed to portray the member's current condition inclusive of medical, behavioral, social and functional issues and needs and development of an individualized care plan utilizing a problem, goal, and intervention methodology. The Community-Based Case Manager works to identify if a member's condition is either clinical or social in nature and if the member would benefit from either clinical or non-clinical care management. At any point, a member's condition may change, warranting a member to be transferred to the care of a clinical or non-clinical Community-Based Case Manager. The clinical staff and consultants work in conjunction with a Community-Based Case Manager to assist in the administrative and clerical duties necessary to carry out the interventions that are part of a member's care plan.

Individualized Care Plan Development

Each member's care plan identifies overall goals that reflect their unique needs, are realistic and measurable, include a time frame for achievement as appropriate, identify services and care to meet member's care goals, and connect the member/caregiver with add-on benefits and services.

Upon completion of the assessment, our systems automatically identify appropriate short-term and long-term goals based on member responses. The Community-Based Case Manager reviews these goals with the member and adds any additional goals identified during discussions with the member and/or medical home. The Community-Based Case Manager works together with the member to rank each short-term goal in order of importance as well as to establish member confidence in ability to achieve these goals. If the Community-Based Case Manager identifies barriers, they are associated with a goal and documented on the care plan. The care plan is generated and sent to the member, the medical home, PCP and specialist (if applicable). It is also present on Meridian's web portal.

Through the development of individualized, member-centric care plans, the member, caregiver, and all other stakeholders, including providers of Home and Community Based Services (HCBS), are able to plan and address common goals and services related to the care of the member. By sharing a member's care plan with all of the providers serving the member, a common goal of improved health and team approach is achieved. Engaging the member in self-directed care together with the support of the care management team will prevent duplication of services and ensure that the member receives the care and services needed for maintaining health.

Targeted Intervention and Education

The Care Coordination program systems facilitate targeted intervention by providing Meridian Community-Based Case Managers with a dynamic work list. This enables them to assign specific goals and dates for follow-up with each member they are managing. In accordance with the care plan, the Community-Based Case Manager conducts numerous interventions and multiple contacts in addition to member telephonic contact. This includes contacting providers for laboratory results, requesting copies of medical records/plans of care from specialists, and contacting discharge planners in hospital. These interventions and contacts are recorded relative to the specific goals they are addressing.

Member Engagement

The Community-Based Case Manager develops self-management plans in collaboration with the member. Self-management is a critical component of the member care plan that is designed to empower the member/caregiver to provide appropriate levels of self-care. These self-management activities are provided to members in oral and written form. They can also be provided to the member by any care team staff, such as Disease Management or Pharmacy staff, a discharge planner, a diabetic educator or a dietician. The self-management plan includes, but is not limited to, member monitoring of symptoms, activity, weight, blood pressure, blood levels such as glucose, scheduling and attending medical appointments, and medication adherence.

A follow-up letter is sent to the member after each contact to reiterate the self-management activities and goals the member has agreed to work on. Additional educational information is sent along with this letter as needed. The documentation includes the specific educational materials sent to the member as well as any verbal self-management instructions and coaching given by the

Community-Based Case Manager. Additionally, the member and PCP are sent a care plan letter which details the short-term and long-term goals to which the member has agreed. This letter also notes the interventions that will be performed to accomplish the goals. The Community-Based Case Manager also creates a medication list which is mailed to the member. The member is expected to follow the medication list and bring it to every provider appointment. A copy of the medication list is also mailed or faxed to the primary care provider for purposes of medication reconciliation. Based on assessment results, members are stratified into low, moderate, high or intensive risk groups. Community-Based Case Managers utilize stratification to prioritize caseloads and determine the degree of intervention needed based upon the member's level of acuity. The intensity, type and frequency of member interventions (direct or indirect) are determined by their combined needs and resulting case risk stratification. Motivational interviewing is one of the mechanisms employed by the Community-Based Case Manager to determine which goal(s) the member appears ready to work on.

Interdisciplinary Care Team (ICT) Meetings

Meridian's Care Coordination Teams meets daily with the Medical Director and Utilization Management team to discuss cases and ensure all internal and external resources are used to meet the member's short-term and long-term needs. All team members attend the daily meeting where they give input and plan next steps in their area of expertise.

Meridian's systems provide the ability to analyze claims and other encounter data to ensure that all captured diagnoses are accounted for. Additionally, assessments include questions geared toward identifying patients at risk based on their social and medical needs. Patients that are identified as having serious mental health illness, substance abuse issues or developmental disabilities are referred to the appropriate Care Coordination Consultant (e.g. Behavioral Health Case Manager) and then managed by an interdisciplinary team.

Care Plan Monitoring

The Community-Based Case Manager assesses progress relative to case management plans and goals, modifying them as needed. The member's progress towards the goal is documented after every member contact as well as any identified barriers to meeting the goals and compliance. By providing specific tools, telephonic support, and education on self-management skills, members will be supported throughout the entire transition process.

Meridian understands the State Resource Centers (SRCs) provide intensive intermediate care facility services for individuals with intellectual disabilities, and are included in coverage provided by Meridian. Meridian will administer and manage coverage of the SRCs consistent with the following:

All admissions to SRCs will be consistent with the requirements of the Conner Consent Decree. The SRC superintendent has the final determination regarding whether or not to admit an individual to the SRC. Each SRC's bed capacity shall be reduced by no less than twelve (12) beds each State fiscal year. Meridian will fund outplacement and transition activities, including training staff at the new placement, staff visits, and staffing for overnight visits during the transition period. Meridian will fund diversion referral activities to appropriately divert referrals from SRC placement to available services in the community. Meridian will fund all placements mandated by the court pursuant to Iowa Code Chapter 812 (not competent to stand trial) or Iowa

Rule of Criminal Procedure 2.22 (not guilty by reason of insanity) which fall within Meridian's Utilization Management Guidelines.

4. Propose institutional diversion strategies and describe successes in other states.

Meridian Health Plan's comprehensive institutional diversion program, which is subject to the State review and approval, targets and addresses the needs of the following: (i) members waiting placement in a nursing home, ICF/ID or other institutional setting, including members who may be on an HCBS waiver waitlist; (ii) members who have a change in circumstance or deterioration in health or functioning and request nursing facility or ICF/ID services; (iii) waiver members admitted to a hospital or inpatient rehabilitation program; and (iv) individuals in a nursing facility for a short-term stay. Meridian acknowledges any subsequent changes to the program after initial approval must be prior approved by the State.

Our goal for individuals with long-term needs is to provide more home and community-based services options for these members. Success in institutional diversion has been related to our person-centered model of care. In Illinois, we have been successful in arranging alternate housing to avoid institutional placement and modifying services to fit our member's needs, which includes utilizing community and natural support systems. Person-centered planning is utilized and encouraged with members to identify a support structure to avoid future or ongoing institutional placement. Meridian has had success working with members through person-centered planning to develop goals and strategies that assist in remaining in the community. We have also had success with person-centered planning in institutional settings to ease discharge and avoid long-term placement by working with the member, providers, and informal supports to address care and transition needs that produced successful strategic outcomes.

Success Story

One of our current members was at risk of being placed in a facility and having their child placed into foster care, but with the dedication and assistance of our Community-based Case Management Team, the member is now able to remain in the community and with their child. The Community-Based Case Manager advocated for the member's desire to remain in the community by assessing the member's needs, determining the member's ability to self-direct care, and applying the member for Home and Community-Based Waiver Services. After the member was found eligible, Meridian assisted the member in having a self-directed care attendant and obtaining Home Modifications to ensure the member's ability to live safely and care for his or her child.

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.

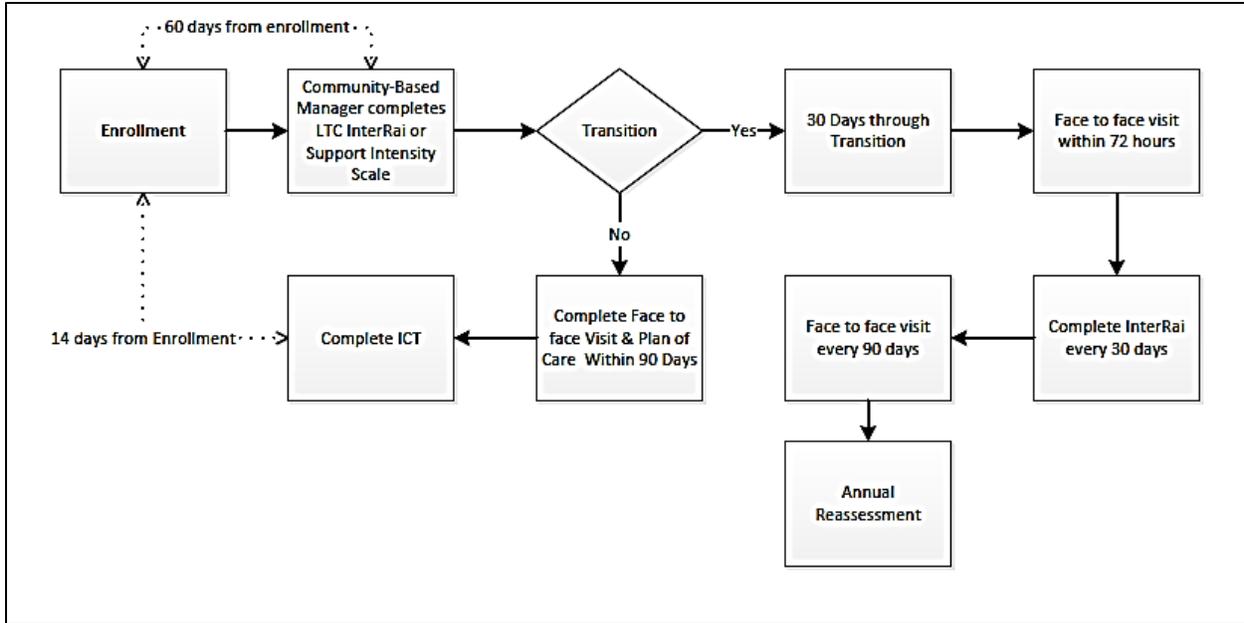
Meridian Health Plan has demonstrated success in identifying members who desire to transition from a nursing facility or ICF/ID setting to community integrated settings. Our strategies, subject to the State review and approval, identify members who have the ability or desire to transition from a nursing facility or ICF/ID setting to the community.

Meridian conducts a transition assessment, using tools which will be pre-approved by the State, on members who have been identified through this process. The transition assessment includes, at minimum, an assessment of the member's desire and ability to transition to the community as well as an identification of risks. For those identified through the assessment process as candidates for transition to the community, Meridian facilitates development of a transition plan and engages the member and representatives of his or her choosing in the transition planning development process. The transition plan addresses all transition needs and services necessary to safely transition the member to the community including, but not limited to: (i) physical and behavioral health needs; (ii) selection of providers in the community; (iii) housing needs; (iv) financial needs; (v) interpersonal skills; and (vi) safety. The transition identifies any barriers to a safe transition and strategies to overcome those barriers. If as part of the transition plan the member enrolls in a 1915(c) HCBS waiver, Meridian will ensure the needs assessment and service plan requirements described in Section 4.5.2 will apply.

Meridian monitors all aspects of the transition process and we take immediate action to address any issues that arise. Meridian monitors hospitalizations and nursing facility and ICF/ID readmissions for members who transition to the community to identify issues and implement strategies to improve outcomes. We conduct face-to-face visits with the member, at minimum: within two (2) days of the transition to the community; every two (2) weeks for the first two (2) months from discharge; and once per month for the first year after transition, with more frequent contact if needed based on the members individualized assessment of their needs and risk factors.

Meridian's Utilization Review activity is conducted in accordance with 42 CFR Part 456 for NF, Nursing Facility for Persons with Mental Illness (NFMI), ICF/ID, PMIC, Mental Health Institute (MHI), and hospitals. For NF, NFMI, ICF/ID, PMIC, MHI providers, an annual on-site review is conducted to evaluate the appropriateness of placement and that services are meeting the treatment needs of our members. For hospitals, a desk review is conducted every three years of each hospital's utilization control processes to assess their comprehensiveness and verify their completion. All providers are notified of the preliminary results during an exit conference at the completion of the review. Meridian will provide a written report to the provider that includes the evaluation of the compliance and recommendations for enhancements, corrective action, or both, within thirty (30) business days of completion of the on-site visit. Meridian will pull all members identified as requiring specialized services into our utilization review sample and report the results to the State.

Meridian Health Plan conducts the InterRAI Long Term Care Comprehensive Assessment for all members residing in facilities to address potential discharge from facility to community. Once a member is identified as appropriate for community transition, the community care coordination staff assists with the transition process. Community Care Coordination staff will conduct pre and post discharge planning protocol which includes documentation in the care plan guided by Attachment 17 (Community Transition Plan Checklist Tool) in Tab 5. The following flow outlines this transition.



6. Describe processes for interacting with the State’s MFP designee and strategies to prevent duplication and fragmentation of care.

Meridian Health Plan acknowledges the State currently operates a MFP grant which provides opportunities for individuals in Iowa to move out of ICF/IDs and nursing facilities and into their own homes in the community of their choice. Grant funds provide funding for the transition services and enhanced supports needed for the first year after an individual transition into the community. MFP assistance is available to individuals with a diagnosis of an intellectual disability or brain injury who have lived in an ICF/ID or nursing facility for at least three (3) months. Meridian will work in collaboration with the State’s MFP designee in implementing the MFP program. We will be responsible for identifying current members who may be eligible for MFP participation and referring those members to the State’s MFP designee. Meridian acknowledges the State retains authority for determining MFP eligibility and MFP enrollment. Once an individual is enrolled in the MFP program, we will work in collaboration with the State’s MFP designee in developing the transition plan. Meridian’s Community-Based Case Manager will serve as a member of the MFP planning team convened by the State’s MFP designee. The State’s MFP designee shall be responsible for the authorization and delivery of services which are non-Medicaid covered services. Meridian will be responsible for the authorization and delivery of Medicaid covered services. Meridian will implement strategies to prevent duplication and fragmentation of care, and when the Money Follows the Person grant is no longer authorized by CMS, Meridian will assist with the development and implementation of the sustainability plan, subject to the approval of the State.

Meridian has had various successes in working with the Money Follows the Person Program. In 2014, an Illinois member was residing in a facility for just over a year. During the assessment process, the Community-Based Case Manager discovered the member’s desire to transition to the community. The Community-Based Case Manager completed a person-centered care plan, InterRAI LTC assessment screening, which resulted in the applying the member for the Money Follows the Person Program. The member was able to reside with his daughter with minimal

resources needed for the transition. The Community-Based Case Manager continues to work with the case manager from the Centers of Independent Living to ensure medical and social support needs are in place. This member has been actively living with his family, participating in community activities, and successfully avoided institutional placement for the past year.

For those members who could potentially be transitioned back into the community, the Community-Based Case Manager conducts an initial transition screening and InterRAI assessment to obtain the member's interest and capacity to complete this transition. Within sixty days of enrollment, if the member expresses desire to repatriate and appears to have the necessary support systems to ensure great success in the appropriate transition, the Community-Based Case Manager in the area will be assigned to the member to assist in the transition. The Community-Based Case Manager will submit a referral to the State's Money Follows the Person referral system to assist with the transition of the member. The Community-Based Case Manager will outreach to the member and, as appropriate, the caregiver, Power of Attorney (POA) and/or member representative to schedule an initial meeting within the State contractual timeframe. If the member chooses to repatriate without the assistance of the State's MFP help or funding, the Community-Based Case Manager will assist in coordinating the proper services.

If the member requires assistance in the community to transition safely, the Community-Based Case Manager will assist in coordinating LTSS and home and community-based services (HCBS) services. Examples of these services include but are not limited to: services such as environmental adaptation, chore services, respite care, personal care, and escort services are not traditional health plan benefits but are crucial to the success of the program. The Community-Based Case Manager will ensure receipt of these services is appropriate in order to ensure a safe transition into the community.

The Community-Based Case Manager will work to deliver care management to the member during the transition period and until the member is determined to be stable and back in the community. The assigned Community-based Case Manager will continue to monitor the member in the community in the post-transition period.

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.**

The State of Iowa currently operates seven (7) 1915(c) HCBS waivers including: (i) Health and Disability Waiver; (ii) AIDS/HIV Waiver; (iii) Elderly Waiver; (iv) Intellectual Disability Waiver; (v) Brain Injury Waiver; (vi) Physical Disability Waiver; and (vii) Children's Mental Health Waiver. Meridian Health Plan will be responsible for the comprehensive needs assessment, care plan development, Community-Based Case Management and authorization and initiation of waiver services for all members enrolled in Meridian's managed care plan under an eligibility category inclusive of a 1915(c) HCBS waiver.

Meridian is responsible for service plan development for each 1915(c) HCBS waiver member, which will include all components of the service plan to meet contractual requirements as well as State and Federal regulations and policies. The service plan will be completed and approved prior to the provision of waiver services and reviewed and revised: (i) at least every twelve (12)

months; or (ii) when there is significant change in the member's circumstance or needs; or (iii) at the request of the member.

The service plan will be established through a person-centered service planning process which is led by the member whenever possible as dictated by CMS standards for the person-centered planning process. The member's representative shall have a participatory role, as needed and as defined by the member. Meridian will establish care teams for the member and with that team identify the member's need for services based on member's needs and desires as well as the availability and appropriateness of services. We will work with the team to identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or when the member's needs change. Meridian will ensure the person-centered planning process:

- Includes people chosen by the individual
- Includes the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery and includes, at minimum, the member and if appropriate the member's legal representative, family, service providers and others directly involved in the member's care including input from the member's PCP (if applicable), specialists and behavioral health providers
- Allows the member to choose which team member shall serve as the lead and the member's main point of contact. If the member elects not to exercise this choice, the team will make the decision who will serve as the lead
- Promotes self-determination principles and actively engages the member;
- Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions
- Is timely and occurs at times and locations of convenience to the member;
- Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b)
- Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants
- Offers informed choices to the member regarding the services and supports they receive and from whom; and provides members with information about potential providers of waiver services and assist members in selecting or changing providers, as requested by the member;
- Includes a method for the member to request updates to the plan as needed;
- Records the alternative home and community-based settings that were considered by the member
- Records discussion and options provided for meaningful day activities, employment, and education opportunities. Members shall be offered choices that improve quality of life and integration into the community

In accordance with 42 CFR 441.301 and the Iowa Administrative Code 441-90.5(1)b and 441-83 Meridian will ensure the service plan reflects the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The

service plan will reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports. The person-centered service planning process shall be holistic in addressing the full array of medical and non-medical services and supports provided by both Meridian or available in the community to ensure the maximum degree of integration and the best possible health outcomes and participant satisfaction.

Meridian will ensure the service plan:

- Reflects that the setting in which the individual resides is chosen by the member. Meridian will ensure that the setting chosen by the member is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS
- Reflects the member's strengths and preferences
- Reflects the clinical and support needs as identified through the needs assessment
- Includes individually identified goals and desired outcomes which are observable and measurable
- Includes the interventions and supports needed to meet members' goals and incremental action steps as appropriate
- Reflects the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports
- Includes the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service
- Includes the identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan
- Includes a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications
- Reflects risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed
- Includes a plan for emergencies as further described in Section 4.4.3.2
- Is understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b)
- Identifies the individual and/or entity responsible for monitoring the plan
- Is finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation
- Is distributed to the member and other people involved in the plan
- Indicates if the member has elected to self-direct services and, as applicable, which services the individual elects to self-direct as described further in Section 4.4.8
- Prevents the provision of unnecessary or inappropriate services and supports

Meridian will ensure the service plan has an emergency plan documented that identifies the supports available to the member in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the member or other persons or in significant amounts of property damage. Emergency plans shall include, at minimum: (i) the member's risk assessment and the health and safety issues identified by the member's interdisciplinary team; (ii) the emergency backup support and crisis response system identified by the interdisciplinary team; and (iii) emergency, backup staff designated by providers for applicable services.

In addition to the service plan content requirements outlined in Section 4.4.2, the service plan for members in supported community living shall include: (i) the member's living environment at the time of 1915(c) HCBS waiver enrollment; (ii) the number of hours per day of on-site staff supervision needed by the member; (iii) the number of other waiver consumers who will live with the member in the living unit; and (iv) an identification and justification of any restriction of the member's rights, including, but not limited to, maintenance of personal funds or self-administration of medications.

Meridian has policies and procedures, subject to State review and approval, which describe measures taken to address instances when a member refuses to sign the service plan. The policies and procedures include an escalation process for a review of the reasons for the member's refusal as well as actions taken to resolve any disagreements with the service plan.

In accordance with 42 CFR 441.301 (b)(1) Meridian will ensure waiver services are not furnished to individuals who are inpatient in a hospital, nursing facility, institution for mental diseases, or ICF/ID. In addition, we'll ensure non-institutional LTSS are provided in settings which comply with the CMS home and community-based setting requirements as defined in regulations at 42 CFR 441.301(c)(4) and 42CFR 441.710(a).

Meridian recognizes there are certain conditions that must be met for an individual to be eligible for a 1915(c) HCBS waiver, and we will track the information required and notify the State, in the manner prescribed by the State, when any of these scenarios occur. Meridian acknowledges the State shall have sole authority for determining if the member will continue to be eligible under the 1915(c) HCBS waiver we will comply with the determination. Meridian acknowledges being eligible under a 1915(c) HCBS waiver, a member must receive, at a minimum, one (1) billable unit of service under the waiver per calendar quarter and need waiver services on a regular basis to be eligible. We monitor receipt and utilization of LTSS and will notify the State if a member has not received at least one (1) billable unit of service under the waiver in a calendar quarter.

Meridian will continually monitor 1915(c) HCBS waiver member's expenditures against the aggregate monthly cost cap, and work with members reaching their cap to identify non-waiver services that are available and appropriate to be provided in the event the cap is met to assist the member in remaining in the community and prevent or delay institutionalization. If Meridian determines a member's needs cannot be safely met in the community and within the aggregate monthly costs defined in the 1915(c) HCBS waiver in which the member is enrolled, we will determine if additional services may be available to allow the member to continue to reside safely in the community. In the event Meridian determines the member can no longer have his or her needs safely met through a 1915(c) HCBS waiver, and the member refuses to transition to a more appropriate care setting, we will provide the information to the State. Additionally, we will notify

the State if a 1915(c) HCBS waiver member receives care in a hospital, nursing facility, or ICF/ID for thirty (30) days in one stay for purposes other than respite care.

Meridian's Community-Based Case Manager, at a minimum, will contact 1915(c) HCBS waiver members at least monthly either in person or by telephone with an interval of at least fourteen (14) calendar days between contacts and visit members in their residence face-to-face at least quarterly with an interval of at least sixty (60) days between visits. After the initiation of services identified in the member's service plan, Meridian will monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan. At minimum, the Care Coordinator will contact 1915(c) HCBS waiver members within five (5) business days of scheduled initiation of services to confirm that services are being provided and that member's needs are being met. We will identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively; and we'll describe our policies and procedures for identifying, responding to and resolving service gaps; in addition to processes to identify changes to a member's risk and address any changes, including, but not limited to, through an update to the member's risk agreement which we acknowledge will be subject to State review and approval.

Meridian will offer 1915(c) HCBS waiver members the option to self-direct waiver services. For the purposes of the response, Meridian acknowledges in Iowa Medicaid the self-direction option is referred to as the Consumer Choices Option consistent with all applicable rules and regulations.

We will ensure that the member and/or the member's representative fully participate in developing and administering the Consumer Choices Option and that sufficient supports are made available to assist members who require assistance. We'll work with our members to determine the appropriate level of assistance necessary to recruit, interview and hire providers. Meridian has demonstrated experience and success in managing the components of Consumer Choices Options, including, but not limited to: (i) identifying resources, including natural and informal supports that may assist in meeting the member's needs; (ii) developing a budget to address the needs of the member; (iii) conducting employer-related activities such as assisting a member in identifying a designated representative if needed, finding and hiring employees and providers, and completing all documentation required to pay self-directed providers; (iv) identifying and resolving issues related to the implementation of the budget; (v) assisting the member with quality assurance activities to ensure implementation of the member's budget and utilization of the authorized budget; (vi) recognizing and reporting critical incidents related to self-directed services; (vii) facilitating resolution of any disputes regarding payment to providers for services rendered; and (viii) monitoring the quality of services provided.

During the service planning process, Meridian advises members of their option to self-direct services. Members expressing an interest in the Consumer Choices Option are required to complete a self-assessment intended to determine a member's ability to make decisions regarding his or her health services, and knowledge of available resources to access for assistance. If the self-assessment results reveal that the member is unable to self-direct services, but he or she is still interested in electing the option, the member will be required to appoint a representative to assume the self-direction responsibilities on his or her behalf. We ensure all members who elect to self-direct sign an informed consent contract, which will be subject to review and approval by the State. All members choosing the self-direction option shall also sign an individual risk agreement that permits the participant to acknowledge and accept certain responsibilities for addressing risks. Services may be self-directed by a member, or a representative selected by the member; and the representative may be either a legal representative or non-legal representative

freely chosen by an adult member. Meridian educates the member that if the member selects a non-legal representative, the non-legal representative cannot be a paid provider of services, and must be eighteen (18) years or age or older. We require the member and the non-legal representative to sign a consent form designating who they have chosen as their non-legal representative and what responsibilities the representative will have. The choice of representative is documented in the member's file and provided to the member and the member's representative. At a minimum, the non-legal representative's responsibilities include ensuring decisions made do not jeopardize the health and welfare of the member and ensuring decisions made do not financially exploit the member. Meridian's quality assurance processes, including, but not limited to, member interviews, determine if a non-legal representative is working in the best interest of the member.

Meridian works with Support Brokers in other states, and we understand and acknowledge required functions of Support Brokers which include: (i) educating members on how to use self-directed supports and services; (ii) reviewing, monitoring and documenting progress of the member's self-directed budget; (iii) assisting in managing budget expenditures and budget revisions; (iv) assisting with employer functions such as recruiting, hiring and supervising providers; (v) assisting with approving and processing job descriptions for direct supports; (vi) assisting with completing forms related to employees; (vii) assisting with approving timesheets and purchase orders or invoices for goods; (viii) obtaining quotes for services and goods as well as identifying and negotiating with vendors; and (ix) assisting with problem solving employee and vendor payment issues. Meridian's policies and procedures, subject to State review and approval, ensure that Support Broker functions are not duplicative of Care Coordinator activities and functions, and that Meridian maintains the responsibility for the enrollment, ongoing training and oversight of the Support Brokers. Additionally, the Support Broker will assist the member or representative in developing a back-up plan for self-directed benefits that adequately identifies how the member or representative will address situations when a scheduled provider is not available or fails to show up as scheduled. We will maintain a copy of the back-up plan in the member's file, and the back-up plan will be assessed at least annually and any time there are changes in services or providers.

2. Submit a sample service plan.

Within in the care plan, the service plan documents the begin/end service dates, service type, provider, functions, duration, total hours, and service cost:



The care plan stores all of the member's problems, goals, updates, start goal dates, targeted goal dates, problem priority, barriers, strengths, and option for member participation.

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To ensure that the member receives his or her needed services at all times, within the service level plan, the back-up service level plan is needed.



3. Describe how member's expenditures are tracked against any aggregate monthly cost caps.

Member's expenditures are tracked against any aggregate monthly cost caps starting with the development of the service level plan. The Community-Based Case Manager coordinates the home and community-based waiver service (HCBS) planning with the member and the care team and determines appropriate services based on the face-to-face InterRAI comprehensive assessment and the service cost set forth by the applicable State agency, and assigned to the member. The authorized waiver services and service cost are tracked within the system which allows the Community-Based Case Manager to monitor authorized services as it relates to the service cost— see screenshot below. If the services outlined in the service level plan fall outside of the service cost range, then the service level plan will be escalated to the Team Lead for further review. Ongoing monitoring is completed through case review audits when claims are compared to the authorized services in the service level plan.

Meridian Health Plan will also contract with an entity or entities for financial management services (FMS) to assist members who elect the Community Choices Option. The FMS approach assists individuals with understanding billing and documentation responsibilities, and to perform payroll and employer-related duties, purchases approved goods and services, track and monitor individual budget expenditures and identify expenditures that are over or under the budget.

Additionally, the Support Broker and member will work collaboratively to develop a budget for the self-directed services the member is identified to need. The budget shall be based on the member's assessed needs and the member shall have the flexibility to negotiate provider rates with their Consumer Choice Option. The Support Broker shall closely monitor the adequacy and appropriateness of the services and rates to determine the extent to which adjustments to the care plan will necessitate adjustments to the budget and that the member does not exceed his or her budget. The member or his or her representative will review and approve timesheets of their providers to determine accuracy and appropriateness, and self-directed services may not exceed forty (40) hours per week per individual provider. Meridian will recoup any unspent funds monthly for service accounts and annually for savings accounts.

Meridian will be responsible for providing all 1915(c) HCBS waiver services to members who elect the Community Choices Option within our network of contracted providers until all necessary requirements have been fulfilled in order to implement the self-direction of services. This includes, but is not limited to verification of the provider's qualifications and completion and signature on all service agreements; and if the member elects not to receive services using our contracted network providers, until all necessary requirements have been fulfilled to implement the self-direction of services, we will document this decision and provide face-to-face visits with our Care Coordinator at the frequency determined necessary to ensure the member's needs are met.

Meridian's FMS solution will verify that potential providers meet all applicable qualifications prior to delivering services, including, but not limited to, compliance with criminal record checks and adult and child abuse registry information. Members will have an employment agreement or vendor agreement, as appropriate, with each of our providers; the template for the agreement will be reviewed and approved by the State. Prior to a payment being made to a provider under the Community Choices Option, Meridian will ensure through its FMS that: (i) the provider meets all qualifications; and (ii) an employment/vendor agreement is signed. Employment agreements will be updated any time there is a change in any of the terms or conditions specified in the agreement and a copy of each employment agreement will be provided to the member and/or representative and also maintained in the member file. Meridian acknowledges providers under the Community Choices Option are not required to be contracted network providers with Meridian, and we will not require Community Choices Option providers to sign a provider agreement. We will require that all members or representatives participate in a training program prior to assuming self-direction. Meridian will also provide ongoing member or representative training upon request and/or if it is determined a member needs additional training. At minimum, the self-direction training programs will address the following: (i) understanding the role of members and/or representatives in self-direction; (ii) selecting and terminating providers; (iii) being an employer and managing employees; (iv) conducting administrative tasks such as staff evaluations and approval of time sheets; (v) scheduling providers; and (vi) back-up planning.

4. Describe proposed methods for monitoring the provision of services identified on a member's service plan.

Monitoring of home and community-based services will be conducted by the assigned Community-Based Case Manager. Services will be monitored by phone or face-to-face contact within five (5) days of new service implementation, and through face-to-face visits or phone contact every thirty (30) days by the member's Community-Based Case Manager. The monitoring will include the quality of service delivery and the health, safety and welfare of members participating in the Consumer Choices Option. Meridian Health Plan monitors implementation of the back-up plan and monitors the member's participation in Consumer Choices Option to determine the success and viability of the member continuing self-direction. If problems are identified, a self-assessment shall be completed to determine what additional supports, if any, could be made available to assist the member.

Meridian ensures members have the option to voluntarily discontinue the self-direction option at any time. We will develop a new service plan with the member if he or she voluntarily discontinues the self-direction option; however, we may initiate involuntary termination of a member's use of the self-direction option if: (i) there is evidence of Medicaid fraud or misuse of funds; or (ii) Meridian determines there is a risk to the member's health or safety by continued self-direction of services. Under these conditions, we will submit a request to the State for review and approval to involuntarily terminate the member from self-direction. Upon approval of disenrollment from self-direction, Meridian will notify the member regarding the termination in accordance with the approved policy and procedures; and we'll facilitate a seamless transition from the Community Choices Option to ensure there are no interruptions or gaps in service delivery.

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.

Meridian Health Plan works with Support Brokers in other states, and we understand and acknowledge required functions of Support Brokers which include: (i) educating members on how to use self-directed supports and services; (ii) reviewing, monitoring and documenting progress of the member's self-directed budget; (iii) assisting in managing budget expenditures and budget revisions; (iv) assisting with employer functions such as recruiting, hiring and supervising providers; (v) assisting with approving and processing job descriptions for direct supports; (vi) assisting with completing forms related to employees; (vii) assisting with approving timesheets and purchase orders or invoices for goods; (viii) obtaining quotes for services and goods as well as identifying and negotiating with vendors; and (ix) assisting with problem solving employee and vendor payment issues. Meridian's policies and procedures, subject to State review and approval, ensure that Support Broker functions are not duplicative of Care Coordinator activities and functions, and that Meridian maintains the responsibility for the enrollment, ongoing training and oversight of the Support Brokers. Additionally, the Support Broker will assist the member or representative in developing a back-up plan for self-directed benefits that adequately identifies how the member or representative will address situations when a scheduled provider is not available or fails to show up as scheduled. Meridian will maintain a copy of the back-up plan in the member's file, and the back-up plan will be assessed at least annually and any time there are changes in services or providers.

Additionally, the Support Broker and member will work collaboratively to develop a budget for the self-directed services the member is identified to need. The budget shall be based on the member's assessed needs and the member shall have the flexibility to negotiate provider rates with their Consumer Choice Option. The Support Broker shall closely monitor the adequacy and appropriateness of the services and rates to determine the extent to which adjustments to the care plan will necessitate adjustments to the budget and that the member does not exceed his or her budget. The member or his or her representative will review and approve timesheets of their providers to determine accuracy and appropriateness, and self-directed services may not exceed forty (40) hours per week per individual provider. Meridian will recoup any unspent funds monthly for service accounts and annually for savings accounts.

Meridian will also contract with an entity or entities for financial management services (FMS) to assist members who elect the Community Choices Option. The FMS approach assists individuals with understanding billing and documentation responsibilities, and to perform payroll and employer-related duties, purchases approved goods and services, track and monitor individual budget expenditures and identify expenditures that are over or under the budget.

Meridian's FMS solution will verify that potential providers meet all applicable qualifications prior to delivering services, including, but not limited to, compliance with criminal record checks and adult and child abuse registry information. Members will have an employment agreement or vendor agreement, as appropriate, with each of our providers; the template for the agreement will be reviewed and approved by the State. Prior to a payment being made to a provider under the Community Choices Option, Meridian will ensure through its FMS that: (i) the provider meets all qualifications; and (ii) an employment/vendor agreement is signed. Employment agreements will be updated any time there is a change in any of the terms or conditions specified in the agreement and a copy of each employment agreement will be provided to the member and/or representative and also maintained in the member file. Meridian acknowledges providers under the Community

Choices Option are not required to be contracted network providers with Meridian, and we will not require Community Choices Option providers to sign a provider agreement. We will require that all members or representatives participate in a training program prior to assuming self-direction. Meridian will also provide ongoing member or representative training upon request and/or if it is determined a member needs additional training. At minimum, the self-direction training programs will address the following: (i) understanding the role of members and/or representatives in self-direction; (ii) selecting and terminating providers; (iii) being an employer and managing employees; (iv) conducting administrative tasks such as staff evaluations and approval of time sheets; (v) scheduling providers; and (vi) back-up planning.

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 service;

Community-Based Case Managers assist members who are seeking to self-direct services through completion of the Sample Self-Assessment Tool. See Attachment 18 (Sample Self-Assessment Tool) in Tab 5.

b. Informed consent contract; and

Meridian Health Plan will provide thoroughly verbal and written explanation of the informed consent contract and the risk agreement to ensure members are given, understand, agree, and approve of their services. See Attachment 19 (Informed Consent and Risk Agreement) in Tab 5 as a sample.

c. Risk agreement.

The risk agreement is interwoven into the informed consent contract to inform members of their rights, options, and responsibilities. See Attachment 19 (Informed Consent and Risk Agreement) in Tab 5 as a sample.

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.

Utilizing the Support Broker function to monitor the ongoing care and services for members that opt into a self-direct consumer choice option will be essential to monitoring the support and welfare of members in this program. Members will have designated Support Brokers and Community-Based Case Manager who are actively involved in the person-centered care plan. Though these are different functions, they will work collaboratively together to support the members they serve. To ensure that members are serviced, Support Brokers will educate members about the program and its responsibilities when opting in. Once services are started, the assigned Community-Based Case Manager will conduct an initial monitoring visit within five (5) days of services. The Support Broker will meet with the individual for education, hiring, monitoring, and all other service coordination needs as needed by the member. The monitoring will include the quality of service delivery and the health, safety and welfare of members participating in the Consumer Choices Option. Meridian Health Plan monitors implementation of

the back-up plan and monitors the member's participation in Consumer Choices Option to determine the success and viability of the member continuing self-direction. If problems are identified, a self-assessment shall be completed to determine what additional supports, if any, could be made available to assist the member.

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.

5.1 General Provisions

- 1. Describe your strategy for ensuring total cost sharing does not exceed five percent (5%) of quarterly household income.**

Meridian Health Plan will comply with all cost sharing provisions in accordance with the State Plan and the State's 1115 waiver for the Iowa Health and Wellness Plan and in accordance with 42 CFR 447.50 – 447.60. It is the intent of Meridian to remove all appropriate financial barriers to appropriate care and, with State approval, will not implement cost sharing for Medicaid members in the State of Iowa; therefore, cost sharing for our Medicaid members will not reach the five percent (5%) of quarterly household income threshold. Even though Meridian is not implementing cost sharing for Iowa Medicaid members, Meridian's proprietary internal software, Managed Care System (MCS), has the capability of monitoring each member's cost sharing maximum.

- 2. Describe processes for making information on premium and cost sharing available to both members and providers.**

Meridian Health Plan does not intend to implement cost sharing with copayments and deductibles at this time. If required by the State, Meridian has a flexible system, Managed Care System (MCS), that has the capability to provide aggregate cost sharing tracking at the individual member or grouped household level to ensure the five percent (5%) quarterly limit is applied appropriately. If the quarterly limit is reached, cost sharing would not be applied and provider reimbursement would not be deducted. Utilizing the flexibility of MCS, individual members and all members within a household costs can be tracked and all applicable cost sharing; consequences of non-payment, cumulative cost-sharing maximums, and mechanisms for making payments for required charges can be applied.

Meridian maintains a portal accessible to both providers and members at all times. Members have access to our portal where they may view their real-time premium and cost sharing responsibilities that includes a list of preferred drugs where applicable drug copayments are applied. If a member does not have access to the Internet, he or she may choose to call and speak directly with a Member Services representative who can assist with providing this information or reference the Member Handbook for general guidelines.

Providers may check eligibility files on the Meridian online Provider Portal, which includes member specific cost sharing information in real-time. If a provider is unable to access the Provider Portal, Meridian also has the ability to provide this information telephonically or via fax. Providers also receive member cost sharing information in their claims payment reports detailing individual member cost sharing. For both members and providers, general information will be available on the Meridian website that will include but not be limited to; the groups of individuals subject to any applicable cost sharing charges, consequences for non-payment, the cumulative cost-sharing maximums, mechanisms for making payments for required charges, and a list of preferred drugs and any applicable copayments.

Sample Provider Portal Report

| Run As Of: | | | | | | | |
|---|-----------------|---|-----------|------------------------------|--------|-----------|----------------------------------|
| | | | | | | | |
| Member Id: | | | | County: | | | |
| Name: | | | | Case Number: | | | |
| Birthdate: | | | | Worker Load: | | | |
| Gender: Male | | | | Coordination Program: | | | |
| | | | | Program Code: | | | |
| | | | | | | | |
| Medicaid | | | | | | | |
| Start Date | End Date | Coverage | Copay | Coins | Deduct | Status | Provider/HMO |
| 04/01/2015 | 04/02/2015 | Health Benefit Plan Coverage | | | | Active | Meridian Health Plan Of Michigan |
| | | Medical Care | \$0.00 | 0% | \$0.00 | | 777 Woodward Ave Ste 600 |
| | | Chiropractic | \$0.00 | 0% | \$0.00 | | Detroit MI 48226 |
| | | Hospital | \$0.00 | 0% | \$0.00 | | Tel: |
| | | Emergency Services | \$0.00 | 0% | \$0.00 | | PCP: |
| | | Pharmacy | \$0.00 | 0% | \$0.00 | | Tel: |
| | | Vision (Optometry) | \$0.00 | 0% | \$0.00 | | |
| | | Hospital - Outpatient | \$0.00 | 0% | \$0.00 | | |
| | | Professional (Physician) Visit - Office | \$0.00 | 0% | \$0.00 | | |
| | | Urgent Care | \$0.00 | 0% | \$0.00 | | |
| | | Hospital - Inpatient | \$0.00 | 0% | \$0.00 | | |
| 04/01/2015 | 04/02/2015 | Health Benefit Plan Coverage | | | | Active | Name |
| | | Substance Abuse | \$0.00 | 0% | \$0.00 | | Address 1 |
| | | | | | | | Address 2 |
| | | | | | | | Tel: |
| 04/01/2015 | 04/02/2015 | Health Benefit Plan Coverage | | | | Active | DENTAL |
| | | Dental Care | \$0.00 | 0% | \$0.00 | | |
| | | | | | | | |
| HEDIS | | | | | | | |
| Measure | Sub Description | | | | | Last Seen | |
| Children's Access to Primary Care Practitioners | | | | | | | |
| | | | | | | | |
| Medicaid Service Counts | | | | | | | |
| Visit Type | Benefit | Count | Available | Next Benefit Date | | | |
| Behavioral Health | 20 | 0 | 20 | | | | |
| Chiropractic | 18 | 0 | 18 | | | | |
| Medicaid SNF Days | 45 | 0 | 45 | | | | |
| Vision - Exam | 1 | 0 | 1 | | | | |
| Vision - Frames | 3 | 0 | 3 | | | | |
| Vision - Lenses | 3 | 0 | 3 | | | | |

5.2 Reserved

Healthy Behaviors Program

Meridian Health Plan will assist and support the State, as requested, in the submission of the Health Behaviors Program standards for the subsequent year. Meridian will comply with the proposed protocols approved by CMS and implement all appropriate policies and procedures to ensure compliance. This includes establishing mechanisms to track member completion of the healthy behaviors and continuing education of member on the importance of healthy behavior completion.

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.

Meridian Health Plan will not be implementing State Plan copayments for any population, including Iowa Health and Wellness Plan and hawk-i members. Meridian believes that charging a copayment creates a barrier to care and places an unnecessary burden and cost on our providers to collect copayments.

2. Describe how exempt populations and services as outlined in Section 5.3.1 and 5.3.2 will not be charged copayments.

Meridian Health Plan will not impose copayments on any population or for any service in the State of Iowa, including exempt populations and services as outlined in Section 5.3.1 and 5.3.2 of the Scope of Work.

In the event Meridian ever does implement copayments on any population, Meridian's system has the capability to identify members as belonging to certain populations and has the additional capability to identify certain services or diagnoses to exempt from routine processes. As an example, Meridian suppresses certain sensitive benefit information from Explanation of Benefits documents and other mailings. Similar modifications could easily be made to the assessment of cost sharing, including the following populations and services:

- Exempt Populations:
 - Individuals between ages one (1) and eighteen (18), eligible under 42 CFR 435.118
 - Individuals under age one (1), eligible under 42 CFR 435.118
 - Disabled or blind individuals under age eighteen (18) eligible under 42 CFR 435.120 or 42 CFR 435.130
 - Children for whom child welfare services are made available under Part B of title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age
 - Disabled children eligible for Medicaid under the Family Opportunity Act
 - Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the sixty (60) day period following termination of pregnancy ends

- Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs
 - An individual receiving hospice care, as defined in section 1905(o) of the Social Security Act
 - An Indian (as defined at 42 CFR 447.51) who is currently receiving or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services
 - Individuals who are receiving Medicaid by virtue of their breast or cervical cancer diagnosis under 42 CFR 435.213
- Exempt Services:
 - Preventive services provided to children under age eighteen (18);
 - Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p) and counseling for cessation of tobacco use
 - Provider preventable services as defined at 42 CFR 447.26(b)
 - Family planning services and supplies described in section 1905(a)(4)(C) of the Social Security Act

If required by the State to implement copays for nonemergency use of the emergency room, Meridian will impose the appropriate eight dollar (\$8) copayment for Iowa Health and Wellness Plan members' nonemergency use of an emergency room and a twenty-five dollar (\$25) copayment for hawk-i members' nonemergency use of an emergency room only on members whose family income is 150 percent of the Federal poverty level or more. Meridian will instruct its provider network hospitals of their responsibility to perform an appropriate medical screening pursuant to 42 CFR 489.24 for determining emergency services and their subsequent notification responsibilities and circumstances under which the hospital must waive or return the copayment as described in sections 5.3.4.1 thru 5.3.4.4 of the Scope of Work.

If required by the State to implement copayments and in situations where a member is unable to pay, Meridian will educate providers on their inability to withhold care or services and enforce this policy through ongoing education and documentation in the Provider Manual. Members reporting a denied service based on the inability to pay will be tracked through our grievance process until resolution and Meridian Provider Network Development Representatives will provide follow up education to providers on an as needed basis. If any copayment is implemented by Meridian, the payment to a provider will be reduced by the member's copayment obligation regardless of collection or waiving of payment, except as provided under 42 CFR 447.56.

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.

For members responsible for a patient liability or client participation that must be met before Medicaid reimbursement for services is available, Meridian Health Plan will utilize the determination from the State on the patient liability amount and communicate with providers through State-approved policies and procedures that will include access through the Provider Portal for real-time member responsibility, telephonic communication at the time of authorization, and within the claim payment remittance advice. In each mode of communication,

the member liability amount will be communicated and the provider will be responsible for the collection. Any amount net of the applicable patient liability amount will be the responsibility of Meridian. Members in an institutional setting and 1915(c) HCBS waiver members will not have patient liability amounts imposed by Meridian. Meridian believes this is a barrier to care for our members. This allows for the cost responsibility for the amount that would be deemed as patient liability to remain with Meridian rather than shifting to the provider. Meridian pays the gross amount of the provided service to the providers

5.5 IDPH Sliding Scale

1. Describe how your organization will ensure the IDPH approved sliding fee schedule is implemented among network providers.

Meridian Health Plan will link IDPH-approved sliding scale fee schedule information to IDPH participants based on their income and family size within our Managed Care System (MCS) demographic and enrollment information. The information will be communicated to providers through the regularly-distributed monthly enrollment file and also available on the Meridian Provider Portal. Provider education will be ongoing through our Provider Network Development Department beginning with the initial orientation and continuing through ongoing education meetings to ensure the IDPH sliding fee schedule is being followed. The Meridian Provider Network Development Department visits providers on a monthly rotation basis to ensure that fee schedules are properly implemented. This includes the ongoing education of IDPH participant billing and collection procedures as established and provided by IDPH, the inability of denied services due to a person or group because of their inability to pay, and no charge for missed appointments except a one-time no-show fee not to exceed the amount established by IDPH.

SECTION 6 – PROVIDER NETWORK REQUIREMENTS

Please explain how you propose to execute Section 6 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

6.1 General Provisions

1. Describe how you plan to meet all network composition requirements.

Meridian Health Plan is a leader in developing Medicaid provider networks in both urban and rural areas, with extensive experience contracting in rural areas. We create exceptionally strong and lasting personal relationships with our providers, which eliminates barriers to access for our members. Through monthly face-to-face visits, we equip our providers with a vast array of technology to help them improve their administrative efficiency, allowing them to focus on delivering high-quality care. In all counties, we will ensure members have access to an in-network provider for routine and preventive care and all medically necessary covered care.

Meridian will demonstrate to the State that we have the capacity to serve the expected enrollment covered by the Contract and that we offer an appropriate range of medically necessary, preventive, primary, specialty, and long-term care services, including all covered services specified in the Contract and as required by 42 CFR 438.206. The network will maintain a sufficient number, mix and geographic distribution of providers in accordance with the general access standards set forth in Exhibit B, including primary care providers (PCPs), specialists, hospitals, mental health providers, and pharmacies within the geographic distance standards for all members. We monitor this network on an ongoing basis to ensure that all covered services delivered by network providers within the scope of this RFP are accessible to members and shall be in compliance for covered services delivered by PCPs. Meridian works with out-of-network providers for medically necessary covered services that our existing network is unable to provide.

Moreover, our providers are available within the hours of operation offered to commercial insurance and fee-for-service members, including evening and weekend appointments. Our network has the capacity to ensure that the waiting times for appointments will not exceed the contractually required days for routine care, specialist appointments, elective hospitalizations, and mental health providers. We will ensure immediate service for any emergent care providers, inform members of hours for pediatric or adult sick care, and will not require prior authorization for emergent care.

Meridian ensures members will have contact with community mental health centers within contractually required hours of any hospital psychiatric discharge. We coordinate follow-up appointments to ensure our members see their behavioral health provider within seven (7) days of their hospital psychiatric discharge. Meridian has experience with performing discharge follow-up for medical hospital admissions and will tailor our current program to meet the needs of this RFP.

All network providers have contractually agreed that members cannot be billed for any remaining unpaid amount by Meridian. We ensure that all payment arrangements are coordinated and agreed upon with out-of-network providers for services rendered. We also provide the option for members to receive a second opinion by a qualified healthcare professional at no cost to the member. All provider-related processes are readily available to members in the Member Handbook.

Meridian's focus on quality and partnership is evident in our Iowa provider network and ensures that our members have access to the high quality care synonymous with our performance in other states. While developing this network, we considered:

- Current and anticipated Iowa Medicaid enrollment
- The expected utilization of services, taking into consideration the characteristics and healthcare needs of the covered Iowa population
- The number and type (in terms of training, experience and specialization) of providers required to furnish the contracted services
- The number of network providers not accepting Iowa Medicaid patients
- The geographic location of providers and members, considering distance, travel time, and common transportation means used by Iowa members
- Accessibility of provider practices for members with disabilities
- Required access standards identified in Exhibit B

Meridian has not and will not discriminate against providers who serve high risk populations or specialize in conditions that require costly treatment. We instead coordinate with any and all providers to identify high risk and high cost members and facilitate education to control and reduce unnecessary costs. Our network has outstanding credentials and we verify that all included providers are eligible to participate in Federal healthcare programs.

We monitor the adequacy, accessibility, and availability of our provider network to all members, including those with special needs and cultural considerations. We notify the State of Iowa in the event that a provider contract is terminated for any reason. Our proprietary Managed Care System (MCS) identifies affected members so we can coordinate proper alternatives. The State of Iowa will be notified as defined by:

- A decrease in the total number of PCPs by more than five percent (5%)
- A loss of all providers in a specific specialty where another provider specialty is not available within thirty (30) minutes or thirty (30) miles
- A loss of a hospital within an area where another contracted hospital of equal service ability is not available within thirty (30) minutes or thirty (30) miles
- Other adverse changes to the composition of the network that may impair or deny adequate member access to in-network providers

In the unlikely event that Meridian decides not to include an individual or group of providers in the network, we shall provide a written notice to affected providers of our decision(s).

Our web-based provider directory is a live reflection of our network. Meridian's network can be searched and sorted by all categories listed, including name, type, specialty, hospital affiliation, county, city, zip code, gender and language. These fields are dynamic to provide members, staff, and providers with functionality to broaden or restrict search criteria. Every search result yields the provider location, phone number, fax number, hours of operation, hospital and provider group affiliation, languages spoken, board certification, and whether or not they are accepting new members, including the age group and gender that they are accepting.

Provider Services representatives maintain effective relationships with providers in states in which we currently operate, including Iowa. Meridian has a longstanding commitment to working constructively with the provider community in the markets we serve to achieve superior quality of

care, cost savings and access to care outcomes. As a physician-owned and operated plan, we know our success is based on the relationships we establish with our providers. This engagement strategy includes the development of a Physician Advisory Committee (PAC) composed of network providers with a broad range of specialties. The PAC meets at least quarterly in person to address concerns and provide the opportunity for our network providers to improve our operations. Not only will we address concerns of the PAC, but we will also offer a provider survey to all network providers to receive feedback to continuously improve our quality of service.

All members will have access to Iowa designated level one (1) and level two (2) trauma centers. In the event that in-network centers are not located within reasonable proximity to members, we will make arrangements with out-of-network providers to make these services available to our members.

Meridian will maintain a network of providers who have admitting privileges at hospitals that participate within the Medicaid Program. This will ensure that our members will be admitted at their physician's discretion for medically necessary treatments.

Every provider who chooses to contract with Meridian is provided with a contract outlining our business arrangements. We do not and will not require providers or provider groups to enter exclusive arrangements for network participation. Our provider contracts, approved by the State of Iowa, are in compliance with all applicable Federal, State, and contractual requirements and any changes will be subject to the State of Iowa approval.

Contracted providers will have full access to our policies through the applicable State of Iowa requirements, including, but not limited to, the provider manual and provider orientation services. The manual and orientation are distributed within the first thirty (30) days and are available online. The State of Iowa will receive all manual updates and changes will be clearly specified for approval. New providers are also given an in-office presentation orienting them to our plan within thirty (30) days of network inclusion. The date of and attendance at the orientation are captured and reported through MCS. All materials will comply with State and Federal Laws and the State of Iowa requirements and will be provided to the State of Iowa upon request.

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.

Meridian Health Plan has demonstrated success in contracting with providers throughout the State of Iowa. Based on accessibility standards, Meridian covers in excess of ninety-five percent (95%) of the State at the present time. We do not anticipate facing network development access challenges in the State of Iowa.

6.1.2 Provider Agreements

1. Describe your process for reviewing and authorizing all network provider contracts.

Meridian Health Plan enters into written agreements with all network providers. Meridian's provider agreements outline requirements for continuation of benefits, specifically the provider's responsibility regarding third party liability. This includes the provider's obligations to identify

any and all third party liability coverage and, unless prohibited by State or Federal regulations, requirements for providers to seek such third party liability payment before submitting claims to Meridian. The provider agreements will require submission of claims, which do not involve a third party payer, within ninety (90) days of the date of service.

Meridian fully credentials all networked providers to verify that each holds the proper licenses, certifications, and are enrolled as an Iowa Medicaid provider. We ensure that our network meets all current and future State and Federal eligibility criteria, reporting requirements, and any other applicable rules or contractual regulations. All providers will have a National Provider Identifier (NPI) and/or a State-issued Medicaid identification number. All of our credentialing is performed in-house by our credentialing specialists, as we believe that our expertise in this area surpasses others.

Our credentialing and re-credentialing standards are aligned with industry standards and follow State and Federal requirements, as do any notices sent to providers. Initial credentialing will occur prior to the effective date of the provider contract and providers will be re-credentialed at least every three (3) years. Meridian does not, and will not, discriminate against any provider for participation, reimbursement, or indemnification who is acting within the scope of designation, license, or certification under applicable State Law, solely on the basis of that designation, license, or certification. Our current re-credentialing process considers provider performance data, which includes but is not limited to, member complaints and appeals, quality of care, and utilization management.

As our Provider Services representatives visit potential network providers, we encourage their participation with the Iowa Medicaid Program as a whole. Meridian believes that increased physician participation makes it easier to raise awareness of important healthcare issues and to ultimately provide better service and access to members. To this end, we help providers enroll with the Iowa Medicaid Program by using our face-to-face relationships to assist with information, forms, and submission of documents. Our local presence ensures that we understand the immediate needs of Iowa members and providers.

In all instances, Meridian will ensure all provider agreements meet the provisions specified in 42 CFR 438.12, 438.214 and this RFP. In addition to Meridian's general provider agreement, Meridian will also include, at minimum, the following requirements in all provider agreements with nursing facilities:

- Require the nursing facility to promptly notify Meridian of a member's admission or request for admission to the nursing facility as soon as the facility has knowledge of such admission or request for admission
- Require the nursing facility to notify Meridian immediately if the nursing facility is considering discharging a member and to consult with the member's Care Coordinator
- Require the nursing facility to notify the member and/or the member's representative (if applicable) in writing prior to discharge in accordance with State and Federal requirements
- Specify the nursing facility's responsibilities regarding patient liability
- Require the nursing facility to notify Meridian of any change in a member's medical or functional condition that could impact the member's level of care eligibility for the currently authorized level of nursing facility services

- Require the nursing facility to comply with Federal Preadmission Screening and Resident Review (PASRR) requirements to provide or arrange to provide specialized services and all applicable Iowa Law governing admission, transfer and discharge policies;
- Provide that if the nursing facility is involuntarily decertified by the State or CMS, the provider agreement will automatically be terminated in accordance with Federal requirements

For HCBS provider agreements, Meridian shall include, at minimum, the following requirements in all provider agreements with HCBS providers:

- Require the HCBS provider to provide at least thirty (30) days advance notice to Meridian when the provider is no longer willing or able to provide services to a member and to cooperate with the member's Care Coordinator to facilitate a seamless transition to alternate providers
- Require that in the event that a HCBS provider change is initiated for a member, regardless of any other provision in the provider agreement, the transferring HCBS provider continue to provide services to the member in accordance with the member's care plan until the member has been transitioned to a new provider, as determined by Meridian, or as otherwise directed by Meridian, which may exceed thirty (30) days from the date of notice
- Require the HCBS provider to immediately report any deviations from a member's service schedule to the member's Care Coordinator;
- Require the HCBS provider to comply with the critical incident reporting requirements;
- Require the HCBS provider to comply with all child and dependent adult abuse reporting requirements

2. Provide sample provider agreements.

Sample provider agreements are provided in Tab 6 as "3.2.7.5 Select Attachments", Attachment 45 Sample Provider Agreements. Sample agreements include:

- Ancillary Provider Agreement
- Delegated Credentialing Agreement
- Hospital Agreement
- Hospital Agreement Critical Access
- Hospital and Ancillary Credentialing Application
- Practitioner Agreement
- Provider Disclosure Form
- Retail Pharmacy Agreement

As required, Meridian Health Plan will update all provider agreements to include and incorporate the applicable terms of its Contract with the State and any incorporated documents, including the RFP. Meridian will ensure the provider agreements require providers to agree to all applicable terms and conditions set out in the RFP, the Contract, and any incorporated documents and all applicable State and Federal Laws as amended, governing the duties and responsibilities of the provider with regard to the provision of services to members.

3. Indicate if you propose to impose any requirements for exclusivity agreements for quality or payment purposes.

Every provider who chooses to contract with Meridian Health Plan is provided with a contract outlining our business arrangements. We do not and will not require providers or provider groups to enter exclusive arrangements for network participation. Our provider contracts, approved by the State of Iowa, are in compliance with all applicable Federal, State, and contractual requirements and any changes will be subject to the State of Iowa approval.

4. 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?

Meridian Health Plan shares the State of Iowa's goal of transforming Iowa's Medicaid Program into a system that rewards improved health outcomes and reduced costs for episodes of care. We believe Meridian can develop partnerships with providers that target inefficiencies and create new approaches, provider partnerships, innovative cost saving programs, and a product that can create a high-quality, cost-effective system resulting in increased measurable goals and outcomes. We will negotiate our incentive program to reward our performance against the approved incentive program. This system will also create a patient centered medical home as well as initiatives that reward providers for improved outcomes through shared savings.

Meridian will have at least forty percent (40%) of our total assigned population in a value based purchasing (VBP) arrangement by calendar year 2018. Our VBP arrangements will recognize population health outcome improvement as measured through our Quality Improvement programs inclusive of the VIS with an emphasis on the decrease in total cost of care for the population in the VBP arrangement. Meridian will drive population health through delivery system reform under VBP with providers achieving a clear understanding of the specific lives for which they are accountable. Meridian members that are part of a VBP will be assigned to a designated primary care provider (PCP). As specified by the State, Meridian will report the PCP information to the State for use in system-wide coordination enhancements such as provider alerts through the Iowa Health Information Network (IHIN). Meridian will also require all contracted hospitals report admission and discharge information to support exchange and coordination. Meridian anticipates by 2018 to have more than fifty percent (50%) of member claims expense incurred with provider partnerships contracted under a value-based purchasing arrangement.

Meridian is currently negotiating value-based, risk sharing agreements with providers. As required, Meridian will notify the State of any risk sharing agreements arranged with providers and will require in the provider agreement submission of encounter data within ninety (90) days of the date of service for any providers paid on a capitated basis.

Examples of value-based, risk-sharing agreements include the following.

Shared Risk Model

Providers assume a portion of the risk and reward in caring for members who have been able to demonstrate the achievement of quality metrics and who also want to share in the upside and downside risk associated with providing care to members.

In this model, Meridian maintains an individual PCP reimbursement Specialty Services Shared Risk Fund to facilitate the compensation of PCPs. This fund will be comprised of a portion of the per member/per month (PMPM) premium Meridian receives from the State of Iowa.

Meridian maintains this fund. The following types of healthcare services are charged to the Specialty Services Shared Risk Fund:

- Outpatient surgery
- Emergency room
- Urgent care
- All specialty referrals and durable medical equipment

The costs of these services include all eligible payments for healthcare services performed by practitioners, hospitals and ancillary service providers for members assigned to a contracted PCP. The following healthcare costs may be charged to the fund:

- Inpatient hospital facility charges
- Portions of healthcare service costs paid by third parties due to coordination of benefits, workers' compensation and/or third-party liability awards

All eligible expenses will be limited to an agreed upon amount per individual member, per year, per fund for purposes of allocating their costs toward the Shared Risk Fund.

In addition to the Specialty Services Shared Risk Fund, a withhold fund is generated through an agreed upon percentage withheld from each fee-for-service (FFS) payment made to a provider for services given to any member.

The Specialty Services Shared Risk Fund is distributed in an annual settlement. If utilization of high-cost services is controlled and there is a surplus, PCPs are paid 100 percent of their withhold amount plus an additional proportion of the surplus based on PCP performance (up to fifty percent (50%) of the total withhold from that PCP).

If there is a fund deficit, each PCP is responsible for paying up to fifty percent (50%) of his/her proportion of the deficit, not to exceed the total amount of the withhold for that PCP in that year.

Meridian uses the following language in our agreements to ensure the model focuses on quality:

[Provider] agrees that payment of any Shared Savings Bonus is expressly contingent on meeting the Quality Performance Threshold for the Reporting Period. For purposes of this Agreement, in order to meet the Quality Performance Threshold [Provider] must meet at least the 75th percentile in [x] or more of the following HEDIS® measures:

- [HEDIS® Measure]
- [HEDIS® Measure]
- [HEDIS® Measure]
- [HEDIS® Measure]

In the event [Provider] fails to meet the Quality Performance Threshold in a given Reporting Period, no Shared Savings Bonus will be due to [Provider] for that Reporting Period

Full Risk Model

Providers are completely responsible for the healthcare costs of members.

Partners that demonstrate the ability to provide quality care are offered the option of a full risk agreement. In this type of agreement, partners are completely responsible for the healthcare costs of members assigned to their network of PCPs. This includes all inpatient and outpatient services. Meridian will continue to perform contracted services like claims processing, credentialing, member services, quality management, etc. This model results in the majority of the premium reimbursed to providers while Meridian receives a negotiated amount to assist with administrative functions. Meridian will also assign an additional percentage of the premium to providers based on quality performance.

Meridian will notify the State of any risk sharing agreements we arrange with a provider. Meridian will require providers who are paid on a capitated basis to submit encounter data within ninety (90) days of the date of service. As applicable, Meridian will ensure provider agreements comply with the requirements set forth for subcontracts in accordance with 42 CFR 434.6. In all instances, Meridian will ensure all provider agreements meet the provisions specified in 42 CFR 438.12, 438.214 and this RFP. Meridian understands the State may require or direct the termination or modification of any provider agreement if the State determines it to be in the best interest of the State.

Meridian uses the following language in our agreements to ensure the model focuses on quality:

[Provider] agrees that payment of any Shared Savings Bonus is expressly contingent on meeting the Quality Performance Threshold for the Reporting Period. For purposes of this Agreement, in order to meet the Quality Performance Threshold [Provider] must meet at least the 75th percentile in [x] or more of the following HEDIS® measures:

- [HEDIS® Measure]
- [HEDIS® Measure]
- [HEDIS® Measure]
- [HEDIS® Measure]

In the event [Provider] fails to meet the Quality Performance Threshold in a given Reporting Period, no Shared Savings Bonus will be due to [Provider] for that Reporting Period

6.1.3 Provider Credentialing

1. Describe your credentialing process.

Meridian Health Plan achieved NCQA Health Plan accreditation, inclusive of Meridian's provider credentialing and re-credentialing processes. Meridian's credentialing and re-credentialing processes meet or exceed NCQA, IAC 441 Chapter 88 as well as State and Federal

regulations and requirements. Meridian maintains written policies and procedures related to provider credentialing and re-credentialing, which include standards of conduct to ensure compliance with all applicable Federal and State standards related to provider credentialing. This includes those required in 42 CFR 438 and 455, Subpart E, which include the following: (i) a training plan designed to educate staff in the credentialing and re-credentialing requirements; (ii) provisions for monitoring and auditing compliance with credentialing standards; (iii) provisions for prompt response and corrective action when non-compliance with credentialing standards is detected; (iv) a description of the types of providers that are credentialed; (v) methods of verifying credentialing assertions, including any evidence of prior provider sanctions; and (vi) prohibition against employment or contracting with providers excluded from participation in Federal health care programs. Meridian's credentialing processes provide for mandatory re-credentialing at a minimum of every three (3) years.

Meridian fully credentials all network providers to verify that each holds the proper licenses, certifications and are enrolled as an Iowa Medicaid provider. We ensure that our network meets all current and future State and Federal eligibility criteria, reporting requirements, and any other applicable rules or contractual regulations. All providers will have a National Provider Identifier (NPI) and/or a State-issued Medicaid identification number. All of our credentialing is performed in house by our credentialing specialists, as we believe that our expertise in this area surpasses others.

Credentialing and re-credentialing standards are aligned with industry standards and follow State and Federal requirements, as well as notices sent to providers. Initial credentialing will occur prior to the effective date of the provider contract and will be re-credentialed at least every three (3) years. Meridian does not, and will not, discriminate against any provider for participation, reimbursement, or indemnification who is acting within the scope of designation, license, or certification under applicable State Law, solely on the basis of that designation, license or certification. Our current re-credentialing process does consider provider performance data which includes, but is not limited to, member complaints and appeals, quality of care, and utilization management.

Meridian's credentialing processes obligate providers to disclose the identity of any person described in 42 CFR 1001.1001(a)(1) as well as other permissible exclusions that would impact the integrity of the provider's contracted status, any such disclosures are forwarded to the State. Meridian will not permit a provider to become a network provider if Meridian or the State determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services program, or if Meridian or the State determines that the provider did not fully and accurately make any disclosure pursuant to 42 CFR 1001.1001(a)(1).

Meridian shall ensure each LTSS provider's service delivery site or services meet all applicable requirements of Iowa Law and have the necessary and current licenses, certification, accreditation, and/or designation approval per State requirements. Meridian will ensure that individuals providing LTSS that are not required to be licensed, accredited, or certified are appropriately educated, trained, qualified, and competent to perform their job responsibilities. In addition, Meridian will ensure all required criminal history record checks and child and dependent adult abuse background checks are conducted for LTSS providers who are not employees of a provider agency or licensed/accredited by a board that conducts background checks. Meridian will ensure criminal history checks and child and dependent adult background

checks are conducted for non-agency affiliated self-direction service providers such as Consumer Directed Attendant Care (CDAC) and Consumer Choices Options (CCO) employees. Meridian will ensure all HCBS waiver providers meet all qualification requirements.

Meridian will ensure substance use disorder treatment services provided to members are provided by programs licensed by the State in accordance with Iowa Code chapter 125 or by hospital-based substance use disorder treatment programs licensed and accredited in accordance with Iowa Code section 125.13.2(a). Meridian will accept counselor certification as specified in Iowa Administrative Rules 641—155.21(8) as an acceptable credential for practitioners employed by a licensed substance use disorder treatment program.

As our Provider Services representatives visit potential network providers, we encourage their participation with the Iowa Medicaid Program as a whole. Meridian believes that more physician participation makes it easier to raise awareness of important healthcare issues and to ultimately provide better service and access to members. To this end, we help providers enroll with the Medicaid Program by using our face-to-face relationships to assist with information, forms, and submission of documents. Our local presence ensures that we understand the immediate needs of Iowa members and providers.

2. Describe methods to streamline the provider credentialing process.

Meridian Health Plan has credentialed over 61,000 providers over the past three (3) years, with no provider exceeding a thirty (30) day turnaround for initial credentialing. Meridian processes files in full compliance with CMS, URAC and NCQA as well as State and Federal requirements.

To process this number of providers through our credentialing process, Meridian maintains a streamlined provider credentialing process. Credentialing and re-credentialing standards are aligned with industry standards and follow State and Federal requirements, as well as notices sent to providers. Initial credentialing will occur prior to the effective date of the provider contract and will be re-credentialed at least every three (3) years. Meridian does not, and will not, discriminate against any provider for participation, reimbursement, or indemnification who is acting within the scope of designation, license, or certification under applicable State Law, solely on the basis of that designation, license, or certification. Our current re-credentialing process considers provider performance data, which includes but is not limited to, member complaints and appeals, quality of care, and utilization management.

Meridian's credentialing processes obligate providers to disclose the identity of any person described in 42 CFR 1001.1001(a)(1), as well as other permissible exclusions that would impact the integrity of the provider's contracted status. Any such disclosures are forwarded to the State. Meridian will not permit a provider to become a network provider if Meridian or the State determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX Services program, or if the Meridian or the State determines that the provider did not fully and accurately make any disclosure pursuant to 42 CFR 1001.1001(a)(1).

3. Describe your plans for performing criminal history and abuse checks and assuring all network providers hold current licensure as applicable.

Meridian Health Plan determines its network facilities and providers are actively licensed and competent through a formal credentialing review. Meridian's Credentialing Committee ensures its credentialed and re-credentialed providers deliver quality health care in a safe, sanitary environment with the use of medical record practices set forth in Meridian's regulatory credentialing standards. The initial credentialing process, including application and primary source verification of information, is completed and approved by the Meridian Credentialing Committee before the effective date of the contract with the Provider.

Providers are required to complete a credentialing application and are entitled to certain review and notification rights as identified in policy. Primary and secondary source verifications are made and documented in the credentialing file in accordance with regulatory requirements.

Meridian credentialing policies identify the types of providers to be credentialed/re-credentialed and clearly document the requirements that must be met to complete the credentialing process. These policies recognize the standards established by CMS, NCQA, The Joint Commission, URAC and The Iowa Administrative Code and use these standards to provide further guidance on standards and practice for applicable geographies.

For individual providers, primary source verifications is required for licensure, education and training, board certification (if applicable) and any disciplinary action identified by the State Licensure Boards, Office of Inspector General (OIG) Sanction Report, National Practitioner Data Bank, System for Award Management (SAM), Medicare Opt-Out list, Social Security Administration's Death File.

For facilities, licensure (if applicable), Medicare certification, System for Award Management (SAM), Office of Inspector General (OIG) and accreditation are verified. In the absence of accreditation, a valid State Site Inspection report; a Medicare Site Inspection report, or a Plan Unaccredited Facility Site Inspection Evaluation report, may be substituted.

The Health Plan ensures its provider network is practicing evidenced-base medicine and is continually monitoring its members. If a provider is identified as potentially not complying with the standards set forth by the health plan, the provider may be presented at a peer review committee where the provider's performance and practice is reviewed.

Ongoing internal monitoring is performed of member complaints relative to providers and quality of care or conduct issues are referred to peer review. Credentialing also performs ongoing monitoring (monthly or as web postings become available) of providers' status through licensure disciplinary action websites and System for Award Management (SAM), Office of Inspector General (OIG), Council for Affordable Quality Health Care (CAQH) sanction reporting, Medicare Opt Out list, Social Security Administration's Death Master File and National Practitioner Data Bank's Continuous Query program. Action is taken based on the information identified, and notifications are forwarded to appropriate authorities as required. Meridian performs monthly monitoring of providers to ensure they have active licensure and have not been sanctioned.

Meridian reviews the licenses of Doctors of Medicine (MD), Doctors of Osteopathic Medicine (DO), Dentists (DDS), Oral Surgeons (DDS), Podiatrists (DPM), Optometrists (OD),

Chiropractors (DC), Doctors of Acupuncture (DABMA), Psychologists (PhD), Addiction Medicine Specialists, Master's Level Social Workers (MSW), Board Certified Behavior Analysts (BCBA), Board Certified Behavior Analyst-Doctorals (BCBA-D), Behavioral Healthcare Specialists, Autism Service Providers (ABA), Physical Therapists (PT), Occupational Therapists (OT) and Speech and Language Therapists who are licensed (if applicable), certified, or registered by the State to practice independently, Physician Assistants (PA), Nurse Practitioners (NP), Midwives (NM), as well as Bachelor/Master of Science in Acupuncture (BS/MSA), Bachelor/Master of Science in Acupuncture & Oriental Medicine (BS/MSAOM), and Master of Science in Acupuncture. The process begins with:

Primary Source Verification – Minimum Requirements for Providers to Participate

Meridian continually reviews the following requirements, which comply with URAC, NCQA and CMS guidelines, in the credentialing and re-credentialing process. Meridian conducts the primary verification using appropriate sources of information according to each type of applicant. Verification of the following documents and information will be conducted within 180 calendar days prior to the credentialing/re-credentialing date where required:

- Completed Meridian, CAQH or State application
- Valid DEA or CDS certificate
- Current valid license to practice and license sanctions
- Status of clinical privileges at the hospital designated by the practitioner/applicant as a primary admitting facility (if applicable)
- Education and training
- Board certification, if the applicant states he/she is other than General Practice
- Work history
- Current malpractice insurance with minimum coverage of \$100,000/\$300,000
- History of liability claims resulting in settlements or judgments paid by applicant
- Provider Disclosure of Ownership and Control
- Contract & W9
- Signed/written statements with respect to:
 - Application Attestation within 180 days of committee review
 - Any limitation or inability to perform essential functions of the position applying for, with or without accommodations
 - Lack of present illegal drug/substance use
 - History of loss of license and felony convictions
 - History of loss or limitation of privileges or disciplinary actions
 - Current malpractice insurance coverage
 - Correctness and completeness of the application

Communication

Meridian communicates with network participant responsibilities and conducts peer review before granting entrance into the network. During the Credentialing Cycle and in between cycles, Meridian verifies credentialing requirements and monitors/reviews items such as grievances, complaints and appeals, quality of service events, and medical record review.

Meridian obtains re-credentialing data on a healthcare professional according to the Credentialing Cycle except: 1) when a healthcare professional submits initial credentials data to Meridian; 2)

when a healthcare professional's credentials data changes substantively; 3) when Meridian requires re-credentialing as a result of patient or quality assurance issues.

Credentialing/Re-credentialing Decision Notification

The participating practitioner is then informed in writing by the Provider Services Department of his/her acceptance or denial of participation within ten (10) calendar days of the Committee's decision. The participation is effective on the first day of the month following the credentialing approval.

On a monthly basis, the Credentialing Specialist reviews the Iowa Department of Public Health website for the latest sanctions as well as the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) database, System for Award Management (SAM), Social Security Administration's Death Master file, and National Practitioner Data Bank's Continuous Query program and utilizes Council for Affordable Quality Health Care (CAQH) sanction reporting. If providers are noted on the list, the information is referred to the Meridian Quality Medical Director and Director of Network Development. The Quality Medical Director immediately reports all findings to the Corporate Credentialing Committee for follow-up and determination of the appropriate action.

4. Describe your plans for ensuring non-licensed providers are appropriately educated, trained, qualified and competent.

All Meridian Health Plan providers will receive initial in-service training upon contracting as well as ongoing education through the web portal and Provider Manual. The Provider Manual is updated annually and is available online at our website at <http://mhplan.com/ia/>. The Provider Manual is also available in hard copy or CD version upon request. Ongoing cultural competency training will be provided through web-based cultural competence training sessions. Meridian will use the annual regional provider meetings to provide competency training updates. Meridian offers provider education on a variety of topics, including cultural diversity training, web-based training, on-site sessions and a host of educational materials. Meridian has a signed Letter of Intent to contract with Brilljent, a certified Business Enterprise Program (BEP) vendor with Meridian offices. Brilljent can support Meridian's efforts to offer provider education on a variety of topics, including cultural diversity training. Brilljent offers web-based training, on-site sessions and a host of educational materials.

Meridian's Provider Services phone lines are staffed by our highly trained Provider Services representatives, who provide personal attention to provider needs. Providers may call Meridian directly to ask questions, offer suggestions, and register complaints or concerns. Our toll-free provider hotline is directly staffed by highly trained Meridian personnel from 7:30 a.m. to 6:00 p.m., Central Standard Time, Monday through Friday. The Provider Services staff receives extensive training to provide efficient, effective service, allowing providers to devote more time to serving our members.

Providing a personal touch to every phone call is our forte; every incoming phone call will be answered by a live employee. If assistance is needed from another Meridian department, our call center staff will provide a warm transfer, instead of an automated answering system. Meridian's policy is to always use "warm transfers" to forward a phone call. Instead of blindly transferring a call, then hanging up with no concern for the proper resolution, our warm transfer process

includes transferring the phone call and staying on the line until someone answers on the other end announcing the caller's name, ID number, and reason for calling.

Our Provider Services representatives practice single call resolution, making every effort to resolve issues with the initial phone call. In cases where follow up is needed, it is initiated by the Provider Services representative rather than the provider.

Calls are routed into appropriate queue using IVR selections. Queues are monitored in order to ensure appropriate queue coverage and Telephone Service Factor (TSF). Daily, weekly, and monthly reports are run to ensure queue coverage and to identify trends in call volume, TSF, Abandonment Service Factor (ASF), and call inquiries. Reports can be run out of our proprietary Managed Care System (MCS) to identify call inquiries via contact codes. Contact codes are placed into member profiles in order to categorize the reason for their call. This information is used in order to identify opportunities for quality improvement. All inbound and outbound call are recorded in Meridian's MCS system within the provider contact log to allow for tracking, reporting and ensuring message consistency.

Additionally, the Meridian Live Chat offers providers and their staff secure, HIPAA-compliant direct access to Provider Services staff members during normal business hours (7:30 a.m. to 6:00 p.m., Central Standard Time) to exchange information and resolve any concerns they may have. After hours, providers may send a secure email, with prompt follow-up the next business day by our internal Provider Service representative. For all days with a closure, Meridian has a documented process for providers to process emergency prior authorizations as needed.

6.1.4 Cultural Competence

1. Describe your plans for ensuring the delivery of services in a culturally competent manner.

All Meridian Health Plan providers will receive initial in-service training upon contracting as well as ongoing education through the web portal and Provider Manual. The Provider Manual is updated annually and is available online at our website at <http://mhplan.com/ia/>. The Provider Manual is also available in hard copy or CD version upon request. Ongoing cultural competency training will be provided through web-based cultural competence training sessions. Meridian will use the annual regional provider meetings to provide competency training updates. Meridian offers provider education on a variety of topics, including cultural diversity training, web-based training, on-site sessions and a host of educational materials. Meridian has a signed Letter of Intent to contract with Brilljent, a certified Business Enterprise Program (BEP) vendor with Meridian offices. Brilljent can support Meridian's efforts to offer provider education on a variety of topics, including cultural diversity training. Brilljent offers web-based training, on-site sessions and a host of educational materials.

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The U.S. Department of Health and Human Services Office of Minority Health defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. Cultural competency is important as it is one of the main ingredients in closing the disparities gap in health care.

Meridian Health Plan delivers services in a culturally competent manner to all members and providers. In accordance with 42 CFR 438.206, Meridian participates in the State's efforts to promote the delivery of services in a culturally competent manner. We accommodate members' needs, including those whose first language is not English, who are visually impaired, who are hearing impaired, who have physical disabilities, and/or who have cognitive disabilities. We understand that our members will be a diverse population with different literacy levels, learning styles, and capabilities, and we respect members whose lifestyles or customs differ from the majority of the population. All Meridian Member Services staff is trained to recognize and respond to the needs of culturally diverse members.

Meridian addresses the special health needs of members who are poor, homeless and/or members of a minority population group. We incorporate in our policies, administration, and service practice the value of: (i) honoring members' beliefs; (ii) sensitivity to cultural diversity; and (iii) fostering in staff and providers attitudes and interpersonal communication styles which respect

members' cultural backgrounds. Meridian has specific policy statements regarding cultural competency and we communicate them to network providers and subcontractors.

Meridian's Training & Development Department is responsible for sending out an e-Learning Cultural Competency module to the staff on an annual basis. All new hires are asked to complete this e-Learning module upon hire.

Meridian recognizes that healthcare services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients can have a big impact on positive health outcomes.

Culture and language influence members':

- Health, healing, and wellness belief systems
- Perception of illness, disease and their causes
- Behaviors in seeking health care and their attitudes toward healthcare providers

Culture and language also influence the delivery of services by the provider who may have different views and values than the member, which could impact access and delivery of care for patients/members from other cultures. Meridian continuously strives to ensure that members receive services from the plan and our provider network in a culturally competent manner. The first step in ensuring cultural competency is to identify the populations. Meridian utilizes all available data sources such as State enrollment data, welcome call data, Health Risk Assessments (HRAs), care coordination assessments, member grievances and provider referrals to identify our members' cultural and language preferences.

Meridian collects cultural and ethnic data on HRAs as described below:

- White/Caucasian
- Black/African American
- Hispanic (of any race)
- American Indian
- Alaska Native
- Native Hawaiian or Pacific Islander
- Middle Eastern
- Asian
- Two or more races
- Other

Meridian confirms the primary language of the member and/or member's family during the first call for future communication and member engagement. Historically, Meridian's largest ethnic population has been white/Caucasian followed by African American and Hispanic, but our assessment tools, prevention, and wellness programs address all cultures.

Meridian has an integrated and coordinated process to ensure cultural competency across the plan and provider network. The roadmap for Meridian's cultural competency is NCQA's Multicultural Health Care (MHC) Distinction program which encompasses the Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). These standards are incorporated into all areas that impact interactions with members and providers.

Meridian's Cultural Competency Plan has the following goals:

- Improve communication for members who have cultural and/or linguistic issues
- Decrease healthcare disparities in the populations that we serve
- Improve employee understanding and appreciation to the cultural diversity among the populations that we serve and within our plan
- Ensure access and availability to culturally appropriate services to meet the needs of our diverse population

To achieve these four (4) goals, Meridian will implement the following strategies:

Data Analysis

Meridian routinely collects data on race, ethnicity and language preferences for members. This data is analyzed to determine barriers and interventions based on changes in our population needs. Data is also collected on the language spoken by our provider network to ensure member access to culturally appropriate services. Meridian analyzes and reports data across multiple HEDIS® measures to identify opportunities for internal performance and quality improvement projects, such as the cervical cancer disparity project.

Health Plan Employee Diversity

Meridian Member Services staff is the first point of contact for members. However, Meridian employees from various departments may interact with members. Meridian does not discriminate with regard to race, religion, sex, national origin (ethnic background), age, or physical or mental disability. Meridian will hire, train and retain diverse and talented employees in all levels of management. We actively seek bilingual staff, whenever available and qualified, to reflect our diverse populations. This is a critical component to improving member interactions. Meridian will provide initial and on-going cultural training for all health plan staff to improve understanding and competency in serving our members.

Language Appropriate Services

Meridian will identify members who have potential language issues and needs through the various data sources described earlier. In addition to hiring bilingual staff, Meridian also contracts with PALS International to provide language services in all states where we operate. These services are provided at no additional costs to our members. Meridian selected PALS based on their ability to provide immediate access, twenty-four (24) hours a day, seven (7) days a week to 150 languages with a staff of over 1,000 professional and certified linguists, excellent quality and technology. PALS' average connect time of thirty (30) seconds is consistent with our customer service standards. Meridian also utilizes PALS for written translation services that include over 170 languages. Interpreter services are available for Meridian members via telephone or for scheduled office visits. Interpretation services are also available for the hearing impaired. Meridian maintains a TTY/TDD line and contracts with local vendors to provide sign language services for the hearing impaired upon member/provider request.

Meridian also provides members with educational materials on health literacy using the AskMe3® platform. The basis of this national health literacy program is to educate members to

ask these three (3) questions every time they talk with a healthcare provider (including their pharmacist):

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

These materials are part of the Member Welcome packets, as well as the Care Coordination mailings. Members are provided with an education piece on getting ready for their PCP appointment and understanding medications. The AskMe3® questions may also be printed on the back of the member ID card, dependent on State approval and available space.

Provider Network Diversity

Provider contracting ensures that we have a culturally diverse selection of providers to care for our population. Meridian collects information on all languages spoken by our credentialed provider network and displays this information in our online provider directory. Members are able to search by a specific language capacity when using the online directory. The provider directory is available in hard copy upon request and is also available in Braille for the visually impaired.

Meridian does not prohibit or restrict a healthcare professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient regarding: (i) the member's health status (ii) medical, behavioral health, or long-term care treatment options, including any alternative treatment that may be self-administered; (iii) any information the member needs in order to decide among all relevant treatment options; (iv) the risks, benefits and consequences of treatment or non-treatment; or (v) the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Provider Education

Meridian providers will receive initial in-service training upon contracting as well as ongoing education through the web portal and Provider Manual. The Provider Manual is updated annually and is available online at our website at <http://mhplan.com/ia/>. The Provider Manual is also available in hard copy or CD version upon request. Ongoing cultural competency training will be provided through web-based cultural competence training sessions. Other examples of these types of training include Academy of Health Insurance Plans (AHIP) web training. The AHIP program offers CEUs for physicians, nurses and Care Coordinators. The training is free for any Meridian contracted physician who requests to take it. Meridian will use the annual regional provider meetings to provide competency training updates. Meridian has a signed Letter of Intent to contract with Brilljent, a certified Business Enterprise Program (BEP) vendor with Meridian offices. Brilljent can support Meridian's efforts to offer provider education on a variety of topics, including cultural diversity training. Brilljent offers web-based training, on-site sessions and a host of educational materials.

Community Resources

Meridian will establish relationships and collaborations with faith and community-based organizations to support our culturally and linguistically diverse population. Meridian utilizes

local health departments, local food banks and shelters, the Salvation Army and other faith-based organizations. Meridian recognizes the importance of ensuring cultural responsiveness throughout our network of providers and staff. We understand that a strong provider-member relationship is key to a healthy population. This can be achieved when members feel they can personally relate to their provider. For our Medicaid line of business, we have created a cultural competency plan that accommodates the needs of our diverse member population. This cultural competency plan, which meets NCQA standards for Culturally and Linguistically Appropriate Services, will also be implemented for our dual-eligible population, with adjustments for their unique needs. This plan includes:

- *Posting language information about each of our network providers*
This information is available in our online Provider Directory and helps our members reach a provider that is able to communicate with them in their native language. Meridian staff is also trained to find providers for our non-English speaking members and work with provider offices to ensure that members are receiving the best possible care in the language they feel most comfortable. The Provider Directory can also be mailed to members, if they do not have internet access
- *Creating materials in the formats and languages needed by our members*
This includes Braille materials for the visually impaired and American Sign Language (ASL) interpreters for the hearing impaired. We supply our providers with a variety of materials through our Provider Portal and also our Provider Network Development Representatives (PNDRs)
- *Hiring Providers Services staff locally*
This ensures that employees have a solid understanding of the community's needs and concerns. PNDRs make monthly in-person visits to provider offices, establishing a personal relationship with every office in our network. PNDRs educate providers on Meridian language assistance program resources. In addition, we offer providers online access to cultural competency training information, with links to the most recent Health Resources and Services Administration (HRSA) materials on culture, language, and health literacy
- *Annual cultural training for Meridian employees*
This training incorporates role-playing, allowing employees to better understand alternative perspectives, reflect on their own biases and beliefs, and consider their personal experiences with discrimination and prejudice. Our training promotes awareness and understanding of diversity
- *Building a provider network that reflects the population*
This reduces barriers to seeking the right care in the right place at the right time. Meridian completes ongoing evaluation of member needs through member demographics reports, member feedback, and census reports. This information is shared with our PNDRs to assist them in building and maintaining an ethnically diverse network similar to the demographic profile of our members. Meridian permits members to choose providers from among the network based on cultural preference. We allow members to change providers, within the network, based on the members' cultural preference. If applicable, members may submit grievances related to inability to obtain culturally appropriate care. Meridian defines culturally appropriate care as care by a provider who

can relate to the member and provide care with sensitivity, understanding, and respect for the member's culture

- *A comprehensive network of community health workers*
These providers include mental health specialists, counselors, screening assessment and support services, home health agencies, and public health departments. Meridian and these community providers diligently collaborate to service the needs of our diverse population
- *Contracting with a language translation service*
Meridian has a strong relationship with PALS International, a translation service that offers interpretation for over 150 different languages by professionally certified linguists. Language cohorts that exceed five percent (5%) of the total plan-enrolled population will also have member materials printed and available in the native language

Through contracting, Meridian will require subcontractors to maintain policies and procedures that ensure compliance with our cultural competency program requirement and demonstrate their capacity to meet these requirements. Meridian will assess vendors for the ability to meet our four (4) key goals and also implement our six (6) strategies. We will supply subcontractors a copy of our Cultural Competency Plan and provide copies of our initial and ongoing training programs. Meridian selects subcontractors that have program goals and quality outcomes that are consistent with the standards with which we adhere. Subcontractors or vendors that do not meet these standards will be placed on a corrective action plan. If they are unwilling or unable to meet expectations, Meridian will terminate the relationship and transition to an appropriate subcontractor who demonstrates the capacity to meet the cultural competency standards.

Meridian will rely on the expertise of its BEP certified vendor, Briljent. The firm has deep experience providing cultural competency curriculum, which can be delivered as online, web-based training or through other delivery systems. Briljent has led the way on development and delivery of cultural competency trainings for the Indiana Minority Health Coalition. In addition, Briljent uses the industry standard for development of adult learning materials, the ADDIE method, and culturally appropriate content is integrated throughout all methods and types of training delivery. The ADDIE method includes an awareness of and actively addressing cultural aspects of the resulting resource materials and training. Briljent can develop targeted training to ensure that all project team members and affiliates demonstrate baseline awareness and learning in the area of cultural competency.

Furthermore, Meridian recognizes that community or locally based organizations have the experience, community acceptance and recognition to provide relevant cultural competency training. Meridian has relationships and has partnered in the past with local community groups such as the State school-based healthcare associations, local health departments, Salvation Army, local food banks such as the Food Bank of Iowa, faith-based organizations, and Family Case Management programs. The organizations provide insight into the cultural norms that are unique within their communities and have been willing to serve as education extenders.

6.1.6 Provider Relations and Communications

1. Describe your provider relations and communications strategy.

Meridian Health Plan meets the needs of our provider community with a blend of personal interaction and high-tech communication, including dedicated Provider Network Development Representatives (PNDRs), in-person office visits, toll-free telephone hotline, bulletins, newsletters, monthly educational flyers, fax blasts, emails, website, provider portal and live web chats.

Our locally-placed PNDRs visit our contracted primary care and high volume specialty care offices on a monthly basis. At each visit, our representatives educate PCPs, specialists and their staff about the latest policies and procedures, including wellness standards, HEDIS®, medical home guidelines, evidence-based practice guidelines, and provider portal education and instruction. The representatives also provide a customized report of assigned members still needing necessary preventive health services and the potential bonuses that can be earned for completing these services. Samples of these communications are presented as Attachment 20 (Provider Communication Sample 1) and Attachment 21 (Provider Communication Sample 2) in Tab 5.

Meridian's comprehensive provider relations and communications strategy includes a provider manual, which serves as the written program manual for use by Meridian's provider network. The provider manual is available electronically and in hard copy, upon a provider's request, to all network providers, without cost. The provider manual includes, but is not limited to: program benefits and limitations; claims filing instructions; criteria and process to use when requesting prior authorizations; cost sharing requirements; definitions and requirements pertaining to urgent and emergent care; members' rights; providers' rights for advising or advocating on behalf of his or her patient; provider non-discrimination information; policies and procedures for grievances and appeals in accordance with 42 CFR 438.414; Meridian and State contact information, such as addresses and phone numbers; and policies and procedures for third party liability and other collections.

2. Describe your policies and procedures to maintain communication with and provide information to providers.

Meridian Health Plan believes that communications should begin even before a provider joins our network. When a Provider Network Development Representative (PNDR) visits the office to introduce Meridian, the provider and office staff is offered a Provider Overview booklet that gives a high-level overview of Meridian and its programs. Providers and staff are also able to review the Provider Orientation booklet that is offered to new in-network providers. The Orientation gives detailed information about prior authorization guidelines, billing, HEDIS® bonus programs and other policies.

Once a provider joins our network, Meridian's PNDRs will visit the office again to complete an initial Provider Orientation. During the Orientation, the PNDR will review in detail with the office the Provider Manual, the Orientation booklet, the Provider Portal and other important information.

Each month, the PNDRs will distribute relevant provider educational outreach materials. Developed jointly by our Provider Services and Quality Management Departments, the education flyers address different topics each month and include evidence-based medicine and practice guidelines, as well as billing and coding information. Our PNDRs are equipped with iPads, so they have instant access to detailed information in a secure, safe and HIPAA-compliant environment when responding to provider questions.

The PNDRs are supported by our highly trained Provider Services Department, which offers additional personal attention. Providers may call Meridian directly to ask questions, offer suggestions, register complaints/concerns, etc. Our toll-free provider hotline is directly staffed by Meridian personnel from 7:30 a.m. to 6:00 p.m., Central Standard Time, Monday through Friday. The Provider Services staff receives extensive training to provide efficient, effective service, allowing providers to devote more time to serving our members.

3. Describe your plan to develop a provider website and describe the kinds of information you will make available to providers in this format.

Meridian Health Plan's website is available to all providers describing key program elements and requirements. The Meridian website includes a downloadable version of the Provider Manual, bulletins, forms, educational materials, our formulary, a searchable provider directory, provider trainings, Provider Portal and online Live Chat. These materials are presented in an organized and easily searchable format for our providers and allow for twenty-four (24) hours a day, seven (7) days a week access at the click of a mouse. In addition, non-contracted providers can initiate the contracting process via a form on the website. The website is accessible and functional via cell phone.

Meridian's Managed Care System (MCS) Provider Portal is a secure, proprietary software program that offers unmatched flexibility and efficiency for our network providers. Free of charge to all participating Meridian providers, our Provider Portal allows providers to verify eligibility, view and submit claims, enter prior authorizations, view detailed member data and reports, enrollment lists, and HEDIS® bonus information, perform self-reporting, and much more.

4. Describe your plans for the provider services helpline, including the process you will utilize to answer, route, track and report calls and inquiries.

Providers will have toll-free access to Member Services Representatives. All calls are answered by a live employee who is trained to provide cross-functional assistance. Calls are routed into appropriate queue using IVR selections. Queues are monitored by a Queue Supervisor in order to ensure appropriate queue coverage and Telephone Service Factor (TSF). Daily, weekly, and monthly reports are run to ensure queue coverage and to identify trends in call volume, TSF, Abandonment Service Factor (ASF), and call inquires. Reports can be run out of our proprietary Managed Care System (MCS) to identify call inquiries via contact codes. Contact codes are placed into member profiles in order to categorize the reason for their call. This information is used in order to identify opportunities for quality improvement. The Meridian Health Plan Live Chat offers providers and their staff secure, HIPAA-compliant direct access to Provider Services staff members during normal business hours (7:30 a.m. to 6:00 p.m., Central Standard Time) to exchange information and resolve any concerns they may have. After hours, providers may send a secure email, with prompt follow-up the next business day by our internal provider service

representative. For all days with a closure, Meridian has a documented process for providers to process emergency prior authorizations as needed.

Meridian's Provider Services phone lines are staffed by our highly trained Provider Services Representatives, who provide personal attention to providers' needs. Providers may call Meridian directly to ask questions, offer suggestions, register complaints or concerns. Our toll-free provider hotline is directly staffed by highly trained Meridian personnel from 7:30 a.m. to 6:00 p.m., Central Standard Time, Monday through Friday, with additional phone coverage available seven (7) days a week for emergencies through our after-hours call center. The Provider Services staff receives extensive training to provide efficient, effective service, allowing providers to devote more time to serving our members.

Providing a personal touch to every phone call is our forte; every incoming phone call will be answered by a live employee. Our Provider Services Representatives practice single call resolution, making every effort to resolve issues with the initial phone call. If assistance is needed from another Meridian department, our call center staff will provide a warm transfer, instead of an automated answering system. Meridian's policy is to always use warm transfers to forward a phone call. Instead of blindly transferring a call, then hanging up with no concern for the proper resolution, our warm transfer process includes: transferring the phone call and staying on the line until someone answers on the other end, announcing the caller's name, ID number and reason for calling. In cases where follow-up is needed, it is initiated by the Provider Services Representative rather than the provider.

Calls are routed into the appropriate queue using IVR selections. Queues are monitored in order to ensure appropriate queue coverage and Telephone Service Factor (TSF). Daily, weekly, and monthly reports are run to ensure queue coverage and to identify trends in call volume, TSF, Abandonment Service Factor (ASF), and call inquiries. Reports can be run out of our proprietary Managed Care System (MCS) to identify call inquiries via contact codes. Contact codes are placed into member profiles in order to categorize the reason for their call. This information is used in order to identify opportunities for quality improvement. All inbound and outbound call are recorded in Meridian's MCS system within the provider contact log to allow for tracking, reporting, and ensuring message consistency.

Additionally, the Meridian Live Chat offers providers and their staff secure, HIPAA-compliant direct access to Provider Services staff members during normal business hours (7:30 a.m. to 6:00 p.m., Central Standard Time) to exchange information and resolve any concerns they may have. After hours, providers may send a secure email, with prompt follow-up the next business day by our internal provider service representative. For all days with a closure, Meridian has a documented process for providers to process emergency prior authorizations as needed.

5. Describe your provider training plans.

Meridian Health Plan offers provider education on a variety of topics, including cultural diversity training, web-based training, on-site sessions and a host of educational materials. Meridian providers will receive initial in-service training upon contracting as well as ongoing education through the web portal and Provider Manual. The Provider Manual is updated annually and is available online at our website at <http://mhplan.com/ia/>. The Provider Manual is also available in hard copy or CD version upon request. Ongoing cultural competency training will be provided through web-based cultural competence training sessions. Meridian will use the annual regional

provider meetings to provide competency training updates. Meridian has a signed Letter of Intent to contract with Brilljent, a certified Business Enterprise Program (BEP) vendor with Meridian offices. Brilljent can support Meridian's efforts to offer provider education on a variety of topics, including cultural diversity training. Brilljent offers web-based training, on-site sessions and a host of educational materials.

Meridian understands all training materials may be reviewed and are subject to approval by the State.

Meridian will provide training to support traditional LTSS providers in transitioning services under this program through features such as information technology, billing and systems operations. All provider training will include the following topics:

- The role of the Care Coordinator and the importance of notifying a member's Care Coordinator, as expeditiously as warranted by the member's circumstances, of any significant changes in the member's condition or care, hospitalizations, or recommendations for additional services;
- Critical incident training;
- Abuse and neglect training including procedures and requirements for: (i) preventing; (ii) identifying; (iii) reporting; (iv) investigating; and (v) remediating suspected abuse, neglect and exploitation of members;
- Provider requirements and responsibilities;
- Prior authorization policies and procedures;
- Claims submission processes;
- Claims dispute resolution processes;
- Any applicable Medicaid policies including updates and changes;
- Person-Centered Planning Process; and
- HCBS settings per CMS regulations.

Meridian shall submit to the State for approval at least thirty (30) calendar days prior to expected use and distribution of all new and existing communications with substantive changes to previously approved communications. Meridian will comply with any State processes implemented to facilitate submission and approval of materials, including making such materials available to the State and archiving them in an electronic library. All required and applicable materials will be available to the State throughout the contract term and transitioned to the State after the contract term.

6.1.8 Notification of Provider Disenrollment

1. Describe procedures for ensuring continuity of care and communication with members when a provider disenrolls.

Meridian Health Plan will maintain a written plan for providing continuity of care in the event of contract termination of any of our contracted providers, or in the event that a PCP closes one or more of their office locations. Our proprietary Managed Care System (MCS) immediately identifies any members impacted by provider contract termination or office closings. Through real-time notification, the system alerts staff to contact affected members and assist with primary care choices and questions. Providers are also contacted to inform them of new member

enrollment with their practice to ensure continuity of care for our members. During this process, we ensure our member privacy is kept confidential according to all contractual, State, and Federal requirements. Meridian ensures notification to members is provided within fifteen (15) calendar days of receipt or issuance of the provider termination. Meridian notifies the State and the Office of the Inspector General of disenrollments in compliance with 42 CFR 1001.

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.

Meridian Health Plan has a long, successful history of working with Providers and their varied information technologies. One of Meridian's technological strengths is our ability to be adaptive and responsive to providers who need connectivity to member information. Meridian is able to conform to all major healthcare standards for data information exchange, such as HIPAA standard transactions, HL7, Continuity of Care Document (CCD), and custom protocols, as needed.

Meridian's fundamental goal is to provide a high level of patient-centered care, reducing the administrative burden on the paper record system and freeing the provider to spend more quality time with members.

Meridian recognizes the role that confidentiality, privacy, and security play in the support of our members. All Meridian employees are thoroughly and regularly trained on all aspects of protecting medical data, and Meridian policies and procedures cover appropriate access and confidentiality of medical data and records. In addition, Meridian utilizes a role-based approach for employees accessing protected and confidential member information.

We only use encrypted channels and encrypted messaging protocols to communicate with our trading partners. All data in transit, at rest, and backups are encrypted. Meridian employs strong encryption methods throughout our systems. Additionally, our systems are protected by layers of firewalls.

Meridian employs the following technology to provide protections for transmission and storage of medical data:

- ZixGateway for email encryption
- Direct Messaging
- SSH File Transfer Protocol (also known as Secure FTP and SFTP)
- Cisco firewalls

Meridian is committed to be in compliance with all privacy policies as required by governmental agencies or State or Federal Law. We will provide adequate security measures for any data that is transmitted between Meridian and the State, or data within our network, storage, or cache.

As a covered entity under HIPAA, Meridian is keenly aware of its responsibilities regarding the protection of member information and has implemented policies and procedures designed to safeguard such information. Meridian educates its employees regularly and requires them to be

cognizant of the requirements of HIPAA and implementing regulations (i.e. the Privacy Rule and the Security Rule) at all times in the performance of their job functions. Meridian fosters an environment of open communication in order to learn of privacy or security incidents and respond to them quickly and appropriately.

Meridian has implemented administrative, physical, and technical safeguards in compliance with Federal and State regulations as recorded in our written policies and procedures. Our independent auditor, Plante Moran, conducts an annual security audit of our system which includes a review of the completeness of our policies and procedures and objective test of our compliance. Our annual audit is conducted using the American Institute of Certified Public Accounts (AICPA) Service Oriented Control (SOC) report standards. Specifically, Plante Moran conducts an SSAE 16 (Statements on Standards for Attestation Engagements No. 16,) which goes beyond the now retired SAS 70 standard by not only verifying the controls and processes but also requiring a written assertion regarding the design and operating effectiveness of the controls being reviewed. The SSAE 16 audit results are reported in a SOC 1 report. This report focuses on internal controls and includes an opinion of the accuracy and completeness of Meridian's design of controls, system and service.

Meridian's policies, procedures and contractual requirements for participating provider medical records content and documentation are in compliance with the provisions of Iowa Admin. Code 441 Chapter 79.3. Meridian acknowledges such policies and procedures are subject to State review and approval and are communicated to network providers. Meridian ensures our records, and those of our participating providers, document all medical services that the member receives in accordance with Law and are consistent with utilization control requirements in 42 CFR 456. Our providers maintain members' medical records in a detailed and comprehensive manner that conform to good professional medical practice, permitting effective professional medical review and medical audit processes, and facilitate an accurate system for follow-up treatment. Meridian requires that our providers medical records must be legible, signed, dated and maintained as required by Law.

Maintenance and Retention

Meridian maintains a medical records system which: (i) identifies each medical record by the States identification number; (ii) identifies the location of every medical record; (iii) places medical records in a given order and location; (iv) maintains the confidentiality of medical records information and releases the information only in accordance with Section 6.1.9.4; (v) maintains inactive medical records in a specific place; (vi) permits effective professional review in medical audit processes; and (vii) facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.

Member Rights

In accordance with 42 CFR 438.100(b)(2)(vi), Meridian maintains methods and procedures that ensure each participant the right to request and receive a copy of his or her medical records, and provides for the ability for members to request that they be amended or corrected. Meridian ensures our network providers will provide a copy of a member's medical record upon reasonable request by the member at no charge, and our providers must facilitate the transfer of the member's medical record to another provider at the member's request. Meridian requires of our network providers that confidentiality of, and access to, medical records must be provided in accordance with the standards mandated in the Health Insurance Portability and

Accountability Act (HIPAA) and all other State and Federal requirements.

Access to Medical and Financial Records

As required by the Department or other authorized entity, Meridian will permit representatives of the State, and other authorized entities, to review members' records for the purposes of monitoring the provider's compliance with the record standards, capturing information for clinical studies, monitoring quality or any other reason.

Confidentiality of Medical Records

Meridian contractually requires all medical records of members to be kept confidential and cannot be released without the written consent of the member or responsible party. Meridian complies with the requirements that identify where written consent is not required: (i) for transmission of medical record information to physicians, other practitioners, or facilities that are providing services to members under contract with Meridian; and (ii) for transmission of medical record information to physicians or facilities providing emergency care. Meridian requires written consent for the transmission of the medical record information of a former member to any physician not connected with Meridian. The extent of medical record information to be released in each instance is based upon tests of medical necessity and a "need to know" on the part of the practitioner or facility requesting the information. Meridian requires all release of medical records to be compliant with 45 CFR 162 and 164.

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.**

Our contracted provider network has the capacity to provide PCP and specialty access for all members. We monitor this network on an ongoing basis to ensure that all covered services delivered by network providers within the scope of this RFP are accessible to members and shall be in compliance as described in this RFP and for covered services delivered by all provider types.

Meridian Health Plan's complete and comprehensive provider network includes PCPs, specialists, hospitals, mental health providers, long-term care facilities, social services, and pharmacies within the geographic distance standards for all members. Our providers are available within the hours of operation offered to commercial insurance and fee-for-service members, including evening and weekend appointments. Our network has the capacity to ensure that the waiting times for appointments will not exceed fourteen (14) calendar days for routine care, twenty-four (24) hours for adult sick care, thirty (30) calendar days for specialist appointments, thirty (30) calendar days for elective hospitalizations, fourteen (14) calendar days for mental health providers, and immediately for any emergent care providers and will not require prior authorization for emergent care. Meridian does work with out-of-network providers for medically necessary covered services that our existing network is unable to provide.

Meridian ensures that members will have contact with community mental health centers within forty-eight (48) hours of any hospital psychiatric discharge. We also coordinate a follow up

appointment to ensure that our members see their behavioral health provider within seven (7) days of their hospital psychiatric discharge. Meridian has experience with performing discharge follow-up for medical hospital admissions and will tailor our current program to meet the needs of this RFP.

Meridian has extensive experience contracting in rural areas. Throughout Iowa, we will ensure that female members have access with an in-network women's health specialist to provide not only routine and preventive care but all necessary covered care. This is in addition to the services rendered by female members' PCPs. All network providers have contractually agreed that members cannot be billed for any remaining unpaid amount by Meridian. We ensure that all payment arrangements are coordinated and agreed upon with out-of-network providers for services. We also provide the option for members to receive a second opinion by a qualified healthcare professional at no cost to the member.

6.1.11 Provider Compliance

1. Describe procedures for ensuring network providers comply with all access requirements and for monitoring providers for compliance.

Meridian Health Plan has established procedures, which we acknowledge are subject to State review and approval, to ensure that our network providers comply with all access requirements, which will include those specified in this RFP, including, but not limited to, appointment times set forth in the RFP. We are able to provide as requested the appropriate documentation demonstrating monitoring of compliance with these standards. Meridian has established mechanisms to regularly monitor providers to ensure compliance, and we take corrective actions if a provider is found to be noncompliant. Meridian maintains an emergency/contingency plan in the event that a large provider of services collapses or is otherwise unable to provide needed services.

Meridian monitors the adequacy, accessibility, and availability of our provider network to all members, including those with special needs and cultural considerations. We notify the State of Iowa in the event that a provider contract is terminated for any reason and MCS identifies affected members so we can swiftly coordinate proper alternatives. The State of Iowa will be notified as defined by:

Primary Care Provider Access Standards

Distance/Time

- Thirty (30) minutes or thirty (30) miles from the personal residences of members.

Appointment Times

- Not to exceed four (4) to six (6) weeks from the date of a patient's request for a routine appointment, within forty-eight (48) hours for persistent symptoms and within one (1) day for urgent care.

Specialty Care Access Standards

Meridian ensures there are a sufficient number of specialists with the applicable range of expertise to ensure the needs of members are met within the provider network. Meridian has a system to refer members to non-network providers if providers with the necessary qualifications or certifications do not participate in the network. Meridian will have a system to refer members to, and pay for, non-network providers when medically necessary. Meridian will also pay for non-network providers when a member has medical needs that would be adversely affected by a change in service providers. All non-network providers referred to and reimbursed must have the necessary qualifications or certifications to provide the medically necessary service. At minimum, Meridian will have provider agreements with providers practicing the following specialties: (i) allergy; (ii) cardiology; (iii) dermatology; (iv) endocrinology; (v) gastroenterology; (vi) general surgery; (vii) neonatology; (viii) nephrology; (ix) neurology; (x) neurosurgery; (xi) obstetrics and gynecology; (xii) occupational therapy; (xiii) oncology/hematology; (xiv) ophthalmology; (xv) orthopedics; (xvi) otolaryngology; (xvii) pathology; (xviii) physical therapy; (xix) pulmonology; (xx) psychiatry; (xxi) radiology; (xxii) reconstructive surgery; (xxiii) rheumatology; (xxiv) speech therapy; and (xxv) urology. Meridian analyzes the clinical needs of our enrolled membership to identify additional specialty provider types to enroll.

Distance/Time

- Sixty (60) minutes or sixty (60) miles from the personal residence of members for at least seventy-five percent (75%) of non-dual members.
- Ninety (90) minutes from the personal residence of members for ALL non-dual members.

Appointment Times

- Not to exceed thirty (30) days for routine care or one (1) day for urgent care.

Hospital and Emergency Services Access Standards

Hospitals

Transport time will be the usual and customary, not to exceed thirty (30) minutes or thirty (30) miles, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

Emergency Care

All emergency care is immediate, at the nearest facility available, regardless of whether the facility or provider is under contract with Meridian.

Long-Term Care Services Access Standards

Network

- **Institutional Providers**
All licensed and Medicaid certified Nursing Facilities and ICF/IDs will be offered inclusion in Meridian's provider network for two (2) years in accordance with the RFP.

Following the minimum period, Meridian will evaluate each facility's continued network enrollment based on assessment of quality and performance outcomes consistent with Meridian's requirements for coordination of care, as approved by the State.

- **HCBS Providers**

Meridian will contract with at least two (2) providers per county for each covered HCBS in the benefit package for each 1915(c) HCBS waiver. In the event a county has an insufficient number of providers licensed, certified, or available, Meridian acknowledges the access standard shall be based on the community standard and must be justified and documented to the State.

Distance/Time

Transport distance to licensed Adult Day Care providers will be the usual and customary not to exceed thirty (30) minutes or thirty (30) miles for members in urban areas and not to exceed sixty (60) miles for members in rural areas except where community standards and documentation apply.

Behavioral Health Access Standard

Distance/Time

- **Outpatient services**

Thirty (30) minutes or thirty (30) miles from the personal residence of members except where community standards and documentation shall apply.

- **Inpatient, residential, intensive outpatient and partial hospitalization**

Sixty (60) minutes or sixty (60) miles from the personal residence of members in urban areas and ninety (90) minutes or ninety (90) miles from the personal residence of members in rural areas using GeoAccess standards for rural and urban travel time.

Appointment Times

Meridian requires network providers have procedures for the scheduling of member appointments in accordance with the following requirements:

- **Emergency:** Members with emergency needs shall be seen within fifteen (15) minutes of presentation at a service delivery site.
- **Mobile Crisis:** Members in need of mobile crisis services shall receive services within one (1) hour of presentation or request.
- **Urgent:** Members with urgent non-emergency needs shall be seen by an appropriate provider within one (1) hour of presentation at a service delivery site or within twenty-four (24) hours of telephone contact with provider or Meridian.
- **Persistent symptoms:** Members with persistent symptoms shall be seen by an appropriate provider within forty-eight (48) hours of reporting symptoms.
- **Routine:** Members with need for routine services shall be seen by an appropriate provider within three (3) weeks of the request for an appointment.
- **Substance Use Disorder & Pregnancy:** Members who are pregnant women in need of routine substance use disorder services must be admitted within forty-eight (48) hours of seeking treatment.

- **Intravenous drug use:** Members who are intravenous drug users must be admitted no later than fourteen (14) days after making the request for admission, or 120 days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual no later than forty-eight (48) hours after such request.

General Optometry Services

Distance/Time

Transport time will be the usual and customary, not to exceed thirty (30) minutes or thirty (30) miles, except in rural areas where community standards and documentation will apply.

Appointment Times

Usual and customary not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care.

Lab and X-Ray Services

Meridian arranges for laboratory services through laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates and in accordance with CLIA Law.

Distance/Time

Transport time will be the usual and customary, not to exceed thirty (30) minutes or thirty (30) miles, except in rural areas where community access standards and documentation will apply.

Appointment Times

Usual and customary not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care.

Pharmacies

Meridian provides at least two (2) pharmacy providers within thirty (30) minutes or thirty (30) miles from a member's residence in each county, excluding pharmacies participating in the Specialty Pharmacy Program.

Meridian's procedures ensure network providers comply with all access requirements specified in this RFP, including, but not limited to, appointment times, and Meridian's documentation demonstrates monitoring of compliance with these standards. Meridian will take corrective actions if a provider is found to be noncompliant.

2. Describe emergency/contingency plans in the event a large provider is unable to provide needed services.

Meridian Health Plan will maintain a written plan for providing continuity of care in the event of contract termination with any of our contracted providers, or in the event that a PCP closes one or

more of his/her office locations. Our proprietary Managed Care System (MCS) immediately identifies any members impacted by provider contract termination or office closings. Through real-time notification, the system alerts staff to contact affected members and assist with primary care choices and questions. Providers are also contacted to inform them of new member enrollment with their practice to ensure continuity of care for our members. During this process, we ensure our members' privacy is kept confidential according to all contractual, State, and Federal requirements.

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.

Meridian Health Plan's network is sufficient to offer members a choice of providers. As members enroll in our plan, their contact information is routed to member outreach personnel to perform a welcome call. This initial contact is aimed at creating a relationship with the member. We inform the new member that a welcome packet has been mailed to them, with information about covered services, the member handbook, PCP assignment and contact information, and member identification card. During this call, we welcome the member to Meridian, perform a Health Risk Assessment (HRA), assist the member in choosing a PCP, make an appointment with the PCP if needed, and answer any member questions.

If a member is enrolled with Meridian and is already established with a provider who is not a part of the network, Meridian will make every effort to arrange for the member to continue with the same provider. Meridian will outreach to the provider to determine if he or she meets the same qualifications as other providers in the network. To ensure appropriate access to the following categories of providers, Meridian Health Plan implements the following contracting activities:

- Mailings of provider education materials and contacts to currently participating Medicaid-only providers and to non-participating providers
- Telephonic outreach from several data base sources, including:
 - Identified providers on the mailing list
 - Email notifications generated automatically through our proprietary Managed Care System (MCS), alerting the Provider Services Department of a requested authorization for utilization through an out-of-network provider
 - Email notification from Meridian's Claims Department informing the Provider Services Department of a claim that has been received for a service that has been rendered to a member by an out-of-network provider
 - Provider-initiated contracting via completion of the form on Meridian's website
- Face-to-face meetings and negotiations for participation
- Execution of Contract
- Credentialing
- Provider orientations and subsequent visits on a recurring basis

Meridian ensures through our credentialing and re-credentialing processes that we do not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or CHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or

who are otherwise are not in good standing with a State's Medicaid program or the Medicare program.

Meridian evaluates and manages network adequacy by monitoring anticipated Medicaid enrollment; the expected utilization of services based on the characteristics and healthcare needs of our specific populations; the number and types of providers required to furnish the contracted Medicaid services; the number of network providers who are not accepting new Medicaid patients; and the geographic location of providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for members with disabilities.

Meridian maintains written policies and procedures for the selection, credentialing, re-credentialing, and retention of providers in accordance with 42 CFR 438.214(c). Meridian does not discriminate against particular providers that serve high-risk population or specialize in conditions that require high cost treatment. Meridian does not refuse to credential or contract with a qualified provider, on the sole basis of the network already meeting the contractual distance accessibility standard, if there is a subset of members in the proposed service area that must travel beyond the average standard to access care.

In accordance with 42 CFR 438.12, Meridian does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

As outlined in the RFP, for the first two (2) years of the Contract, Meridian will give all of the following providers, which are currently enrolled as DHS providers, the opportunity to be part of our provider network: (i) community mental health centers (CMHCs); (ii) 1915(i) HCBS Habilitation Services providers; (iii) nursing facilities; (iv) ICF/IDs; (v) health homes; (vi) 1915(c) HCBS waiver providers, with the exception of case managers and Care Coordinators; and (vii) substance use disorder treatment programs that are also in the IDPH-funded network. During this two (2) year time period, Meridian may recommend disenrollment of providers not meeting defined performance measures, understanding the State will retain authority for development of the performance standards, with input sought from Meridian. Meridian acknowledges the State will also maintain final authority for review and approval of any disenrollment recommendations. Meridian acknowledges that after the two (2) year time period, Meridian will continue to reimburse at a rate that is, at a minimum, equal to the current Iowa Medicaid fee-for-service rate.

For all provider types not described above, and not already contracted with Meridian, during the first six (6) months of the Contract, Meridian will extend contract offers, at minimum, at Medicaid fee-for-service rates and; Meridian acknowledges that after the six (6) month time period, Meridian will continue to reimburse at a rate that is, at a minimum, equal to the current Iowa Medicaid fee-for-service rate.

Meridian acknowledges the IDPH will procure the provider network for IDPH-funded substance abuse treatment services. Meridian will contract with the IDPH network.

Meridian's documentation of adequate network capacity will meet or exceed the requirements of the State. Meridian will ensure appropriate documentation and notification to the State at any time there is a significant change in Meridian's operation or program, inclusive of changes in services, changes in benefits, changes in payments, enrollment of a new population, or as

otherwise requested by the State. The documentation of network adequacy shall be signed by Meridian's President/Chief Executive Officer (CEO) and submitted at the required frequency and in the required format as outlined by the State and make reasonable efforts to provide written notice within ninety (90) calendar days in advance, when possible, of Meridian's inability to maintain a sufficient network in any county.

2. Describe your strategies for provider outreach and contracting in rural areas.

The Meridian Health Plan Provider Services Department is also responsible for identifying non-participating providers and initiating the contracting process with them. Once a provider has been pinpointed for potential participation, the Provider Services Department tracks this information through our proprietary Managed Care System (MCS) for frequent review and follow-up. Once the gaps and potential providers have been detected, the contracting and outreach process begins.

The Contracting Process includes:

- Mailings of provider education materials and contacts to currently participating Medicaid-only providers and to non-participating providers
- Telephonic outreach from several data base sources, including:
 - Identified providers on the mailing list
 - Email notifications generated automatically through MCS, alerting the Provider Services Department of a requested authorization for utilization through an out-of-network provider
 - Email notification from Meridian's Claims Department informing the Provider Services Department of a claim that has been received for a service that has been rendered to a member by an out-of-network provider
 - Provider-initiated contracting via completion of the form on Meridian's website
- Face-to-face meetings and negotiations for participation
- Execution of Contract
- Credentialing

Provider orientations and subsequent visits occur on a recurring basis.

Meridian's assertive provider outreach is inclusive of providers in rural areas where services may be less available than in more urban areas, and Meridian has demonstrated success in contracting in these areas. Meridian continuously monitors utilization across the State and in rural and urban areas to assure equality of service access and availability. If Meridian's monitoring ever shows the need for increased access to services, Meridian will submit an action plan to the State for approval.

3. Detail any way in which you propose to limit members to in-network providers.

Meridian Health Plan will not limit members to in-network providers during the initial transition periods associated and outlined within the RFP. Meridian will evaluate providers, using tools such as those outlined in the SIMs, which include the VIS, to determine success in meeting performance benchmarks and targets. Based on provider performance against benchmarks and targets, Meridian may implement limitations to in-network providers for designated and approved services.

After the initial transition periods outlined in the RFP, with the exception of family planning, emergency services, and continuity of care requirements, and when Meridian has met the network adequacy standards set forth in Exhibit B, Meridian may require members to seek covered services from in-network providers. Prior to closing our network, Meridian will obtain the State's approval. If Meridian's network is unable to provide medically necessary covered services to a particular member using contract providers, Meridian will ensure adequate and timely coverage of medically necessary services for the member using non-contract providers, for as long as Meridian's provider network is unable to provide the medically necessary services. Meridian will negotiate and execute written single-case agreements or arrangements with non-network providers, when necessary, to ensure access to covered services. Meridian will require out-of-network providers to coordinate with us with respect to payment. Meridian will ensure no provider bills a member for all or any part of the cost of a treatment service, except as allowed for Title XIX cost sharing and patient liability. Meridian will ensure the cost to the member is no greater than it would be if services were provided within the 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.

Meridian Health Plan providers are all contractually required to accept payment from Meridian as payment in full, minus any plan identified member contribution(s) liability (e.g. copayment), outlined on the remittance advice (RA), for services rendered; providers are contractually prohibited from balance billing members. Meridian will ensure no provider bills a member for all or any part of the cost of a treatment service, except as allowed for Title XIX cost sharing and patient liability. Meridian will ensure the cost to the member is no greater than it would be if services were provided within the network.

When a member is dually eligible and requires services that are covered under the Contract but are not covered by Medicare, and the services are ordered by a Medicare provider who is a non-contract provider, Meridian shall pay for the ordered, medically necessary service if it is provided by a contract provider. Meridian may require the ordering physician be a contract provider if the ordered service requires prior authorization; the dually-eligible member has been clearly informed of the contract provider requirement and instructed on how to obtain assistance identifying and making an appointment with a contract provider; and if Meridian assists the member in obtaining a timely appointment with a contract provider upon request of the member or upon receipt of an order from a non-contract provider.

6.3 Requirements by Provider Type

1. Indicate if you will use a primary care provider (PCP) model of care delivery.

Meridian Health Plan uses today, and will use with all members, a primary care provider (PCP) model of care delivery.

2. If a PCP model will be utilized, describe the following:

a. Physician types eligible to serve as a PCP.

Providers that will traditionally act as a PCP in the Meridian Health Plan network are:

- Internists
- Family Practitioners
- General Practitioners
- OB/GYNs
- Physician Assistants
- Advanced Practice Nurses
- Specialists (upon approval of the Meridian Medical Director)

Meridian will maintain compliance with 42 CFR 438.208. Meridian will ensure each member has an ongoing source of primary care appropriate to his or her needs and a person formally designated as primarily responsible for coordinating the healthcare services furnished to the member. Meridian will ensure the availability of a physician to serve as the ongoing source of care appropriate to the member's clinical condition in accordance with the network accessibility and adequacy standards outlined within the RFP. Meridian will provide to the State for review and approval our PCP assignment methodology and any associated policies and procedures. Meridian will adhere and implement the approved policies and procedures and receive approval prior to making any changes to previously approved policies and procedures.

b. Any panel size limits or requirements.

Meridian follows NCQA, URAC and CMS guidelines in assessing access to primary care for our members. It is our policy to have at least one adult PCP for every 2,000 members, within a driving time and distance of thirty (30) minutes or thirty (30) miles. On an annual basis, Meridian assesses this standard by integrating member and provider population size analysis with Quest Analytics software to make sure these standards are maintained. Identified opportunities for improvement shall be reported to our Quality Improvement Committee (QIC) with a plan to correct any deficiencies. Meridian allows PCPs to control their panel sizes based on enrollment, age, and gender parameters that allow them to practice most effectively given their specialty. These panel assignments are indicated at the time of credentialing and they may be augmented through correspondence with the PCP's assigned Provider Network Development Specialist. The adjustment is made within our proprietary Managed Care System (MCS) which will prevent assignment of members that are not within the indicated parameters. The institution of assignment parameters allows members to be appropriately assigned to providers that are able to meet their health needs. It also allows providers with specialties specific to certain cohorts (i.e. women's healthcare providers, geriatrics specialists) to receive assignment of only those members that qualify for their services without the administrative burden of manual tracking.

c. Proposed policies and procedures to link members to PCPs.

Meridian follows NCQA, URAC and CMS guidelines in assessing access to primary care for our members. It is our policy to have at least one adult PCP for every 2,000 members, within a driving time and distance of thirty (30) minutes or thirty (30) miles. On an annual basis, Meridian assesses this standard by integrating member and provider population size analysis with Quest Analytics software to make sure these standards are maintained. Identified opportunities for improvement shall be reported to our Quality Improvement Committee (QIC) with a plan to correct any deficiencies.

Meridian establishes PCP medical homes for members by considering the member's healthcare needs and the PCPs that are open and accepting new members in the member's local network territory. The goal is to assign a member to a medical home that is closest to the member's residence. This requires having a comprehensive provider network that is able to meet the needs of all potential members. Meridian's Provider Services Department continually monitors the adequacy, accessibility, and availability of our provider network to all members in order to ensure timely access to a medical home.

The Provider Services Department is also responsible for identifying opportunities for non-participating providers to contract with Meridian and then initiate the contracting process with them in order to grow our network of potential medical homes. Once a provider has been pinpointed for potential participation, the Provider Services Department tracks contract eligibility and process information through our proprietary Managed Care System (MCS) for frequent review and follow-up.

Opportunities for increasing access to medical homes include but are not limited to:

- Identifying providers in the Medical Assistance Program
- Identifying providers in the NPES Registry
- Automatically generated email notifications from MCS that alert Provider Services staff of an out-of-network provider's request to join our network
- Email notification to Provider Services staff regarding receipt of a claim for an out-of-network provider's care of a member
- Member Complaints/Grievances reported at the Quarterly Quality Improvement Committee (QIC) meeting
- Monthly face-to-face interaction between the Provider Network Development Representative (PNDR) and PCP offices that reinforce the PCMH concept

Meridian also has the ability to ensure members are assigned medical homes with providers who have the degree of specialized knowledge and skill to effectively manage their underlying conditions. This is achieved through the following:

- Permitting a specialist to serve as the PCP
- Permitting co-management arrangements between a PCP and specialist

All medical homes are required by contract to provide twenty-four (24) hour, seven (7) days per week coverage to meet after-hour member health needs. Members can contact Meridian twenty-four (24) hours a day, seven (7) days a week through its after-hours answering service. If a member's PCP cannot be contacted, the after-hours answering

service is capable of connecting the member to a behavioral health specialist, substance abuse clinician or an on-call medical provider after normal business hours.

3. If a PCP model is not proposed, describe methods to ensure compliance with 42 CFR 438.208 as described in Section 6.3.1.

Meridian Health Plan uses today, and will use with all members, a primary care provider (PCP) model of care delivery.

4. Describe your plan for providing a sufficient network of all provider types outlined in Section 6.3, including timelines and tasks.

Meridian Health Plan will maintain compliance with 42 CFR 438.208. Meridian will ensure each member has an ongoing source of primary care appropriate to his or her needs and a person formally designated as primarily responsible for coordinating the healthcare services furnished to the member. Meridian will ensure the availability of a physician to serve as the ongoing source of care appropriate to the member's clinical condition in accordance with the network accessibility and adequacy standards outlines within the RFP.

In accordance with 42 CFR 441.22, Meridian ensures nurse practitioner services are available to Medicaid members and are included within the provider network.

Meridian will provide a network of appropriately credentialed physical and behavioral health providers to assure the availability of services for both adults and children and to meet the general access requirements described within the RFP, including:

- **Essential Hospital Services** – sufficient access to essential hospital services to serve the expected enrollment and to meet, at minimum, the access and availability requirements set forth in the RFP.
- **Physician Specialists** – network of physician specialists adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of Meridian members without excessive travel requirements. Meridian will have signed provider agreements with providers of the specialty types listed in the RFP who accept new Medicaid members and are available on at least a referral basis and will be in compliance with the access and availability requirements set forth in the RFP.
- **Health Homes** – network of Integrated Health Homes and Health Homes. Meridian will ensure contracting strategies which encourage additional participation. In developing the Integrated Health Homes and Health Homes networks, Meridian will ensure all providers meet the minimum requirements for participation as defined in the State Plan and the State policy.
- **Federally Qualified Health Centers and Rural Health Clinics** – contract with all Federally Qualified Health Centers (FQHCs) and rural health clinics (RHCs) located in Iowa.
- **Family Planning Clinics** – contract with local family planning clinics funded by Title X moneys.

- **Maternal and Child Health Centers** – contract with maternal and child health centers funded by Title V moneys.
- **Urgent Care Clinics** – contract with urgent care clinics to deliver care to members. Meridian encourages all members to utilize Urgent Care Clinics as an alternative option to the emergency room in non-life threatening situations and when members need services outside of their PCP’s hours of operation. Meridian acknowledges and will implement and adhere to the DHS approved approach for using Urgent Care Clinics, and will seek approval from the DHS prior to making any changes in the approved approach.
- **Other Safety Net Providers and Community Partners** – Meridian partners with community entities, and intends to continue and expand partnerships with community entities such as the Area Agencies on Aging. Meridian acknowledges and will implement and adhere to the DHS approved approach for partnering with other Safety Net Providers and Community Partners, and will seek approval from the DHS prior to making any changes in the approved approach.
- **Community-Based Residential Alternatives** – Meridian will demonstrate good faith efforts to develop the capacity to have a travel distance of no more than sixty (60) miles between a member’s community-based residential alternative placement and the member’s residence before entering the facility.

Meridian’s contracted provider network meets the accessibility requirements for medical and behavioral health providers outlined with the RFP for over ninety percent (90%) of the State of Iowa today. Meridian anticipates achieving and meeting the accessibility requirements for medical and behavioral health providers in 100 percent of the State of Iowa by the end of 2015. Meridian is not currently contracted with Consumer Choice/Consumer Directed care providers in the State of Iowa. Meridian will begin contracting these provider types in the summer of 2015, with anticipation and expectation of meeting network accessibility requirements for these and all HCBS provider types by the end of 2015.

5. Describe your plans for meeting the requirements regarding Indian Healthcare Providers.

Meridian Health Plan is actively recruiting and contracting with Indian Healthcare Providers, and we do not anticipate any challenges meeting the requirements regarding Indian Healthcare Providers.

In accordance with Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), Meridian does:

- Permit any Indian member who is eligible to receive services from a participating Indian healthcare provider to choose to receive covered services from that Indian healthcare provider, and if that Indian healthcare provider participates in the network as a PCP (if applicable), to choose that Indian healthcare provider as his or her PCP, as long as that Indian healthcare provider has the capacity to provide the service
- Demonstrate sufficient Indian healthcare providers in Meridian’s network to ensure timely access to services available under the Contract for Indian members who are eligible to receive services from such providers
- Reimburse Indian healthcare providers, whether in-or out-of-network, for covered services provided to Indian members who are eligible to receive services from such providers either at: (i) a contracted rate negotiated with the Indian healthcare provider; or

(ii) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the services were provided by an in-network provider that is not an Indian healthcare provider

- Make prompt payment to all in-network Indian healthcare providers
- To the extent Meridian utilization and/or reimbursement data is required to make any applicable supplemental payment to an Indian healthcare provider, Meridian will provide the requested data in the timeframe and manner required by the DHS
- Not reduce payments to Indian healthcare providers, or other providers of contract health services under referral by an Indian healthcare provider, for covered services provided to an Indian member by the amount of a co-payment or other cost-sharing that would be due from the Indian member if not otherwise prohibited under Section 5006(a) of ARRA

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.

Meridian Health Plan shall execute all elements in Section 7. Proposed strategies, including descriptions of relevant experience, are explained in further detail below.

Eligibility

Meridian Health Plan will partner with the State of Iowa to best meet the needs of the State's Medicaid population. We acknowledge and accept Iowa's authority in determining Medicaid eligibility, as well as, the State's related processes for Contract enrollment (as indicated in Section 7 in the Scope of Work). Meridian will work with the State to provide any pertinent information indicating that a member's eligibility may have changed.

MCO Selection and Assignment

Meridian Health Plan acknowledges the State of Iowa's Medicaid policy regarding voluntary and auto-assignment enrollment. Members have a choice to voluntarily select their Managed Care Organization (MCO) or be automatically assigned to an MCO based on the State's algorithm guidelines (as indicated in Section 7.2.3 in the Scope of Work). Meridian is involved with current managed care markets that allow members to enroll either through voluntary enrollment or through auto assignment. These markets submit specific elements in their enrollment files indicating whether a member enrolled with us voluntarily or through the auto-assignment process. We provide high quality healthcare services to all Meridian members, regardless of how they enrolled with us.

Current Members

Meridian recognizes the State of Iowa's Medicaid policy regarding auto-assignment enrollment. Meridian will work with the State and Enrollment Broker to accommodate those members who may choose an alternative contractor within the allocated ninety (90) day time frame.

Meridian has experience assisting members in better understanding their eligibility; Meridian uses the redetermination date provided on State enrollment files to target members for outreach sixty (60) days prior to redetermination. Our redetermination outreach campaign is run weekly, reminding members to submit the required paperwork necessary to maintain eligibility to the State. We populate the redetermination date within our proprietary Managed Care System (MCS) on the member demographics screens, so it is visible to all staff that comes in contact with the member. This effort helps to ensure continuity of care, removing any possibility of gaps in coverage or loss of Medicaid eligibility due to administrative reasons.

Meridian also has a program to assist non-compliant members in understanding the appropriate use for their benefits. These members are referred to the Compliance Program for targeted education and outreach. The Compliance Program works with members and their providers to establish healthcare goals, identify and eliminate barriers to care, and facilitate care coordination. At the end of this program, members transition from non-compliant, high-cost members into knowledgeable and active participants in their health care.

1915(c) HCBS Waiver Member and Institutional Populations:

Meridian Health Plan understands the State of Iowa has 1915(c) HCBS waiver and institutionalized members who may select a program contractor prior to the start date of operations. Members who have voluntarily selected Meridian prior to operations, or have been auto assigned to Meridian (and reside in an institution, nursing facility or ICF/ID, and individuals enrolled in a 1915(c) HCBS waiver) will be enrolled seamlessly into Meridian's system using enrollment files provided by the State of Iowa. Upon enrollment with Meridian, Care Coordination will provide plans and address common goals and services related to the care of each member under 1915(c) HCBS waiver or residing in an institution. Meridian will facilitate the care of members under 1915(c) HCBS waiver as well as institutionalized members who enroll in advance of the start date of operations. Meridian acknowledges that being able to enroll these members in advance of the start date of operations will allow for a successful and smooth transition into Meridian Health Plan with limited interruption to members' coordination of care. Should eligible individuals decide to transfer to another health plan within the ninety (90) day timeframe, Meridian will assist the State and the eligible individuals to provide a seamless transition.

New Members

Meridian will work with the State to accommodate newly eligible applicants that may select, or be auto assigned to Meridian's program. Meridian has experience in onboarding new members in a timely and efficient manner. Meridian will collaborate with the State to support the highest level of efficacy in enrolling new members into Meridian's program through integration and collaboration.

New Member Plan Selection Information:

Meridian Health Plan shall support the State of Iowa in developing informational materials for potential members in accordance with 42 CFR 438.10 (e) and 42 CFR 438.10(f). Meridian will provide the State with information regarding Meridian's service area, benefits covered, cost-sharing and network provider information. Meridian will comply with all State requests for information needed to develop informational materials for potential members.

Currently, Meridian's affiliates, including Medicaid managed care organizations, work with State enrollment agencies to integrate our system with State systems to support real-time sharing of information, such as service areas, cost-sharing, plan benefit information, provider network information, HEDIS® scores, and more.

Auto Assignment

Meridian will collaborate with the State to comply with the auto assignment provisions outlined in 42 CFR 438.50(f), including striving to preserve existing provider-beneficiary relationships, inclusive of Long-Term Services and Supports (LTSS) providers. Meridian is committed to assisting members in building long-term relationships with providers. Meridian has the capability within our database to retain member's historical selection of primary care provider and assignment. Meridian understands that we are subject to intermediate sanctions at 42 CFR 438.702(a)(4) regarding auto assignment of eligible individuals. Meridian will accommodate, Per 42 CFR 438.56(c), beneficiaries who are disenrolled solely because of loss of eligibility for a time period of two (2) months or less. Meridian will work with the State to re-enroll member who fall within this timeframe.

Enrollment Discrimination

In accordance with 42 CFR 438.6(d), Meridian will accept individuals eligible for enrollment in the order in which they apply without restriction. Meridian will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll. Additionally, Meridian will not discriminate against individuals eligible to enroll on the basis of race, color, or national origin and will not use any policy or practice that has the effect of discriminating in such manner.

7.4 Member Disenrollment

Meridian recognizes that in accordance with 42 CFR 438.56(c), members may disenroll from their managed care plan without cause during the first ninety (90) days of initial enrollment with the Meridian.

Member Disenrollment for Cause

Cause

Meridian will accommodate the disenrollment of members who choose to disenroll based on “cause” outlined within section 7.4.1.1 of the Scope of Work.

Process

To request disenrollment for cause, the member must first file an oral or written request to address the issue through Meridian’s grievance system. This initial request will provide Meridian with adequate opportunity to attempt to resolve the concern. Meridian will follow the timelines of an expedited grievance in this situation. If the member remains dissatisfied with the outcome, Meridian will assist the member in engaging the Enrollment Broker to request disenrollment. Meridian will provide a copy of the member’s grievance record to the Enrollment Broker to allow the Enrollment Broker to render a recommendation for the State review regarding approval or denial of the disenrollment request. The effective date of the disenrollment shall be no later than the first day of the second month following the month in which the member files the request. If the State fails to make a disenrollment determination within the timeframes specified, the disenrollment is considered approved.

Contractor Initiated Disenrollment

Meridian shall not disenroll a member or encourage a member to disenroll because of his or her health care needs or a change in health care status or because of the member’s utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Meridian’s ability to furnish services to either this particular member or other members). In instances where the exception is true, Meridian will provide evidence to the State that continued enrollment of a member seriously impairs Meridian’s ability to furnish services to either this particular member or other members. Meridian will have methods by which the State is assured that disenrollment is not requested for any other reason. State-initiated disenrollment may occur based on changes in circumstances including:

- Ineligibility for Medicaid;
- Shift to an eligibility category not covered by the Contract;
- Change of place of residence to another state;
- The State has determined that participation in the Health Insurance Premium Payment Program (HIPP) is more cost-effective than enrollment in the Contract; and
- Death.

Notification of Member Death or Incarceration

Meridian will notify the State, in the manner prescribed by the State, within thirty (30) calendar days of the date it becomes aware of the death or incarceration of one of its members. Meridian also acknowledges that we have no authority to pursue recovery against the estate of a deceased Medicaid member.

1. Describe your grievance process for addressing member quality of care concerns and member disenrollment after the first ninety (90) days of enrollment.

Grievances

Meridian Health Plan takes member grievances very seriously. Grievance information is contained in the Member Handbook. Member Service representatives and Grievance and Appeal Coordinators receive detailed and regular training on grievance, appeal and State fair hearings procedures so that they may answer any questions that a member or provider might have. Information is available to members who may visit Meridian's offices, and providers are informed of the member grievance and appeals process regularly in provider materials, during provider office visits and on Meridian's provider portal.

Members may file a grievance at any time, either in writing or by calling the toll-free number for the Meridian Member Services Department; translation and interpretation services are available upon request. Members may designate in writing another person, such as a relative or a physician, to file the grievance on their behalf. A member's estate representative of a deceased member may also file a grievance. Members may request assistance from a Grievance Coordinator or a Member Service Representative in filing the grievance. Members are never discriminated against because they filed a grievance or appeal.

All grievance records are maintained in the MCS Grievance Module (a software program contained within Meridian Health Plan's Managed Care System (MCS)). Access to this module is secured and restricted to only Meridian staff involved in the grievance process. The module stores records/notes relevant to the complaint's investigation, member and provider information, copies of letters sent to the member and other related material. MCS notifies the appropriate staff when complaints/grievances/appeals are received, when deadlines are approaching and when follow-up is required.

Grievances (Standard)

Meridian acknowledges grievances with written confirmation sent to the member and/or the member's representative within three (3) business days of receipt of the grievance. The acknowledgement is written at a sixth (6th) grade reading level and includes a description of all available levels of review, both internal and external.

Grievances are documented in the Meridian Grievance Module in MCS, including the substance of the grievance and the action taken. Once this is done, grievances are distributed to the appropriate contact person(s) within Meridian for review and determination of action to be taken.

The appropriate contact person(s) fully investigates the grievance, including any aspects of clinical care involved. Health professionals who have the appropriate clinical expertise review all grievances that involve a clinical issue.

Grievances are resolved within thirty (30) calendar days, with written notification of the disposition provided to the member and/or the member's representative. This notification is written at the sixth (6th) grade reading level.

The member or Meridian may request an extension, up to fourteen (14) calendar days from the member to render a resolution. If Meridian requests an extension, this extension is requested only when Meridian has not received necessary information from a health care facility or health professional required to make an informed resolution. Thus, this extension is beneficial to the member. Written notification is provided to member. Services are continued throughout the grievance/appeal processes.

Grievances (Expedited)

Meridian performs expedited grievance reviews when the member's complaint is determined to be clinically urgent. Clinically urgent complaints are those in which a failure to adjudicate or manage the issues involved within seventy-two (72) hours can potentially have a significant negative impact on the member's health or well-being. When this type of grievance is received, the Meridian Grievance Coordinator verbally informs the member that his/her grievance will be resolved within seventy-two (72) hours.

Meridian documents expedited grievances in the Meridian Grievance Module, including the substance of the grievance and the action taken. Meridian clinical staff investigates the substance of the grievance and all aspects of clinical care involved. The Meridian Grievance Coordinator provides verbal notification of the resolution to the member's expedited grievance within seventy-two (72) hours of receipt of the grievance. In addition, the Meridian Grievance Coordinator provides written notification to the member no later than forty-eight (48) hours after a decision has been made.

Quality Monitoring of Grievances

Grievances are evaluated at this meeting and regularly by the Quality Department to determine if changes are needed to Meridian policies and procedures, or if there are access or utilization issues that must be addressed.

A grievance report is submitted to the Meridian Quality Improvement Committee on a quarterly basis for review, to identify any systematic opportunities for improvement and to ensure that appropriate actions are being taken. This report is also reviewed at the monthly meeting of Meridian's Board of Directors, and provided to the Department.

SECTION 8 – MEMBER SERVICES

Please explain how you propose to execute Section 8 in its entirety, including, but not limited to, the specific elements highlighted below, and describe all relevant experience.

8.1 Marketing

1. Describe in detail your marketing and outreach plans.

Meridian Health Plan believes that Medicaid dollars should be utilized to enhance the quality of member health care. Therefore, Meridian prefers community-oriented marketing focused on providing health and wellness education to the general community and potential members. Community-oriented marketing includes hosting and/or participating in health and wellness fairs, providing information on healthy living to all members of the community who attend these events, and sponsoring activities and organizations that promote the well-being of Iowa communities.

Partnership with Iowa organizations is essential to sustaining and engaging in a comprehensive health network. Meridian has existing relationships with Federally-qualified health centers (FQHCs), the Iowa Department of Public Health (IDPH) Title V, Title X, maternal and child health clinics, and the Maternal, Infant, and Early Childhood Home Visitation program. Local public health agencies are frequently responsible for onboarding and enrolling Medicaid-eligible Iowa residents during the presumptive eligibility period. Meridian recognizes the value of a partnership with IDPH in ensuring members receive adequate, timely information about the health plan at the time of enrollment. Meridian sends IDPH coverage maps monthly and assists with questions and concerns from members and provides routed from IDPH to Meridian. By working at the State level, Meridian has assuredly reached the greatest number of local public health agencies. Meridian also partners well with FQHCs, whether by consistently engaging with networks or individual centers, such as Eastern Iowa Health Center (EICH). The relationship between EICH is mutually beneficial as Meridian held a focus group at the center, assists with targeted outreach of members including assessing barriers to care, and now remotely accesses member records to improve timeliness and completeness of quality measure reporting. Meridian will expand efforts to new partners in less populated areas of the State such as rural health clinics, the Iowa Counties Public Health Association, and the Iowa Public Health Association.

Meridian has discussed member enrollment, outreach, and care coordination with multiple entities seeking to eliminate duplication of efforts and determine what works best for members. IDPH and several FQHCs have strong onboarding and enrollment processes, but appreciate having appropriate contact, benefits, and incentive information to assist in educating members.

Meridian Community-Based Case Managers and Long Term Care Support Specialists (LTSSs) offer in-person support and education to members regarding preventive services and to conduct health assessments. Community-Based Case Managers and LTSSs act as community-based liaisons between Meridian and our members.

Meridian is committed to actively participating in and supporting the communities we serve. We see this as our fiduciary responsibility, not only as a state partner but as an organization dedicated to improving the quality of care for our members. In Iowa, Meridian has sponsored the Governor's Conference on Public Health, the Iowa School Nurses Organization, and Iowa Immunization Coalition; and made donations to the Young Women's Resource Center, the

American Heart Association annual heart walk, and the Count the Kicks public awareness campaign. The Vice President of Quality and Performance Improvement for Meridian serves as the primary investigator, and Meridian as a corporate sponsor, of the Cribs for Kids project that provides cribs to families in need in four Iowa counties.

Meridian Provider Services Representatives, Outreach Specialists, and other offsite team members (such as Community-Based Case Managers) actively participate with our provider and community organizations partners to identify sponsorship opportunities. These Meridian team members also outreach to members in their local communities by attending or organizing community events, such as health fairs, health screening events, community baby showers, and similar programs. At other events, we coordinate with our provider partners to provide health care services such as well-child exams, lead screenings, and immunizations. By reaching out to members in their communities, including family resource centers, school-based health centers, youth service centers and other community organizations, we can offer needed health education and screening services (such as lead screenings or immunizations) in a familiar setting. We partner with local organizations to reinforce and support existing community health care services, and identify opportunities for strengthening health care resources.

All health information, communications, and marketing materials potentially provided to members by Meridian for these events, and for all Meridian members or potential members, are provided in a manner and format that is easily understood and will meet the requirements indicated in Section 8.2 of the Scope of Work. In addition to health information, Meridian may distribute gifts of nominal value during public events. Promotional items provided at these events have a practical, health-focused approach. Instead of the usual novelty giveaways, we offer toddler drinking cups, adhesive bandages in portable packages, tote bags, dosing spoons, diapers, baby wipes, hats, gloves, and other useful items. These items are in compliance with all Law and policy guidance regarding inducements in the Medicaid program, including marketing provisions provided for in 42 CFR 438.104.

Innovation and Local Partnerships

In 2014, Meridian initiated a project with the Iowa Department of Public Health (IDPH) intended to prevent sleep-related mortality in infants. Meridian provided an analysis of infant mortality data examining racial disparity in sleep-related deaths and identified four counties in Iowa with high disparity or increased incidence of minority deliveries.

Meridian and IDPH were able to secure more than \$80,000 for the purchase of cribs, or more than 2,000 cribs. These cribs are being distributed at five Iowa birthing hospitals at time of delivery to women in need. In order to measure impact, The Maternal, Infant, and Early Childhood Home Visitation (MIECHV) program agreed to add safe sleep assessment questions to their survey. MIECHV is assessing the presence of safe sleep environments within intervention counties and in comparison counties. The result of this effort is a characterization of the prevalence of safe sleep environments, which will hopefully be higher in the intervention counties compared to non-intervention counties.

Meridian has a vested interest in improving and promoting maternal and child health. Programs such as Cribs for Kids encourages mother to secure safe sleep spaces for children and also interaction with maternal home visitors. Peripheral benefits of the program may include more timely access of maternity care at intervention hospitals, better education and engagement with home visitation services, and increased feelings of support within intervention counties between members, Meridian, and home visitation services.

8.2 Member Communications

1. Describe your overall strategy for communicating with members.

Meridian Health Plan recognizes motivation for health management stems from encouraging, thorough, and accessible information supplied in multiple formats and approaches. Meridian prioritizes providing exceptional member communication through outreach as well as through operational efforts. Meridian employs a multi-pronged approach to member communication as reiteration of health communications results in better uptake and understanding. All Meridian staff is trained on member interaction and the importance of quality healthcare. Every engagement with a member is an opportunity to educate, empower, and inform. This multi-pronged approach has proven successful within the Iowa plan, as well as other states. The following are examples of member communication strategies currently in place:

- Mailings (monthly, seasonal, condition-specific, or as needed based on member contact; samples can be found in Appendix E, Member Communication and Outreach)
- Telephonic outreach (Presence automated dialing system)
 - New member welcome calls
 - Reminder calls to members identified as needing to complete a HEDIS® measure-related preventive care service
- Live Chat (online access to converse with a Member Services Representative)
- Member web portal (secure access for members to update demographic information, complete a Health Risk Assessment, request Member Handbooks, order ID cards, change PCPs, track claims, and enroll into wellness programs, etc.)
- Attendance at community events, conferences, and activities

Passive forms of communication include mailings, such as those for members with complex needs. These members receive educational information via mail on chronic disease management, preventive care, and various medical topics to provide a better understanding of medical coverage, as well as the need for ongoing care.

A critical approach for communicating with members requires Meridian presence in the community. Meridian has achieved optimum success with member engagement using community-based stakeholders. An investment in the community demonstrates Meridian's intent to go beyond the delivery of health services. Meridian has existing relationships with the Iowa Department of Public Health (IDPH), Iowa Department of Human Services (DHS), and many other entities. In working with IDPH, Meridian ensures health plan information is adequately and accurately provided to members at the time of enrollment. Local public health agencies, with support by IDPH, make essential connections with Medicaid-eligible persons. When questions around enrollment, benefits, provider or network access, and more arise, IDPH is able to refer members to the appropriate contact within Meridian. Meridian has assisted Title V clinics with payment questions, understanding provider incentives and in resolving other issues. With help from Provider Services Representatives, Community-Based Case Managers, and other field staff, Meridian is intentional at supplying providers with preventive and routine health educational materials, suggestions for provider improvement of member health, and general understanding of member benefits.

Meridian is committed to actively participating in and supporting the communities we serve. We see this as our fiduciary responsibility, not only as a state partner but as an organization dedicated to improving the quality of care for our members. In Iowa, Meridian has sponsored the Governor's Conference on Public Health, the Iowa School Nurses Organization, and Iowa Immunization Coalition; and made donations to the Young Women's Resource Center, the American Heart Association annual heart walk, and the Count the Kicks public awareness campaign. Meridian became a partner in the Cribs for Kids project by serving as a lead organization in the provision of cribs at hospitals in four Iowa counties. In other states of operation, Meridian has award-winning grant-funded projects such as Strong Start for Mothers and Babies. Strong Start is an intensive, community-based alliance between the county health agency, local obstetrics providers, and Meridian staff. Member communications are supplied in the clinic setting and emphasized during in-home visits, conducted by home visitation staff or a Meridian Community-Based Case Manager. This program resulted in declines in pre-term and low-birth-weight babies after only two years.

Provider Services Representatives make monthly visits to all provider offices to ensure providers are aware of what preventive and routine health services a member may need. This enables the provider to discuss needs directly with the member and is an approach trusted more than nearly any other means. Community-Based Case Managers strive to identify members with urgent health needs, particularly those Meridian has been unable to reach. Community-Based Case Managers iterate provider messages for establishing primary care, getting preventive and routine health care, and staying on top of chronic conditions. Meridian Community-Based Case Managers frequently express the value in in-person interactions with members and how their efforts make a critical connection with members otherwise unable to be reached.

All health information, communications, and marketing materials potentially provided to members by Meridian for these events, and for all Meridian members or potential members, are provided in a manner and format that is easily understood and will meet the requirements indicated in Section 8.2 of the Scope of Work. In addition to health information, Meridian may

distribute gifts of nominal value during public events. Promotional items provided at these events have a practical, health-focused approach. Instead of the usual novelty giveaways, we offer toddler drinking cups, adhesive bandages in portable packages, tote bags, dosing spoons, diapers, baby wipes, hats, gloves, and other useful items. These items are in compliance with all Law and policy guidance regarding inducements in the Medicaid program, including marketing provisions provided for in 42 CFR 438.104.

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.

Meridian Health Plan is committed to serving all members, communicating in the language of their choice and building literacy bridges with members without a delay in services, benefits, or treatment. Meridian's proprietary software, Managed Care System (MCS) tracks member language preference for future calls and communications, ensuring that our employees are able to collaborate with our members according to their individualized needs. MCS captures the member's primary language preference and triggers all materials sent to the member are sent in that primary language, if that non-English language is greater than five percent (5%) of our threshold, as required by the State.

This feature also allows Member Services to more efficiently search for PCPs and other providers who speak the same language.

Meridian offers these services to accommodate non-English speaking members:

- A Member Services Help Line offering telephone-accessible services in over 170 languages
- In-house staff with fluency in the language of large non-English speaking member groups
- A training program that builds cultural awareness and language fluency for our employees
- A commitment to staffing diversity, especially those in daily member contact, reflecting the composition of membership
- Website content in English, Spanish, and any other languages as determined by the State

During the Welcome Call, members are informed of their ability to receive information in their preferred language if that non-English language is greater than five percent (5%) of our threshold, as required by the State. The Member Handbook and website will include this information as well.

Meridian will ensure all written materials shall be provided in English and Spanish, and any additional prevalent languages identified by the Agency in the future at no additional cost to the Agency. Meridian currently reviews the general population in our service area to identify if additional languages that are prevalent among our membership. Meridian will also ensure that essential communication materials, such as the Member Handbook, include footnotes in prevalent languages directing members to the version of the item in the member's preferred language.

3. Describe your plans to provide all written materials in alternative formats and how you will identify members needing alternative formats.

Meridian Health Plan is committed to providing the same outstanding service to every member, including those needing extra assistance. Upon enrollment, Meridian's Managed Care System (MCS) tracks any primary language or communications format information received in the enrollment file. If no such information is received, our Member Services staff is trained to ask for this information during our Welcome Call. Member preferences are documented in MCS. Subsequently, essential member communication will be provided in the preferred language or other alternative formats as indicated by the member.

If Welcome Calls are repeatedly unsuccessful, members are mailed a contact form. If returned, member contact information is updated in MCS. If no response is received from the contact form mailing, members are referred to a Community-Based Case Manager for in-person follow-up. Community-Based Case Managers are often successful at locating members and, when doing so, connect members to community resources, assist with scheduling appointments, and remind member of the need for preventive and routine health services.

Additional consideration for alternative communication formats include:

- A toll-free Teletypewriter (TTY) and Telecommunications Device for the Deaf (TTD) services for members with hearing or speech impairment, as well as online Live Chat service which allows members and providers to instant message with Meridian employees
- Production of materials in alternative formats (large print, Braille, audio) to assist member understanding
- Individual assistance and personalized programs for members with cognitive impairments
- A training program for Member Services staff to evaluate special accommodations on a case-by-case basis, with consideration for the level at which the member is able to verbalize information, the length of time the member is able to speak, and how much of the member's speech can be comprehended by others

The above needs are also tracked in MCS to ensure appropriate support is given to our members.

4. Describe your policies and procedures for ensuring materials are accurate in content and translation.

Meridian Health Plan has a strong relationship with PALS International, a translation service that offers interpretation for over 170 different languages by professional translators. PALS provides high quality translation services to organizations that need to communicate to a diverse community and global companies that need to conduct business in a variety of countries and languages.

The PALS policy and procedure for ensuring materials are accurate in content and translation is outlined below. The typical translation process follows the industry standard flow which is adjusted during the assessment phase of project initiation based on client requirements. The typical steps are:

- **Step 1: Project Review**
The PALS Project Manager (PM) completes a review of the overall scope of the project: timeline, inventory of files, glossaries (if applicable), and final file delivery. Working with Meridian, the PALS PM identifies all text that should remain in the source language and develops a list for the translator's and editor's use. It is at this point in the project life cycle that the PALS PM also identifies possible issues in the source document (or any other area requiring client clarification) and reviews these concerns with Meridian.
- **Step 2: Template Building/Translation Preparation**
During the project review, PALS will determine whether a template needs to be built for the translation phase. There are several reasons this might be necessary. For example, Meridian's source file might need to be cleaned up or recreated if it is in a non-editable format. By creating a template, PALS is able to easily process formatted documents through TRADOS, a translation memory software program.
- **Step 3: Glossary Development**
For large-scale projects and over time, PALS has developed a standard glossary that all translators can reference when working with Meridian materials. This way, Meridian has an established list of approved terms to ensure the consistency in subsequent projects. The glossary is the key to ensuring the highest levels of quality and consistency and is an ongoing process that PALS continually update as the volume and unique nature of the work PALS performs evolves over time.
- **Step 4: Translation**
At this stage, the PALS PM places the translation with an appropriately qualified and experienced target language translator, based on the content and translator's subject matter expertise. Only translators who are native speakers of the target language are utilized. The translator will translate the materials and return it to the PALS PM for review.
- **Step 5: Editing**
All initial translations are reviewed by a second, and equally qualified, professional translator/editor to ensure the quality of the translation. This ensure that more than one set of qualified eyes review every translation, specifically targeting grammar, typography, word choice, etc.
- **Step 6: Translator Final Review**
Once the editor has reviewed the initial translation, he/she incorporates the comments and submits them to the original translator.
- **Step 8: Formatting (optional)**
The PALS desktop publishing team will precisely format each translation to match the original material, while also being sensitive to the audience's cultural nuances. Normally, PALS will format translations with the same application that was used to lay out the source document. However, in some cases PALS may choose to use an application that is better suited to a target language's fonts and other requirements. The PALS PM will work with Meridian to ensure all our deliverables meet requirements.

- **Step 9: Quality Control/Proofreading**
After formatting is completed, PALS will produce a mechanical proof to determine that:
 - The layout matches the source language document
 - The correct fonts have been used
 - The headers and footers are consistent with the source language document
 - Proper names are spelled correctly
 - The pagination matches the source document and the text flows correctly
 - Margins, graphics and positioning are correct

- **Step 10: Final Translator Review**
A PALS in-house translators or the original translator will conduct a final review of the project to ensure that the text has been formatted correctly. He/she will verify that words have been hyphenated properly and nothing has been omitted from the text during the formatting stage. The reviewer will proof a hard copy printout and/or perform an on-screen review, depending on the need of each particular project.

- **Step 11: Final Check/Delivery**
The PALS PM will gather all the final deliverables, verifying that they meet original specifications. He/she will make sure the layout, page numbers, proper names and other details match the source document one last time and deliver the final project to Meridian.

5. Provide sample member enrollment materials as described in Section 8.2.6.

New member communications, as described in Section 8.2.6 of the Scope of Work, will be distributed to each member within five (5) business days of receipt of the member enrollment information via the eligibility files provided by the State. All information in the enrollment materials shall meet the requirements set forth in Section 8.2 and shall be submitted for the State review and approval prior to distribution in accordance with the process established in Section 8.2.4 of the Scope of Work.

Sample member enrollment materials, are attached and include:

| Sample Member Enrollment Materials Attached | | |
|--|---|--|
| Scope of Work Reference | Information Included | Attachment Name Filename |
| 8.2.6.1 | Information on how to find a network provider near the member’s residence on-line and via the Member Helpline | <ul style="list-style-type: none"> • Attachment 22 (Meridian Health Plan Iowa Member Handbook) <p>The Meridian Provider Directory is available online at www.mhplan.com/ia and includes all information detailed in 42 CFR 438.10(e). This directory is searchable and updated in real-time.</p> |

| Sample Member Enrollment Materials Attached | | |
|--|---|--|
| Scope of Work Reference | Information Included | Attachment Name Filename |
| 8.2.6.2 | Contractor's contact information, including address, telephone number, web site | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) Attachment 23 (Sample ID Card Letter) |
| 8.2.6.3 | The amount, duration and scope of services available under the Contract in sufficient detail to ensure that members are informed of the services to which they are entitled, including service authorization requirements | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |
| 8.2.6.4 | Contractor's office hours/days, including the availability of the Member Helpline and the 24-hour Nurse Call Line; | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |
| 8.2.6.5 | The procedures for obtaining benefits, including authorization requirements | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |
| 8.2.6.6 | Description of any restrictions on the member's freedom of choice among network providers, as well as the extent to which members may obtain benefits, including family planning services, from out of network providers; | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |
| 8.2.6.7 | Description of how to complete a health risk screening, a process described in Section 9.1.1; | <ul style="list-style-type: none"> Attachment 24 (Welcome Newsletter Excerpt) |
| 8.2.6.8 | As required at 42 CFR 438.10(g)(1), the following information on the grievance and appeal process including: | |
| 8.2.6.8.1 | The right to file grievances and appeals, including (i) requirements and timeframes for filing a grievance or appeal; (ii) the availability of assistance in the filing process; (iii) the toll-free numbers that the member can use to file a grievance or appeal by phone; (iv) the fact that, if requested by the member and under certain circumstances, benefits will continue if the member files an appeal or requests a State fair hearing within the specified timeframe; however, the member may be required to pay | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |

| Sample Member Enrollment Materials Attached | | |
|--|--|---|
| Scope of Work Reference | Information Included | Attachment Name Filename |
| | the cost of such services furnished during the appeal if the final decision is adverse to the member | |
| 8.2.6.8.2 | The right to a State hearing, including the method for obtaining a hearing and the rules that govern representation at the hearing; | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |
| 8.2.6.9 | The extent to which, and how, after-hours and emergency coverage are provided, as well as other information required under 42 CFR 438.10(f)(6)(viii) related to emergency services; | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |
| 8.2.6.10 | As set forth in 42 CFR 422.113(c), the post stabilization care services; | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |
| 8.2.6.11 | If applicable, any cost-sharing information, including patient liability responsibilities for 1915(c) HCBS waiver members, 1915(i) program members, ICF/ID, and nursing facility residents, and contact information where the member can ask questions regarding their cost-sharing obligations and consequences for failure to comply with cost sharing and patient liability requirements; | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |
| 8.2.6.12 | Information about the availability of non-emergency transportation and how to access; | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |
| 8.2.6.13 | Member protections, rights and responsibilities, as further enumerated in 42 CFR 438.100 and Section 8.10; | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |
| 8.2.6.14 | Procedures for obtaining out-of-network services and any special benefit provisions (for example, co-payments, limits or rejections of claims) that may apply to services obtained outside the Contractor's network; | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |

| Sample Member Enrollment Materials Attached | | |
|--|--|---|
| Scope of Work Reference | Information Included | Attachment Name Filename |
| 8.2.6.15 | Standards and expectations for receiving preventive health services; | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |
| 8.2.6.17 | Procedures for making complaints and recommending changes in policies and services; | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |
| 8.2.6.18 | Information about advance directives as further described in Section 8.9; | <ul style="list-style-type: none"> Attachment 22 (Meridian Health Plan Iowa Member Handbook) |
| 8.2.6.19 | Information on how to contact the Enrollment Broker; | <ul style="list-style-type: none"> Attachment 25 (LTSS Member Handbook Excerpts) |
| 8.2.6.20 | Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking members and how members can access those methods or formats at no expense; | <ul style="list-style-type: none"> Attachment 25 (LTSS Member Handbook Excerpts) |
| 8.2.6.21 | Information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect; | <ul style="list-style-type: none"> Attachment 25 (LTSS Member Handbook Excerpts) |
| 8.2.6.23 | For members enrolled in a 1915(c) HCBS Waiver or 1915(i) State Plan, the Contractor shall also provide the following information: | |
| 8.2.6.23.3 | When applicable, information on the option to self-direct, a process described in Section 4.45.8, including, but not limited to: (i) the roles and responsibilities of the member; (ii) the ability of the member to select a representative; (iii) the services that can and cannot be self-directed; (iv) the member's right to participate and voluntarily withdraw; (v) how to select the self-direction option; and (vi) who can and cannot be hired by the member to perform the services; and information on estate recovery. | <ul style="list-style-type: none"> Attachment 26 (Self-Directed Care Flyer) |

6. Describe your processes for identifying significant changes as described in Section 8.2.8 and notifying members of such changes.

Meridian Health Plan has processes for handling changes impacting members. All significant changes affecting members are communicated to the appointed Meridian liaison for the State (typically the Director of Operations) prior to any member notification. The change notification is communicated to applicable departments for operational adjustments and initiating member notification.

Change information is drafted into a written notification then reviewed by the Communications Department. Once approved, the written notification is sent to all members for whom the significant change effects. Significant changes may include, but are not limited to:

- 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, members 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

Meridian shall give members written notice of any action, not just service authorization actions, within the timeframes for each type of action as described in State and Federal rules, regulations, and policies. Information specific to authorization actions is found in 11.2.7.

8.3 Member Services Helpline

1. Describe your plans for the member services helpline, including the days and hours of operation.

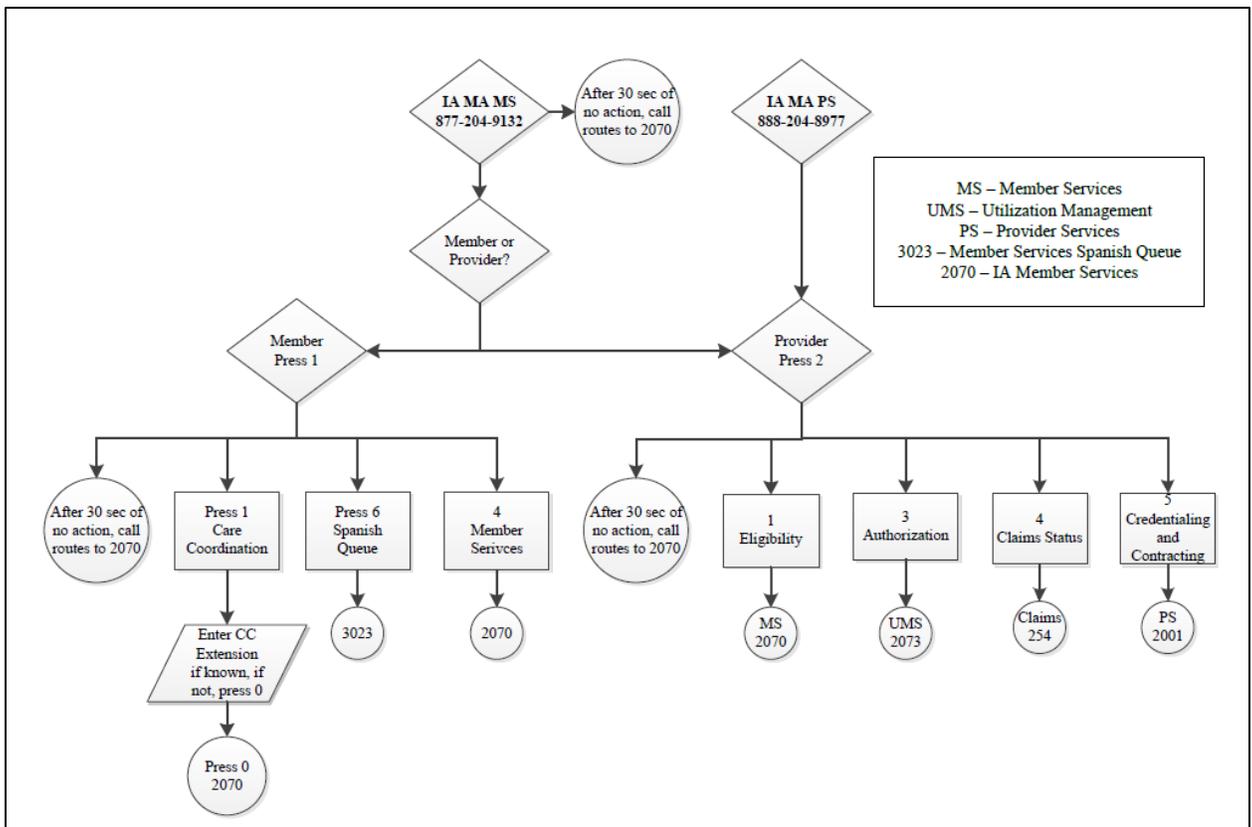
Members and providers have access to Member Services Representatives through a toll-free phone number, twenty-four (24) hours a day, seven (7) days a week. All calls enter Meridian's Interactive Voice Response (IVR) phone tree, where the call routed to the correct department. Calls are then answered by a live employee who is trained to offer assistance and route calls as appropriate. Meridian's goal is to have all calls answered by a live person within thirty (30) seconds of the caller selecting the option to speak with a representative. When a call is routed to the Member Services Department our Member Services Representatives are trained to handle every call using our Single Call Resolution promise. Combining this personal touch with our proprietary technology, Member Services Representatives can provide members with proactive alerts for healthcare needs and preventive services, delivering an unparalleled level of service. The Meridian call center is open Monday through Friday from 7:00 a.m. to 8:00 p.m., Central Standard Time. After 8:00 p.m., calls are routed to an after-hours vendor who is contracted with Meridian to service calls. The call center is open these days and times, with the exception of State holidays, as determined by the State (i.e. (i) New Year's Day; (ii) Martin Luther King, Jr.'s

Birthday; (iii) Memorial Day; (iv) July Fourth; (v) Labor Day; (vi) Veterans Day; (vii) Thanksgiving; (viii) Day after Thanksgiving; and (ix) Christmas Day. In cases where members or providers choose to leave a secure voicemail for Meridian after hours, the voicemail will be returned with a follow up phone call to the member within one business day.

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.

Meridian Health Plan has optimized automation for the benefit of our members. Currently, callers enter our Interactive Voice Response (IVR) system, where they are able to select the department they would like to speak with. The IVR system streamlines the call by ensuring that members are routed to the correct department as quickly as possible. Queues are monitored by a Queue Monitor in order to ensure appropriate queue coverage, service level, and Telephone Service Factor (TSF). Daily, weekly, and monthly reports are run to ensure queue coverage and to identify trends in call volume, TSF, Answer Service Factor (ASF), service level, and call inquiries. Reports can be run out of our Managed Care System (MCS) to identify call inquiries via contact codes. Contact codes are placed into member profiles in order to categorize the reason for their call. This information is used in order to identify opportunities for quality improvement.

A diagram representing Meridian’s IVR system is shown below.



3. Describe your plans to provide services for the hearing impaired and non-English speaking population.

Meridian Health Plan is committed to serving all members, communicating in the language of their choice and building literacy bridges with members without a delay in services, benefits, or treatment. Our proprietary system, MCS, tracks member language and communication format preference for future calls and communications, ensuring that our employees are able to collaborate with our members according to their individualized needs. Capturing this communication preference in MCS also ensures that mailings sent to the member are in the member's preferred language and/or format. This feature also allows Member Services to more efficiently search for PCPs and other providers who speak the same language.

Meridian offers these services to support hearing impaired and non-English speaking members:

- A Member Services Help Line offering telephone-accessible services in over 170 languages
- A toll-free TTY line for hearing impaired members
- In-house Spanish-speaking Member Service Representatives (presently five percent (5%) of our Member Services Representatives)
- IVR options are available in Spanish
- A training program that builds cultural competency for our employees, completed for new hires and on an annual basis for all staff members.
- A commitment to staffing diversity, especially those in daily member contact, reflecting the composition of membership
- Website content in English (and Spanish in 2016), as well as any other languages as determined appropriate by the State

4. Describe your training program curriculum and training process for call center staff.

Meridian Health Plan provides a comprehensive training program for all Member Services staff to ensure high quality customer service to all members and providers. Upon hire and annually, our Member Services staff receives in-depth training, including plan policies and procedures; plan benefits, including description of all covered services; behavioral health services; Long-Term Services and Supports (LTSS); identification of members with complex care needs and appropriate referral processes; cultural competency; and assisting members with Limited English Proficiency (LEP).

This initial training is complimented with routine staff meetings and corporate trainings throughout the year to ensure Member Services representatives maintain professional competency. Trained in the Meridian Customer Care Factor, our employees are able to assist both members and providers with questions relating to all areas of the Medicaid system. They are prepared assist members and providers with questions or concerns, including, but not limited to:

- How to access health care services
- Identification or explanation of covered services
- Procedures for submitting a grievance or appeal
- Reporting fraud or abuse
- Locating a provider

- Health crises, including, but not limited to, suicidal callers
- Balance billing issues
- Cost-sharing and patient liability inquiries
- Incentive programs

Our representatives also practice single call resolution, making every effort to resolve issues with the initial phone call. In cases where follow up is needed, it is initiated by the representative rather than the member or provider.

Employee quality evaluations are performed on a weekly basis to ensure adherence to customer service and quality standards. A total of five (5) quality evaluations are conducted per Member Services Representative per week. Each quality evaluation is discussed with the Member Services Representative who processed the call, to acknowledge strengths and accomplishments, discover opportunities for improvement, and establish goals to improve member satisfaction. Member Services Representatives who do not meet these quality guidelines receive coaching and additional training from the Member Services Team Lead and/or Manager.

5. Describe your call center monitoring process to ensure helpline performance metrics are achieved.

The Meridian Health Plan call center follows industry best practices to offer an unparalleled level of service. Meridian’s call center successfully answers more than 128,000 phone calls every month. Our internal goal is to answer ninety percent (90%) of calls with a live representative within thirty (30) seconds of the call entering the Member Services phone queue. Meridian has a full time Queue Monitor, who supervises the queues and is capable of monitoring all calls coming into the call center. The Queue Monitor runs daily reports on call center performance metrics, identifies areas for improvements, implements interventions, and conducts re-measurements. Some of the metrics measured by the Queue Monitor are Average Hold Time (AHT), Telephone Services Factor (TSF; call answered within thirty (30) seconds), Answer Services Factor (ASF; abandoned calls), and Average Call Duration (ACD). Additionally, Meridian will continuously monitor service levels based on the following equation created by the State: $SL = \left(\frac{T - (A+B)}{T} \right) * 100$ where T= all calls that enter queue, A=calls that are answered after thirty (30) seconds, B=calls that are abandoned after thirty (30) seconds. Call center metrics are reported at the Meridian weekly Operations meetings and also quarterly to the Quality Improvement Committee (QIC). During these meetings, opportunities for improvement are presented or identified and interventions are discussed. Metrics will also be reported to the State via the health plan’s appointed State Liaison.

Meridian’s current Iowa Member Services line performance metrics for the 2013-2014 calendar year are presented below.

| Calls | Average Call Duration (MM:SS) | Telephone Service Factor | Answer Service Factor | Average Hold Time (MM:SS) |
|---------|-------------------------------|--------------------------|-----------------------|---------------------------|
| 117,541 | 3:30 | 93.57% | 100% | 0:28 |

These performance metrics are defined as follows:

- **Telephone Service Factor** – Calls answered within thirty (30) seconds of entering the Member Service Phone Queue
- **Answer Service Factor** – Rate of calls answered of those offered to the queue
- **Average Hold Time** – Hold Time Experience once call enters the queue
- **Average Call Duration (MM:SS)** – Minutes:Seconds for which the call is active

Meridian shall not have separate numbers for members to call regarding behavioral health and/or long-term care services.

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.

In case of power failure or outage, calls can be routed to the Meridian Health Plan after-hours vendor in order to avoid any interruption in service. Network infrastructure has been designed to eliminate single sources of failure. This includes redundant carrier access, firewalls, and WAN Connections for critical services. Telecommunications services are built to accommodate multiple carriers with number portability. Alternate Enhanced Redirect Solution (AERS) from AT&T is used to re-route calls to a disaster recovery site in the event of an emergency. In the event of power failure or outage, any interruption in service will be reported to Meridian's Director of Operations, who will then report the outage to the State.

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).

To facilitate the delivery of integrated healthcare services, the Member Services helpline can be utilized by all members, regardless of whether the member is calling about physical health, behavioral health, and/or long-term care services. There are many different areas that members can be warm transferred to in order to better assist the member. Those areas include, but are not limited to:

- Behavioral Health Care Coordination
- Smoking Cessation
- Weight Management
- Medical Care Coordination
- Long-Term Care Services and Supports
- Pharmacy

8. Describe proposed entities to which you will be capable of warm transferring member calls.

Meridian Health Plan's policy is to always use "warm transfers" to forward a phone call. Instead of blindly transferring a call, then hanging up with no concern for the proper resolution, our warm transfer process includes:

- Transferring the phone call and staying on the line until someone answers on the other end
- Announcing the caller's name, ID number, and reason for calling

Entities to which we warm transfer include, but are not limited to:

- Provider Offices
- MeridianRx
- Transportation Vendor
- State Agencies
- Dental Care Vendors
- Beacon Health Options

Additionally, Meridian is able to add the member to a conference call between the member, Meridian, and Meridian's interpretation vendor in order to assist non-English speaking members.

8.4 Nurse Call Line

1. Describe how the Nurse Call Line will be publicized to members.

Meridian Health Plan will publicize its Nurse Call Line or Medical Advice Line, in the Member Handbook, member web portal, during the member's Welcome Call from the plan, and in general member conversations about plan benefits. Additionally, information about the Nurse Call Line or Medical Advice Line can be discussed with Member Services Representatives. The line is available twenty-four (24) hours a day, seven (7) days a week. When a member requires medical advice, they may contact Meridian's Member Services phone number and request to speak with a medical professional for medical advice. At that time, the Member Services Representative warm transfers the member to the on-call Medical Director. The Medical Director then provides medical advice and information regarding the call is documented in the member's file. As a result of immediate, warm transfers, medical decisions may be made by a physician within thirty (30) minutes. Follow up with the member's primary care provider (PCP) can be completed by the Medical Director, if necessary.

2. Describe the credentials Nurse Call Line staff must possess.

Nurse Call Line staff must possess the following credentials:

- Current license (without restriction) to practice in the state of operation
- Medical Doctor or Doctor of Osteopathic Medicine

3. Describe processes and protocols for when a physician must be consulted.

Meridian Health Plan utilizes licensed Medical Directors to answer questions received from members through the Medical Advice Line. Thus, all Medical Advice Line calls are automatically transferred and processed by a physician.

8.5 Electronic Communications

1. Describe how technology will be leveraged to communicate with members.

Meridian Health Plan is committed to providing members with information and outreach in multiple mediums, ensuring that members have access to information they need wherever and whenever they may need it. Supporting this commitment is heavily reliant on leveraging electronic communications as more and more Americans, particularly Medicaid beneficiaries, are utilizing digital communication to obtain information.

Meridian utilizes the following forms of electronic communication to support our members.

Phone System

Meridian has optimized automation for the benefit of our members. Currently, callers enter our Interactive Voice Response (IVR) system, where they are able to select the department they would like to speak with. The IVR system streamlines the call by ensuring that members are routed to the correct department as quickly as possible. Queues are monitored by a Queue Monitor in order to ensure appropriate queue coverage, service level, and Telephone Service Factor (TSF). Daily, weekly, and monthly reports are run to ensure queue coverage and to identify trends in call volume, TSF, Answer Service Factor (ASF), service level, and call inquiries. Reports can be run out of our Managed Care System (MCS) to identify call inquiries via contact codes. Contact codes are placed into member profiles in order to categorize the reason for their call. This information is used in order to identify opportunities for quality improvement.

Another component of our comprehensive phone system is our preventive care reminder campaign program. Meridian utilizes outreach software to begin contacting new members prior to their effective date with Meridian in order to welcome them to the health plan and provide benefit information. Meridian has a large number of outreach campaigns, which include, but are not limited to:

- Welcome Calls and Health Risk Assessments (HRAs)
- Preventive Services Due (HEDIS®)
- Eligibility Redetermination
- Prenatal/Postpartum Follow Up

An Iowa-specific example involves our seasonal influenza prevention campaign. This campaign began in early fall 2014 and consisted of numerous forms of member and provider communication around influenza vaccination, practices to avoid getting the flu, and early detection of illness. A phone campaign was designed and implemented to provide member reminders for getting vaccinated. As this was the first year for this program, vaccination and utilization data were captured and will be tracked again as the program will be repeated in 2015.

Meridian Website

Meridian's website is a comprehensive source of information for all members, featuring Meridian contact information, dynamically updated and searchable Provider Directories (providers can be searched by a variety of factors including proximity to a member's home address), electronic versions of the Member Handbook, Meridian health education, links to trusted preventive health websites, and information about preventive care services and disease management programs.

Members are able to link to the MeridianRx website, which features the ability to search for local in-network pharmacies and identify which drugs are available in their formulary. Website content is available in English and all communication materials are available in Spanish. If another language is needed, members can contact Member Services, and with use of Meridian's translation services, request the needed materials in the needed language. Content is culturally appropriate and written at or below a sixth-grade reading level.

Meridian Website (Mobile Version)

Smartphones, tablet computers, and their associated applications (apps) are changing how members obtain and interact with healthcare related information. Meridian's responsive design allows access to all information available on the desktop website and goes one step further by tailoring the user experience to the device by which they are accessing it. Following best practices for user interface, our website will ensure that information is easily accessible. Since many Medicaid beneficiaries access the internet via their mobile devices, Meridian has spent considerable time designing the mobile phone interface of our public-facing website to appear app-like. This allows users to access Meridian information without having to download an app and reduce any concerns over memory on their phone.

MeridianRx Mobile Application

Meridian members with pharmacy benefits through Meridian's pharmacy benefit manager, MeridianRx, also have access to the MeridianRx Mobile App. The app allows members to:

- Access a digital version of their ID number
- View prescription history
- Receive health reminders
- Find a pharmacy by name, address, or near the member's current location
- View their PCP's contact information (and driving directions to their PCP's address)
- Easily contact MeridianRx or Meridian at the tap of screen

Secure Member Portal

Actively enrolled members have free access to Meridian's secure online member portal. While logged in to the portal, members can view needed preventive care services, complete their Health Risk Assessment, view PCP information, request a PCP change, access claims history, receive preventive care reminders, and order replacement Member Handbooks and ID cards.

Live Chat

In addition, the website offers a HIPAA-compliant Live Chat function that allows members to communicate with a Member Services Representative in a real-time, online chat format. Website visitors utilizing Live Chat can immediately choose whether to speak to Member Services, Pharmacy, or Provider Services to ensure they reach their desired representative as soon as possible.

Social Media

Using Facebook, Twitter, and other social media platforms, Meridian provides preventive care information to members and encourages a healthy lifestyle. We are also able to engage with community organizations that have a social media presence and cross-promote any health-related activities and information.

Texting

In addition, Meridian is also able to exchange preventive care reminders, including medication or appointment reminders, via text message for members who sign up for our Text Reminder Program.

Meridian's Long-Term Services and Supports (LTSS) subcontractor is able to develop a tiered secure text messaging platform that can provide messages as simple as generic reminders of health recommendations to as specific as notification that lab results are available for viewing in their electronic health record or appointment reminders.

Email

Meridian sends a monthly email to all members who provide an email address. Emails provide relevant, seasonally-appropriate health tips, guidance, and preventive and routine health recommendations. Members are able to opt out from emails at any time. Emails do not include protected health information.

As evidenced by the numerous forms and methods of member communication, Meridian is adept at leveraging electronic communication. By increasing the diversity of mediums by which consistent health information is relayed to members, Meridian empowers members to optimize their individual healthcare outcomes.

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.

Meridian Health Plan is committed to ensuring that members receive information from us in the mode in which they prefer. Upon receipt of the enrollment file, Meridian's Managed Care System (MCS) tracks information on member's preferred mode of receipt of Meridian communications. If no such information is received in the enrollment file, MCS defaults to sending print communications by mail. However, Member Services Representatives are trained to ask for a member's preferred contact mode during Welcome Calls and other interactions.

If members are not reachable by phone, a contact form is mailed to the member requesting revised contact information and communication preference. Responses are tracked in MCS. If no response is received from the contact form mailing, members are referred to a Community-Based Case Manager for in-person follow-up. Community-Based Case Managers are often successful at locating members and when doing so connect members to community resources, assist with scheduling appointments, and remind member of the need for preventive and routine health services.

Meridian modes of member communication include, but are not limited to, paper communications via mail or electronic communications through the Meridian secure web portal. If messages are

posted to the Meridian secure web portal, an email will be sent to the member alerting them of a new notice. Emails do not include protected health information. If a member portal notification email to a member is returned as undeliverable, Meridian will send the member portal notice by regular mail within three (3) business days of the failed notification email.

3. Describe how electronic communications will be received.

Meridian Health Plan is able to receive inbound electronic communications from members via email and the member website.

Email

Meridian notifies members of our Member Services email in our Member Handbook, sent to members upon enrollment, and posted on the Meridian website. The inbox for this email address is monitored by Member Services Representatives that will respond to inquiries within one (1) business day.

Live Chat

In addition, the website offers a HIPAA compliant Live Chat function that allows members to communicate with a Member Services Representative in a real-time, online chat format. During Member Services hours of operation, responses are received almost instantaneously. Outside of our Member Services hours of operation, Member Services Representatives will respond to inquiries within one (1) business day.

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.

Meridian Health Plan has a member website in operation, including a secure Member Portal. Website content is available in English and all communication materials are available in Spanish. If another language is needed, members can contact Member Services, and with use of Meridian's translation services, request the needed materials in the needed language. Content is culturally appropriate and written at or below a sixth-grade reading level.

Meridian Website

Meridian's website is a comprehensive resource for all members, including, but not limited to, the following information:

- A searchable provider directory that is updated in real-time
- Information on how to find a network provider near the member's residence on-line and via the member helpline
- Meridian's contact information, including address, telephone number, and website

- The amount, duration, and scope of services available under the Contract in sufficient detail to ensure that members are informed of the services to which they are entitled, including service authorization requirements
- Meridian's office hours/days, including the availability of the member helpline and the twenty-four (24) hour Nurse Call Line
- The procedures for obtaining benefits, including authorization requirements
- Description of any restrictions on the member's freedom of choice among network providers, as well as the extent to which members may obtain benefits, including family planning services, from out of network providers
- Description of how to complete a health risk screening, a process described in Section 9.1.1
- As required at 42 CFR 438.10(g)(1), the following information on the grievance and appeal process including:
 - The right to file grievances and appeals, including (i) requirements and timeframes for filing a grievance or appeal; (ii) the availability of assistance in the filing process; (iii) the toll-free numbers that the member can use to file a grievance or appeal by phone; (iv) the fact that, if requested by the member and under certain circumstances, benefits will continue if the member files an appeal or requests a State fair hearing within the specified timeframe; however, the member may be required to pay the cost of such services furnished during the appeal if the final decision is adverse to the member
 - The right to a State hearing, including the method for obtaining a hearing and the rules that govern representation at the hearing
- The extent to which, and how, after-hours and emergency coverage are provided, as well as other information required under 42 CFR 438.10(f)(6)(viii) related to emergency services
- As set forth in 42 CFR 422.113(c), the post stabilization care services
- If applicable, any cost-sharing information, including patient liability responsibilities for 1915(c) HCBS waiver members, 1915(i) program members, ICF/ID, and nursing facility residents, and contact information where the member can ask questions regarding their cost-sharing obligations and consequences for failure to comply with cost sharing and patient liability requirements
- Information about the availability of non-emergency transportation and how to access
- Member protections, rights and responsibilities, as further enumerated in 42 CFR 438.100 and Section 8.10
- Procedures for obtaining out-of-network services and any special benefit provisions (for example, co-payments, limits or rejections of claims) that may apply to services obtained outside Meridian's network
- Standards and expectations for receiving preventive health services
- Procedures for changing contractors and circumstances under which this is possible, as described in Section 7.4
- Procedures for making complaints and recommending changes in policies and services
- Information about advance directives as further described in Section 8.9
- Information on how to contact the Enrollment Broker
- Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking members and how members can access those methods or formats at no expense
- Information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect

- Contact information and description of the role of the Ombudsman
- For members enrolled in a 1915(c) HCBS Waiver or 1915(i) State Plan, Meridian will also provide the following information:
 - A description of the community- based case management’s or integrated health home Care Coordinator’s’ roles and responsibilities
 - Information on how to change community based case management or integrated health homes care coordination
 - When applicable, information on the option to self-direct, a process described in Section 4.45.8, including, but not limited to: (i) the roles and responsibilities of the member; (ii) the ability of the member to select a representative; (iii) the services that can and cannot be self-directed; (iv) the member’s right to participate and voluntarily withdraw; (v) how to select the self-direction option; and (vi) who can and cannot be hired by the member to perform the services; and information on estate recovery

Mobile Website

Smartphones, tablet computers, and their associated applications (apps) are changing how members obtain and interact with healthcare related information. Meridian’s responsive design allows access to all information available on the desktop website and goes one step further by tailoring the user experience to the device by which they are accessing it, including smart phones. Following best practices for user interface, our website will ensure that information is easily accessible. Since many Medicaid beneficiaries access the internet via their mobile devices, Meridian has spent considerable time designing the mobile phone interface of our public-facing website to appear app-like. This allows users to access Meridian information without having to download an app and reduce any concerns over memory on their phone.

Meridian will submit all website materials, prior to posting, for the State review and approval in accordance with Section 8.2.4.

Members are also able to link to the MeridianRx website which features the ability to search for in-network pharmacies and identify which drugs are available in their formulary.

8.7 Health Education and Initiatives

1. Describe your proposed health education initiatives including topic areas and strategies for communication. Provide sample materials.

Meridian Health Plan is committed to sustaining a consumer-directed approach to every member and has established aggressive outreach campaigns incorporating protective actions, chronic disease management, and promotion of healthy behaviors. Meridian utilizes multiple contact methods to encourage members to seek routine and preventive care. Postcard reminders are sent to members monthly. Some postcards remind the member of an upcoming needed screening or exam, ask the members to write in the appointment date and time, mail the tri-fold back and once received, Meridian provides incentives to members who respond with a confirmed appointment.

Monthly member emails are sent containing healthy behavior recommendations and newsletters are mailed to members at least bi-annually. Meridian conducts periodic call campaigns for the

promotion of influenza vaccination, routine appointment access, or other preventive services. Individual member outreach is completed by Quality staff throughout the calendar year to members in need of routine or preventive services.

Disease-specific education is a critical aspect of Meridian health education. Programs are in place to address three levels of disease severity for members with diabetes, asthma, congestive heart failure (CHF), and/or chronic obstructive airway disease (COPD). Mail and phone outreach are the primary forms of communication for members with these diseases. Members with these diseases and an inpatient admission are placed into Care Coordination for more intensive monitoring and assistance with securing needed care.

To ensure materials are useful and appropriate, Meridian surveys members in disease management for program satisfaction annually. Results are used to adjust program content, frequency, and method of communication.

Meridian also values provider participation in health education. Provider orientations and monthly provider office visits offer the opportunity to ask questions and learn about the tools and resources available to our providers. A comprehensive listing of educational materials is available on Meridian's provider website, which includes tools such as:

- Asthma Action Plan
- Emergency Room Asthma Discharge Instructions
- Identify and Treat Asthma in the Office (one page flyer)
- Transition to HFA Inhalers
- Clinical Practices Guidelines, Including, But Not Limited To:
 - Global Initiative for Chronic Obstructive Lung Disease for the Management and Prevention of COPD
 - Asthma, Diagnosis and Management
 - Asthma, Management in Children Zero (0) to Four (4) Years
 - Asthma, Management in Children Five (5) to Eleven (11) Years
 - Asthma, Management in Ages Twelve (12) and Older

Monthly HEDIS® Reports and quarterly Provider Report Cards monitor adherence and provide feedback for quality improvement activities. These reports give providers real-time data and actionable data based on their member enrollment profile. In addition, Meridian supplies asthma provider educational pieces at least two (2) times per year (April and October). Both of these educational pieces stress the importance of annual flu vaccines and are timed to coincide with flu season outbreaks.

2. Describe how you would propose to participate and interface with the Healthiest State Initiative.

Meridian Health Plan has expressed an interest to participate in and interface with the Healthiest State Initiative (HSI). HSI has partnerships and support with a diverse group of stakeholders whose goals and objectives align well with the priorities of member health. The initiative has five (5) focus areas identified- tobacco use reduction, workplace wellness, nutrition, dental health, and lifelong learning. Meridian has existing programs to address tobacco use and promotes positive nutrition choices through member education. However, joining efforts with this statewide partnership would likely result in stronger, more successful reductions in negative behaviors and

strides in positive actions. Meridian's Vice President of Quality and Performance Improvement has volunteered to serve on any of the HSI focus area committees starting the summer of 2015. Meridian may be able to supply evaluation or outcomes data from intervention efforts similar to those of HSI. Expertise in drafting health policy may also be of use to HSI. Meridian is excited to join this initiative and for the opportunity to align priorities resulting in a healthier Iowa.

8.8 Cost and Quality Information

1. Describe proposed strategies to provide price and quality transparency to members.

Transparency of quality data has always been an operational mandate of Meridian Health Plan. Meridian is proud of remarkable accomplishments reached in the National Committee for Quality Assurance (NCQA) quality rankings and accreditation in recent years. Meridian reports NCQA-required Healthcare Effectiveness Data and Information Set (HEDIS®) measures through audited and secure means annually for consideration for national ranking and accreditation. In 2014, Meridian Health Plan of Michigan, Inc. was ranked the ninth (9th) Medicaid HMO in the country, Meridian Health Plan of Illinois, Inc. was ranked the tenth (10th) Medicaid HMO in the country, and Meridian Health Plan of Iowa, Inc. was ranked the thirty-eighth (38th) Medicaid HMO in the country according to NCQA's Medicaid Health Insurance Plan Rankings 2014–2015. These rankings were out of hundreds of plans reviewed. In addition, Meridian Health Plan of Michigan reached "Excellent" accreditation status, Meridian Health Plan of Illinois was "Commendable", and Meridian Health Plan of Iowa also reached "Commendable" accreditation status for the first year of performance.

Quality is paramount to Meridian. As part of all State contracts, including Iowa, an annual evaluation of the quality improvement program is produced. This report contains extensive statistical, anecdotal, and programmatic information about all aspects of quality care provision. The annual evaluation displays year-over-year performance and details special projects addressing health concerns of members. The highlights of this report are reported in member newsletters following release of the report.

Community interactions are viewed as opportunities to share Meridian's success in providing quality healthcare. In past years, Meridian has collaborated with the Public Policy Center of Iowa to determine how managed care performed against other forms of administration, such as fee-for-service. The results of annual analyses are publicly available through the Policy Center. Quality data will be publicly reported to the State of Iowa as requested and required. Quality performance data are presented to stakeholders and community partners. Highlights are also provided in member and provider newsletters and education pieces.

Lastly, Meridian has partnered with FAIR Health (<http://www.fairhealth.org/>) to provide cost information to members. FAIR Health is an independent, non-profit corporation whose mission is to bring transparency to healthcare costs and health insurance information. FAIR Health is working to create the nation's largest collection of private medical and dental claims data accessible to healthcare consumers in a simplistic format. Examples of data provided through FAIR Health include average costs of common services and the cost of urgent versus emergent utilization costs. Meridian will publicize FAIR Health to our members via our website upon enrollment.

2. Provide sample EOBs as an exhibit or attachment.

See Attachment 27 (Sample Member EOB) in Tab 5.

Meridian Health Plan shall provide an explanation of benefits (EOBs) to all members or a statistically valid sample of all members. This includes members in the Iowa Health and Wellness Plan as well as hawk-i. EOBs shall be available via paper and secure web-based portal, and to members based on their preferred mode of receipt. EOBs shall be designed to address requirements in 42 CFR 433.116(e) and (f). EOBs shall not be sent on family planning services.

3. Describe processes for making provider quality information available to members.

State-level performance data on provider quality is available in annual quality evaluation reports. These data are presented to stakeholders and community partners, and directly to providers in the form of consumer survey education. Areas needing improvement are highlighted as are areas of success.

Meridian Health Plan will ensure member access to provider quality information. Currently, Meridian supplies monthly data files to Treo for integration into the Value Index Score (VIS). VIS calculates provider performance based on data received on attributed members using a core set of measures. VIS then scores providers for all Medicaid members, regardless of plan administrator. Meridian will support VIS as the means of completing provider-level quality scoring, if directed by the State.

Otherwise, Meridian shall collect quality information about our network providers and make this information available to members based on their preferred mode of receipt. In making this information available to members, we will identify if there are any limitations of the quality information or related data.

Advance Directive Information

In addition to cost and quality information, Meridian Health Plan shall comply with the advance directive requirements outlined in Section 8.9.1 and Section 8.9.2 of the Scope of Work. Meridian has experience providing advance directive information to our Medicaid members in Iowa and other states.

8.10 Member Rights

1. Describe your process for ensuring member rights as described in Section 8.10.

Policies and procedures created by Meridian Health Plan and reviewed annually are set in place to ensure member rights are protected. Meridian is committed to treating all members in a manner that respects their rights and ensuring that all staff and provider network take those rights into account when furnishing services. Meridian guarantees members have the following rights:

- The right to receive information in accordance with 42 CFR 438.10

- The right to be treated with respect and with due consideration for his or her dignity and privacy
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand
- The right to participate in decisions regarding his or her health care, including the right to refuse treatment
- The right to 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
- The right to request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164
- The right to treatment in the least restrictive setting
- The right to fully participate in the community and to work, live and learn to the fullest extent possible
- The right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210

Meridian ensures that the rights of members are preserved by providing training on member rights during new hire training and also by conducting call quality audits on Member Service Representatives weekly.

8.11 Redetermination Assistance

1. Describe in detail your plans to assist members in the eligibility redetermination process and control against prohibited activities.

Meridian Health Plan will conduct outreach calls, through our outreach software, to members whose eligibility redetermination is approaching to remind them to renew their eligibility. Member Services staff will be trained to review redetermination requirements with the member, answer questions about the redetermination process as determined by the State, and help the member obtain required documentation and contact information in order to renew eligibility.

Meridian will not engage in prohibited activities identified by the State. Meridian staff members are trained on member rights, and information on member rights is included in one of Meridian's policies, which states that members are free from discrimination prohibited by State and Federal regulation. To prospectively inhibit prohibited activities, Meridian trains the Member Services staff to refrain from speaking with members about changing health plans, providing any indication as to whether the member will be eligible, engage in or support fraudulent activities, or any other activities prohibited by the State. Meridian also conducts weekly quality audits on calls processed by Member Service representatives in order to identify any deviations from training as it relates to prohibited activities. If deviations are identified, appropriate action is taken against the employee.

8.12 Member and Stakeholder Engagement

1. Describe in detail your member and stakeholder engagement strategy.

Member Engagement

Meridian Health Plan has a long-running, successful member engagement strategy used in multiple service areas. Member focus groups are held quarterly in every state, for every benefit plan. Focus groups are structured according to qualitative research protocols with the intent of gathering the member experience accessing care while a Meridian member. Groups are limited to four (4) to twelve (12) participants, one facilitator, and an observer, and are held in an easily accessible location. All groups are recorded; transcriptions produced, and analyzed using thematic coding. Analytic summaries are presented at every quarterly Quality Improvement Committee meeting with the intent of identifying actions needed to remediate member concerns or issues. Members are incentivized to attend and transportation expenses are covered, if needed. Focus groups are most often centered on member motivation to access care, barriers to care, or disease-specific issues such as maternal health or diabetes or asthma management.

Results of focus groups are shared with stakeholder groups, when appropriate. Maternal health feedback has been shared with the State Maternal Health Task Force in Iowa. Access to care information has been provided to Primary Health Care.

Members are asked to join the Board of Directors for each state plan. The active participation of members is critical for ensuring member advocacy occurs in the review of operations and activities of Meridian.

An action plan developed based on feedback from our most recent Iowa Medicaid member focus group results is provided below:

| Iowa Medicaid Member Focus Group Results | | |
|--|--|---------------------------------------|
| Specific strategies | Action | Responsible Party |
| Stay active, exercise | Promote of weight management support-Weight Watchers™ to providers and members | Provider Services, Communications, QI |
| Provider characteristics-Supportive (“very good” or “great”) | Summarize findings and include in provider newsletter | QI, Communications, Provider Services |
| Provider characteristics-Unsupportive | Consider sharing findings through summary for providers | |
| Confusion about difference between Meridian and the state | Discuss opportunities for clarification with IME: <ul style="list-style-type: none"> • Welcome letter • FAQ • Provider education • Develop published enrollment guidelines Share findings with Member Services | QI, IME |

| Iowa Medicaid Member Focus Group Results | | |
|---|---|-------------------------------------|
| Specific strategies | Action | Responsible Party |
| Experiences of insensitivity and stigma | Discuss opportunities for addressing stigma with IME: Regional education sessions Provider education | QI, IME |
| Receiving reminders | Focus retention of and frequent updates to email and phone number information Expand use of text and email messaging Explore options for postcard appointment reminders | Member Services, Communications, QI |
| Making and attending appointments | Strengthen education messages with anecdotes, statistics and attention-grabbers | Communications |

Stakeholder Engagement

From the start of Meridian’s presence in Iowa in March 2012, numerous stakeholder engagement efforts have been initiated, many with Meridian leading the charge. Stakeholder feedback, partnership, even conversation, promotes action directed at improving the health of Iowa’s Medicaid population. Meridian frequently and actively solicits partnerships throughout the State dependent upon population health needs. The following is a list of active stakeholder groups, Meridian’s role, and a description of the purpose of the engagement.

Maternal Health Task Force

Stakeholders: Iowa Medicaid Enterprise (lead), Iowa Department of Public Health, Meridian Health Plan

Description: This group meets quarterly to discuss issues affecting maternal, infant, and child health. Past topics have included a research project defining factors contributing to perinatal complications, premature birth, and low birth weight, long-action reproductive contraception, and prenatal screening assessment.

Chlamydia Coalition

Stakeholders: Meridian Health Plan (lead), Iowa Department of Public Health (IDPH) Bureau of Hepatitis C, HIV, and STDs, State Hygienic Laboratory, Iowa Primary Care Association

Description: This Meridian-initiated effort began in 2014 in response to a need to improve chlamydia screening rates in Iowa. Disease incidence has increased every year for more than ten (10) years in a target group of female young adults. The project focused on evaluating existing data, including completeness of billing and reporting for tests performed by the State Hygienic Laboratory. The group continues to explore ways to improve testing through provider education, member incentives, and support for Title X clinics.

Iowa Department of Public Health, Bureau of Family Health- Title V program, Title X program, LARC project

Stakeholders: Meridian Health Plan (co-lead), Iowa Department of Public Health (co-lead)

Description: Several active partnerships exist with the Bureau of Family Health. Meridian works with the Bureau to provide regular service area maps, assist with maternal or child health clinic billing issues, communication of member incentives and education programs, and general support for Meridian member access to maternal and child health programs.

Recently, Meridian began working with the Bureau on a project to evaluate provision of long-acting reproductive contraception at the time of delivery.

Cribs for Kids

Stakeholders: Meridian Health Plan (lead), Iowa Department of Public Health Bureau of Family Health, Allen Hospital, Great River Medical Center, Covenant Medical Center, Mercy Clinton, Iowa Maternal, Infant, and Early Child Home Visitation Program

Description: Meridian leads this exceptional project focused on reducing infant mortality associated with unsafe sleep environments. Following an analysis of sleep-associated infant mortality, it was determined parents in high-incidence counties with significant racial disparity were in need of cribs. Meridian assisted with securing funding and provided supplemental funds for the purchase of more than 2,000 cribs being distributed at five (5) Iowa hospitals. The outcomes of this project are being tracked through home visitation occurring in pilot and comparison counties. This project is the first in the nation to assess the impact of crib provision on sleep-related infant mortality.

Improving Access to Care

Stakeholders: Meridian Health Plan (lead), Primary Health Care (PHC)

Description: In the summer of 2014, Meridian launched a pilot project with an Iowa Federally-qualified health center, PHC, in an effort to improve access to care and establishing care. Meridian outreached to members assigned to PHC and assisted with appointment scheduling.

State Hygienic Laboratory

Stakeholders: Meridian Health Plan (lead), State Hygienic Laboratory (SHL)

Description: Meridian has been working with SHL to assess completeness of laboratory reporting, potential expanded use of the laboratory, and a study of prenatal screening.

Iowa Health Information Network

Stakeholders: Iowa Department of Public Health (IDPH), Meridian Health Plan

Description: Meridian and IDPH have an ongoing collaboration to promote the expansion and adoption of Iowa's Health Information Network. The partnership recognizes the value of involving third party payers in health information exchange development, as coordinated care through secure information sharing results in better patient outcomes.

University of Iowa Public Policy Center (PPC)

Stakeholders: University of Iowa, Meridian Health Plan

Description: The PPC has provided statistical services and managed research projects for Iowa Medicaid Enterprise (IME) for several years, including studies of HEDIS® measure performance comparison between fee-for-service, MediPass, and managed care. Meridian engaged in interactions with PPC in 2014 with the goal of supporting comprehensive projects focused on the Iowa Medicaid population.

Iowa Child Death Review Team (ICDRT)

Stakeholders: Several State agencies, education and child advocacy organizations, law enforcement, insurance (Meridian Health Plan serves as State representative)

Description: The ICDRT is charged with the review of selected cases of child death in an effort to identify opportunities for intervention and prevention of future deaths. Meridian's V Vice President of Quality and Performance Improvement serves as the insurance representative and statistician for the production of annual reports.

American Cancer Society

Stakeholders: American Cancer Society (ACS), Meridian Health Plan

Description: ACS and Meridian have a regional relationship focused on education of members on cancer screening and detection. ACS provided educational member mailing materials for co-branding recently adopted for use in reminding members about cancer screenings. Co-branded mailings are used in all three (3) Meridian Medicaid states, though a more comprehensive campaign is underway in Michigan.

Drake University Health Sciences Program Experiential Learning Site

Stakeholders: Drake University, Meridian Health Plan

Description: Meridian has an ongoing engagement with Drake University. Meridian hosts Drake Health Sciences students as interns, and will serve as a capstone experiential learning site in 2015.

Healthiest State Initiative

Stakeholders: Healthiest State Initiative, Meridian Health Plan

Description: Meridian recently requested to participate on the Initiative's planning committees and committed support for the Initiative's annual conference in June. Significant opportunity exists between Meridian and the Healthiest State Initiative and Meridian is excited to join the effort to improve the health of Iowans.

In addition to continuing our existing stakeholder engagement, Meridian shall convene and facilitate a Stakeholder Advisory Board within ninety (90) days of an executed contract with the Agency. The Stakeholder Advisory Board shall provide input on issues such as: (i) service delivery; (ii) quality of care; (iii) member rights and responsibilities; (iv) resolution of grievances and appeals; (v) operational issues; (vi) program monitoring and evaluation; (vii) member and provider education; and (viii) priority issues identified by members.

Meridian shall develop a plan for the Stakeholder Advisory Board, incorporating all elements defined in Section 8.12 of the Scope of Work, and submit it to the Agency for review within thirty (30) days after Contract execution. A final plan, incorporating any changes requested by the Agency, shall be submitted to the Agency within ninety (90) days after the first submission of the plan. Meridian shall execute, adhere to, and provide the services set forth in the Agency-approved plan. Meridian acknowledges that changes to the plan must receive prior approval from the Agency, and the Meridian shall make any updates to maintain a current version of the plan.

2. Submit your Stakeholder Advisory Board strategy and discuss how meaningful representation from member stakeholder groups will be ensured.

Meridian Health Plan's current Community Stakeholder Advisory Board (CSAB) is comprised of internal leadership staff from Quality Improvement, Utilization Management, Medical Management and Care Coordination, as well as local representation from key community stakeholders such as faith-based organizations, advocacy groups, and other community-based organizations.

Meridian will convene and facilitate a CSAB within ninety (90) days of an executed contract with the State. The CSAB shall provide input on issues such as: (i) service delivery; (ii) quality of care; (iii) member rights and responsibilities; (iv) resolution of grievances and appeals; (v) operational issues; (vi) program monitoring and evaluation; (vii) member and provider education; and (viii) priority issues identified by members.

For the State of Iowa, the Stakeholder meeting will include a mix of members, caregivers, and location representatives from key community stakeholders. Approximately fifty-one percent (51%) of the board will be comprised of members and this composition will reflect the diversity of the population. Meridian shall develop a plan for the CSAB, incorporating required elements from Section 8.12 of the Scope of Work, and submit it to the State for review within thirty (30) days after Contract execution.

Stakeholder meetings will occur no less than quarterly and Meridian will notify the State at least fifteen (15) days in advance of every meeting.

3. Describe how feedback obtained from the Stakeholder Advisory Board will be utilized.

Meridian Health Plan proposes to capture feedback from the Community Stakeholder Advisory Board (CSAB) in multiple ways. Meetings will always be recorded, transcribed, and minutes reviewed. Quarterly recommendations will be solicited from the CSAB. Issues raised by stakeholders shall be incorporated into Meridian's quality assessment and performance improvement program, and into other Meridian activities, such as proposals for collaborative opportunities between Meridian and stakeholder groups.

8.13 Stakeholder Education

1. Describe your plan for stakeholder education including proposed timelines and topics.

Meridian Health Plan has numerous existing stakeholder relationships and conducts continuous education with most groups. When constructing a plan for stakeholder education, Meridian sorted groups into: Maternal and Child, Access to Care and Disease-Specific, Electronic Data Interchange and Health Information Network, Academic Partnerships, and Community Stakeholders. Meridian will retain meetings with all existing groups emphasizing new benefit coverage, past performance, new performance priorities, opportunities for program integration and enhancement, and potential for community health improvement. All existing partnerships are active engagements and education occurs at every meeting.

The following is a list of active stakeholder groups, Meridian's role, and a description of the purpose of the engagement.

Maternal Health Task Force

Stakeholders: Iowa Medicaid Enterprise (lead), Iowa Department of Public Health, Meridian Health Plan

Description: This group meets quarterly to discuss issues affecting maternal, infant, and child health. Past topics have included a research project defining factors contributing to perinatal complications, premature birth, and low birth weight, long-action reproductive contraception, and prenatal screening assessment.

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Stakeholders: Meridian Health Plan (lead), Iowa Department of Public Health (IDPH) Bureau of Hepatitis C, HIV, and STDs, State Hygienic Laboratory, Iowa Primary Care Association

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Stakeholders: Meridian Health Plan (co-lead), Iowa Department of Public Health (co-lead)

Description: Several active partnerships exist with the Bureau of Family Health. Meridian works with the Bureau to provide regular service area maps, assist with maternal or child health clinic billing issues, communication of member incentives and education programs, and general support for Meridian member access to maternal and child health programs.

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Stakeholders: Meridian Health Plan (lead), Primary Health Care (PHC)

Description: In the summer of 2014, Meridian launched a pilot project with an Iowa Federally-qualified health center, PHC, in an effort to improve access to care and establishing care. Meridian outreached to members assigned to PHC and assisted with appointment scheduling.

State Hygienic Laboratory

Stakeholders: Meridian Health Plan (lead), State Hygienic Laboratory (SHL)

Description: Meridian has been working with SHL to assess completeness of laboratory reporting, potential expanded use of the laboratory, and a study of prenatal screening.

Iowa Health Information Exchange

Stakeholders: Iowa Department of Public Health (IDPH), Meridian Health Plan

Description: Meridian and IDPH have an ongoing collaboration to promote the expansion and adoption of Iowa's Health Information Network. The partnership recognizes the value of involving third party payers in health information exchange development, as coordinated care through secure information sharing results in better patient outcomes.

University of Iowa Public Policy Center (PPC)

Stakeholders: University of Iowa, Meridian Health Plan

Description: The PPC has provided statistical services and managed research projects for Iowa Medicaid Enterprise (IME) for several years, including studies of HEDIS® measure performance comparison between Fee for Service, MediPass, and managed care. Meridian engaged in interactions with PPC in 2014 with the goal of supporting comprehensive projects focused on the Iowa Medicaid population.

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Stakeholders: Several State agencies, education and child advocacy organizations, law enforcement, insurance (Meridian Health Plan serves as state representative)

Description: The ICDRT is charged with the review of selected cases of child death in an effort to identify opportunities for intervention and prevention of future deaths. Meridian's Vice

President of Quality and Performance Improvement serves as the insurance representative and statistician for the production of annual reports.

American Cancer Society

Stakeholders: American Cancer Society (ACS), Meridian Health Plan

Description: ACS and Meridian have a regional relationship focused on education of members on cancer screening and detection. ACS provided educational member mailing materials for co-branding recently adopted for use in reminding members about cancer screenings. Co-branded mailings are used in all three Meridian Medicaid states, though a more comprehensive campaign is underway in Michigan.

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Stakeholders: Drake University, Meridian Health Plan

Description: Meridian has an ongoing engagement with Drake University. Meridian hosts Drake Health Sciences students as interns, and will serve as a capstone experiential learning site in 2015.

Healthiest State Initiative

Stakeholders: Healthiest State Initiative, Meridian Health Plan

Description: Meridian recently requested to participate on the Initiative's planning committees and committed support for the Initiative's annual conference in June. Significant opportunity exists between Meridian and the Healthiest State Initiative and Meridian is excited to join the effort to improve the health of Iowans.

Meridian has also determined new stakeholder groups to target for interaction including Area Aging Agencies, rural health clinics, and public health associations. Meridian will readily educate groups on relevant information including benefits provided to members, incentive programs, past performance in quality, future performance measure goals, opportunities for collaboration and enhanced member services, and again, potential for improving the health of Iowans.

New stakeholders will be contacted prior to the end of 2015 with the intent of meeting once within 2015 and at least quarterly on an ongoing basis.

2. Describe how you will identify and outreach to stakeholders.

In past years, Meridian Health Plan has leveraged the local relationships of staff to identify and outreach to stakeholders. Most Iowa team members have strong community connections and have served in a variety of functions, whether in State government, academic institutions, or as volunteers with community organizations. Meridian researches major stakeholders in service counties and often seeks guidance from State partners as well as providers to secure new contacts. State agency connections are vital and often yield extensive opportunities.

Meridian has served as the lead agency for many Iowa stakeholder groups, ensures regular meetings occur, and actions are documented. Whether as the lead or a participant, continued outreach to stakeholders is a Meridian priority.

For the purposes of this Contract, Meridian shall develop a formal process for ongoing education of stakeholders prior to, during and after implementation of the Contract. Meridian shall submit a Stakeholder Education Plan to the State for review and approval in the timeframe and manner determined by the State.

8.14 Implementation Support

1. Describe proposed strategies to support members during program implementation.

Throughout these expansions and program implementations, Meridian Health Plan has successfully transitioned enrollment while maintaining excellence in customer service and performance metrics and communication with members. This experience has strengthened our capacity for continued growth.

To ensure that members are aware of their ability to contact Meridian with questions or concerns related to program implementation, information regarding the plan as well as contact information will be placed on the Meridian website. The contact information will include the Member Services Department helpline. In order to ensure there are no gaps in care for members transitioning to Meridian, the health plan makes proactive calls to the members, prior to their effective date with Meridian. At that time, the member is welcomed to the health plan and benefits are discussed. Additionally, a Health Risk Assessment (HRA) is completed at that time, so that the member can be placed into appropriate Care Coordination programs. Primary care providers can be assigned and appointments can be scheduled during the Welcome Call as well. Meridian also verifies that all contact information is correct in order to ensure that the member receives all necessary communications from the plan.

8.15 Grievances, Appeals, and State Fair 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.

Meridian Health Plan will ensure that member grievances are consistently documented and resolved in a timely manner according to regulatory requirements. Meridian maintains a member appeal process that is consistent with the requirements of all State regulatory and Federal requirements and allows for timely and appropriate resolution. This process is documented in policies and procedures, which will be forwarded to the State for approval prior to implementation.

The terms “grievance” and “appeal” are defined as follows:

- **Grievance** – A grievance is a complaint on behalf of a member concerning the availability, delivery, or quality of healthcare services, including a complaint regarding an adverse determination made pursuant to utilization review. A grievance may also be a complaint regarding benefits or claims payment, handling or reimbursement of healthcare services, and/or matters pertaining to the contractual relationship between a member and the insurer or health maintenance organization.

- **Appeal** – An appeal is expressed member dissatisfaction regarding denied, suspended, reduced, or terminated healthcare services (adverse determination). An adverse determination is defined as a determination that an admission, the availability of care, continued stay, or other healthcare service has been reviewed and denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination also constitutes an adverse determination.

Grievances

Meridian takes member grievances very seriously. Grievance and appeal information is outlined in the Member Handbook, as is information about how to contact the State's Ombudsmen's office. Member Services staff and Grievance and Appeal Coordinators receive detailed and regular training on grievance, appeal and state fair hearings procedures so that they may answer any questions that a member or provider might have. Information is available to members who may visit Meridian's offices and providers are informed of the member grievance and appeals process regularly in provider materials, during provider office visits, and on Meridian's Provider Portal.

Members may file a grievance at any time, either in writing or by calling the toll-free number for the Meridian Member Services Department; translation and interpretation services are available upon request. Members may designate in writing another person, such as a relative or a physician, to file the grievance on their behalf. A member's estate representative of a deceased member may also file a grievance. Members may request assistance from a Grievance Coordinator or a Member Service Representative in filing the grievance. Members are never discriminated against because they filed a grievance or appeal.

All grievance records are maintained in the Grievance Module (a software program), contained within Meridian's Managed Care System (MCS). Access to this module is restricted to only Meridian staff involved in the grievance process. The module stores records/notes relevant to the complaint's investigation, member and provider information, copies of letters sent to the member and other related material. MCS notifies the appropriate staff when complaints/grievances/appeals are received, when deadlines are approaching, and when follow-up is required.

Grievances (Standard)

Meridian acknowledges grievances with written confirmation sent to the member and/or the member's representative within three (3) business days of receipt of the grievance. The acknowledgement is written at a sixth grade reading level and includes a description of all available levels of review, both internal and external.

Grievances are documented in the Grievance Module in MCS, including the substance of the grievance and the action taken. Once this is done, grievances are distributed to the appropriate contact person(s) within Meridian for review and determination of action to be taken.

The appropriate contact person(s) fully investigates the grievance, including any aspects of clinical care involved. Health professionals who have the appropriate clinical expertise review all grievances that involve a clinical issue.

Grievances are resolved within thirty (30) calendar days, with written notification of the disposition provided to the member and/or the member's representative. This notification is written at the sixth grade reading level.

The member or Meridian may request an extension, up to fourteen (14) calendar days from the member to render a resolution. If Meridian requests an extension, this extension is requested only when Meridian has not received necessary information from a healthcare facility or health professional required to make an informed resolution. Thus, this extension is beneficial to the member. Written notification is provided to member. Services are continued throughout the grievance/appeal processes.

Grievances (Expedited)

Meridian performs expedited grievance reviews when the member's complaint is determined to be clinically urgent. Clinically urgent complaints are those in which a failure to adjudicate or manage the issues involved within seventy-two (72) hours can potentially have a significant negative impact on the member's health or well-being. When this type of grievance is received, the Meridian Grievance Coordinator verbally informs the member that his/her grievance will be resolved within seventy-two (72) hours.

Meridian documents expedited grievances in the Grievance Module in MCS, including the substance of the grievance and the action taken. Meridian clinical staff investigates the substance of the grievance and all aspects of clinical care involved. The Meridian Grievance Coordinator provides verbal notification of the resolution to the member's expedited grievance within seventy-two (72) hours of receipt of the grievance. In addition, the Meridian Grievance Coordinator provides written notification to the member no later than forty-eight (48) hours after a decision has been made.

Quality Monitoring of Grievances

Grievances are evaluated at this meeting and regularly by the Quality Department to determine if changes are needed to Meridian policies and procedures or if there are access or utilization issues that must be addressed.

A grievance report is submitted to the Meridian Quality Improvement Committee on a quarterly basis for review, to identify any systematic opportunities for improvement and to ensure that appropriate actions are being taken. This report is also reviewed at the monthly meeting of Meridian's Board of Directors and provided to the Department.

Appeals

In the event a member is dissatisfied with the denial, suspension, reduction, or termination of healthcare services, the member may file an appeal. In addition, all written or verbal communications by a member regarding dissatisfaction with an adverse determination or denial of payment by Meridian is an appeal. Members and their providers receive written notification of action or denial. Written at a sixth grade reading level, the notification includes the reason for the determination, an explanation of the right to file an appeal, and information about the structure and timeframe of the appeals process. This notice informs the member of their right to receive, upon request, reasonable access to, and copies of all documents relevant to the appeal free of charge. This request can be made at any time during the appeal process. An appeal form is

included, as are instructions for requesting a written statement of the clinical rationale (including clinical review criteria). In addition, members are informed that they can call the toll-free Meridian number if they have questions, need help in initiating the appeal, and/or are requesting clinical rationale and review criteria.

A member, member's authorized representative or estate representative of a deceased member may file an appeal with Meridian at any time. The appeal may be filed orally or in writing, with translation and interpretation services available upon request. Members can file an appeal in writing or by calling the toll-free number for the Meridian Utilization Management (UM) Department. Members may designate in writing another person, such as a relative, a physician, or a lawyer, to file the appeal on their behalf. Services continue, without interruption, throughout the appeal process.

Appeal of an adverse determination or payment decision may be made by a member up to thirty (30) days after the date of the determination. Meridian provides assistance to the member in submitting the appeal and throughout the completion of other procedural steps, including requests for state fair hearings.

Meridian provides special assistance for persons with hearing impairments, speech impairments, limited English proficiency, and/or illiteracy. Meridian will provide an interpreter for members with limited English proficiency at no cost to the member. Members with a hearing impairment will be directed to call 800-735-2942 for TTY/TDD services.

Under the direction of the Director of Grievance and Appeals, the Appeals Coordinator is responsible for receiving the appeal, administering the appeal process, and ensuring that all timeframes are met.

The confidentiality of member information is a priority of all Meridian staff, including any staff that administers the grievance and appeals processes. Appeal records are also maintained in MCS. The module stores records/notes relevant to the complaint's investigation, member and provider information, copies of letters sent to the member, and other related material. MCS notifies the appropriate staff when complaints/grievances/appeals are received, when deadlines are approaching, and when follow-up is required.

Appeal Process

After an appeal request is received, the Appeals Coordinator sends an acknowledgement letter to the member within three (3) calendar days of receipt of the appeal. This notification is written at the sixth grade reading level.

The member and/or member's representative may provide any information they wish for Meridian to consider as part of the appeal. The Appeals Coordinator reviews all submitted documentation that relates to the appeal. The substance of the appeal is investigated, including any clinical care aspects. In the event that Meridian has not received requested information from a healthcare facility or provider that is needed to render a decision, an extension of up to fourteen (14) calendar days is permitted. In the event that a fourteen (14)-day extension is needed, the Appeals Coordinator provides timely written notification as to the progress of the investigation. The notification is written at a sixth grade reading level.

A Meridian physician (other than the physician involved in the review of the initial adverse determination and who is not the subordinate of such physician) reviews the appeal. Appeals regarding medical necessity are reviewed by a practitioner in the same or similar specialty that typically treats the medical condition or performs the procedure that is the subject of the appeal. Appeals are completed within thirty (30) calendar days from receipt of the request.

The Appeals Coordinator provides written notification (in writing at the sixth grade reading level) regarding the results of the investigation and Meridian's determination. This information is sent to the member in an easily understood summary that includes the following:

- An explanation of Meridian's decision and/or the resolution of the appeal.
- Reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was made.
- A list of the title and qualifications of each individual participating in the appeal review, including the provider's specialty.
- The member's further appeal rights, including the state fair hearing process.

Continuation of Benefits Pending the Resolution of an Appeal

If the member would like benefits to continue while their appeal is pending, they must meet certain criteria. Specifically, Meridian is obligated to continue the member's benefits if the appeal is filed timely, meaning on or before the later of the following:

- Within ten (10) days of Meridian's mailing the notice of action.
- The intended effective date of Meridian's proposed action.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The authorization period has not expired.
- The member requests extension of benefits.
 - If Meridian continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one (1) of the following occurs:
 - The member withdraws the appeal.
 - The member does not request a fair hearing within ten (10) days from when Meridian mails an adverse decision.
 - A State Fair Hearing decision adverse to the member is made.
 - The authorization expires or authorization service limits are met.
- If the final resolution of the appeal is adverse to the member, that is, upholds Meridian's initial determination, Meridian may recover the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of this requirement.

Expedited Appeals Process

Expedited appeals are available to members based on an adverse determination for urgent care. Urgent care is defined as any request for medical care or treatment where the time medical care or treatment where the time periods allowed for making non-urgent care determinations 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; or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is the subject of the request.

Expedited review is also granted for all requests that concern admissions, continued stays, or other healthcare services for a member who has received emergency services, but has not been discharged from the hospital.

An expedited appeal review begins when a member, the member's representative, or a practitioner acting on behalf of the member, requests an expedited appeal. If the request for expedited review is submitted by a member, it must be followed by documentation from a physician, either verbally or in writing, that the appeal meets the requirements for the expedited process.

The Appeals Coordinator reviews the request and obtains input from the Chief Medical Officer or designee to determine if the request meets the requirements for an expedited appeal. If a request for an expedited review is denied, the appeal is transferred to the timeframe for standard resolution of an appeal.

Meridian makes reasonable efforts to give the member and/or member's representative and the provider a prompt verbal notice of the denial to treat the appeal as expedited, and to follow-up with a written notice, at a sixth grade reading level, within two (2) calendar days. If the member or an authorized representative of the member requests an extension of the decision time frame of an expedited appeal, the appeal is moved to the standard decision time frame of thirty (30) calendar days.

The substance of the appeal is investigated, including any aspects of clinical care involved. A Meridian physician (other than the physician involved in the review of the initial adverse determination and who is not the subordinate of such physician) completes the review of the expedited appeal. Appeals regarding medical necessity are reviewed by a practitioner in the same or similar specialty that typically treats the medical condition or performs the procedure that is the subject of the grievance/appeal.

Expedited appeals are completed as expeditiously as the medical condition requires, but no later than seventy-two (72) hours after the request. The Appeal Coordinator provides verbal and written notification of the determination to the member and provider no later than seventy-two (72) hours after receipt of the request. The written notice is written at the sixth grade reading level and includes:

- An explanation of Meridian's final decision or resolution of the appeal
- Reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was made
- A list of the title and qualifications of each individual participating in the appeal review, including the provider's specialty
- A description of the member's further appeal rights for a state fair hearing

Quality Monitoring of Appeals

The Appeals Coordinator is responsible for all appeal documentation. Appeals are documented (including the substance of the appeal and any actions taken), to aid in evaluating the medical necessity decision-making process. This includes evaluating patterns of appeals for impact on the formulation of policies and procedures and access and utilization issues. Copies of all appeals, their investigation, and disposition are maintained at Meridian and are available for inspection for two years following the year the appeal is filed.

Aggregate data on appeals activities are reported to the Utilization Management and Quality Improvement Committees on a quarterly basis, and reviewed at least annually for medical management and member/provider satisfaction opportunities. This information is also presented to the Meridian Board of Directors on a quarterly basis.

State Fair Hearing Process

Meridian notifies members of their right to a state fair hearing in the Member Handbook, at least annually in the member newsletter and in any appeal related correspondence. All notifications will comply with the requirements of 8.15.8. If requested, Meridian Grievance and Appeal staff will assist the member with the filing of a state fair hearing and provide all needed materials to the State Fair Hearing Department within the required timeframes. Continuation of Medicaid coverage will continue while the member completes the fair hearing process.

2. Describe your proposed exception to Contractor policy process.

Meridian Health Plan will administer the State of Iowa benefit in accordance with our Contract, abiding by the State's eligibility rules and structure of benefits. However, Meridian may review for benefit exception in certain circumstances. Criteria to be used may include, but not be limited to:

- Recent changes in the status of a procedure or device (e.g., no longer considered experimental by the US Food & Drug Administration; the issuance of a position statement or consensus opinion by a relevant clinical specialty organization on its effectiveness and/or safety, etc.)
- The adoption by other major payers and reinsurers of coverage for the procedures and services in question

Meridian acknowledges that an exception to policy is a last resort request.

SECTION 9 – CARE COORDINATION

Please explain how you propose to execute Section 9 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

9.1 General

1. Describe proposed strategies to ensure the integration of LTSS care coordination and Contractor-developed care coordination strategies as described in Section 9.

Meridian Health Plan's Care Coordination Program includes:

- Performance of an initial health risk screening
- Placement of members in a Care Coordination Program based on assessed level of risk
- Performance of a Comprehensive Health Risk Assessment for members identified as having a special health care needs
- Care plan development
- Reassessment

Meridian's Care Coordination Program complies with 42 CFR 438.208 and includes, at minimum, the following components: (i) performance of an initial health risk screening; (ii) placement of members in a Care Coordination Program based on assessed level of risk; (iii) performance of a Comprehensive Health Risk Assessment for members identified as having a special health care need; (iv) care plan development; and (v) reassessment. Our Care Coordination Programs have a demonstrated record of: (i) improving quality outcomes; (ii) coordinating care across the healthcare delivery system; (iii) increasing member compliance with recommended treatment protocols; (iv) increasing member understanding of their healthcare conditions and prescribed treatment; (v) empowering members; (vi) coordinating care with other plans and or State agencies; and (vii) providing flexible person-centered care.

Meridian's Care Coordination Program focuses on members with special healthcare needs and their families. The purpose is to link the member's needed services and resources in a coordinated effort, achieve better access to needed care, navigate the member through the complex healthcare system, and to increase self-management and self-advocacy skills. The program is designed to ensure timely and thorough coordination of services across various domains, such as primary care, substance abuse, mental health, non-emergency transportation, durable medical equipment repair, dental providers, and community supports, as well as connecting providers through the exchange of relevant information so that treatment for any one of the member's needs includes recognition of their full set of needs. The goal of the program is to maximize the member's potential and provide them with optimal care. In addition the program is designed to identify members who may be overusing and/or abusing services resulting in increased quality care management across the healthcare continuum. (i) catastrophic case management; (ii) disease management; (iii) programs to target members overusing and/or abusing services; (iv) discharge planning; and (v) transition planning.

Meridian will identify members with disabilities, chronic complex medical needs, serious mental illness, and intellectual/developmental disorders that may require services that will allow them to continue to live in a community setting. We emphasize continuity of care through a core services team, assertive outreach, and individualized and on-going treatment plans. Assertive outreach

involves actively going out to meet the member's needs in the community and to avoid placement into facilities. Members with complex medical needs who are at risk for being institutionalized are supported through a team of trained licensed social workers and nurses to advocate and support placement needs using a multifaceted approach that includes interventions in homes, schools, churches, and community centers. The Community-based Case Manager, the member's direct point of contact, will improve access to care for members by linking them with primary care providers (PCPs), arranging transportation, promoting appointment compliance, developing service level plans, and connecting members to community resources.

Meridian will implement a Long Term Care and Integrated Care Program to assist members in receiving the appropriate care in the appropriate care setting. Implementing this program provides members with community-based care alternatives in lieu of nursing home placement effectively reducing costs in the program.

Meridian will utilize an Interdisciplinary Care Management approach designed to provide comprehensive coordination of care through care management, disease management and coordination of Long-Term Services and Supports (LTSS). As part of this interdisciplinary team, LTSS Care Coordinators help manage the needs of an individual, process, evaluate, assess and recommend specific LTSS care coordination interventions that include, but are not limited to, coordinating core services as needed, identifying formal and informal resources for services, and providing social services as necessary.

Meridian ensures the following systems and supports are secured for every member where applicable:

- Adult Companion Services
- Adult Day Care/Health Services
- Assisted Living Services
- Chore Services
- Consumable Medical Supply Services
- Environmental Accessibility Adaptation Services
- Escort Services
- Family Training Services
- Financial Assessment/Risk Reduction Services
- Home Delivered Meals
- Home Healthcare Services
- Homemaker Services
- Nursing Facility Services
- Nutritional Assessment/Risk Reduction Services
- Occupational Therapy
- Personal Care Services
- Personal Emergency Response Systems (PERS)
- Physical Therapy
- Respite Care Services
- Speech Therapy

Meridian coordinates these social services for members requiring such care with local providers, including area agencies on aging, and assists the health plan in:

- Health Risk Assessments
- Risk Stratify the Membership
- Develop Individualized Care Plans
- Perform Ongoing Evaluation and Monitoring of Care Plans
- Implement Interdisciplinary Teams

Meridian will also work with the following provider partners to ensure that services are obtained and the members' needs are met:

- Adult Day Care & Adult Day Health
- Assisted Living Facilities
- Homemaker/Companion/Escort/Chore
- Personal Care
- Home Health Agencies
- Skilled Nursing Facility
- Meals/PERS/Select Contractors
- Home-Environmental Modifications

9.1.1 Initial Screening

1. Describe your plan for conducting initial health risk screenings.

Meridian Health Plan has contracted with Johnson & Johnson Health & Wellness Solutions (HWS) to utilize the Succeed™ Health Assessment as our initial health risk screening. Meridian will conduct the Johnson & Johnson HWS Succeed™ Health Assessment for new members within ninety (90) days of enrollment. We conduct a subsequent health screening, using the tool reviewed and approved by the State, if a member's health care status is determined to have changed since the original screening, which is determined by multiple methods, examples of which include claims review or provider notification. The tool is available for completion in person; by phone; electronically through Meridian's web member portal or by mail. The Johnson & Johnson HWS Succeed™ Health Assessment is National Committee for Quality Assurance (NCQA) certified and complies with the standards for health risk screenings and contains questions that tie to social determinants of health. The Succeed™ Health Assessment consultation is derived from more than a dozen validated research measures and is guided by evidence-based recommendations, including the *United States Preventive Services Task Force*, *Behavioral Risk Factor Surveillance Survey*, and the *United States Department of Health and Human Services*. The Succeed™ Health Assessment determines the need for care coordination, behavioral health services, or any other health or community services.

Meridian will conduct the Johnson & Johnson HWS Succeed™ Health Assessment for new members as part of the welcome call, within ninety (90) days of enrollment for the purpose of assessing need for any special health care or care coordination services; members who have not been enrolled in the prior twelve (12) months; and members for whom there is a reasonable belief they are pregnant. Welcome Calls are completed by our Member Services staff using outreach software. Meridian's outreach software, Presence, is an effective tool Meridian utilizes to contact members in order to welcome them onto the plan. During these calls, we welcome the member to Meridian, perform the initial screening, assist the member in choosing a PCP, offer assistance in arranging an initial visit with their PCP (as applicable) for 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, and answer any questions the member may have. Presence is an efficient tool to attempt to contact members in order to complete initial screenings on our members within ninety (90) days of effectuating with the plan.

The initial health risk screening is conducted either: (i) in person; (ii) by phone; (iii) electronically through a secure website; or (iv) by mail. Attempts are made to reach the member on different days and times, and multiple methods are used to obtain a correct telephone number or address including reviewing claims in the system and calling the member's providers. If the member remains unable to reach (UTR) after three telephonic outreach attempts, a Meridian Community-Based Case Manager will attempt to complete the assessment face-to-face with the member at their home or together with the member at their primary care provider (PCP) office. The Johnson & Johnson HWS Succeed™ Health Assessment is also mailed to the member for completion with a pre-paid postage return envelope.

Members choosing to complete the tool on Meridian's web member portal use Single Sign On technology to seamlessly access the Succeed™ Health Assessment to produce a tailored action plan focused on the member's health risks. The web-based Health Assessment emulates an interaction with a health professional, providing real-time feedback as a user moves through questions. The Assessment has a responsive design where question sets dynamically change based on an individual's responses to previous questions, pinpointing sources of motivation and self-confidence, which is a key intersection where behavior change can happen. When completed telephonically, the real time feedback will be provided by the Member Services representative to the member. Using this technology allows us to analyze each individual's Succeed™ Health Assessment data and then produce a comprehensive, individually tailored action plan focused on the participant's health risks, just as a health coach would.

2. Submit a proposed initial health risk screening tool. Exhibits and attachments may be included.

Johnson & Johnson HWS Succeed™ Health Assessment is provided as Attachment 28 (Health Risk Screening Tool) in Tab 5.

3. Describe the methods that you will use to determine whether changes in member health status warrant subsequent screening.

Meridian Health Plan will conduct a subsequent health screening, Johnson & Johnson HWS Succeed™ Health Assessment if a member's health care status is determined to have changed since the original screening. Meridian will determine if subsequent screening is required based on the following sources:

- Johns Hopkins AGC Predictive Model
- Provider Notification
- Member Request
- Utilization Management referrals
- Disease Management referrals and stratification changes

4. Describe methods that you will use to maximize contacts with members in order to complete the initial screening requirements.

Outreach occurs at the start of enrollment to conduct the Johnson & Johnson HWS Succeed™ Health Assessment to ensure screenings are completed within the required timeframes. Data tracking of screening completion is built into Meridian Health Plan's tracking system. Meridian's system allows for transparency in data reporting and tracking of reassessments. Reporting metrics include completion rates of assessments, timeframe compliance, and risk stratification. To ensure quality and compliance of timeframe assessment and reassessment, audits are conducted regularly of records are conducted regularly.

Telephonic attempts are made to reach the member on different days and times, and multiple methods are used to obtain a correct telephone number or address including reviewing claims and calling the member's providers. If the member remains unable to reach (UTR) after three (3) telephonic outreach attempts, a Meridian Community-Based Case Manager will attempt to complete the assessment face-to-face with the member at his or her home or together with the member at his or her primary care provider (PCP) office. The assessment is also mailed to the member for completion with a pre-paid postage return envelope upon enrollment into Meridian.

Meridian's outreach software, Presence, is an effective tool Meridian utilizes to contact members in order to welcome them onto the plan and complete the Johnson & Johnson HWS Succeed™ Health Assessment. Meridian has telephonic outreach campaigns that are utilized to either contact a member directly, or prompt a call from the member to Meridian.

9.1.2 Comprehensive Health Risk Assessment

1. Submit a proposed validated comprehensive health risk assessment tool. Exhibits and attachments may be included.

The initial health screening described above will be followed by a Comprehensive Health Risk Assessment (HRA) by a Meridian Health Plan Care Coordinator when a member is identified in the initial screening process as having a special health care need, or when there is a need to follow-up on problem areas identified in the initial screening. The comprehensive HRA includes an assessment of a member's need for assignment to a health home and incorporates: a review of the member's claims history; contact with the member and his/her family, caregivers or representative; and contact with the member's health care providers. Members eligible for an HRA have a care coordination case automatically loaded in the system and assigned to the appropriate Care Coordinators.

Meridian's HRA captures information in the following domains:

- Frailty
- Physical, psychosocial, cognitive, and functional needs
- Co-morbidities
- Medical home
- Utilization History
- Individual preferences, strengths, and goals including self-determination arrangements

- Natural supports, including family and community caregiver capacity and social strengths and needs
- Communication needs, including hearing, vision, cultural and linguistic needs and preferences, and member health literacy
- Current services, including those covered by Medicare and Medicaid (in accordance with contractual agreements), local services, and care transition needs
- Medical health risk status and history, including, but not limited to, medications (prescription, over-the-counter, and herbal supplements), frequent falls, and treatment for recurring urinary tract infections; Behavioral Health (BH), Intellectual/Developmental Disability (I/DD) and Substance Use Disorder (SUD) risk status; BH, SUD and I/DD history and needs, including medications
- Nutritional strengths and needs
- Activities of daily living and instrumental activities of daily living, including any assistive technology used or needed and immediate environmental or housing needs
- Cognitive strengths and needs
- Long-Term Services and Supports (LTSS)
- Quality of life including physical, mental and psycho-social well-being
- Discussion of abuse, neglect, or exploitation
- Advance directive and assure provider knowledge of member's directives

The HRA also documents the member's clinical history, assesses life planning activities, and evaluates caregiver resources and supports.

The purpose of Meridian's HRA is to ensure continuity of care, identify members with chronic DM conditions and issues that require immediate resolutions, and initial risk stratification for Care Coordination purposes. In addition, the assessment has defined questions that trigger referrals for follow-up items as appropriate based upon the member's responses. Members are referred for care coordination or other services based on their responses to the HRA questions. The HRA includes appropriate involvement of caregivers, family members and/or other allies and obtaining the member's consent when the desire for such involvement is identified.

The HRA identifies the member's medical care and supportive service needs, including those for primary care, specialty care, durable medical equipment (DME), assistive device, medications, LTSS, HCBS, BH and I/DD and SUD and other necessities and preferences that will inform the development of a care plan if the member is enrolled into Meridian's Care Coordination Program. The HRA identifies and assesses the need for other activities, services and supports to assist members in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve the quality of life and the ability to live in the community.

Meridian's HRA (initial Health Risk Assessment tool) is provided as Attachment 28 (Health Risk Screening Tool) in Tab 5.

2. Propose the timeframe in which all comprehensive health risk assessments shall be completed after initial member enrollment.

Meridian Health Plan Care Coordinators initially attempt to complete the Health Risk Assessment (HRA) telephonically through outreach calls within sixty (60) days of enrollment into Care Coordination. The member's care coordination case is updated when the HRA is completed. The Care Coordinator monitors the timeframe of HRA completion, along with the Care Coordination Team Lead. Attempts are made to reach the member on different days and times, and multiple methods are used to obtain a correct telephone number or address including reviewing claims in the system and calling the member's providers, all of which is documented. If the member cannot be reached by telephone or in person, the HRA is mailed to the member for completion with a pre-paid postage return envelope. Members do have the choice to opt out of HRA completion if they wish.

If a member cannot be contacted by telephone or does not return the mailed assessment form within thirty (30) days, an internal referral will be made to Community-Based Case Manager for a home visit to complete the assessment within the applicable timeframe.

The reassessment process reviews progress towards goals, efficacy of the current care plan, and provides data to compare against the information obtained in the HRA, specifically looking for changes in the member's:

- Functional Status
- Caretaker Status
- Skilled Care Needs
- Cognitive Status
- Behavioral Health Status

At a minimum, Meridian will complete reassessment annually. A reassessment may also be administered when there is a significant change in the member's condition, or upon request of the member.

With every reassessment, the member is brought back to the Interdisciplinary Care Team (ICT) for review and the person-centered care plan is updated. The member's medical, behavioral health, and home community based services are evaluated and his or her care plan is developed specific to the member's preferences and needs, to delivering services with transparency, individualization, respect, linguistic and cultural competence, quality of care, quality of life and dignity. The ICT is responsible for establishing and implementing the individualized care plan for each Meridian member.

3. Describe how the assessment process will incorporate contact with the member and his/her family, caregivers or representative, healthcare providers and claims history.

The Comprehensive Health Risk Assessment (HRA) incorporates a review of the member's claims history; contact with the member and his/her family, caregivers or representative; and contact with the member's health care providers. Prior to the initial outreach, the assigned Care Coordinator reviews all information housed in Meridian Health Plan's system. Our system is a repository for claims data, supplemental data entries, pharmacy, historical claims, and immunization data. This data is utilized by the Care Coordinator to develop familiarity with the

member's past medical history to help guide the initial conversation. Completion of the HRA includes appropriate involvement of caregivers, family members and/or other allies and obtaining the member's consent when the desire for such involvement is identified. At the start of the HRA call, the Care Coordinator will ask the member if they would like to have his/her family, caregivers or representative participate in the call. If the member would like to have another party involved in the completion of the HRA, the Care Coordinator will coordinate with the member and the other party to facilitate the HRA completion telephonically or face to face, if necessary. If the inclusion of another party requires the HRA to be completed face to face, the Care Coordinator will send a referral to the Community-Based Case Manager and schedule a visit for the HRA completion.

9.1.3 Care Coordination

1. Describe in detail your proposed care coordination program including selection criteria and proposed strategies.

Meridian Health Plan's Care Coordination Program focuses on members with special healthcare needs and their families. The purpose is to link the member's needed services and resources in a coordinated effort, achieve better access to needed care, navigate the member through the complex healthcare system, and to increase self-management and self-advocacy skills. The program is designed to ensure timely and thorough coordination of services across various domains, such as primary care, substance abuse, mental health, non-emergency transportation, durable medical equipment repair, dental providers, and community supports, as well as connecting providers through the exchange of relevant information so that treatment for any one of the member's needs includes recognition of their full set of needs. The goal of the program is to maximize the member's potential and provide them with optimal care. In addition, the program is designed to identify members who may be overusing and/or abusing services resulting in increased quality care management across the healthcare continuum: (i) catastrophic case management; (ii) disease management; (iii) programs to target members overusing and/or abusing services; (iv) discharge planning; and (v) transition planning.

Members are evaluated for care coordination services based on an analysis of a variety of data sources including, but not limited to: historical claims and prior authorizations, utilization management information, service level plan, changes in risk stratification, Health Risk Assessment (HRA) responses, laboratory results, pharmacy, hospital discharge, authorization, gaps in care, member/caregiver, member and provider referrals, and predictive modeling. Historic claims data is utilized to identify members with high costs, high admission and/or emergency room use along with specific types and/or numbers of existing diagnoses.

The primary characteristics of members identified for care coordination are those with the multiple chronic physical health problems and face a variety of socioeconomic barriers, e.g., inadequate caretaker support, and unstable housing. Mental illness and substance abuse are also present due to their propensity to add a greater risk of an exacerbation of the member's chronic physical conditions.

Meridian utilizes the Johns Hopkins predictive modeling software to identify patterns of uncoordinated care using criteria-driven algorithms that apply a method for risk stratification based upon claims. Data derived from member assessments are also included in the algorithms such as the status of the member's caretaker and social needs.

The tenets of Meridian's Care Coordination Program include:

- Develop and support an ongoing, person-centered care plan
- Monitor progress towards goals
- Assess risk regularly
- Connection to services: primary care, specialty care, behavioral health, substance abuse, Long-Term Services and Supports (LTSS), acute care, post-acute care, and transitional care
- Establish a consistent medical home
- Link members with community resources to facilitate referrals and respond to social service needs
- Guide transition of care
- Medication reconciliation
- Maintain regular contact with member/caregiver
- Dedicated team-based care management
- Chronic disease self-management education
- Link members with community resources to facilitate referrals and respond to social service needs

The Meridian Care Coordination Team is highly focused on prevention, care coordination, care process re-engineering, dissemination of best practices, team-based care, community-based care, continuous quality improvement, and the use of data to support new care delivery models. Training and educational experiences are continuously provided to help develop this knowledge and skills. Meridian's Care Coordination Model utilizes highly-trained individuals who interact with members in a focused way to address preventive health and chronic conditions.

Integration with Disease Management

Meridian's Care Coordination Program integrates Meridian chronic disease management clinical guidelines for the following conditions: diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, coronary artery disease (CAD), and depression. As such, the Care Coordinators and team consultants provide chronic care management self-education to the member and measure progress towards goals.

Healthcare Effectiveness Data and Information Set (HEDIS®) preventive care alerts are present on each member's medical record that assists the Care Coordinator in creating the member's care plan to access to the services.

Through Meridian's system alerts, the Care Coordinator is advised when disease-specific education mailings are sent to the member. The Care Coordinator reviews the materials with member and creates action plans with the member/caretaker as indicated to optimize health outcomes

The member's assigned Care Coordinator works together with the member to:

- Direct communication between the provider and member/family
- Member and family education
- Coordination of carved-out and linked services, and referrals

- Promotion of co-location of service delivery, particularly for members receiving specialty mental health or chronic substance use disorder services
- Intense coordination of resources to meet care plan goals
- With member and primary care provider (PCP) input, development and support of a person-centered care plan specific to individual needs, and updating of these plans at least annually
- HRA completion for assessment of clinical risks and needs Enhanced self-management training and support
- Direct and indirect member contact, as appropriate and needed
- Coordinating and conducting the Interdisciplinary Care Team (ICT) meetings and activities
- Participating in case rounds and ICT meetings as needed
- Refer members to community resources, supports and services for appropriate medical or social services, including, but not limited to, items outside Meridian's responsibilities, in cooperation with the respective agencies
- Facilitate communication among a member's medical care, LTSS, and behavioral health providers when appropriate
- Engage in other activities or services needed to assist beneficiaries in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health outcomes
- Facilitate timely access to primary care, specialty care, medications, behavioral health and other health services needed by the member, including referrals to address any physical or cognitive barriers to access
- Notify the ICT of the member's hospitalization (psychiatric or acute) and coordinate a discharge plan if applicable
- Facilitate direct communication between the provider and the member
- Facilitate member and family education
- Coordinate and make referrals to community resources (i.e. housing, home-delivered meals, energy assistance programs) to meet care plan goals
- Monitor the implementation of the care plan with the member, including facilitating the member's evaluation of the process, progress and outcomes, and identifying barriers and facilitating problem resolution and follow-up
- Advocate with or on behalf of the member as needed, to ensure successful implementation of the care plan
- Support transitions in care when the member moves between care settings
- Engage in other activities or services needed to assist the member in optimizing his or her health status, including assisting with self-management skills or techniques; face-to-face annual medication review and member education; health education; referrals to support groups, services, and advocacy agencies, as appropriate; and other modalities to improve health status
- Assure the Medicaid eligibility redetermination process is completed timely to prevent the loss of benefits
- Identify changes in conditions or utilization of services for all members, including, but not limited to, newly diagnosed acute and chronic conditions, high frequency of emergency room visits, hospitalizations, or LTSS or Behavioral Health/Substance Use Disorder and Intellectual/Developmental Disability referrals

- Develop, with member and ICT, a care plan specific to individual needs and monitor and update the care plan at least annually or following a significant change in needs or other factors

The Care Coordinators will initially conduct telephonic Health Risk Assessments with members and/or their care givers. The Health Risk Assessment (HRA) tool addresses a member's physical, social, medicinal, developmental, behavioral, nutritional, environmental and clinical areas/needs. The Care Coordinator is expected to collect the information from the member or family caregiver within ninety (90) days of enrollment. Reassessments are performed at least annually and when there is a significant change in healthcare or caretaker status. The information obtained through the assessment will be shared in the form of a Summary Profile and a person-centered care plan that will be shared with the member and/or their caregiver, along with the member's primary care provider (PCP). The Care Coordinator will coordinate the services, inclusive of preventive health screenings, together with the member, and/or caregiver, and member's primary care provider and ensure that all appropriate handoffs occur.

During the initial Health Risk Assessment, complete medication reconciliation is recorded for each member. As a component of the care plan, interventions are designed around evaluating medication compliance, poly-pharmacy, and medication education and over all medication management. Care Coordinators and pharmacy staff will follow-up with members to verify compliance with medication plans and provide continuous medication alignment. The care management system can be modified to base interventions on any standards or models to ensure proper compliance and management. For example, triggers can be set in the system to apply interventions related to HEDIS® measures, such as annual monitoring for patients on persistent medications.

Meridian's Community-Based Case Manager will conduct face-to-face visits with members and their caregivers where applicable. Instances include, but are not limited to, when the Care Coordinator is unable to reach the member or results of the assessment indicate the member requires a face-to-face assessment to identify medical, behavioral, social and functional issues and needs. Based upon the data obtained through the assessments and a review of historical claims, an individualized care plan is developed for the member that will address the member's needs including the member's cultural and linguistic preferences. The member's individualized care plan will be developed using a problem, goal, intervention methodology with interventions designed to address each identified problem.

Through Care Coordinator outreach, additional risk factors may be identified in which case a referral/consultation is made to a medical, behavioral health (BH), nutrition, or smoking cessation program or to a Pharmacist for medication review. Based on the set of medical and psychosocial risk factors, a referral can be made to the Community-Based Case Managers to deploy for a home visit and assessment.

Triggers for a Community-Based Case Manager referral and a home visit include, but are not limited to:

- Face-to-face Assessment completion
- Assessment of disabilities and resources needed to function at home
- Members who reside in designated county with multiple comorbidities and multiple HEDIS® gaps

- High-ER utilizers unable to reach with the goal of education and developing a linkage to the PCP
- Members with multiple socioeconomic barriers who need help navigating the system
- Behavioral Health members with multiple emergency room/inpatient (IP) admissions with no outpatient follow up
- Provider referral to Care Coordination due to non-compliance
- Members with renal failure and or on dialysis

Meridian Care Coordination (CC) Teams meet with the Interdisciplinary Care Team (ICT) to discuss cases and make sure all internal and external resources are used to meet the member's short-term and long-term needs. All CC Team members attend the daily meeting where they give input and plan next steps in their area of expertise.

Meridian's systems provide the ability to analyze claims and other encounter data to ensure that all captured diagnoses are accounted for. Additionally, assessments include questions geared to identifying patients at risk based on their social and medical needs. Patients that are identified as having serious mental health illness, substance abuse issues or developmental disabilities are referred to the appropriate Care Coordination consultant, (e.g. Behavioral Health Case Manager) and then managed by an ICT.

The Care Coordinator develops self-management plans in collaboration with the member. Self-management is a critical component of the member care plan that is designed to empower the member/caregiver to provide appropriate levels of self-care. These self-management activities are provided to members in oral and written form. They can also be provided to the member by any care team staff, such as Disease Management or Pharmacy staff, a discharge planner, a diabetic educator or a dietician. The self-management plan includes, but is not limited to, member monitoring of symptoms, activity, weight, blood pressure and blood substance levels, scheduling and attending medical appointments and medication adherence.

The system documentation includes the specific educational materials sent to the member, as well as any verbal self-management instructions and coaching given by the Care Coordinator. Additionally, the member and primary care provider (PCP) are sent a care plan letter which details the short-term and long-term goals to which the member has agreed. This letter also notes the interventions that will be performed to accomplish the goals. The Care Coordinator also creates a medication list which is mailed to the member. The member is expected to follow the medication list and bring it to every provider appointment. A copy of the medication list is also mailed or faxed to the primary care provider for purposes of medication reconciliation. Based on assessment results, members are stratified into low, moderate, high or intensive risk groups. Care Coordinators utilize stratification to determine acuity of the disease and determine the degree of intervention needed based upon the member's level of acuity. The intensity, type and frequency of member interventions (direct or indirect) are determined by their combined needs and resulting case risk stratification. Motivational interviewing is one of the mechanisms employed by the Care Coordinator to determine which goal(s) the member appears ready to work on. The Care Coordinator assesses progress relative to case management plans and goals, modifying them as needed. The member's progress towards the goal is documented after every member contact as well as any identified barriers to meeting the goals and compliance.

See the following chart for Meridian's Care Coordination Continuum.

| Meridian Care Coordination Continuum | | | |
|--------------------------------------|---|---|--|
| | Included in Care Coordination | Description | Services |
| LOW | <p>Primary Contact: Community-Based Case Manager, Member Services</p> | Healthy, well members who require occasional assistance | <ul style="list-style-type: none"> • Regularly Scheduled Outreach Calls • Appointment Reminder Calls • Preventive Health Service Reminders • Personalized Disease Management letters • Collaboration with PCP • Community Resource Referrals • Transportation Referrals |
| MODERATE | <p>Primary Contact: Care Coordinator</p> <p>Consultants: Care Coordination Team Lead, BH Case Manager, Nutritionist, Pharmacist, Community-Based Case Manager</p> | Members with a chronic illness who are able to self-manage and would benefit from education about their illness | <ul style="list-style-type: none"> • Regularly Scheduled Outreach Calls • Appointment Reminder Calls • Preventive Health Service Reminders • Collaboration with PCP • Community Resource Referrals • Transportation Referrals • Complete Assessment • Develop Problems and Goals with Member/Caregiver • Create Integrated Care Plan • Personalized Disease Management letters • Condition-Specific Educational Packets • Work with Member Toward Self-Management of Condition • Life Planning Activities • Face-to-Face Personalized Care Coordination by Community-Based Case Manager, if applicable • Interdisciplinary Care Team Participation |
| HIGH | <p>Primary Contact: Care Coordinator</p> <p>Consultants: Care Coordination Team Lead, BH Case Manager, Complex Case Manager, Nutritionist, Pharmacist, Community-Based Case Manager</p> | Members with chronic diseases, behavioral health conditions with some complications | <ul style="list-style-type: none"> • Regularly Scheduled Outreach Calls • Appointment Reminder Calls • Preventive Health Service Reminders • Collaboration with Multiple Providers • Community Resource Referrals • Transportation Referrals • InterRAI Comprehensive Assessment • Develop Problems and Goals with Member/Caregiver • Create Integrated Care Plan • Condition-Specific Educational Packets • Personalized Disease Management letters • Work with Member Toward Self-Management of Condition • Life Planning Activities • Face-to-Face Personalized Care Coordination by a Community-Based Case Manager • Coordination of Behavioral and Medical Services • Interdisciplinary Care Team Participation |
| INTENSIVE | <p>Primary Contact: Care Coordinator or Complex Case Manager</p> <p>Consultants: Care Coordination Team Lead, BH Case Manager, Complex Case Manager, Nutritionist, Pharmacist, Community-Based Case Manager</p> | Members with complex care needs who have (or are at high risk for) chronic physical, developmental, behavioral, neurological, or emotional conditions that may have an increased need for healthcare services due to their conditions | <ul style="list-style-type: none"> • Regularly Scheduled Outreach Calls • Appointment Reminder Calls • Preventive Health Service Reminders • Collaboration with Multiple Providers • Community Resource Referrals • Transportation Referrals • InterRAI Comprehensive Assessment • Develop Problems and Goals with Member/Caregiver • Create Integrated Care Plan • Condition-Specific Educational Packets • Personalized Disease Management letters • Work with Member Toward Self-Management of Condition • Life Planning Activities • Face-to-Face Personalized Care Coordination by Community-Based Case Manager • Coordination of Behavioral and Medical Services • Post-discharge transition assessment, if applicable • Assessment of support systems/caregiver resources and involvement • Certified Education classes or Rehabilitation services, if available • Interdisciplinary Care Team Participation |

Catastrophic Case Management

Meridian's catastrophic case management program is known as complex case management and includes the coordination of services for a subset of high-risk members whose conditions and/or medical fragility are described as persistent, substantially disabling or life threatening and who require treatment and intervention across a variety of domains of care, such as medical, social and mental health. The entire Meridian member population is assessed against defined algorithms to determine the members who comprise this subset. Their conditions can require treatment from multiple providers of care and sites of service.

Meridian's complex case management program focuses on providing members with tools for successful self-management. Self-management is a critical component of the complex case management care plan, designed to empower the member and/or member's care team to provide self-care when appropriate.

At least annually, Meridian evaluates its complex case management process and components. This evaluation takes into consideration the characteristics of those members enrolled into the complex case management program over the previous year and the needs they presented. Meridian updates and redefines the program's structure and resources (e.g. staffing ratios, clinical qualifications, training, external resources, cultural competency) as needed based on this analysis. The components of the program are tailored to meet the needs of this population subset so Meridian complex case managers can perform appropriate population management.

Our complex case managers complete assessments within thirty (30) days from the date their referral is assigned. The complex case manager will contact the member (may occur in multiple contacts) to confirm the data collected from the system and to:

- Assess the member's health status, including condition-specific issues, and document the information in the initial assessment and condition specific assessment(s) relevant to the member's condition(s), e.g. diabetes, CVD, COPD, asthma, sickle cell disease.
- Document the member's clinical history (including disease onset and key events such as acute phases, inpatient stays, treatment history, and medication schedule and dosages) in the Clinical History, Medication Adherence, and Utilization History assessment tools.
- Assess the member's ability to perform activities of daily living as well as hearing and vision needs, documenting the information in the Activities of Daily Living/Caregiver assessment tool.
- Assess the member's mental health status, including psychosocial factors and cognitive functions, and document the information in the Behavioral Health assessment tools.
 - If the member responds "yes" to either of the depression screening questions, the complex case manager will either warm transfer the member to a Behavioral Health staff member to complete a PHQ-9 depression screening or make a behavioral health consult for follow up by the behavioral health Care Coordinator for completion of depression screening and to assist member in obtaining services if needed.
 - If the member is determined to have a score less than four (4), the Behavioral Health Care Coordinator will provide the member with behavioral health benefit and access information. The behavioral health Care Coordinator will also notify the member's provider(s) of the depression screening score and fax a copy of the PHQ-9 results to the provider. The complex case manager will follow up with the member to ensure that the member has been able to secure providers for follow

- up. The behavioral health Care Coordinator will contact the member in three (3) months to complete a repeat PHQ-9 for reassessment to ensure that member is following up and is receiving appropriate services. A copy of the repeat PHQ-9 will be faxed to the member's provider(s).
- Cognitive and Psychosocial factors: If the member is unable to communicate, understand instructions or process information regarding their illness due to physical or behavioral health issues, the complex case manager will work with the member's designee/guardian upon to provide education on the member's illness and care plan.
 - The Meridian Complex Case Manager also evaluates the member's cultural and linguistic needs, preferences or limitations, documenting the information in the Cultural/Language assessment tool. Also evaluated are the members' caregiver resources such as family involvement and decision-making about the care plan. Available benefits are evaluated along with other pertinent financial information regarding benefits, and current use of community resources, and are documented in the Healthcare/Service assessment tool.
 - Assessment of life planning activities is also completed and documented with all members.

Upon completion of each assessment, the Complex Case Manager will summarize the results in narrative form in the case notes. This documentation will also include if an assessment was not applicable to a member.

Transitions of Care

The transition of care process is in place to reduce potentially preventable readmissions by improving the transitioning of care from one setting to the next by providing the member with the tools and support that promote knowledge and self-management of his/her condition(s). The transition coordination process assures the right systems and supports are in place to complete successful transitions for all members. The transition of care process will always be supervised by a clinical Care Coordinator, such as a nurse or licensed social worker; if the member is assigned to a non-clinical Care Coordinator at the time of transition. The member is reminded at each point of transition that his/her consistent point of contact at the plan is the Meridian Care Coordinator as he/she moves through the continuum of care.

The member's Care Coordinator is notified through the prior authorization process of planned and unplanned transitions. Entry of a new authorization appears as an alert on the Care Coordinator's work list and requires acknowledgement to be removed. For planned transitions, this authorization will have an authorization start date in the future. For unplanned transitions, this authorization will have an authorization start date of the same day.

Once the Care Coordinator is notified of the impending or occurring transition, the case is reassigned to a clinical Care Coordinator to assume care of the member during the transition. He/she communicates with the member either telephonically or in-person to explain the upcoming procedure or admission. The Care Coordinator ensures the member is prepared for the admission and provides support throughout the transition period into the facility.

Once the member is admitted to the facility for both planned and unplanned transitions, the Clinical Care Coordinator provides follow up and monitors the case appropriately; making contact with both the member and/or the member's authorized representative and staff at the

facility. The Care Coordinator ensures the member is receiving the needed care and has no concerns.

Typically, members experiencing a transition will have an intensive acuity level and will be monitored by the Care Coordinator on a daily basis. This monitoring can include but is not limited to:

- Direct contact with the member
- Contact with the discharge planner
- Contact with other hospital staff members
- Contact with provider office staff members
- Review of utilization claims
- Review of inpatient review notes

Support varies case by case and can include but is not limited to the following types of activities:

- Assessing the member's current living conditions
- Assessing member's independence and or caregiver status
- Review of the discharge plan in accordance with the member's Meridian care plan, member's needs, and preferences
- Determination of needs at discharge
- Education regarding the importance of following the discharge plan
- Appointment scheduling for follow up visit with primary care provider (PCP) and/or specialist(s) after discharge
- Arrangement of transportation services
- Arrangement of skilled home care or other appropriate outpatient services such as meals on wheels
- Referrals to community service agencies or assistance in arranging personal care services
- Procurement of durable medical equipment or other medical supplies
- Verification of discharge medications to determine if prior authorization is required
- Referral for a transition of care home visit if necessary within forty-eight (48) hours of discharge to assess current living situation and family and caregiver supports, need for community referrals, assist with appointment and transportation scheduling, medication reconciliation, and confirm that arranged services have made contact with the member and or caregiver

The PCP is notified of the member's transition via automatic fax of the Transition Notification letter from the authorization within twenty-four (24) hours of discharge notification. The Care Coordinator will then fax the Transition of Care Summary within twenty-four (24) hours of the discharge date. The Transition of Care Summary includes the following information: member's Interdisciplinary Care Team (ICT) review dates, care plan, utilization history, current transition information, and previous transition information and a summary of the discussions with facility staff and the member including results of post inpatient call to the member.

The PCP will receive this notification for any acute transition that the member experiences. The PCP will also receive a copy of the discharge instructions if received by facility and medication adherence assessment within seventy-two (72) hours of discharge as faxed by the Care Coordinator.

The Care Coordinator ensures the member's care plan including the member objective profile is shared from the sending setting to the receiving setting. Upon confirming the receipt of the Care plan and objective profile, the Care Coordinator documents appropriately.

If the sending setting is home, the member or member's authorized representative/caregiver is responsible for bringing the member's medication record to the facility as well as the Meridian member-centered care plan.

The Care Coordinator assists the member in obtaining and maintaining the records above as well as providing the member a copy of the care plan each time it is updated. The Care Coordinator reminds the member to take these records upon any transition through telephonic contact, face to face contact and member newsletters as necessary. If the member fails to bring his/her records upon transition, the Care Coordinator will fax the medication record and the member care plan to the facility within one business day of notification of the transition. These records will be faxed to the treating provider or the hospital case manager (if applicable) once identified through admission data.

The member objective summary will be faxed to the receiving setting by the Care Coordinator to the treating provider or hospital case manager within one (1) business day of the transition. If the sending setting is one facility and the member is transferring to another facility, an inter-facility transfer form is used to share medical information between the facilities and is the responsibility of the sending setting. The transfer form summarizes the member's medical issues and medications and acts as a care plan. The sending setting's care plan is sent with the member upon transfer.

Throughout the inpatient process, the Care Coordinator works with the facility discharge planner and staff to create an appropriate discharge plan in accordance with the Meridian care plan and ensure all of the member's needs will be met. The Care Coordinator communicates either telephonically or face-to-face, the discharge plan to the member and/or the member's authorized representative within one (1) day of the transition whenever possible.

If the Care Coordinator is unable to contact the member and/or the member's authorized representative, Meridian delegates to the attending physician, hospitalist, and/or the sending setting's discharge planner the responsibility to communicate with the member or responsible party concerning the care transition process, changes in the member's health status, and care plan within one (1) day of transfer.

Documentation in Meridian's system includes the following:

- Pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment, and other in home support services received, such as personal care services, medical appointment escorts, home delivered wheels or community based adult services
- Pre-discharge factors, including an understanding of the medical condition or functional status, physical and mental health status, financial resources, and social supports.
- Services needed after discharge including setting preferred by member, specific agency/home recommended by the hospital, specific agency/home agreed to by the member and pre-discharge counseling recommended

- Post-transition access to necessary medical care and follow up, medications, durable medical equipment and supplies, transportation, and integration of community-based long term support services and supports (LTSS) programs
- Coordination with county agencies for in home support services and behavioral health services, community based adult services, community based outreach such as Area Agencies on Aging, and nursing facilities, as appropriate. For in home support services, the coordination between the county social service agencies regarding the discharge plan.
- Summary of the nature and outcome of member involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution
- Expedited process for Multipurpose Senior Services Program assessment and eligibility determination for members who are being discharged from the hospital or at risk of immediate placement in a skilled nursing facility
- For members receiving county-administered specialty mental health or substance use service , notification of the Interdisciplinary Care Team (ICT) of hospital admission (psychiatric or acute) and coordination of a discharge plan including how a member's medical problems or member's mental health problems are being addressed

For members transitioned to a long term, skilled, or custodial care setting, Meridian's Transitional Case Manager maintains communication with the receiving facility and conducts concurrent review. Meridian's Transitional Case Manager works collaboratively with the Care Coordinator and the facility to plan for a safe transfer to the next appropriate level of care.

If the member is not already assigned a community Care Coordinator, the member will be transitioned to a community Care Coordinator at this time. The Community-Based Case Manager will visit the member in the facility and engage the member about their condition and discharge plan in order to determine the type of support the individual will need at discharge. Arrangements will be made prior to discharge in relation to skilled nursing services, therapies, and personal care services, meals on wheels, transportation, durable medical equipment, and review of medications including procurement of any prior authorizations.

Once the member is medically able to be transitioned to a home setting, the long term care facility, skilled nursing facility, or custodial nursing facility completes a discharge care plan and communicates that care plan to the member and/or the member's authorized representative and to the PCP assuming the member's care upon discharge. The information provided includes:

- Current health status
- Treatment summary
- Medication regimen
- Services required upon discharge
- Appointments required at discharge
- Community resource referrals such as transportation, meals, medical escort, homemaker and personal care attendant

The Care Coordinator follows up with the facility to ensure this information has been provided to the member and the member's PCP, that discussion has occurred with the members and/or caregivers as to needs at discharge and that all needed services as well as appointments are scheduled prior to discharge. A referral is made for a transition of care home visit for members hospitalized with specified conditions within forty-eight (48) hours of discharge to assess living

situation, social support, community resource referrals, medication reconciliation, appointment and transportation scheduling if needed, and confirmation that arranged services have been in contact with the member.

For members transitioned to a home setting that are not referred for the transition home program, the Care Coordinator will contact the member either telephonically or in-person within seventy-two (72) hours of discharge to:

- Confirm the member understands the discharge plan/care plan
- Confirm the member has scheduled a follow-up appointment with his/her PCP and specialists
- Confirm the member has transportation for all appointments. If not scheduled, he or she will assist with appointment scheduling and transportation as needed
- Ensure that needed services (e.g. home health care) have been arranged and have contacted the member as ordered
- Member has received any needed durable medical equipment
- Explaining the signs and symptoms that may necessitate a call to the PCP or specialist
- Offer assistance in overcoming any barriers
- Complete a medication reconciliation and identify any new medications prescribed at discharge
- Ensure the member has filled the medications prescribed and is taking appropriately

Members who have been hospitalized for selected conditions will be referred for a transition of care home visit within forty-eight (48) hours of discharge. Activities that will be performed at this visit include:

- Assessment of member's current living situation including social support
- Assessment of member's and/or caregiver's ability to care for the member.
- Review of member's discharge instructions
- Ensure that member has follow up visit scheduled with PCP within seven (7) days of discharge and other appointments as needed. Will schedule transportation if needed.
- Assessment of need for community resource referrals such as meals, transportation, homemaker services, medical escort, personal care assistant.
- Medication reconciliation
- Action plan review so member/caregiver knows when to call PCP for changes in condition
- Arrangement of meals if needed
- Confirmation of arranged services being delivered and durable medical equipment being delivered

Overuse/Abuse of Services

Meridian utilizes a variety of data reports to identify members who are overusing and/or abusing services. These reports include longitudinal review of data derived from claims (both Meridian and historical claims received from the State that include drug and medical claims, ICD-9, NDC, and DRGs), laboratory, pharmacy, hospital discharge, authorization, member/caregiver, and provider-supplied data. By reviewing these reports from multiple data sources, Care Coordination leadership can ensure members receive the appropriate care management based on current needs.

Members who overuse and/or abuse emergency room services are managed through Care Coordination and include, members who have had more than six emergency room visits in a rolling six month period, repeated emergency room visits with no follow-up with a primary care (or specialist when appropriate) physician, more than one outpatient hospital emergency room facility used in a quarter, and repeated emergency room visits for non-emergent conditions. Also included are members who overuse and/or abuse pharmacy services and physician services (utilizing more than one physician/physician extender in different practices to obtain duplicate or similar services for the same or similar health condition and/or to obtain prescriptions for the certain drug categories in one quarter.

In addition to the identification reports, members can be referred to the Care Coordination Program individually. Referrals to Care Coordination can be generated by all Meridian staff and are automatically routed to Care Coordination leadership team for review.

Following the initial contact, the Care Coordinator works with the member and member's care team to identify and document problems, short-term goals, long-term goals, and barriers in the system. The Care Coordinator discusses the services and assistance that he/she can provide and asks the member and member's care team for input in development of the member's care plan.

The Care Coordinator develops a schedule for communication with the member based on the member's level of acuity. Prior to concluding any telephonic contact with the member, the Care Coordinator reinforces with the member the selected follow-up goal and confirms the date of the next scheduled contact with the member. Interventions and contacts are made with external resources such as hospital discharge planners and provider office staff to reach goals, e.g. contacting a specialist to request a copy of the member's medical record. Each contact/intervention is recorded with the specific goal it addresses. Any information obtained from an external resource is included in the member's permanent record within system.

The Care Coordinator monitors his/her work queue on a daily basis to identify scheduled follow-up plans with members and review any new member activity, e.g. new hospitalization. The Care Coordinator develops and communicates self-management plans with the member. Self-management attempts will be documented by the Care Coordinator by entering contact codes specific to self-management activities in the member's system case documentation. The Care Coordinator will assess progress against the care plan and goals and modify as needed.

Progress toward reaching goal(s) will be updated by the Care Coordinator with each member contact and when interventions are performed. Barriers identified that prevent the member from meeting the goals or maintaining compliance is documented at this time.

With every contact, the Care Coordinator will ask the member four reassessment questions related to their utilization, medications, and current conditions and document the member's response in the system. These reassessment questions are used to help assess any change in the member's condition. Progress will also be documented when a transition of care occurs. Transitions can lead to the completion of goals, the identification of new goals, the removal of existing barriers, and/or the presence of new barriers.

2. Provide data on outcomes achieved in your care coordination programs operated in other states, if applicable.

Meridian Health Plan has contracted with Johnson & Johnson Health & Wellness Solutions (HWS) to utilize the Succeed™ Health Assessment as our initial health risk screening. Meridian will conduct the Johnson & Johnson HWS Succeed™ Health Assessment for new members within ninety (90) days of enrollment. We conduct a subsequent health screening, using the tool reviewed and approved by the State, if a member's health care status is determined to have changed since the original screening, which is determined by multiple methods, examples of which include claims review or provider notification. The tool is available for completion in person; by phone; electronically through Meridian's web member portal or by mail. The Johnson & Johnson HWS Succeed™ Health Assessment is NCQA certified and complies with the standards for health risk screenings and contains questions that tie to social determinants of health. The Succeed™ Health Assessment consultation is derived from more than a dozen validated research measures and is guided by evidence-based recommendations, including the *United States Preventive Services Task Force*, *Behavioral Risk Factor Surveillance Survey*, and *the United States Department of Health and Human Services*. The Succeed™ Health Assessment determines the need for care coordination, behavioral health services, or any other health or community services.

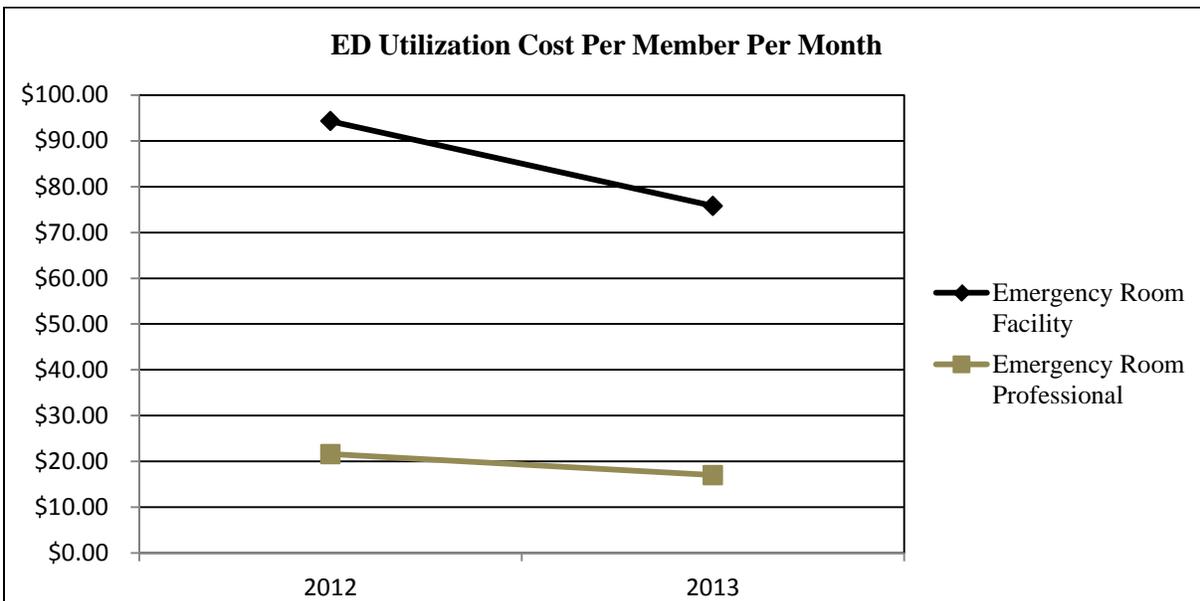
Meridian will conduct the Johnson & Johnson HWS Succeed™ Health Assessment for new members as part of the welcome call, within ninety (90) days of enrollment for the purpose of assessing need for any special health care or care coordination services; members who have not been enrolled in the prior twelve (12) months; and members for whom there is a reasonable belief they are pregnant. Welcome calls are completed by our Member Services staff using outreach software. Meridian's outreach software, Presence, is an effective tool Meridian utilizes to contact members in order to welcome them onto the plan. During these calls, we welcome the member to Meridian, perform the initial screening, assist the member in choosing a primary care provider (PCP), offer assistance in arranging an initial visit with their PCP (as applicable) for 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, and answer any questions the member may have. Presence is an efficient tool to attempt to contact members in order to complete initial screenings on our members within ninety (90) days of effectuating with the plan.

Meridian excels at routine and preventive care measures and focuses on the management of chronic conditions prevalent in our populations. Our clinical infrastructure identifies high-risk members necessary in coordinating the specific care needed, as well as facilitating a preventive and proactive delivery of education and treatment. Meridian's development of award-winning software enables predictive analysis with the goal of personalizing member management. The aforementioned technology assists in identifying the right care at the right time for the right member. It results in evidence-based, member-centered care being delivered in the most efficient manner possible.

In 2013, Meridian saw a nineteen point six-four percent (19.64%) reduction in emergency room utilization and a fifty-eight point eight-six percent (58.86%) reduction in urgent care facility utilization for the members reviewed. Additionally, a twenty-seven point five percent (27.50%) reduction in inpatient facility utilization was recognized for these members. The reduction in utilization represents a positive impact of the Care Coordination Program.

One of the goals for the Care Coordination Program is for members who have an inpatient hospital admission to follow-up with their PCP within seven (7) days of discharge. Our Care Coordination Nurse Team Leads are required to attempt to contact a member within seventy-two (72) hours of having been discharged from an inpatient stay. The Nurse Team Lead will assist the member in scheduling any follow-up appointments with their physician(s), thus assisting with the coordination and continuity of medical care.

| | First Period January- June 2012 | Second Period January- June 2013 | Total Percentage Change 1 st - 2 nd Period |
|-----------------------------|---------------------------------------|--|--|
| Emergency Room Facility | \$94.31 | \$75.79 | -19.64% |
| Emergency Room Professional | \$21.57 | \$16.99 | -21.23% |
| Inpatient Facility | \$504.85 | \$366.03 | -27.50% |
| Inpatient Professional | \$54.34 | \$35.84 | -34.05% |
| Outpatient Facility | \$198.10 | \$160.14 | -19.16% |
| Pharmacy | \$259.98 | \$259.16 | -0.31% |
| Professional | \$267.13 | \$234.15 | -12.34% |
| Urgent Care Facility | \$0.84 | \$0.35 | -58.86% |
| Total | \$1,401.12 | \$1,148.45 | -18.03% |



Strong Start Program

In February of 2013, Meridian was awarded a Centers for Medicare and Medicaid Services (CMS) Innovations grant for decreasing the number of preterm deliveries. Meridian was one of twenty-seven (27) awardees selected for the four (4) year grant. Meridian has targeted a five (5) county area surrounding Allegiance Health, a hospital system in lower-central Michigan. Meridian designated two telephonic Care Coordinators and a Community-Based Case Manager

located within the community. Participants were enrolled in the program beginning September 1, 2013. By the end of 2014, there were 1,219 women enrolled in the program.

Strong Start enrollment by quarter, 2014

| | Q1 | Q2 | Q3 | Q4 | Total |
|-------------------|-----|-----|-----|-----|-------|
| Enrollment | 349 | 222 | 226 | 196 | 992 |

Meridian’s interventions have resulted in reductions in preterm delivery and low birth rates within the focus area, the results are outlined in the table below. Meridian is continuing our emphasis on maintaining strong relationships with provider offices and community organizations in the area, and in this final year we anticipate sustained success resulting in further reductions. Our outreach through the Community-Based Case Manager has proven to be a valuable asset, observing contact rates of almost thirty percent (30%), with thousands of attempts to contact members.

Meridian has received recognition for our successful results with the Strong Start program. CMS has identified Meridian as a leading awardee organization, and they have invited us to present our program and results at several events. Meridian also received recognition through the Michigan Association of Health Plans (MAHP) for its partnership with Allegiance and the positive results achieved thus far in the project study period. Meridian and Allegiance will continue to track the results of the impact on members in the targeted community while planning for the sustainability of the program when the grant funding ends in February of 2016.

Strong Start birthing outcomes, 2014

| Measure | Strong Start | State Rate | National Rate | March of Dimes Goal |
|---|--------------|------------|---------------|---------------------|
| Preterm Delivery Rate | 9.04% | 11.5% | 11.8% | 11.8% |
| Low Birth Weight (under 5 ½ lbs. or 2,500 grams) | 8.07% | 8.4% | 8.0% | 7.8% |

9.1.4 Risk Stratification

1. Describe your proposed risk stratification methodology.

Meridian Health Plan utilizes risk stratification levels determined by the intensity and frequency of follow-up care that is required for each member participating in the Care Coordination Program. Meridian uses the Johnson & Johnson HWS Succeed™ Health Assessment as an initial screening tool along with the Comprehensive Health Risk Assessment (HRA), predictive modeling and surveillance data to stratify members into the appropriate level of intervention, proactively identify high-risk members, and monitor gaps in care. Meridian analyzes predictive modeling reports and other surveillance data for all members at least monthly to identify risk level changes. Surveillance data includes referrals, transition information, service authorizations, alerts, memos, information from families, caregivers, providers, community organizations, and Meridian personnel.

Members are stratified within a four (4) tier structure. These stratification levels are assigned by combining the output of the Johnson & Johnson HWS Succeed™ Health Assessment, the Comprehensive Health Risk Assessment (HRA) and the Johns Hopkins Adjusted Clinical Grouper (ACG) Predictive Modeling software. The Johns Hopkins ACG Predictive Model is run on all new members and analyzes all historical or current data for each member. The model scores the members based on medical and pharmacy claims data and assigns a risk score. The risk score is then supplemented by the output from the HRA to assign each member their initial risk stratification or, acuity level. Complex algorithms combine pharmacy and medical claims to assign a resource utilization band that is translated into a risk score. The risk score is combined with the member's self-reported conditions from the Johnson & Johnson HWS Succeed™ Health Assessment and the HRA to illustrate a more complete picture of each member's risk level.

Members are stratified monthly, and Meridian monitors the changing of stratification levels monthly through a reporting tool in system. Care Coordination leadership can enter a user-defined date range, select a specific population, and generate a monthly report that will show the stratification level changes within that timeframe. The report will show the original stratification level and the new stratification level as well as the date the level was changed. Care Coordinators will conduct a Comprehensive Health Risk Assessment on members who were initially identified as low-risk but become moderate or high-risk.

2. Describe your proposed risk stratification levels.

Meridian Health Plan members are placed into the appropriate Care Coordination Program based on their assigned risk stratification level. Meridian's risk stratification levels are as follows:

- Low – Healthy, well members who require occasional assistance
- Moderate – Members with a chronic illness who are able to self-manage and would benefit from education about their illness
- High – Members with chronic diseases, behavioral health conditions with some complications
- Intensive – Members with complex care needs who have (or are at high risk for) chronic physical, developmental, behavioral, neurological, or emotional conditions that may have an increased need for healthcare services due to their conditions

The following chart describes Meridian's risk stratification levels:

| Meridian Care Coordination Continuum | | | |
|--------------------------------------|---|---|--|
| | Included in Care Coordination | Description | Services |
| LOW | Primary Contact: Community-Based Case Manager, Member Services | Healthy, well members who require occasional assistance | <ul style="list-style-type: none"> • Regularly Scheduled Outreach Calls • Appointment Reminder Calls • Preventive Health Service Reminders • Personalized Disease Management letters • Collaboration with PCP • Community Resource Referrals • Transportation Referrals |
| MODERATE | Primary Contact: Care Coordinator Consultants: Care Coordination Team Lead, BH Case Manager, Nutritionist, Pharmacist, Community-Based Case Manager | Members with a chronic illness who are able to self-manage and would benefit from education about their illness | <ul style="list-style-type: none"> • Regularly Scheduled Outreach Calls • Appointment Reminder Calls • Preventive Health Service Reminders • Collaboration with PCP • Community Resource Referrals • Transportation Referrals • Complete Assessment • Develop Problems and Goals with Member/Caregiver • Create Integrated Care Plan • Personalized Disease Management letters • Condition-Specific Educational Packets • Work with Member Toward Self-Management of Condition • Life Planning Activities • Face-to-Face Personalized Care Coordination by Community-Based Case Manager, if applicable • Interdisciplinary Care Team Participation |
| HIGH | Primary Contact: Care Coordinator Consultants: Care Coordination Team Lead, BH Case Manager, Complex Case Manager, Nutritionist, Pharmacist, Community-Based Case Manager | Members with chronic diseases, behavioral health conditions with some complications | <ul style="list-style-type: none"> • Regularly Scheduled Outreach Calls • Appointment Reminder Calls • Preventive Health Service Reminders • Collaboration with Multiple Providers • Community Resource Referrals • Transportation Referrals • InterRAI Comprehensive Assessment • Develop Problems and Goals with Member/Caregiver • Create Integrated Care Plan • Condition-Specific Educational Packets • Personalized Disease Management letters • Work with Member Toward Self-Management of Condition • Life Planning Activities • Face-to-Face Personalized Care Coordination by a Community-Based Case Manager • Coordination of Behavioral and Medical Services • Interdisciplinary Care Team Participation |
| INTENSIVE | Primary Contact: Care Coordinator or Complex Case Manager Consultants: Care Coordination Team Lead, BH Case Manager, Complex Case Manager, Nutritionist, Pharmacist, Community-Based Case Manager | Members with complex care needs who have (or are at high risk for) chronic physical, developmental, behavioral, neurological, or emotional conditions that may have an increased need for healthcare services due to their conditions | <ul style="list-style-type: none"> • Regularly Scheduled Outreach Calls • Appointment Reminder Calls • Preventive Health Service Reminders • Collaboration with Multiple Providers • Community Resource Referrals • Transportation Referrals • InterRAI Comprehensive Assessment • Develop Problems and Goals with Member/Caregiver • Create Integrated Care Plan • Condition-Specific Educational Packets • Personalized Disease Management letters • Work with Member Toward Self-Management of Condition • Life Planning Activities • Face-to-Face Personalized Care Coordination by Community-Based Case Manager • Coordination of Behavioral and Medical Services • Post-discharge transition assessment, if applicable • Assessment of support systems/caregiver resources and involvement • Certified Education classes or Rehabilitation services, if available • Interdisciplinary Care Team Participation |

3. Describe how care would be managed for members in each risk stratification level.

Based on the Comprehensive Health Risk Assessment (HRA) and stratification level, a schedule for follow-up, re-assessment, and communication, and the person-centered care plan is developed based upon the member's dynamic risk status. Risk status levels are described as:

- Low – Healthy, well members who require occasional assistance
- Moderate – Members with a chronic illness who are able to self-manage and would benefit from education about their illness
- High – Members with chronic diseases, behavioral health conditions with some complications
- Intensive – Members with complex care needs who have (or are at high risk for) chronic physical, developmental, behavioral, neurological, or emotional conditions that may have an increased need for healthcare services due to their conditions

Low stratification members receive the following forms of management:

- Regularly Scheduled Outreach Calls
- Appointment Reminder Calls
- Preventive Health Service Reminders
- Personalized Disease Management letters
- Collaboration with PCP
- Community Resource Referrals
- Transportation Referrals

Moderate stratification members are enrolled into Meridian Health Plan's Care Coordination Program and receive the following forms of management:

- Regularly Scheduled Outreach Calls
- Appointment Reminder Calls
- Preventive Health Service Reminders
- Collaboration with PCP
- Community Resource Referrals
- Transportation Referrals
- Complete HRA
- Develop Problems and Goals with Member/Caregiver
- Create Integrated Care Plan
- Personalized Disease Management letters
- Condition-Specific Educational Packets
- Work with Member Toward Self-Management of Condition
- Life Planning Activities
- Face-to-Face Personalized Care Coordination by Community-Based Case Manager, if applicable

High stratification members are enrolled into Meridian's Care Coordination Program and receive the following forms of management:

- Regularly Scheduled Outreach Calls

- Appointment Reminder Calls
- Preventive Health Service Reminders
- Collaboration with PCP
- Community Resource Referrals
- Transportation Referrals
- Complete HRA
- Develop Problems and Goals with Member/Caregiver
- Create Integrated Care Plan
- Personalized Disease Management letters
- Condition-Specific Educational Packets
- Work with Member Toward Self-Management of Condition
- Life Planning Activities
- Face-to-Face Personalized Care Coordination by Community-Based Case Manager, if applicable
- Coordination of Behavioral and Medical Services

Intensive stratification members are enrolled into Meridian's Complex Case Management program and receive the following forms of management:

- Regularly Scheduled Outreach Calls
- Appointment Reminder Calls
- Preventive Health Service Reminders
- Collaboration with Multiple Providers
- Community Resource Referrals
- Transportation Referrals
- Complete HRA
- Develop Problems and Goals with Member/Caregiver
- Create Integrated Care Plan
- Condition-Specific Educational Packets
- Personalized Disease Management letters
- Work with Member Toward Self-Management of Condition
- Life Planning Activities
- Face-to-Face Personalized Care Coordination by Community-Based Case Manager
- Coordination of Behavioral and Medical Services
- Post-discharge transition assessment, if applicable
- Assessment of support systems/caregiver resources and involvement
- Certified Education classes or Rehabilitation services, if available

Based on a member's stratification level and specific conditions, additional assessments are completed to gain a better understanding of current health status. Each member completes certain assessments such as utilization history, medical home, care team, medication adherence, and life planning. With each increase in stratification level, members require completion of additional assessments. Below is a grid of assessments to be completed at each level.

| Stratification Level | Assessments |
|----------------------|--|
| Moderate | <ul style="list-style-type: none"> • Utilization History • Medical Home • Care Team • Medication Adherence • ADL/Caregiver-optional based on answers on HRA if answers show limited support or assistance • Behavioral Health of history of BH issues or answers yes to depression screening questions • ETOH/Substance abuse if applicable done by Chemical/SA CM • PHQ-9 to be done by BH if answers yes to depression screening questions • Cultural Language-optional based on HRA and demographic screen • Healthcare/Service • Life Planning • Any applicable condition specific assessments |
| High | <ul style="list-style-type: none"> • Utilization History • Medical Home • Care Team • Medication Adherence • ADL/Caregiver-optional based on responses on HRA if answers show limited support or assistance • Cultural Language-optional based on HRA and demographic screen • BH assessment if history of BH condition or if answers yes to depression screening on HRA • PHQ-9 done by BH if answers yes to depression screening questions • ETOH/Substance abuse if applicable done by Chemical/SA CM • Healthcare/Service • Life Planning • Any applicable condition specific assessments • Pain Management (if applicable) |
| Intensive | <ul style="list-style-type: none"> • Utilization History • Medical Home • Care Team • Medication Adherence • ADL/Caregiver • Behavioral Health • PHQ-9 done by BH if answers yes to depression screening questions • ETOH/SA if applicable done by Chemical Substance CM • Cultural Language • Healthcare/Service • Life Planning • Initial Assessment • Any applicable condition specific assessments and • Clinical History • Pain Management (if applicable) |

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:

a. Predictive modeling;

Meridian Health Plan's Care Coordination module utilizes a plan designed Comprehensive Health Risk Assessment (HRA) and Predictive Modeling software to stratify members as a function of their potential high-cost risk, (e.g., high, medium, low). Stratified members are case managed based on their stratification placement (i.e., high-risk members need more intervention than medium-risk members, who in turn need more intervention than low-risk members) by Care Coordinators and the Interdisciplinary Care Team (ICT). This model prioritizes member cases by potential risk, allowing the focus of the Case Management function and resources on those members with the greatest need and the greatest potential for cost reduction via managed care.

Cases are automatically distributed to Care Coordinators based on the member's risk level and county of residence. The risk level hierarchy determines how cases are distributed to coordination of care teams.

Consultation cases created from the primary Coordination of Care case are automatically distributed to one of the consultants assigned to that team or a generic queue, where it will be distributed by the team lead.

b. Claims review;

Meridian Health Plan's Information Technologies (Information Systems) Department generates files to be run through the Predictive Modeling software. These files include member information, medical claims, and pharmacy claims and are created for all new members. These files are processed by the predictive modeling software and combined with the HRA results. Members are assigned into one of four (4) risk levels. The file generated from the Predictive Modeling software is imported into our system, which will automatically create coordination of care cases.

c. Member and caregiver requests; and

Members and caregiver requests can be obtained by calling Meridian Health Plan. This is an opportunity for the Care Coordinator to follow-up with members, enroll them into the program, and coordinate their care.

d. Physician referrals.

Providers can refer members to care coordination programs via phone, fax, or through the Provider Portal "Notify Plan" option. The Care Coordinator will call the members; enroll them into the program and partner with the physician on coordination of care.

9.1.6 Care Plan Development

1. Describe in detail how person-centered care plans will be developed for each member.

Based upon the data obtained through the assessments and a review of historical claims, each Care Coordinator will develop an individualized person-centered care plan for the member that will address the member's needs, reflecting cultural considerations of the member and will be developed in plain language, and will be accessible to members who have disabilities and/or have limited English proficiency. The member's individualized care plan will be developed using a problem, goal, intervention methodology with interventions designed to address each identified problem. Each member's person-centered care plan identifies overall goals that reflect their unique needs, are realistic and measurable, include a time frame for achievement and are prioritized as appropriate, identifies services and care to meet member's care goals, connects the member/caregiver with add-on benefits and services and facilitates seamless transitions between care settings.

Upon completion of the assessment, Meridian Health Plan's system automatically identifies appropriate short-term and long-term goals based on member responses. The Care Coordinator reviews these goals with the member and adds any additional goals identified during discussions with the member and/or medical home. The Care Coordinator works together with the member to rank each short-term goal in order of importance, as well as to identify any potential barriers, and determine the members' confidence in ability to achieve these goals. If the Care Coordinator identifies barriers they are associated with a goal and documented on the care plan. Through the development of individualized, person-centered care plans the member, their family and/or advocates and caregivers, or others chosen by the member, and all other stakeholders; including specialists caring for the member, are able to plan and address common goals and services related to the care of the member. Care plans will be jointly developed with other caseworkers for members who are accessing multiple services concurrently or consecutively with the goal of providing an integrated care plan which avoids duplication and/or fragmentation of services. The care plan will be approved by Meridian Care Coordination staff in a timely manner and in accordance with applicable quality measures and utilization review standards. The care plan is generated within system and sent to the member, the medical home, PCP and specialist (if applicable). It is also present on Meridian's web portal. The care plan can also be provided to the member additional opportunities to review the care plan as requested. By sharing a member's care plan with all of the providers serving the member, a common goal of improved health and team approach is achieved. For members determined to meet a course of treatment or regular monitoring, Meridian Care Coordinators will have direct access to a specialist as appropriate to the member's condition and identified needs.

Meridian secures seamless transitions between care settings and across the healthcare continuum for all members through our Transition of Care (TOC) program. Thorough follow up, the Community-Based Case Manager coordinates with the member and the Care Coordinator to ensure the care plan reflects goals to facilitate the seamless transition between care settings.

The system Care Coordination Module facilitates targeted intervention by providing the Meridian Care Coordinator with a dynamic work list. This enables them to assign specific goals and dates for follow-up with each member they are managing. In accordance with the care plan, the Care Coordinator conducts numerous interventions and multiple contacts in addition to member telephonic contact to monitor whether the member is receiving the recommended care. This includes contacting providers for lab results, requesting copies of medical records/plans of care

from specialists and contacting discharge planners in hospital. These interventions and contacts are recorded in system relative to the specific goals they are addressing.

2. Describe how the care plan development process will be individualized and person-centered.

Person-Centered Planning is used in Meridian Health Plan's Care Coordination Program, as well as with our members who have behavioral health conditions, serious mental illnesses (SMI), and those with developmental disabilities. We use this model to assist our members in planning their life (i.e., medical and mental health care) and to enable them to increase their personal self-determination and improve their own independence. Our use of this evidenced based practice is an ongoing problem-solving process used to help people plan for their future medical and mental health care. Meridian is committed to providing comprehensive behavioral health services to our members. Integration of medical and behavioral health services is critical to ensure access to the full spectrum of necessary services.

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The goals of using Person-Centered Planning include:

- Seeing our members as people first, rather than diagnostic labels
- To respect the role our members play in their own health care by using ordinary language, rather than professional jargon
- To actively search for members gifts and capacities in the context of life, and strengthening the voice of our members
- To evaluate our members present conditions and define desirable changes in their mental health care

Successes with improving outcomes using Person-Centered Planning include:

- Focused listening, creative thinking and alliance building with our members, which have led to members becoming more involved in their mental health care
- Increased ability to plan with people who might otherwise find it difficult to plan their lives, or who find that other people and services are planning their lives for them

In Meridian's Care Coordination Program, the Person-Centered Planning model is utilized by having one Care Coordinator assigned to a member with the goal to assist the member in orchestrating all his/her medical, mental, behavioral, and social needs. As the member identifies his/her needs, the Care Coordinator responds by implementing outreach strategies to meet the members stated need(s). The goal is to develop a care plan that will focus on the member's needs,

as identified by the member, identify member strengths and assets that can be used and assist them in identifying needed community resources. The professional staff working with the member is a neutral and unbiased person who leads the member through the process of achieving his/her goals (e.g., scheduling therapy services for treatment of depression, obtaining transportation services, locating food banks or identifying occupational/speech therapy services for an autistic child, etc.).

Outreach strategies may include, but are not limited to, consulting with behavioral health professionals, pharmacy technicians, the member's primary care provider, medical specialist and our medical directors. Meridian utilizes a Community-Based Case Manager to perform a home visit and assessment which identifies member's needs and preferences. The Community-Based Case Manager can also offer services that member might not be aware of, and helps the member navigate the health care system. Community-Based Case Managers can evaluate and assess the different barriers that providers might not be aware of and help the member to eliminate those barriers. The member is an active partner in goal setting when linguistically and culturally appropriate education and interventions are planned.

Continuous monitoring of the member's care plan is done with every member contact. Care Coordinators identify unmet care needs, coordinate services for these needs, facilitate evaluation and monitoring processes to meet these needs, and troubleshoot new issues as they arise. Through an integrated Alert System in Meridian's system, the Care Coordinator is made aware of all member activity from claims data, medications, hospital and/or emergency room utilization, prescribed durable medical equipment (DME), prescribed services such as physical therapy, occupational therapy, speech therapy, home health care, etc. Through management of these alerts, the Care Coordinator is able to readily identify any unmet care needs the member may incur and also any changes in the member's health status.

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.

Meridian Health Plan utilizes a comprehensive Health Risk Assessment tool to assess members. This tool not only provides evaluation to the member's eligibility for institutional services, but also provides a comprehensive evaluation of member risk related to the following categories:

- Physical, psychosocial, cognitive, and functional needs
- Co-morbidities
- Medical home
- Utilization History
- Individual preferences, strengths, and goals including self-determination arrangements
- Natural supports, including family and community caregiver capacity and social strengths and needs
- Communication needs, including hearing, vision, cultural and linguistic needs and preferences, and member health literacy
- Current services, including those covered by Medicare and Medicaid (in accordance with contractual agreements), local services, and care transition needs
- Medical health risk status and history, including, but not limited to, medications (prescription, over-the-counter, and herbal supplements), frequent falls, and treatment for

recurring urinary tract infections; Behavioral Health (BH), Intellectual/Developmental Disability (I/DD) and Substance Use Disorder (SUD) risk status; BH, SUD and I/DD history and needs, including medications

- Nutritional strengths and needs
- Activities of daily living and instrumental activities of daily living, including any assistive technology used or needed and immediate environmental or housing needs
- Cognitive strengths and needs
- Long-Term Services and Supports (LTSS)
- Quality of life including physical, mental and psycho-social well-being
- Discussion of abuse, neglect, or exploitation
- Advance directive and assure provider knowledge of member's directives

All of this information is used to develop the member's individualized care plan.

Responses and data from the Comprehensive Health Risk Assessment (HRA) tool allow for the unique stratification of the member's health status. Specific interventions are generated from this data and used to populate the comprehensive individualized member care plan.

Upon enrollment, numerous efforts are made to facilitate the participation of the member, including the caregiver, legal guardian or other authorized representatives whenever feasible. The goal of the program is to maintain members in the least restrictive environment with the right amount of resources to support the member. With that goal in mind, completing an assessment and establishing a care plan once a member is eligible within the program is crucial. Completing assessments in a timely manner will ensure that a member continues to receive needed services. The Care Coordinator reviews and utilizes State-required forms when completing the initial assessment of the member and developing the initial care plan.

The Care Coordinator conducts the initial HRA with the member and appropriate participants during the initial telephonic contact. Meridian's system and software application allows for initial stratification of the member's overall risk, health status and care needs based on an established criteria and algorithms. Responses to HRA questions and other inputs also drive interventions for the member's person-centered care plan. Ultimately, the Care Coordinator in collaboration with the member, caregiver and/or family, guardians and providers initiate the person-centered care plan and work with the primary care provider (PCP) to develop an ongoing care plan. The care plan reflects stratified needs that are matched to services and benefits so that the vulnerable and sickest member receive care proportionate to their needs. At the time of the HRA, the member, with additional input from the caregiver and/or family, is asked to identify his/her personal health goals. This information is incorporated into the person-centered care plan. During the on-going development and delivery of the care plan, the care coordination team ensures the member's goals and preferences are identified and are documented in the care plan.

Items used in development of the individualized care plan include:

- Results from the initial Health Risk Assessment
- Member's medical history
- Member's healthcare preferences
- Member's pharmaceutical profile
- Goals and objectives
- Service schedules

- Service gaps contingency and back-up plan
- Medication management
- Barriers to progress

Individual care and treatment goals are incorporated into the member's person-centered care plan. Each member's care plan identifies overall goals that reflect their unique needs, are realistic and measurable, include a time frame for achievement as appropriate, identifies services and care to meet member's care goals and connects the member/caregiver with Home and Community-Based Services (HCBS) as well as add-on benefits and services. The care plan reflects stratified needs that are matched to interventions to address services and benefits so the vulnerable and sickest members receive care proportionate to their needs. Each intervention is developed in a "problem, goal, and intervention" model so that there is a clear link between the problem being addressed, the goal of the outcome and the specific intervention to address the problem.

The care plan is revised when appropriate to reflect the member's current needs, based on evaluation of new clinical data, progress towards goals, identification of barriers to progress, response to care and treatment and/or significant changes in the enrollee's status, such as transitions of care settings. The member education process uses an interdisciplinary approach, as appropriate to the care plan. The member's care plan will support member education appropriate to his or her assessed needs, abilities, readiness, and preferences. The care planning process incorporates information from the member's assessment regarding his or her education needs and ensures there is a mechanism for member and family input into the care plan.

Through the development of individualized, member-centric care plans the member, caregiver, and all other stakeholders, including providers of HCBS, are able to plan and address common goals and services related to the care of the member. By sharing a member's care plan with all of the providers serving the member a common goal of improved health and team approach is achieved. Engaging the member in self-directed care together with the support of the care management team will prevent duplication of services and ensure that the member receives the care and services needed for maintaining health.

Through engagement of the member in self-directed care along with the support of the complete Interdisciplinary Care Team (ICT), duplication of services is prevented and the member is ensured to receive the care and services needed for maintaining health. The member's status of condition is reviewed periodically through the ICT Meeting to ensure prompt review, member participation and engagement, and thorough follow-up of the member's care plan.

Each ICT is person-centered, built on each member's specific preferences and needs, and delivering services with transparency, individualization, respect, linguistic and cultural competence, quality of care, quality of life and dignity. Each ICT consists of clinical and non-clinical staffs whose skills and professional experience complement and support each other in the oversight of each member's needs. The ICT is responsible for establishing and implementing the individualized care plan for each Meridian member, which will incorporate goals identified and agreed upon by the Care Coordinator and the member and/or member's caregiver. The ICT reviews and updates the individualized care plan as needed while providing care planning support, discussing the member's unique needs, challenges, and successes to assist the member in meeting his/her goals. The ICT participants assume an important role and work collaboratively to develop, implement, and maintain individualized care plans, coordinating care, ensuring continuity of care and sharing information with the ICT and member.

4. Submit a sample care plan for each proposed risk stratification level.

The following are sample care plans for members in each of Meridian Health Plan's four (4) risk stratification levels.

Low Stratification Care Plan Example

Member Number One (#1)

Initial Stratification: Initially stratified as Moderate; upon reassessment and compliance, stratification was reduced to Low.

Member number one (#1) is a sixty-one (61) year old with a body mass index (BMI) of twenty five point zero nine (25.09). He smokes one (1) pack of cigarettes daily and reports no usage of street drugs. He has been sober since August 2011 and lives in a halfway house, unable to administer medications or test his blood sugar daily at the time of the initial assessment. He has difficulty coordinating medical appointments, but the member has a guardian as well as an external Care Coordinator and a nurse from the Behavioral Health Team.

Upon completion of the Comprehensive Health Risk Assessment (HRA), the member is identified to have a history of diabetes and hypertension. He reports that he is receiving treatment for chronic pain but states the pain level is currently at a two (2) on a scale from one (1) to ten (10). This member has also been diagnosed with bipolar disorder and depression. He has utilized the emergency room more than three (3) times over the past year but also visits physician offices for treatment, including a therapist. He reports that he is "pretty confident" in managing his health on a daily basis and has significant support available. Member reports no limitations in his daily activities such as housework or ambulation.

He was initially placed in stratification, Moderate, with a high acuity level. Due to his extensive prior history of both medical and behavioral health conditions, he required active case and condition management. He required medication assessment and assistance, as he was unable to self-administer at the time of enrollment. He also required advanced care planning to coordinate his services with external care teams. He has remained at this level until member became compliant with his care. Upon reassessment of the member's medical and behavioral health and compliance for treatment, this member's stratification was changed to stratification, Low.

After completing the HRA, the member was invited to attend the Interdisciplinary Care Team (ICT) meeting. While the member did not attend, his external care team did attend (i.e. his guardian from Adult Well Being, his external case manager, and nurse from the Behavioral Health Team). The discussion included concerns that the member is unable to remember to take medications and test blood sugar; therefore, the Meridian Care Coordinator made daily reminder phone calls to the member to take his medication and test blood sugar levels. The member's external case manager and BH nurse agreed to accompany this member to appointments and assist in coordinating care. Finally, the Meridian Care Coordinator pursued home health care and a physical therapy evaluation with orders from the member's primary care provider (PCP).

The finalized care plan for this member included short-term goals of educating the member on a number of items: smoking cessation, blood sugar testing, healthy diet, and hypertension control and complication prevention; ensuring the member had substance abuse treatment to remain sober; and addressing any psychiatric or psychosocial barriers preventing the member from

receiving care. The long-term goals aimed to educate the member on the importance of keeping his physicians informed of changes in his health status and understanding what lifestyle changes are needed to improve overall health.

This member consistently refused home health care during initial outreach, but he finally accepted assistance and receives regular visits. He continues to work cooperatively with his Behavioral Health Team and his guardian. The Meridian Care Coordinator also continues to work with this care team to provide this member the resources he needs to maintain and improve his health status. The member is now able to self-administer medications and understands the purpose of each medication that he takes. His blood sugar levels are within normal limits, and he is attempting to quit smoking. He attends Alcoholics Anonymous meetings six (6) times per week.

| | | | | |
|--|---|----------------------------------|--|----------------------|
| PROBLEM: I am not confident in managing my health condition | | | Start Date: 11/01/2014 | |
| Priority 1 | Short Term Goal Understands importance of healthy diet on hypertension control | | Long Term Goal Keep your PCP and specialist(s) informed of changes in your health care condition, treatments received, and services needed | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/01/2014 | 30 Days | Partially Met | |
| Comments: 5/7/2015 Member self -administers medications and understands the purpose of each medication. | | | | |
| PROBLEM: I am not confident in managing my health condition | | | Start Date: 11/01/2014 | |
| Priority 1 | Short Term Goal Facilitate member/caregiver education related to glucose control | | Long Term Goal Know what to do when symptoms appear that indicate a change in your condition | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/01/2014 | 30 days | Partially Met | |
| Comments: 5/7/2015 Members blood sugar levels are within normal limits. | | | | |
| PROBLEM: Reports problems with medication administration | | | Start Date: 11/01/2014 | |
| Priority 2 | Short Term Goal I will identify and/or work with my supports, service providers and community resources to help me manage my concerns | | Long Term Goal I agree to develop and follow long term solutions for remembering how and when to take my medications | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/01/2014 | 30 days | Fully Met | |
| Comments: 5/7/2015 Member self -administers medications and understands the purpose of each medication. | | | | |

| PROBLEM: I do not see a therapist or psychiatrist regularly and have not seen one recently | | | Start Date: 11/01/2014 | |
|--|--|--|-------------------------------|----------------------|
| 3 | Short Term Goal I agree to keep BH appointments and if unable to keep will reschedule and attend | Long Term Goal I will establish and maintain communication with my medical home | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/01/2014 | 45 days | Fully Met | |
| Comments: 5/7/2015 Member continues to work cooperatively with his Behavioral Health Team and his guardian. | | | | |
| PROBLEM: Member smokes tobacco | | | Start Date:11/01/2014 | |
| 4 | Short Term Goal Member/caregiver verbalizes importance of not smoking | Long Term Goal I will identify lifestyle changes to improve my overall health | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/01/2014 | 180 Days | Not Met | |
| Comments: 5/7/2015 Member is attempting to quit smoking. | | | | |
| PROBLEM: Alcohol/drug use is effecting member's mental and physical health | | | Start Date:11/01/2014 | |
| 5 | Short Term Goal Member can verbalize understanding of need to limit alcohol use | Long Term Goal Member will obtain substance abuse/chemical dependency treatment services | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/01/2014 | 90 Days | Partially Met | |
| Comments: 5/7/2015 Member attends AA meetings 6 days/week. | | | | |

| | | | |
|---|---|---|---------------|
| PROBLEM: I have nutritional habits that are affecting my health and activities of daily living | | Start Date:11/01/2014 | |
| 6 | Short Term Goal I will discuss a healthy nutrition plan with my provider and care team | Long Term Goal I will have improved nutritional status | |
| | Goal Start Date | Timeframe for Completion: | Status |
| | 11/01/2014 | 180 Days | Not Met |
| Comments: | | | |
| PROBLEM: I do not feel I have the support I need to be safely independent | | Start Date:11/01/2014 | |
| 7 | Short Term Goal I agree to have someone come to my home to do an assessment of my needs | Long Term Goal I will participate in services, supports, and treatments to help me safely maintain independence and quality of life | |
| | Goal Start Date | Timeframe for Completion: | Status |
| | 11/01/2014 | 90 Days | Fully Met |
| Comments: 5/7/2015 Member accepted assistance at home and receives regular visits. | | | |

Strengths:

| | |
|---|---|
| 1 | 5/7/2015 Member is now able to self-administer medications and understands the purpose of each medication. |
| 2 | 5/7/2015 Member is attempting to quit smoking. |
| 3 | 5/7/2015 Member attends AA meetings 6 days/week. |
| 4 | 5/7/2015 Blood sugar levels are within normal limits. |

Moderate Stratification Care Plan Example

Member Number Two (#2)

Initial Stratification: Moderate

Member number two (#2) is a sixty-four (64) year old male who lives alone and is independent with medication administration and Activities of Daily Living (ADL). He uses a walker for ambulation and tires easily. The member states he is a non-smoker and drinks less than half a glass of alcohol per day.

Upon completion of the Comprehensive Health Risk Assessment (HRA), this member states he is diagnosed with asthma and hypertension. He also reports treatment for chronic back pain that radiates down his left leg, ranking the pain level at eight (8) out of ten (10). He states that Vicodin relieves the pain. He was diagnosed with colon cancer in January 2013 and was informed that the cancer had spread to his bones. He receives infusion treatment once a month and has successfully completed a round of chemotherapy. This member states he is trying to quit drinking, as it affects him differently now than before. He has a close relationship with his minister, who provides him with support.

Member was initially placed into stratification, Moderate, due to multiple medical conditions including cancer. He was placed in a high acuity level and has seen this level fluctuate throughout his time with Meridian, while his stratification level has remained the same. Based on the member's needs at different times through his care, he has ranged from an intensive acuity level to a moderate acuity level.

The member was invited to the Interdisciplinary Care Team (ICT) on November 11, 2013. He attended the meeting in person with his minister. Multiple goals were discussed at the meeting. The member requested information regarding an asthma action plan and wondered if he could obtain a blood pressure cuff to take his own readings at home. He also reported concerns about dental care and requested a list of resources for possible locations for dental care. He reported a low appetite and was agreeable to a conversation with the Meridian Registered Dietician.

The finalized care plan included short-term goals to educate the member on asthma control, proper inhaler technique, and importance of blood pressure control; explore treatment options for chronic pain; prevent readmission to hospital or emergency room by providing education on complication prevention; and facilitate evaluation for depression symptoms. The member's long-term goals include developing comprehension of all prescribed medications; keeping his primary care provider (PCP) and specialists informed of changes in health conditions; managing conditions and identifying signs of a complication; and understanding what lifestyle changes are needed to improve overall health.

This member was inpatient in December 2012 for kidney stent placement, during which he began radiation treatments for his cancer diagnosis. He was discharged after more than a week-long stay. This member continued to transition in and out of the hospital over the next few months as his health declined before agreeing to hospital care in April 2013. The member was set up with a hospital bed and oxygen at home along with medications to keep him comfortable.

| PROBLEM: I am not confident in managing my health condition | | | Start Date: 11/01/2012 | |
|--|---|--|-------------------------------|----------------------|
| 1 | Short Term Goal Practices proper inhaler techniques (MDI w/spacer and/or nebulizer) | Long Term Goal Keep your PCP and specialist(s) informed of changes in your health care condition, treatments received, and services needed | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/01/2012 | 30 Days | Not Met | |
| Comments: | | | | |
| PROBLEM: I am not confident in managing my health condition | | | Start Date: 11/01/2012 | |
| 1 | Short Term Goal Member understands signs/sx of worsening hypertension | Long Term Goal Know what lifestyle changes are needed to improve your overall health | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/01/2012 | 30 Days | Not Met | |
| Comments: 11/11/13 member requested blood pressure cuff. | | | | |
| PROBLEM: My pain is impacting my daily life | | | Start Date: 11/-1/2012 | |
| 2 | Short Term Goal I will talk with my health care provider about medication options and alternatives for pain control | Long Term Goal I will improve my health status by actively managing my symptoms | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/01/2012 | 30 Days | Not Met | |
| Comments: | | | | |

| | | | | |
|--|---|---|-------------------------------|----------------------|
| PROBLEM: Member not aware of appropriate reasons to utilize the ER | | | Start Date: 11/01/2012 | |
| 3 | Short Term Goal Member understands importance of keeping follow-up appointments | Long Term Goal Understand appropriate ER usage and when to call PCP | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/01/2012 | 30 Days | Not Met | |
| Comments: Member was inpatient in 2012 for kidney stent placement and radiation for cancer. | | | | |
| PROBLEM: I do not see a therapist or psychiatrist regularly and have not seen one recently | | | Start Date: 11/01/2012 | |
| 4 | Short Term Goal I agree to schedule an appointment with BH provider | Long Term Goal I will establish and maintain communication with my medical home | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/01/2012 | 30 days | Not Met | |
| Comments: | | | | |
| PROBLEM: I do not always take my medication as prescribed | | | Start Date: 11/01/2012 | |
| 5 | Short Term Goal Understands proper dose and administration of medications | Long Term Goal Be able to tell your physician the name(s) of the medication(s) you are taking and why you are taking them | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/01/2012 | 30 Days | Not Met | |
| Comments: | | | | |

Strengths:

| | |
|---|--|
| 1 | Member has hospital bed and oxygen at home to keep him comfortable. |
| 2 | 11/11/13 Dental care resources provided to member. |
| 3 | 11/11/13 member reported a low appetite and was referred to dietician. |

High Stratification Care Plan Example

Member Number Three (#3)

Initial Stratification: Low; upon reassessment and compliance issues, stratification was changed to Moderate; after numerous emergency room visits and inpatient hospitalizations, stratification was changed to High.

Member number three (#3) is a forty-six (46) year old male with prior medical history of hypertension, chronic pain, acid reflux, anxiety disorder, post-traumatic stress disorder, schizophrenia, depression, and substance abuse. He smokes half a pack of cigarettes daily, drinks under half a glass of alcohol daily, and uses cocaine daily. He states he has no limitations in daily activities. It is unclear if the member has his own residence, lives in an AFC home, or is homeless.

Upon completion of Comprehensive Health Risk Assessment (HRA), this member was placed in stratification, Low, based on his responses. However, beginning at the time of his enrollment to Meridian Advantage Plan, the member made multiple phone calls regarding psychiatric issues and was moved to a stratification, Moderate, within one (1) month. A few days later, he was moved to stratification, High, where he remains. The member is difficult to contact due to uncertainty of both telephone numbers and living situation. He has been in and out of the hospital over ten (10) times for psychiatric concerns in the two (2) months since his enrollment with Meridian.

The member was invited to the Interdisciplinary Care Team (ICT) meeting but did not attend, as he had not been home to receive the invitation letter. He expressed that he wishes he could have been there. ICT discussion included concerns that member uses \$200-\$300 worth of cocaine every other day and changes providers frequently in order to obtain prescriptions for narcotics. Because the member is on Medicare, he is unable to be placed in a narcotic lock. He reported regular outpatient treatment for his behavioral health diagnoses, but the provider's office states that member has not been seen in several months. The goal of this member's ICT meeting was to get in contact with the member and attempt admission into an inpatient psychiatric facility for treatment.

The member's finalized care plan included short-term goals to facilitate adherence with prescribed psychotropic medications, address psychiatric issues that interfere with his care, and ensure coordination of a substance abuse evaluation. The member must be stabilized before working toward long-term goals, which include: identifying and understanding medications; communicating his health status with his PCP and other health professionals; identifying lifestyle changes needed to improve his health status; accessing community support services; and understanding what to do when feeling depressed or helpless.

This member was non-compliant with follow-up care and difficult to reach after discharging from facilities due to his lack of telephone. He has been in and out of multiple facilities in the area, and there is concern that soon, no hospitals will accept him. The member finally started attending outpatient treatment at the end of his third month on with Meridian but then was administratively discharged from the office due to not showing up for three (3) visits in a row. He continues to use cocaine and barbiturates and was off his medications for a week due to incarceration for missing child support payments. The member continues to go in and out of multiple hospitals for treatment.

| | | | | |
|---|--|----------------------------------|---|-------------------------------|
| PROBLEM: Member has chronic medical condition(s) that impacts his/her ability to self-manage and perform activities of daily living | | | | Start Date: 11/12/2014 |
| 1 | Short Term Goal Member will be able to effectively manage his/her chronic health condition(s) | | Long Term Goal Regularly schedule appointments to monitor the progress of condition(s) and complete preventive care visits | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/12/2014 | 90 Days | Not Met | |
| Comments: 5/1/2015 Member will schedule and keep all doctor appointments and update all providers with any change in his conditions, medications or health care needs regarding his hypertension, chronic pain, acid reflux, substance abuse, post-traumatic stress disorder, schizophrenia, anxiety disorder and depression. | | | | |
| PROBLEM: Alcohol/drug use is effecting member’s mental and physical health | | | | Start Date: 11/12/2014 |
| 2 | Short Term Goal I will acknowledge that I have a serious medical or mental health condition that becomes worse when I misuse alcohol or drugs which I will therefore avoid | | Long Term Goal I will strictly follow my doctor’s treatment plan for me so that I can recover from my serious medical condition. This includes avoiding drug use and making appropriate lifestyle changes | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/12/2014 | 60 Days | Partially Met | |
| Comments: 5/1/2015 Member will agree to inpatient psychiatric treatment to address his behavior health and substance abuse issues to include; adherence with psychotropic medications, development of coping skills, establishing health support system as well as stable living environment and intensive outpatient relapse prevention program (Narcotics Anonymous – obtain sponsor, weekly check-in’s with therapist) | | | | |
| PROBLEM: I do not feel I have the support I need to be safely independent in the lifestyle I have chosen | | | | Start Date: 11/12/2014 |
| 3 | Short Term Goal I will identify stable housing and support system | | Long Term Goal I will identify and/or work with my supports, service providers and community resources to help me manage my concerns | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/12/2014 | 60 Days | Not Met | |
| Comments: 5/1/2014 Member has not been attending outpatient treatment or follow-up visits with providers. Member has been incarcerated and continues to be in and out of multiple hospitals | | | | |

| PROBLEM: I am addicted to tobacco products | | | Start Date: 11/12/2014 | |
|---|--|---|-------------------------------|----------------------|
| 4 | Short Term Goal Member verbalized understanding of benefits of smoking cessation | Long Term Goal I will identify lifestyle changes to improve my overall health | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/12/2014 | 90 Days | Not Met | |
| Comments: 5/1/2015 Member is not committed to working on this goal currently. | | | | |
| PROBLEM: Member did not make/keep their f/u appointment after hospitalization/ER visit | | | Start Date:11/12/2014 | |
| 5 | Short Term Goal Member understands importance of keeping follow-up appointments | Long Term Goal Understand appropriate ER usage and when to call PCP | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 11/12/2014 | 14 Days | Not Met | |
| Comments: | | | | |

Intensive Stratification Care Plan Example

Member Number Four (#4)

Initial Stratification: Moderate; upon reassessment and multiple inpatient hospitalizations for non-compliance with extensive surgical procedures the stratification was changed to Intensive.

Member number four (#4) is a fifty-two (52) year male with past medical history of type II diabetes, hypertension, chronic pain related to neuropathy, chronic renal failure, depression, and substance abuse. He smokes three (3) packs of cigarettes per daily and uses fifty dollars (\$50) of heroin daily. Member resides in his own home but is unable to care for himself due to recent above the knee amputation of his right leg. Member also has open non healing wound on left distal calf requiring dressing change three (3) times daily. Member reports not having proper equipment to check blood sugar and refuses to use insulin. The member was discharged with orders for Hemodialysis three (3) times weekly to which member has attended only one session.

The member was invited to the Interdisciplinary Care Team (ICT) meeting but did not attend, as he declines all participation regarding his health care. ICT discussion included placement of member into Skilled Nursing Facility due to failure of self-care management. Member continues to use multi hospital ER's for care as he refuses to establish and see a primary physician.

The member's finalized Care plan included short-term goals to facilitate adherence with monitoring of glucose four (4) times daily, 2,000 calorie ADA - Low sodium diet, chronic pain management, wound therapy and behavior health needs. The member must be stabilized before working toward long-term goals, which include: identifying lifestyle changes needed to improve his health status; accessing community support services: identifying and understanding medications; communicating his health status with his PCP and other health professionals; and understanding what to do when feeling depressed or helpless.

The member was non-compliant with follow care and unable to be reached upon discharge from the hospital. Member has agreed to outpatient substance abuse treatment, is seeing a behavioral health therapist, and allowing home health care in the home for wound care.

| PROBLEM: I am not confident in managing my health condition | | | Start Date: 10/14/2014 | |
|---|--|---|-------------------------------|----------------------|
| 1 | Short Term Goal Maintain blood sugars between 80-120 mg/dl | Long Term Goal I want to get control of my diabetes to prevention any further complications from this condition such as kidney disease, vision issues, amputation | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 10/14/2014 | 30 Days | Not Met | |
| Comments: | | | | |
| PROBLEM: I am not confident in managing my health condition | | | Start Date: 10/14/2014 | |
| 1 | Short Term Goal Understands importance of healthy diet on hypertension control | Long Term Goal Know what lifestyle changes are needed to improve your overall health | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 10/14/2014 | 30 Days | Not Met | |
| Comments: | | | | |
| PROBLEM: I do not see a therapist or psychiatrist regularly and have not seen one recently | | | Start Date: 10/14/2014 | |
| 2 | Short Term Goal I agree to keep BH appointments and if unable to keep will reschedule and attend | Long Term Goal I will establish and maintain communication with my medical home | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 10/14/2014 | 45 Days | Not Met | |
| Comments: 5/7/2015 Member is seeing a behavioral health therapist. | | | | |

PROBLEM: Alcohol/drug use is effecting member’s mental and physical health **Start Date: 10/14/2014**

| | | | | |
|---|---|--|---------------|----------------------|
| 3 | Short Term Goal Coordinate necessary substance abuse services | Long Term Goal I will strictly follow my doctor’s treatment plan for me so that I can recover from my serious medical condition. This includes avoiding alcohol and drug use | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 10/14/2014 | 45 Days | Partially Met | |

Comments: 5/7/2015 Member agreed to outpatient therapy.

PROBLEM: My pain is impacting my daily life **Start Date:10/14/2014**

| | | | | |
|---|---|---|---------------|----------------------|
| 4 | Short Term Goal I will talk to my PCP about a referral to see a pain specialist | Long Term Goal I will improve my health status by actively managing my symptoms | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 10/14/2014 | 30 Days | Not met | |

Comments:

PROBLEM: Not interested in smoking cessation program **Start Date:10/14/2014**

| | | | | |
|---|---|---|---------------|----------------------|
| 5 | Short Term Goal MD action plan for quitting smoking | Long Term Goal I will identify lifestyle changes to improve my overall health | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 10/14/2014 | 180 Days | Not Met | |

Comments:

PROBLEM: I have nutritional habits that are affecting my health and activities of daily living **Start Date:10/14/2014**

| | | | | |
|---|--|--|---------------|----------------------|
| 6 | Short Term Goal I will discuss a healthy nutrition plan with my provider and care team | Long Term Goal I will have improved nutritional status | | |
| | Goal Start Date | Timeframe for Completion: | Status | Goal End Date |
| | 10/14/2014 | 180 Days | Not Met | |

Comments:

Strengths:

| | |
|---|---|
| 1 | 5/7/2015 Member allowed home healthcare into home for wound care. |
|---|---|



5. 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.

The care plan is developed together with the Care Coordinator and the member, their family and/or advocates and caregivers, or others chosen by the member, and all other stakeholders; including specialists caring for the member. The care plan can be developed over the phone, telephonically, or with the member face-to-face based on the member's preference. When developing the care plan, the Care Coordinator will ask the member if they would like to have his/her family, caregivers or representative participate in the call. If the member would like to have another party involved in the care plan development, the Care Coordinator will coordinate with the member and the other party to facilitate the care plan development telephonically or face to face, if necessary. If the inclusion of another party requires the care plan development to be completed face to face, the Care Coordinator will send a referral to the Community-Based Case Manager and schedule a visit for the care plan development. The care plan is then taken to an Interdisciplinary Care Team (ICT) meeting where care plan is reviewed and further developed.

Meridian Health Plan's ICT is multidisciplinary and comprised of the member's Care Coordinator, member or authorized representative (caregiver, family member, etc.), member's PCP and/or specialists, as needed, and Meridian internal staff. The Meridian internal staff includes, but is not limited to, the following participants who make certain the member is not receiving any duplication of services, medications, or specialists managing the care of the same diagnosis:

- Medical Director
- Behavioral Health Medical Director
- MeridianRx Pharmacist
- Care Coordinator
- Behavioral Health Case Manager
- Member Services Representative
- Utilization Management Director
- Manager of Case Management
- Administrative Coordinator
- Provider Services Representative
- Meridian Registered Dietician
- Community-Based Case Manager
- Nurse Team Lead

The member is invited to the Meridian office to participate in the ICT meeting and also has the option to participate by phone as well. Based upon the member's needs, other healthcare professionals, both internal and external, may be invited to attend the member's specific ICT meeting. For example, the member's home care/hospice nurse, pharmacist, physical therapist, speech therapist, behavioral health provider, specialist, pastoral care specialist and/or Meridian's chemical/substance abuse case manager can be invited to attend. The member may also invite their caregiver, family member or anyone else they would like to attend.

6. 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.

Meridian Health Plan will jointly complete the care plan with other caseworkers for members who are accessing multiple services concurrently or consecutively. Other caseworkers will be identified through conversations between Meridian Care Coordinators and the member, and his/her family, caregivers or representative as well as their providers. Through the development of individualized, person-centered care plans, the member, caregiver, and all other stakeholders, including other caseworkers, are able to plan and address common goals and services related to the care of the member. By sharing a member's care plan with all of the providers serving the member, a common goal of improved health and team approach is achieved. Through engagement of the member in self-directed care, along with the support of the complete care management team, duplication of services is prevented and the member is assured to receive the care and services needed for maintaining health.

7. 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.

The member and PCP are sent a care plan letter, which details the short-term and long-term goals to which the member has agreed. This letter also notes the interventions that will be performed to accomplish the goals. The Meridian Health Plan Care Coordinator also creates a medication list which is mailed to the member. The member is expected to follow the medication list and bring it to every provider appointment. A copy of the medication list is also mailed or faxed to the primary care provider (PCP) for purposes of medication reconciliation. The member's person-centered care plan is also available to the member's providers through our Provider Portal. Each time the care plan is updated, it is automatically updated on the Portal as well.

8. 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.

At least annually, all Meridian Health Plan staff is required to complete cultural competency training. Meridian's cultural competency training program includes training on key topics such as:

- Methods to improve cultural awareness and sensitivity
- Awareness of personal cultures, prejudices, and stereotypes
- Potential barriers which members may encounter
- Compliance with State and Federal contracts
- Compliance with the Americans with Disabilities Act (ADA), Culturally and Linguistically Appropriate Services (CLAS) standards, Title VI and Limited English Proficiency (LEP) Individuals of the Civil Rights Act, and section 5307 of the Affordable Care Act (ACA).The Institute of Medicine (IOM) six standards of equitable care
- Barriers to health care
- The states of multi-cultural awareness
- The importance of self-awareness and key cultural terms
- Knowledge-centered versus skill centered approaches

- Strategies for improved patient-centered awareness
- The importance of transcultural communication techniques

Through this cultural competency training, Meridian Care Coordinators are able to approach communicating with members who have different backgrounds and experiences by using a combination of both knowledge-centered and skill-centered approaches. Meridian Care Coordinators practice patient-centered awareness and transcultural communication techniques throughout the care planning process as well as in all interactions with the member.

Meridian identifies Limited English Proficiency (LEP) individuals through various data sources. In addition to hiring bilingual staff, Meridian also contracts with PALS International (PALS) to provide language services. These services are provided at no additional costs to our members. Meridian selected PALS based on their ability to provide immediate twenty-four (24) hours a day, seven (7) days a week access to 170 languages with a staff of over 1,000 professional and certified linguists, excellent quality, and technology. PALS's average connect time of thirty (30) seconds is consistent with our customer services standards. Meridian also utilizes PALS's written translation services that include over 170 languages. Interpreter services are available for Meridian members via telephone or for scheduled office visits. Meridian is currently using PALS in all states where we operate. Interpretation services are also available for the hearing impaired. Meridian maintains a TTY/TDD line and contracts with local vendors to provide sign language services for the hearing impaired upon member/provider request.

9. Describe how the proposed care plan process will include a system to monitor whether the member is receiving the recommended care.

The Meridian Health Plan Care Coordinator assesses progress relative to case management plans and goals, modifying them as needed. The member's progress towards the goal as well as any identified barriers to meeting the goals and compliance is documented after every member contact is made. Through an integrated Alert System in our system, the Care Coordinator is made aware of all member activity from claims data, medications, hospital and/or emergency room utilization, prescribed durable medical equipment (DME), and prescribed services such as physical therapy, occupational therapy, speech therapy, home health care, etc. Through management of these alerts, the Care Coordinator is able to readily identify any unmet care needs the member may incur and also any changes in the member's health status. This helps the Care Coordinator's facilitation and ongoing monitoring of the member's care plan.

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.

Care Coordination reports are compiled quarterly for the Quality Improvement Committee (QIC). Care Coordination reports are assessed for variance and the determination is made as to whether a corrective action plan or quality improvement plan is warranted. The QIC makes recommendations based on report findings and tracks progress made on corrective action or quality improvement plans.

The QIC is also responsible for approving annual evaluations prepared for each state, and often unique benefit plan, inclusive of summaries of all Care Coordination activity. This report is provided to the State and information is frequently shared with stakeholders, including provider groups. Meridian Health Plan will readily supply information on Care Coordination activities with members, whether through member advisory committees or through provision on the member website.

Performance of Care Coordination programs is also evidenced through performance improvement projects. In Iowa, Meridian tracked maternity Care Coordination activities over two (2) years, assessing prenatal and postpartum visit rates, administration of depression screens, and referrals made to mental health services when appropriate. Other benefit plan programs monitor readmission prevention efforts or efficacy of cardiovascular disease programs. The outcomes of these programs are shared with the State, stakeholders, including providers, and will be made available to members.

Meridian's operational reports assist with program administration, including enrollment and case management ratios, call volumes, successful reach rates, unable to reach, month-over-month program retention, etc. These reports are reviewed internally with significant variance reported to the QIC. Examples may be found in Attachment 29 (QIC Reports) in Tab 5.

Meridian uses a coordinated approach to member care that incorporates people, processes and technology into a care delivery model. This model ensures timely and accurate information is available to staff and stakeholders to support the care needs of our members where, when and in the form it is needed to support decisions and drive efficiencies. Underpinning this approach, our systems have been designed to provide real-time integration of data across the enterprise, providing a coordinated view of a member's care both through time and across multiple disciplines.

2. Describe the system that you will use to integrate and share information about members in order to facilitate effective care coordination.

Meridian Health Plan understands the importance of communication and its role in optimization of health care. All members of the care team have access to the Meridian web portal twenty-four (24) hours a day, seven (7) days a week. All members of the care team have direct access to the Comprehensive Health Risk Assessment (HRA) via our system. Our system is our repository, which all members of the care team have real-time access to, while members and providers have access through Meridian's secure, online web portals.

In addition to recording HRA results, system provides a number of care alerts for members, including needed HEDIS® measures, case management alerts, care coordination alerts, pharmacy alerts, and others. These alerts are tools Meridian uses to impact member health status directly and immediately. When the care team notices an alert, that person can give instant information to member. Information can range from needed care, such as vaccinations, to medication recalls. Information will also be given to providers during the monthly meeting with their assigned Meridian Provider Network Development Representative (PNDR). The Community-Based Case Managers will update the provider or PNDR of any health alerts and gaps in care. In this way, the system acts as a reservoir of real-time data collection, a mechanism for tracking and reporting up to the Quality Improvement Committee (QIC). From the QIC, quality improvement plans and/or

corrective action plans are executed and implemented internally assuring the highest quality of care continuously.

Our systems allow for integration of data to be received from various vendors incorporating incorporate medical, behavioral, pharmacy, utilization, and member data to create a full picture of each member's health. This data is distributed across the enterprises in real time providing enhanced capabilities for program identification, gaps in care documentation, care planning, and undesirable outcomes identification. The systems automate and integrate core business functions by utilizing a shared platform and deploying services that ensure there is no delay accessing information needed to support member needs. Specifically, the plan is able to leverage consolidated data and provide information transparency across:

- Member enrollment and reconciliation
- Provider credentialing and network management
- Benefits and contract management
- Predictive modeling/risk stratification
- Case management
- Service authorization and referral management
- Claims processing
- Coordination of benefits/third party liability detection
- Fraud and abuse detection
- Capitation/risk fund management
- Consumer directed care support
- Customer service
- Electronic data interchange
- Service authorizations

Central to the efficient management of member populations is our SQL database environment which allows real-time access across the continuum of care to stakeholders based on their roles in the organization. Roles can be defined dynamically, grouping system functions/screens/data elements into parent groupings to which employees can be assigned in read/write or read only mode. Employees may also be assigned to multiple roles. Examples of standard roles within the system are:

- Enrollment
- Case Management
- Member Support
- Authorization/Utilization Management
- Claims
- Document Management
- Financial/Financial Reporting

The enrollment module administratively loads members into the system, consumes/submits HIPAA X12 enrollment transactions to and from the State, manages printing of ID cards and welcome letters and auto-transfers members to the permanent member file for Care Coordinator assignment when all enrollment criteria have been met. Once this function transfers a member to production, Care Coordinator and member support staff are notified upon login of the new membership and begin assign tasks.

Based on their assigned role(s) staff will access member assigned to them, with the ability to create and/or access in real time:

- Demographics
- Assessments
- Care Plan Creation
- Eligibility and Facility History
- Notes
- Care Coordinator and Insurance information
- Notes
- Scanned Documents
- Medications
- Complaint and Grievance Tracking
- Safety/Fall Prevention information
- Medical Record Summary
- Care Coordinator Encounter Creation
- Display of Payment History

9.1.8 Monitoring

1. Describe your care coordination monitoring strategies.

The Care Coordination leadership team monitors and evaluates the processes within the Care Coordination program regularly with a comprehensive annual evaluation that encompasses analysis of all processes, activities, improvement initiatives, and results over the past year. Our comprehensive program monitors, on an ongoing basis, the effectiveness of our care coordination program and processes. We remediate all case specific findings identified through the monitoring process and track and trend findings to identify systemic issues of poor performance or non-compliance. If identified, we implement strategies to improve our care coordination program and processes and resolve areas of non-compliance.

Examples of strategic initiatives that are conducted by the care coordination leadership team are:

- Conducting regular and formal review/audits of assessments and care plans to assure that all services provided to members are timely, relevant to member-stated outcomes, and cost-effective. Documents and reports used to evaluate the Care Coordination program and identify areas for improvement along with reports on current and past improvement projects are maintained and saved electronically. These items are:
 - Presented at least quarterly to the Quality Improvement Committee
 - Presented at least quarterly to the Meridian Health Plan Member Advisory Committee
- Care Coordination leadership will monitor staff production and performance at least monthly to ensure data accuracy and quality service through:
 - Production reports pulled based upon contact codes
 - Phone reports pulled based upon time spent on the telephone
 - Quality audits based upon phone and case note monitoring, which will include (without limitation) quarterly case file audits of:

- Members who are receiving waiver services, ensuring the service plans are completed with each assessment or in between assessments if the member's needs have changed;
- Services listed on the service plan address member needs identified in the assessment; and
- Care team members, emergency contact lists and back-up plans are created for members receiving in-home services and are comprehensive

2. Describe how case specific findings will be remediated.

The Care Coordination leadership team monitors staff competency and implement integrated performance management processes including additional training aimed at growing the professional competencies of the staff. All personal and triggered short and long-term goal outcomes are reviewed and followed up on. In the face of poor performance, quality improvement plans (QIP) and/or corrective action plans (CAP) are implemented internally in order to bring about the desired result within an identified timeframe.

Among those criteria reviewed are the following:

- Risks are identified and addressed
- Preventive and chronic health HEDIS® measures
- Cost and resource use
- Timeliness of initiating community-based LTSS
- Timeliness of member contact
- Timeliness of completing level of care assessments
- Nursing facility or other institutional admissions
- Monitoring for quality, performance and appropriateness of all supports and services
- Monitoring of community transition
- Receipt of services authorized in the care plan

Short and long-term goal outcomes will be measured, including: health and functional status, independence and community integration, quality of life, access to care, member satisfaction, and outcomes for family members and informal supports.

9.1.9 Reassessments

1. Describe in detail your process for reviewing and updating care plans.

At a minimum, Meridian Health Plan will complete reassessments annually. A reassessment may also be administered when there is a significant change in the member's condition, or upon request of the member. With every reassessment, the member is brought back to the Interdisciplinary Care Team (ICT) for review and the person-centered care plan is updated. The member's medical, behavioral health, and home and community-based services (HCBS) are evaluated and his or her care plan is developed specific to the member's preferences and needs, ensuring delivery of services with transparency, individualization, respect, linguistic and cultural competence, quality of care, quality of life, and dignity. The ICT is responsible for establishing and implementing the individualized care plan for each Meridian member.

Reassessments of the care plan may be performed by the Interdisciplinary Care Team (ICT) more frequently based upon certain triggers. For instance, poor health status, an occurrence of an acute exacerbation or change of condition, changes in healthcare providers, reduction of caregiver availability, a lack of progress towards meeting goals, or review of required services may require more frequent review.

An initial assessment and periodic reassessments are required to make sure members are receiving appropriate services and detect any change in their health status that may require additional or more skilled level of care. Every effort will be made to maintain a member's ability to live in the community, up to and including home visits.

Periodic assessments of progress against plans and goals are conducted and modifications to the plan are made as needed. At a minimum, a reassessment of a member's care plan is conducted at least annually and includes the medical, mental, psychosocial, functional, environmental and financial ability of the member. Progress or lack of progress with care plan goals trigger reassessments, goal setting and revised interventions.

2. Describe the protocol that you will use for re-evaluating members to determine if their present care levels are adequate.

The Interdisciplinary Care Team (ICT) reviews the results of each reassessment and revised care plan in comparison to the previous HRA and care plan to determine if changes are required to the member's care levels. Scheduled follow-up, reassessment and communication of the care plan are based upon the member's dynamic risk status. The ICT is to ensure the member understands his or her care plan and involvement in changes to the plan, which empowers the member to manage his or her own health care. Members and/or their caregiver are offered to participate directly with the ICT to develop a care plan either in person or via telephone.

The reassessment and communication of the member's Care plan is conveyed through documentation in our system that collects and records member information and creates electronic reminders for communication among ICTs. Our system alerts the Disease Management Nurses and Case Managers to correspond with each member concerning the outcomes and needed interventions through written and verbal notification. Primary care providers (PCPs) and specialists are asked to update their care plan in accordance with Meridian Health Plan changes and updates as needed per each member's case manager. The member then receives an initial written care plan detailing the agreed upon short-term and long-term goals, as well as updates to his or her care plan throughout enrollment with Meridian.

Reassessments of the care plan may be performed by the ICT more frequently based upon certain triggers. For instance, poor health status, an occurrence of an acute exacerbation or change of condition, changes in healthcare Providers, reduction of caregiver availability, a lack of progress towards meeting goals, and with every transition of care, review of required services may indicate a need for more frequent review.

3. Indicate the triggers which would immediately move the member to a more assistive level of service.

Triggers which immediately move the member to a more assistive level of care are:

- New generation of inpatient authorization (medical or behavioral)
- Significant change in health status
- Increase in emergency room utilization of three (3) times in a six (6) month period
- Change in caretaker status affecting member's ability to self-manage
- Member is discharged from an inpatient facility
- Members who are transitioned to a skilled nursing facility
- Members with reported chronic behavioral health conditions
- Members who are prescribed eight (8) or more medications
- Members with cognitive impairment who require more frequent intervention
- Members who do not have secured housing
- Members scoring a three (3) or four (4) on their Comprehensive Health Risk Assessment

Care Coordination Success Stories

Meridian Community-Based Case Manager Number One (#1): Scott County, IA

“I went to a Transition of Care (TOC) visit at a home of a family with a five (5) year old boy with a brain tumor. The member explained to me what they had been through as a family. She discussed her stress and anxiety and cried during most of the visit. I asked if I could make an appointment for her to speak to someone about her stress and anxiety. I explained she needed to take care of herself, for herself and for her family. I made the appointment; she cried and said she wouldn't have been able to do that on her own. The case was referred to me again a few weeks ago. I called the member to see if there was anything she or her family needed from Meridian. The member's mom let me know she has told everyone how much Meridian cares and how much that one visit did for her family during such a dark time.”

Meridian Community-Based Case Manager Number Two (#2): Muscatine County, IA

“I visited a member in her hotel room this morning for a Transition of Care (TOC) visit. She is a twenty-five (25) year old female who recently had a miscarriage, is working full-time, and was admitted for uncontrolled asthma. She seemed to really want to manage her asthma and was thankful to have insurance, but was frustrated that her pharmacy told her that both her inhaler and her nebulizer solution were not covered by Meridian. I knew this was wrong, called MeridianRx (MRx), Meridian's Pharmacy Benefit Management affiliate, while in her room. I was informed that the nebulizer solution needed Drug Utilization Review (DUR) override and the inhaler required prior authorization. I called her pharmacy and had DUR override placed and the nebulizer solution was available to the member in thirty (30) minutes. I also helped the member get set up with a new primary care provider (PCP), since she did not have one, and she will be seeing him next week with intention to obtain new inhaler. All of this seems like standard follow-up to us, but this member was so happy to have my help. When I was leaving, she stated, ‘I'm going to shout out to you guys on my Facebook page! I had no idea my insurance could help like this!’”

Meridian Community-Based Case Manager Number Three (#3): Scott County, IA

“I was working with Maternity to identify single, working mothers with no car seats. As I was performing Unable to Reach (UTR) visits for prenatal, a particular mom stood out to me. She was working full time, moved to Iowa from another state, living in low-income housing, her baby's father had left, and her entire family and support system was in another state. I began looking for

places that donated car seats to help this member by contacting various agencies and acquaintances. A man I went to high school with emailed me stating he would like to purchase a new car seat for a new mom. He wired \$150 to Walmart. I met the member there so she could pick out the seat herself. I explained that it was not from Meridian but an anonymous donation. The member was able to get a car seat, crib sheets, blanket, and a pair of pajamas for her other son. At one point, the member looked at me after she had picked everything out and started to cry, explaining how she was completely overwhelmed by this. ‘You have no idea what this means to me!’ She hugged me and was in awe that her insurance cared enough to make visits in the first place and cared that her new baby didn’t have a car seat. Since then, I found an agency that donates new car seats to new mothers if they take a series of parenting classes.”

Meridian Community-Based Case Manager Number Four (#4): Oakland County, IA

“About two (2) months into my field work, I scheduled a Transition of Care (TOC) home visit with a man in Washington Township. Upon starting the home visit, I came to find out the man and his wife both were Meridian members. The man was a self-employed handyman who was recovering from a second heart attack that required bypass surgery. The member was already out of work for over three (3) months when I met with him. He and his wife were close to using up their savings, and every penny was being counted.

During the course of the TOC meeting, we discussed monitoring the member’s weight and blood pressure; however, he could not pay for a weight scale or blood pressure monitor. I informed the member that Meridian offered weight scales and blood pressure monitors that could be delivered right to his home with no out-of-pocket expense.

The member’s cardiology team was based out of Detroit Medical Center (DMC) in downtown Detroit. I mentioned that Meridian uses LogistiCare transportation service, which is free to Meridian members. I also explained that there was a gas reimbursement form the member could fill out to get reimbursed for gas for all trips to his doctors. I made a call in the home to LogistiCare and had gas reimbursement forms sent out for the member. As soon as I ended the call, the member began to get emotional, and it was hard for me not to as well. This was clearly a time when the member needed some good news, and I was glad I was able to bring something positive to the process.

His wife also needed new diabetes testing supplies, since she had been using a friend’s supplies only when she was able to. I informed her that through Healthy Living Medical, Meridian members could receive testing supplies at no out-of-pocket expense with delivery to their door. I placed a call right there in the members’ home to Healthy Living Medical and set up the delivery of testing supplies for the wife.

A week after the meeting, I followed up with the member by phone. He had received the weight scale, blood pressure monitor, diabetes testing supplies, and gas reimbursement forms. He was very thankful that we had met, and I was very happy to have helped relieve some stress from his and his wife’s lives.”

Meridian Community-Based Case Manager Number Five (#5): Wayne County, MI

“A Meridian member who uses oxygen and a walker to get around was discharged from a local hospital without her oxygen tank and valve/adaptor, so she was unable to use oxygen once home. I conducted a Transition of Care (TOC) visit shortly after discharge, when I discovered this issue.

While the hospital was only a block or two down the road, the member did not have transportation and was unable to walk there. I agreed to go to the hospital to pick up the member's oxygen equipment. The member gave me her ID and also called the hospital to inform them that I was coming for pick-up. I was able to obtain necessary medical equipment for the member and the member was very thankful."

Meridian Community-Based Case Manager Number Six (#6): Wayne County, MI

"A Meridian member had recently moved to the city and was frequently admitting to the hospital for chronic heart conditions. The member was discharged home with prescriptions for her medications but had no way to transport herself to the pharmacy. After trying to contact delivering pharmacies and having no luck, I agreed to take scripts to a local pharmacy to be filled. I knew that without medications, this member would soon readmit to the hospital. The member provided her ID, insurance card, and prescriptions, so I was able to fill the prescriptions, deliver them to the member's home, and educate the member on setting up pharmacy stops after medical appointments to have future prescriptions filled. This member was very thankful."

Meridian Community-Based Case Manager Number Seven (#7): Oakland County, MI

"A twenty-three (23) year old Meridian member struggling with substance abuse of heroin refused a Transition of Care (TOC) visit upon Unable to Reach (UTR) TOC contact. This member was residing with her mother, who had recently obtained guardianship over the member due to hospital admissions and an inability to care for herself. The member's mother informed me that she was desperate for any assistance, overwhelmed, and broke down crying during the visit. I agreed to work with the Community-Based Case Manager team to find some way to contribute to the situation. With help from a Meridian Medical Director, the High-ER Team, and Behavioral Health (BH) Department, I provided a Substance Abuse (SA) rehab contact to the mother that the member agreed to utilize. I kept regular communication with the member's mother and was able to provide medical resources and help manage the member's type 1 diabetes. I assisted with finding doctors, filling medications, and educating the member on her condition. As of the most recent contact with the member, she was actively participating in an outpatient SA rehab program."

Meridian Community-Based Case Manager Number Eight (#8): Wayne County, MI

"As a Community-Based Case Manager, I have conducted many home visits and have come in contact with numerous members since I have held this position. Although I have made an impact on many members' lives, I have one member who has made a major impact on my life. I had previously conducted two (2) visits with this member, as she was gravely ill. With each visit it, was apparent that this member may not survive as she was becoming progressively worse due to her diagnosis. This member was only thirty-seven (37) years old and was beginning to accept the fact that she may not survive without proper intervention. During my last visit with her, I had an end of life conversation with her, as she was not certain if she was going to survive. During this conversation, I disclosed to her a time in my life in which I had a similar experience. I could relate to how she was feeling, and I felt that I needed to express this to her. Upon leaving the visit, I felt that I had made an impact on her and hoped that she would indeed pull through. Several weeks later, this member came back onto my caseload, as she was in the hospital again. This would be my third visit and I was unsure what this visit would bring. As I was lead into her room, it looked as though she was beaming. She was able to sit up on her own and stated that since her procedure, she no longer had to depend on her oxygen or wheelchair. I was so elated. I

asked during the visit if she remembered our last conversation, and she stated that she did. I told her how happy I was for her and that I was so glad that everything was okay. She thanked me for taking the time to be so concerned for her. Upon leaving this visit, I was so thankful to see the difference in her health and even more grateful that I had truly made an impact on her life. This is why I love doing what I do on a daily basis, as it is my passion to be able to make a difference in someone's life, no matter how big or small."

Meridian Community-Based Case Manager Number Nine (#9): Kent County, MI

"I recently visited a member who had multiple conditions and was very grateful that we had come out to visit her. I was able to help her go through her medications and list them all on a single sheet of paper to keep them organized as well as schedule her to see a specialist. The member had limited supports and was very overwhelmed with her conditions and appointments, so she was very happy to have someone there to talk with her. Before I left, the member said something that stuck out in my mind; she stated, 'I can't believe my insurance company cares enough about me that they actually come to my house for a visit!'"

Meridian Community-Based Case Manager Number 10 (#10): Muskegon County, MI

"I recently visited a member who had been hospitalized due to heart complications. When I visited with him, he expressed a desire to lose weight but was unsure where to begin. He knew it was important that he make an effort to maintain a healthier lifestyle. I educated the member on the importance of a nutrition referral as well as his Weight WatchersTM (WW) benefit through Meridian. The member was very interested and excited. He had been unhappy because he had been unable to volunteer at his usual volunteer programs over the holidays due to being inpatient. I referred the member to the Meridian Nutrition Department. Nutrition staff contacted him and set him up with WW. During my most recent follow-up call with the member, he stated he was attending WW regularly and had already lost a couple pounds. The member thanked me for visiting with him and stated it was nice to know his insurance cared about his health enough to send someone out to his home. The member also expressed that because he was becoming healthier, he was able to resume volunteering, which gave him a great deal of joy."

Meridian Community-Based Case Manager Number Eleven (#11): Washtenaw County, MI

"Along with a Meridian Nurse Team Lead (TL), I visited a member after she came home from the hospital. Upon arrival, the member immediately broke into tears because on top of her medical concerns, she felt completely alone. The member openly discussed the cause of her recent hospital admission and how her health condition is affecting her social life and career. During the visit, we discussed how to better manage her medical condition as well as the importance of attending a support group or possibly seeking therapy. By the end of the visit, the member was very appreciative to have an insurance company that cared deeply about her entire wellbeing. The member was so touched that she asked if it was okay to hug us before we left. Of course, we were more than happy to."

Meridian Community-Based Case Manager Number Twelve (#12): Washtenaw County, MI

"After one of our members was discharged from the hospital, I met her at her apartment for a scheduled visit. Upon arrival, I began asking questions about her recent hospital stay. I noticed that the member began to mumble her words and have difficulty breathing. When I asked the member if she was okay, she could hardly respond. The member's face became flushed and she

suddenly appeared to be very limp in her chair. The member responded, saying she is having problems with breathing and her inhalers were not helping. The member went on to say a home healthcare nurse had recently left and advised member to go back to the hospital. When I asked why the nurse didn't call 911, the member stated she told the nurse she would make the call herself but felt too weak to actually do it. I asked if the member wanted me to call 911 and the member agreed. About ten (10) minutes later, an ambulance arrived. It scares me to think what might have happened if I'd never visited the member or been there to help in that crucial moment."

SECTION 10 – QUALITY MANAGEMENT AND IMPROVEMENT STRATEGIES

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.

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.**

Quality Improvement initiatives are embedded in the culture and daily functions of Meridian Health Plan. Enterprise goals consistently emphasize the criticality of providing high quality health care. Longitudinal planning is essential for ensuring that quality improves throughout periods of growth. Experience, including established community partnerships, has been essential in determining which interventions are successful long-term and positively impact member health.

Long-term planning is the key to a stable and successful Quality Improvement Program (QIP). Meridian embraces this process and is confident current planning efforts exceed the expectations of the State. Meridian's five-year strategic plan sets measurable goals, establishes specific objectives, identifies the strategies to be undertaken, and monitors results and assesses progress of Meridian's Iowa-specific QIP. All information related to Meridian's QIP will be made available to providers and members via the Meridian website. The following core goals are central to the five-year strategic plan:

Prioritize HEDIS®, state performance measures, and consumer and provider surveys to sustain and achieve excellence in all areas of quality.

Meridian recognizes the criticality of achieving sustained performance improvement in State performance measures. Iowa-specific performance measures will be prioritized, similarly to other states of operation in previous years. Quality measure achievement will remain essential as Meridian has reached exceptional levels of success in Illinois and Michigan and assumes the same responsibility in Iowa. While Meridian is concertedly focused on the Healthcare Effectiveness Data and Information Set (HEDIS®) measures, Meridian is cognizant of the importance of examining consumer and provider satisfaction. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) will continue in accordance with the National Committee on Quality Assurance (NCQA) guidelines and results shared with providers similar to in previous years. Meridian conducts an annual survey of provider satisfaction in all states where we currently operate, including Iowa, using an impartial third-party vendor. Overall satisfaction in 2014 reached nearly eighty percent (80%) for physicians and specialists. See Attachment 30 (Provider Satisfaction Analysis) in Tab 5 for further details.

Collaborate within stakeholders and community partners to accomplish annual goals.

Meridian supports inquiries into the characterization of membership and epidemiologic review of disease patterns. Quality leadership and analysts have conducted such analyses for populations in Michigan and Illinois. Meridian also values collaboration with academic institutions and has existing relationships with Drake University, Iowa State University, and the University of Iowa.

Meridian recently formed a student intern team intended to provide long-term support for quality outreach in all states.

Establish an integrated quality system leveraging state and corporate resources to maximize efficiency and effectiveness.

As part of an effort to move toward electronic data interchange (EDI) for all HEDIS® data, prioritization lists were developed for each state including Iowa. In 2014, more than forty percent (40%) of member data were available through remote electronic medical record access or through EDI. This percentage is expected to increase in successive years with anticipated participation in the Iowa Health Information Network and with large system providers.

Set standards for operations including core functions, delineation of corporate and state responsibilities, and expectations for communication and state reporting.

As a result of Meridian's extensive experience administering Medicaid services, the Quality Department has developed standard document templates for core documents such as annual quality reports, Quality Improvement Committee (QIC) meeting minutes, agendas, tracking documents, etc. The Quality Department also set a common staffing structure using membership and accounting for benefit plan complexity. The result is a staffing structure that is scalable and agile tying into goal six of this strategic plan.

Recognize the need for annual planning, strategic, and budgetary, accounting for population change (including lines of business), shifts in contractual, NCQA or other requirements, and draft a continuous plan for reference for the department.

Meridian has an annual and five-year prospective budgeting plan that include per member allocations for incentives and outreach, as well as resources to support external consumer and provider surveys, further staff education and training, and validate internal data processes.

Develop a uniform perception of need; consider whether business units are scalable and agile.

With the advent of Medicaid Expansion, Meridian realized a need to identify business units that were scalable and agile. The Quality Department standardized staffing models and positions and also determined which data elements best characterized idiosyncrasies in State membership.

The Meridian Quality Improvement Program operates using a continuous strategic planning cycle. State-specific plans are evaluated annually along with an accompanying work plan. The annual plan contains goals and measureable objectives which are tracked using key performance indicators (KPIs). Progress reporting on KPIs occurs weekly and helps identify areas needing focus or programmatic adjustment. The weekly report template limited to goals and objectives for the current year is provided in Attachment 31 (Quality KPIs) in Tab 5. Goals are expected to evolve over time and the Quality Department strategic plan is reviewed twice a year. Work plans are utilized to ensure daily activities are performed in support of goals and objectives. A sample work plan is provided in Attachment 32 (QI Work Plan) in Tab 5.

Resource staffing and Quality and Performance Improvement support

The Quality and Performance Improvement Department has a staffing structure designed to respond to changes in population composition and/or health while sustaining the highest level of quality care. The Quality and Performance Improvement Department is led by a doctoral-level Vice President, who oversees the business units within the Department including Clinical Program Development, Performance Improvement, Medicare Star Ratings, and State-level quality departments.

The Clinical Program Development unit is responsible for the design, coordination, monitoring, measurement, and evaluation of outreach efforts. Efforts include member outreach, education, mailings, incentives, focuses groups, telephonic contact, etc. The unit also collaborates with the Network Development Department to refine provider education initiatives, training, pay-for-performance programs, and outreach. This unit performs the functions of disease management by examining the impact of outreach interventions on health status. The unit has analytic capacity to assess variance in populations using principles of epidemiology.

The Performance Improvement unit is dedicated to intensive monitoring of quality metrics, including the HEDIS®, state-specific performance measures, and population health metrics. Meridian captures multiple data sources including historical claims, demographics from enrollment data, claims, and Health Risk Assessment (HRA) surveys. Data are accessible through database extracts and through Meridian's data warehouse.

In Iowa, the Quality Department made great strides in accomplishing exceptional population health goals in a short period of time. Five (5) staff and a Director support the core functions of the Quality Department. Community collaborations are essential to building and sustaining success in quality improvement.

In addition to the committee and subcommittee infrastructure, Meridian has dedicated resources to ensure all aspects of quality improvement are achieved. The Quality Department includes the following staff; Vice President of Quality and Performance Improvement, Medical Director, Director of Quality Improvement, Quality Coordinators, and a Junior Analyst. The Quality Improvement staff works directly with Member Services, Provider Services, Care Coordination, Compliance, Utilization Management, Behavioral Health, and Communications to implement Performance Improvement Projects (PIPs) and related activities and to ensure compliance.

Physical and behavioral health and long-term care support services

Meridian tracks utilization of all physical services, behavioral health services, and long-term care services through Meridian's Managed Care System (MCS). Claims data for all services are entered and stored in MCS and the Quality Department analyzes the claims data to identify utilization trends, Healthcare Data Effectiveness Information Set (HEDIS®), over- and under-utilization, a process to monitor variation in practice patterns, and for opportunities in improvement. The Quality Department staff is able to identify when a member is due for a service as MCS is able to pull HEDIS® information from the claims that are received and stored. When a member is missing a service, the 'H' alert for HEDIS® is triggered in MCS to inform Meridian staff that this member is due for the service. Quality Department staff as well as other staff in other various departments work with both the members and providers to ensure that members have access to the services needed and assist with scheduling appointments and necessary transportation.

The Meridian website also includes a downloadable version of the Provider Manual, bulletins, forms, educational materials, medication formulary, a searchable Provider Directory, Provider Portal, and online Live Chat. These materials are presented in an organized and easily searchable format, which gives providers twenty four (24) hours a day, seven (7) days a week access at the click of a mouse.

The Provider Portal is a secure, proprietary software program that offers unmatched flexibility and efficiency for our network providers. Free of charge to all participating Meridian providers, the Provider Portal allows providers to verify eligibility, view and submit claims, enter prior authorizations, detailed member data and reports, enrollment lists, HEDIS® bonus information, self-reporting, and much more.

For physical services, the Quality Department staff focuses primarily on HEDIS® to determine utilization of preventive services. Such HEDIS® measures include:

- Adult Access to Care
- Well-Child Visits
- Breast Cancer Screening
- Childhood Immunizations

These measures are also supported by clinical practice guidelines adopted by Meridian and are used to ensure that providers are adhering to these guidelines. All of the clinical practice guidelines are reviewed and approved by the Quality Improvement Committee (QIC) and are available on the Meridian website for providers to view. These include guidelines such as:

- Management and Prevention of Osteoporosis
- Routine Prenatal and Postpartum Care
- Adult Preventive Services Ages Eighteen (18) to Forty-Nine (49)

In regards to behavioral health, Meridian will provide all benefits and services deemed medically necessary that are covered under the contract with the State. Referencing our clinical practice guidelines, Meridian does not arbitrarily deny or reduce the amount, duration, and scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. Through our Utilization Management procedures, Meridian may potentially place appropriate limits on services based on medical necessity criteria for the purpose of utilization control, in accordance with the overarching goals of the Iowa High Quality Healthcare Initiative (IHQHI). Meridian intends to leverage our current relationships with our comprehensive network of providers to deliver covered services. As the sole Medicaid managed care organization currently operating in the State of Iowa, Meridian's established and growing provider network will provide members, to the extent possible and appropriate, adequate choice in selecting his or her health professional.

Meridian staff tracks utilization of services through Meridian's Managed Care System (MCS). Claims data is synchronized with a continuously updated "Member Service Counts" module. This module includes visit tracking of chiropractic, vision, and behavioral health services, as well as physical/occupational therapy, inpatient days, and skilled nursing facility days. Meridian staff keeps members and providers updated on the amounts remaining of those services that are limited. Meridian also uses this information for HEDIS® which allows Meridian to ensure analyze utilization and overall health of the membership. Such HEDIS® measures include: seven

(7) and thirty (30) day follow-up after hospitalization and adherence to medication measures. Meridian also uses health assessments to help better serve members individually to their needs by addressing their physical and behavioral health.

The Long-Term Services and Supports (LTSS) program also includes a comprehensive Health Risk Assessment tool that addresses a member's physical, social, development, behavioral, nutritional, environmental, and clinical areas. The Community-Based Case Manager is expected to collect the information from the member or family caregiver within sixty (60) days of enrollment. Reassessments are performed at least quarterly. The information obtained through the assessment is shared in the form of a summary profile and an individualized care plan that is shared with the member and/or their caregiver, along with the member's medical home. The Care Coordination Team Lead coordinates the services, inclusive of preventive health screenings, together with the member and/or caregiver, and the member's primary care provider and ensures that all appropriate handoffs occur.

During the initial Health Risk Assessment, a complete medication list is recorded for each patient. As a component of the care plan, interventions are designed around evaluating medication compliance, poly-pharmacy, medication education, and overall medication management.

Community-Based Case Managers will follow-up with members to verify compliance with medication plans and provide continuous medication alignment. The care management system can be modified to base interventions on any standards or models to ensure proper compliance and management. For example, triggers can be set in the system to apply interventions related to HEDIS® measures such as annual monitoring for patients on persistent medications.

Policies and procedures

The Quality Improvement Program develops policies and procedures sent to the Quality Improvement Committee (QIC) for approval on an annual basis. All new policies must receive approval from the QIC prior to implementation. The policies and procedures are written to streamline processes and reports to ensure that the data in the reports are comparable and standardized to ensure the highest level of efficiency and quality is achieved. Meridian has created a standardized policy and procedures template that is followed by both Corporate and State level staff where a description of the policy is given, and then the procedure for process is laid out, including: the responsible party, method, and timeline, if applicable. A few of the key Quality Improvement policies that have been approved and implemented include:

- Monitoring Member Satisfaction
- Grievances and Appeals Reporting Methodology
- Quality of Care Complaints
- Clinical Practice Guidelines
- Health Education and Promotion Policy

All policies are stored on a widely accessible SharePoint site and the Compliance Department helps ensure necessary updates occur.

2. Describe how you will utilize program data to support the development of the Quality Management and Improvement Work Plan.

HEDIS® data are pulled directly from the Meridian Health Plan Managed Care System (MCS) and may be viewed real-time. HEDIS® measures are central to quality monitoring of population health. Multiple analysts within the Quality Department routinely investigate variances in rates, track longitudinal trends, comparison to performance within the State, and to other Medicaid plans nationally. A standard quality operations report is provided in Attachment 33 (Operations Report) in Tab 5.

The Quality and Performance Improvement Department sits within the Division of Clinical Performance and Analytics (CPA). CPA is comprised of experienced epidemiologists, statisticians, and clinicians. The group designed Meridian's care transformation initiative, including the use of predictive modeling to ascertain utilization behavior and targeted behavior interventions.

Due to the uniqueness of each state wherein Meridian operates, Quality Departments specific to the State are located within local offices. Each state Quality Department is headed by a Director, with a background in nursing or an advanced graduate degree, and is supported by local Quality Department staff. The state Quality Departments prioritize population-specific health needs and frequently collaborate with community health partners.

All data obtained in routine reporting, whether operational or to the Quality Improvement Committee (QIC), are used to drive changes to the quality work plan. Meridian frequently adjusts targeted activities within work plans as a result of variances in trends. For example, seasonal increases in respiratory utilization were observed in all three states of operation for successive years. Influenza is a known driver of respiratory illness and, in an effort to reduce respiratory utilization, Meridian implemented its first influenza prevention campaign. The campaign included promotion vaccination to members, educational faxes for providers throughout the season on topics such as antiviral medication use, and staff education on influenza disease. Meridian plans to continue the influenza prevention program and annually measure the impact and effectiveness through utilization, pharmacy, and vaccination data.

Utilization Monitoring

Meridian analyzes data from multiple sources in its effort to monitor under- and over-utilization. These sources include:

- Utilization authorization and claims data
- HEDIS® data
- Physician profile report
- Member complaints and grievances
- External quality review data
- Pharmacy data
- Financial utilization data

This data is evaluated for patterns that may indicate inappropriate utilization and/or fraud and abuse among population groups and individual practitioners, practitioner groups, and facilities. Meridian then compares this information to other health plans as well as regional and national

data. If plan-wide monitoring results fall outside the established thresholds, a focused review will be conducted. This may include, but is not limited to, practitioner or facility specific information separated by risk, delegate, specialty type, or other significant categories. If areas of deficiency are identified, the Quality Improvement Committee (QIC) will conduct an analysis to identify barriers or specific circumstances and make recommendations for correction of the variance.

Reports prepared for the QIC also account for measurement of the effectiveness of treatment services as evidenced by HEDIS® performance. This includes close monitoring of prescribing patterns and checks for appropriateness. Key indicators for assessing effective and appropriate treatment include:

- Children with pharyngitis—events where a child is diagnosed with pharyngitis are reviewed for the provision of antibiotics; a practice not supported as effective treatment
- Coordination of diabetic care—not only are diabetes screening encounters viewed for members with diabetes, but the presence of labs evidencing control is as well
- Controlling high blood pressure—a measure of whether high blood pressure is being controlled is reviewed following the close of a calendar year drawing from the last available blood pressure screen

If awarded, Meridian would seek to expand monitoring of effective treatment similar to other states of operation. Meridian is concerned with ensuring members starting antidepressant medication continue for a clinically-appropriate period of time and ensuring children and adolescents beginning attention deficit disorder medication are tracked for long-term adherence.

Measures of functional status are typically assessed and reassessed as part of the Health Risk Assessment process conducted with Medicaid members, including those with long-term support services. More thorough assessments are used with members that have complex or long-term health needs and may require extensive, in-home support.

Controlled Substance Monitoring

The MeridianRx Live Integrated Network (MERLIN) adjudication system employed by MeridianRx routinely checks all incoming claim submissions for indications of fraudulent activity, including (but not limited to):

- Multiple fills of narcotic medications
- Identical fills from different pharmacies for same patient
- Identical medications from different prescribers for same patient
- Extraordinary quantities in relation to days' supply
- Pharmacies with high rates of brand or narcotic dispensing

The analysis of the utilization data includes identification of patterns that may indicate inappropriate utilization by members, physicians, and pharmacies. Identifying patterns of fraud, abuse, and/or gross overuse can be identified by any of the above processes with the ability to drill down to the specific member, physician, and even claim level to determine the appropriateness. Meridian completes provider and member profiling on a monthly basis. The Finance Department provides the provider report, which renders detailed utilization patterns by all Meridian providers. Analysis of the report is completed on a monthly basis by the Medical

Director. This analysis includes investigation of outliers in pharmacy utilization patterns in a specialty specific manner, by cost, and type of medication prescribed.

Meridian's process for identifying member fraud, abuse, or gross over use is the responsibility of the MeridianRx Narcotic Monitoring Coordinator. A monthly report is pulled to capture our Medicaid population that have three (3) or more narcotic claims, from three (3) or more different prescribers, and filled at three (3) or more different pharmacies. The parameters of this report can be adjusted to meet contractual agreements. Once a member has been identified as narcotic seeking, a request for lock agreement is sent to the member's primary care provider. Once the lock agreement is complete and returned to MeridianRx, the overall approval comes from a MeridianRx Pharmacist. This process restricts members to only obtain prescriptions from their primary care provider. In the event a provider is unwilling to contract, the member is placed in a pharmacy lock that limits them to filling prescriptions from one pharmacy. Once the locks are approved by the MeridianRx Pharmacist and status updates are sent to all previous prescribers informing them of the applied lock.

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.

Achieving the highest percentile rankings in all quality metrics is part of the Meridian Health Plan mission to provide quality health care in a low resource environment. Meridian strives to be the best health plan in the State of Iowa and top ten (10) nationally as demonstrated by quality indicators including HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®); methods used by more than ninety percent (90%) of health plans. Meridian Health Plan of Michigan, Inc. and Meridian Health Plan of Illinois, Inc. were ranked the number ninth (9th) and tenth (10th) Medicaid HMO in the country respectfully according to NCQA's Medicaid Health Insurance Plan Rankings 2014–2015.

Meridian's Iowa Medicaid affiliate was eligible to participate in the HEDIS® compliance audit for accreditation and Quality Compass reporting in calendar year (CY) 2014. In its first full year of reporting, Meridian Health Plan of Iowa, Inc. was ranked the thirty-eighth (38th) Medicaid HMO in the country according to NCQA's Medicaid Health Insurance Plan Rankings 2014–2015 and achieved "Commendable" accreditation status.

Meridian will also use the Iowa Participant Experience Survey for members receiving Home and Community Based Services in future contract years. Necessary efforts for data exchange and collaboration with the State of Iowa and subcontracted service providers will be completed by Meridian.

Past Performance in Iowa

Meridian made significant progress on multiple HEDIS® measures in Iowa over the past several years. The first year of tracking in 2012 provided an adequate baseline for comparison and the identification of areas where strategies were needed to improve health outcomes. Meridian performed exceptionally well in several categories. Quality Improvement (QI) staff tracked sixty-one (61) measures in 2013, including some drawn from data provided by Iowa Medicaid Enterprise. Three quarters of sixty-one (61) measures monitored were ranked in the fiftieth (50th)

percentile or higher. One-quarter were ranked in the ninetieth (90th) percentile. Statistically-significant gains were experienced in more than a dozen measures.

Multi-year comparison rankings are provided below for twenty-four (24) key HEDIS® measures.

| Measure | 2012 | | 2013 | | Year to Year Change | | |
|---|-------|------------|-------|------------|---------------------|----------|---------|
| | Rate | Percentile | Rate | Percentile | % Change | χ^2 | p-value |
| Childhood Immunizations – Combo 3 on or before 2 nd birthday | 48.3% | <50th | 76.5% | 50th | 28.2% | 30.4 | 0.00* |
| Well Child- First 15 months (6+)* | 53.3% | <50th | 79.4% | 90th | 26.1% | 23.04 | 0.00* |
| Well Child 3-6 years* | 66.1% | <50th | 80.6% | 75th | 14.5% | 34.5 | 0.00* |
| Well Child – Adolescent* | 32.0% | <50th | 58.7% | 75th | 26.8% | 88.68 | 0.00* |
| Children and Adolescents’ Access to Primary Care Practitioners – 12 to 24 months | 94.9% | <50th | 99.3% | 90th | 4.4% | 20.29 | 0.00* |
| Children and Adolescents’ Access to Primary Care Practitioners – 25 months to 6 years | 85.9% | <50th | 94.0% | 90th | 8.1% | 74.12 | 0.00* |
| Children and Adolescents’ Access to Primary Care Practitioners – 7 to 11 years | 82.7% | <50th | 92.0% | N/A | 9.3% | 62.73 | 0.00* |
| Children and Adolescents’ Access to Primary Care Practitioners – 12 to 19 years | 84.3% | <50th | 94.1% | N/A | 9.8% | 77.47 | 0.00* |
| Lead Screening in Children | 74.0% | 50th | 85.8% | 75th | 11.8% | 7.85 | 0.005* |
| Timeliness of Prenatal Care | 90.4% | 75th | 96.3% | 90th | 5.9% | 0.61 | 0.44 |
| Postpartum Care | 67.3% | 75th | 74.4% | 90th | 7.1% | 1.68 | 0.196 |
| Comprehensive Diabetes Care – HbA1c Testing | 77.8% | <50th | 95.2% | 90th | 17.4% | 8.64 | 0.003* |
| Comprehensive Diabetes Care – Diabetic Eye Exam | 55.2% | 50th | 71.0% | 90th | 15.8% | 5.37 | 0.02* |
| CDC LDL Screening* | 62.6% | <50th | 77.4% | 50th | 14.8% | 3.74 | 0.053 |
| Immunizations for Adolescents* | 40.8% | <50th | 62.1% | N/A | 21.4% | 9.41 | 0.002* |
| Adults’ Access to Preventative/Ambulatory Health Services Total* | 81.7% | <50th | 91.5% | 90th | 9.9% | 69.55 | 0.00* |
| Chlamydia Screening* | 64.7% | 90th | 61.2% | 50th | -3.5% | 1.34 | 0.25 |
| Cervical Cancer Screening* | 70.7% | 50th | 76.0% | 75th | 5.3% | 7.66 | 0.0056 |

*p-value<0.05

Notes: Percentiles were taken from NCQA for each reporting year. Chi-square was calculated using the year to year comparison of hits and misses by measure.

Maternal and child health is a strong area of focus for Meridian. Care Coordination supports member access to routine prenatal screenings and as well as baby visits following delivery. The following population metrics on accessing care, as determined by HEDIS® measure reporting.

- Ninety-seven percent (97%) of mothers received prenatal care and seventy-five percent (75%) receive postpartum care
- Eighty percent (80%) of children received all ACIP recommended immunizations by age two (2)
- Eighty-six percent (86%) of children were screened for lead poisoning by age two (2)
- Ninety-nine percent (99%) of infants were seen by their PCP by age two (2)
- There were 228 boarder babies requiring NICU stays greater than three (3) days
 - In 2012, fifteen percent (15%) of deliveries resulted in a prolonged NICU stay
 - In 2013, this rate dropped to eleven point five percent (11.5%)
 - The national average as reported by the March of Dimes ranges between ten to fifteen percent (10-15%)

Chronic disease management is a function of the Quality Department and Care Coordination Department. Ensuring adequate diabetic care is a constant focus, whether through member education or one on one contact. The following evidences Meridian’s work in chronic disease management in 2013.

- Ninety-five percent (95%) of diabetic members receive routine screenings
- Seventy-five percent (75%) of members have high blood pressure under control
- Sixty-eight percent (68%) of diabetic members received an eye exam

Iowa Medicaid and Meridian Performance Comparison

Meridian’s performance exceeds that of MediPass and fee-for-service (FFS) within the State of Iowa, as determined by the University of Iowa Public Policy Center. A multi-year comparison (see tables below) showed Meridian members completed well-child visits twenty percent (20%) more often than either Medicaid plan alternative.

| | MediPass | | FFS | | Meridian | Difference (MediPass 2012/Meridian 2013) |
|--|----------|-------|-------|-------|----------|--|
| | SFY11 | SFY12 | SFY11 | SFY12 | SFY13 | |
| Well Child 6 or more visits | 46% | 51% | 43% | 48% | 79% | 28% |
| Well Child 3-6 years | 56% | 60% | 55% | 57% | 81% | 21% |
| Children's Access to PCP's (12-24 Month) | 63% | 97% | 62% | 95% | 99% | 2% |
| Children's Access to PCP's (25 Month - 6Yr) | 52% | 87% | 53% | 87% | 94% | 7% |
| Children's Access to PCP's (7-11 Years) | 53% | 89% | 60% | 90% | N/A | N/A |
| Children's Access to PCP's (12-19 Years) | 56% | 89% | 61% | 89% | 94% | 5% |
| Combined | 54% | 89% | 58% | 89% | 96% | 7% |
| Adults Access to Prev Serv. (20-44 Yrs Old) | 95% | 89% | 94% | 87% | 92% | 3% |
| Adults Access to Prev Serv. (45-64 Yrs Old) | 93% | 89% | 91% | 86% | 89% | 0% |
| Prenatal/Postpartum - Prenatal | 78% | 80% | 70% | 71% | 96% | 16% |
| Prenatal/Postpartum - Postpartum | 40% | 43% | 39% | 40% | 75% | 32% |
| Diabetes - HbA1c | 80% | 63% | 75% | 65% | 95% | 32% |

| | MediPass | FFS | Meridian | Difference MediPass/Meridian 2013 CAHPS® |
|---|----------|-----|----------|--|
| Timely care | 73% | 77% | 84% | 13% |
| Care coordination | 69% | 76% | 82% | 16% |
| Communication with child's person doctor | 89% | 93% | 92% | 3% |
| Personal doctor's staff was courteous, respectful and helpful | 80% | 75% | 88% | 9% |
| Comprehensive care | 45% | 41% | 51% | 12% |

Remarkable differences were seen with prenatal and postpartum visit rates, at sixteen (16) and thirty-two (32) percent (16-32%) higher than FFS or MediPass respectively. Children accessing care was more prevalent among Meridian’s membership, as was diabetes HbA1c screening at thirty-two percent (32%) above either MediPass or FFS.

All consumer satisfaction scores were higher for Meridian than MediPass or FFS.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

Meridian participates in the annual CAHPS® survey process as part of National Committee for Quality Assurance (NCQA) accreditation and annual ratings submissions. CAHPS® surveys are administered by an independent, NCQA-certified vendor to an auditor-approved sample of Meridian members. Members are asked their opinions of services received and encounters with their health plan within the six months prior to the survey.

CAHPS® allows identification of areas of high performance and where improvement is needed. Data are calculated into composite scores for comparison to the national score and into percentile rankings. As with HEDIS®, Meridian strives to reach the ninetieth (90th) percentile in all areas of member experience.

Meridian initiated its first state-specific adult CAHPS® survey in 2014 to capture member experience. Meridian reached a twenty point five percent (20.5%) response rate, completing 353 surveys. There were 1,369 members who did not respond to mailings or phone calls and thirty-three (33) were determined to be ineligible. Interpreter services were used for Spanish-speaking members.

Demographic data revealed solid distribution of surveys among race and ethnic group. The age of members reached was representative of the actual member population. Self-reported health status indicated most members have very good or good health, with only eighteen percent (18%) reporting fair or poor health status. Meridian reached the ninetieth (90th) percentile for five measures, the seventy-fifth (75th) percentile for four (4) measures, and had two (2) measures in the fiftieth (50th) percentile. These results exceeded goals for the 2014 reporting year. The following lists key consumer satisfaction measures and Iowa’s national percentile ranking.

- *Measures in the Ninetieth (90th) Percentile*
 - How well doctors communicate
 - Show respect for what you say
 - Listen carefully to you
 - Explain things so you understand
 - Rating of personal doctor

- *Measures in the Seventy-Fifth (75th) Percentile*
 - Spent enough time with you
 - Getting needed care
 - Appointment with specialists
 - Discussing Strategies
- *Measures in the fiftieth (50th) Percentile*
 - Got care when needed
 - Rating of health care

See the tables below for Meridian CAHPS® results summaries.

| CAHPS® Measure | 50th Percentile | 75th Percentile | 90th Percentile | 2014 Rate | 2014 Current Percentile |
|----------------------------------|-----------------|-----------------|-----------------|-----------|-------------------------|
| How well doctors communicate | 89.4% | 90.7% | 92.6% | 93.2% | 90th |
| Show respect for what you say | 91.4% | 92.9% | 93.9% | 95.8% | 90th |
| Listen carefully to you | 90.4% | 91.6% | 93.4% | 93.8% | 90th |
| Explain things so you understand | 89.6% | 91.3% | 93.4% | 93.8% | 90th |
| Rating of personal doctor | 78.7% | 80.7% | 82.9% | 86.6% | 90th |
| Spend enough time with you | 86.8% | 88.7% | 90.2% | 89.6% | 75th |
| Getting needed care | 81.0% | 83.3% | 85.4% | 84.4% | 75th |
| Appointment w/specialists | 79.2% | 81.9% | 84.7% | 82.4% | 75th |
| Discussing strategies | 40.7% | 44.9% | 50.7% | 47.1% | 75th |
| Got care when needed | 83.3% | 86.4% | 88.4% | 84.8% | 50th |
| Rating of health care | 70.6% | 73.3% | 76.3% | 72.2% | 50th |

Meridian reviews the results of the CAHPS® surveys, even member comments, to identify areas of needed improvement. Results of the survey were communicated to providers through educational documentation with state-specific results. In addition, provider satisfaction surveys were administered and results aligned with CAHPS® for department-level areas of improvement.

Outreach Strategies and Iowa Programming

Strategies for improving quality indicators are multi-faceted and intensive. The Meridian Quality Department constantly seeks opportunity for betterment. Local quality staff cultivates relationships with healthcare providers, clinics directors, and health systems to facilitate optimum data and information sharing, while protecting patient confidentiality. Iowa staff sets a strategic goal of increasing remote access and electronic data feeds. By the end of 2014, over forty percent (40%) of all member records were accessible remotely or through data transmission. These efforts provide a more complete health picture than claims and are less labor-intensive than manual abstractions. Provider Network Development Representatives assist with identifying potential for HEDIS® score improvement by reviewing monthly HEDIS® status reports with clinic staff.

A summary of essential strategies is as follows:

- Specific member outreach for those needing time-sensitive and routine preventive care
- Care coordination of members with serious chronic conditions
- Member and provider education aligned with HEDIS® measures
- Provider feedback including high and low performing CAHPS® measures

- Partnerships with community health providers such as maternal, infant, and child health programs, Federally-Qualified Health Centers, family planning clinics, and local public health agencies
- Participation in coalitions focused on improving access to care, reducing disease burden, and promoting safe infant sleep practices

All of the aforementioned strategies are actively employed in Iowa. Meridian will strive to expand and strengthen these quality-focused efforts to continue improving the health of the members.

Meridian's primary objective of its Quality Improvement Program (QIP) is to continuously improve the delivery of healthcare services in a low resource environment to enhance the overall health status of its members. Direct improvement in individual and aggregate member health status is measured using the applicable HEDIS® quality measures, State of Iowa performance measures, internal Performance Improvement Projects (PIPs), and health outcomes data. Indirect improvement in individual and aggregate member health status is measured using critical operational metrics designed to monitor accessibility and availability of care.

The goal of Meridian's clinical performance and preventive health program is to engage and improve member health management. Baseline rates for HEDIS® measures were established in 2013. Rates for state-identified measures were drawn from performance improvement plans and performance measures. New performance goals were set for 2014 and included:

- Obtain ninetieth (90th) or seventy-fifth (75th) percentile for HEDIS® in lead screening, postpartum visits, prenatal visits, well-child visits within the first fifteen (15) months of life, well-child visits for children ages three (3) through six (6), and adult access to care measures
- Conduct phone outreach to members reminding them to schedule preventive care appointments. Assisted with scheduling of these visits upon member request
- Review and carry out a member incentive program for health conditions of importance.
- Provide incentives for contracted providers for completing routine and preventive services in a timely manner
- Utilized mailing campaigns to remind and encourage members to complete routine and preventive care appointments
- Established regular data extracts from the Iowa Immunization Registry Information System
- Secured regular monthly data files from one Federally-Qualified Health Center (FQHC) site in eastern Iowa
- Implemented and expanded an integrated system in Meridian's Managed Care System (MCS) to track referrals to and from disease management and care coordination programs
- Providing monthly face-to-face education in all contracted provider offices on HEDIS® measures and billing requirements
- Developed a plan for expanding electronic access to electronic records information at the health system level to assist in identifying members truly in need of preventive and routine care and to allow more accurate and completed member data

4. Describe your experience and strategies in working with network providers to improve outcomes.

Meridian Health Plan is committed to improving outcome through the engagement of providers. An expansive, engaged Provider Network Department strives to accomplish regular, trusted interaction with providers through numerous efforts. Provider Network Development Representatives visit every in-network office monthly to reinforce clinical practice guidelines, review opportunities for improving patient access to routine and preventive services, and discuss timely and accurate claims submission. Provider educational materials are developed with consideration for seasonal patient patterns (e.g., well-child visits are encouraged in summer). All provider materials, including clinical practice guidelines, are available on Meridian's website. Bi-annual provider newsletters reinforce disease management concepts, encourage provider feedback, and detail how to maximize interactions with members.

The HEDIS® bonus program has proven efficacy in better outcomes and provider satisfaction. Bonuses are structured around key preventive and routine health services, such as immunizations, well-child visits, postpartum and prenatal visits, diabetes management, and disease screenings. Providers are given a monthly list of upcoming services members are due to receive. Monthly HEDIS® bonus reports are accessible through the Provider Portal; a secure website where providers can view information about member services needed, submit authorizations, and claims.

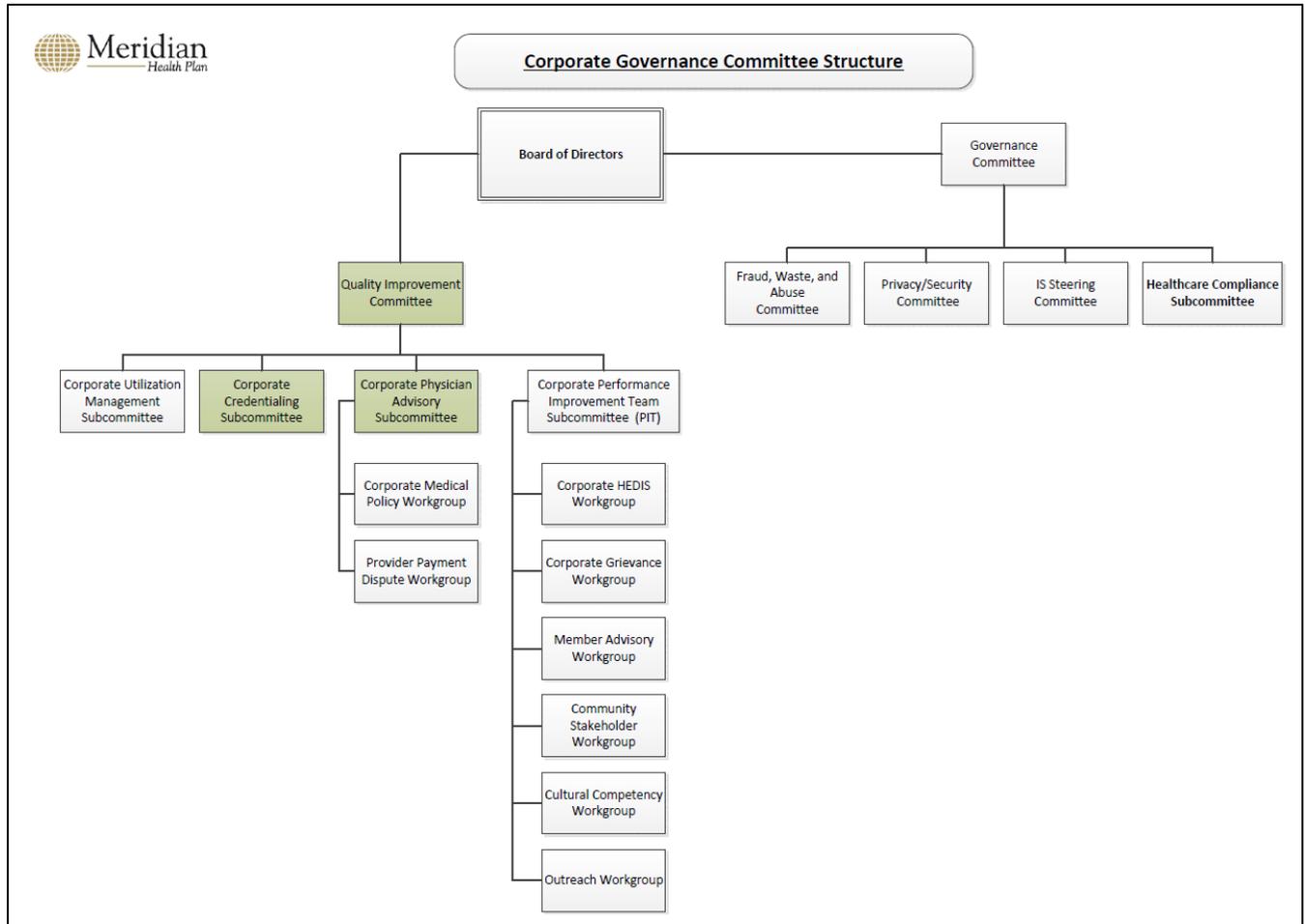
5. Outline the proposed composition of your Quality Management and Improvement Committee, and demonstrate how the composition is interdisciplinary and appropriately represented to support the goals and objectives of the Quality Management and Improvement Committee.

Meridian Health Plan's Quality and Performance Improvement Department infrastructure is comprised of continuous monitoring, evaluation and improvement in care, safety, and service. The Quality Improvement (QI) Program is established within Meridian to engage internal staff, the external provider network, and each member to improve services and healthcare outcomes. To ensure the ongoing progress of Quality Improvement initiatives, Meridian conducts a quarterly Quality Improvement Committee (QIC) meeting. This QIC shall analyze and evaluate the results of the QI activities, recommend policy decisions, ensure that providers are involved in the QI Program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QI Program description, annual evaluation, and associated work plan prior to submission to the State. This analysis and evaluation is done by reviewing policies and procedures as well as quarterly and annual reports that show trends in the population over an extended period of time, interventions taken to improve those trends, possible barriers to improvement, and opportunities of improvement. Examples of these reports include:

- Quarterly HEDIS® Update
- Annual Evaluation
- Quality Improvement Work Plan
- Critical Incidents Report
- Culturally and Linguistically Appropriate Services (CLAS) Analysis

The quarterly meetings are scheduled three (3) months in advance to ensure attendance. The State will be notified of these meetings at least ten (10) days prior to the meeting. These meetings are

also transcribed and thorough meeting minutes are recorded and sent to the State within thirty (30) days after the meeting date. The committee membership includes both local and corporate internal leadership staff, including medical, behavioral health, and long-term care staff, contracted network providers, and a member of the Board of Directors (BOD). The QIC serves both as an action body which reports directly to BOD and as a coordinating committee where other committees are the action bodies. Subcommittees responsible for reporting up to the QIC include the Physician Advisory Committee, Utilization Management Committee, Credentialing Committee, and the Grievance Subcommittee, all of which include local and corporate leadership staff and physicians. The Corporate Quality Governance Committee structure is outlined in chart below.



In addition to the committee and subcommittee infrastructure, Meridian has dedicated resources to ensure all aspects of quality improvement are achieved. The Quality Improvement Department includes the following staff; Vice President of Quality and Performance Improvement, Medical Director, Director of Quality Improvement, Quality Coordinators, and a Junior Analyst. The Quality Improvement staff works directly with Member Services, Provider Services, Care Coordination, Compliance, Utilization Management, Behavioral Health, and Communications to implement Performance Improvement Projects (PIPs) and related activities, and to ensure compliance.

10.2 State Quality Initiatives

1. Describe how you propose to work with the Healthiest State Initiative.

Meridian Health Plan has engaged with the Healthiest State Initiative (HSI) and has expressed a willingness to serve on advisory committees, as well as discuss opportunities for strengthen community wellness through collaboration. HSI has partnerships and support with a diverse group of stakeholders whose goals and objectives align well with the priorities of member health. The HSI has five (5) focus areas identified – tobacco use reduction, workplace wellness, nutrition, dental health, and lifelong learning. Meridian has existing programs to address tobacco use and promotes positive nutrition choices through member education. However, joining efforts with this statewide partnership would likely result in stronger, more successful reductions in negative behaviors and strides in positive actions. Meridian may be able to supply evaluation or outcomes data from intervention efforts similar to those of HSI. Expertise in drafting health policy may also be of use to HSI. Meridian is excited to join this initiative and for the opportunity to align priorities resulting in a healthier Iowa.

Meridian also has the ability to adjust or adapt member incentives to support Healthiest State Initiative priorities among the Medicaid population. For example, Meridian offers in-house smoking cessation counseling and provides multiple mechanisms to ensure greatest success with quitting. These resources could be enhanced by incenting member participation.

2. Describe how you propose to work with the Mental Health and Disability Services Redesign.

The Mental Health and Disability Services Redesign that began in July of 2014 established regional resourcing for accessing mental health services. Meridian Health Plan supports the Mental Health and Disability Services Redesign objective of resource pooling to expand access to core services. Meridian utilizes regional Network Development service areas for representative assignment and focused development. Access and available standards are currently reviewed at the county level and are audited annually to assess contractual compliance. These standards could easily be aggregated into a regional service area in alignment with the Mental Health and Disability Services Redesign project.

In addition, Meridian would gladly participate in workgroups or stakeholder meetings for 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).

The Value Index Score (VIS) tool is a dynamic and valuable resource for consumers and providers. VIS indicators stretch beyond the requirements of HEDIS® and provide an encompassing picture of the provider's member attribution. Meridian Health Plan participated in the early and ongoing stages of implementation of VIS in Iowa. As one of only two managed care organizations in Iowa, Meridian joined planning sessions, measurement evaluation, and provided feedback to the State on the State Innovation Model and use of VIS. Over the past year, Meridian has routinely provided encounter data to the State for incorporation into the VIS tool, with the intent of producing provider-centric feedback on the provision of care. Results from VIS are not

available at this time, though release is slated for some time in 2015. If selected, Meridian will continue its existing engagement with the State Innovation Model (SIM) and other value-driven initiatives as requested by the State.

Meridian recognizes the significance of developing strategic goals to align with the healthcare system with the Centers for Medicare and Medicaid Service's Triple Aim. Meridian's current strategic plan centers on efforts to improve population health where success is monitored using HEDIS® and other measures. Meridian supports the enhancement of patient experiences through extensive care coordination, disease management programs, provider outreach, and member incentives. Meridian regularly seeks member input on health system experiences through focus groups and the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. These data are used to inform and modify Meridian programs and processes resulting in more positive experiences for members.

Meridian's existing project plan will continue to serve as the guiding tool for implementation activities in 2016 and moving forward. Meridian will partner with stakeholders to ensure collective efforts to implement Triple Aim goals are achieved. The current project plan is located in Attachment 32 (QI Work Plan) in Tab 5.

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.

Operating as ValueOptions of Kansas, Beacon Health Options (Beacon) has supported the State of Kansas for nearly eight years 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. Their long history and effectiveness working with the State of Kansas is yet another reason Meridian Health Plan has partnered with Beacon to help serve the behavioral health and substance use disorder needs for individuals in Iowa.

Beacon began managing the Kansas Prepaid Inpatient Health Plan for Substance Use Benefits in July 2007 on behalf of the Kansas Department of Social and Rehabilitation Services and supervised by the Division of Addiction and Prevention Services. Since that time, they have administered on behalf of the State of Kansas additional funds for Substance Abuse Prevention and Treatment Block Grant (SAPT BG), State general funds, and fee funds for 240,000 individuals. Allocation amounts for each fiscal year are based on the need of special populations as well as the prior year's utilization by individual providers.

In partnership with the State of Kansas, they have implemented an accounting and reporting system whereby these funds are separately documented, and support the process with data management. Substance Use Disorder (SUD) service requirements are monitored in conjunction with the Kansas Department for Aging and Disability Service (KDADS) and eligibility is determined by Beacon clinicians via the Kansas Client Placement Criteria (KCPC) data system. All of these functions occur daily and in real time.

KDADS and Beacon jointly developed a block grant monitoring protocol, which is currently in its third review cycle. The monitoring protocol is designed to audit for compliance with Federal regulations including tracking and maintaining contact with individuals, timely access, the provision of Substance Abuse Prevention and Treatment Block Grant (SABG) interim services as

well as eligibility and residency requirements. Monitoring visits and reports are generated by KDADS to be submitted. When deficiencies are identified by KDADS, Beacon's Quality staff establishes, monitors, and approves all provider corrective actions needed to remedy the non-compliance issue. They have tracked and trended block grant monitoring outcomes for the Kansas SUD network and has provided KDADS with an analysis of the deficiencies for the development of performance improvement efforts. In 2013, the top violations included no proof of income, confidentiality issues, and non-compliance with Federal access requirements for pregnant women clinically determined to be in need of SUD treatment. As a result, they made joint efforts with KDADS to improve these areas.

Treatment Services for Pregnant Women

Compliance with Federal regulations regarding treatment services for pregnant women is included in the block grant monitoring, and in the provider licensing tools, and compliance has been jointly conducted based on a block grant monitoring protocol was established between KDADS and Beacon. KDADS staff conducts monitoring visits and then develop and submit monitoring reports for follow-up. Beacon is then responsible for provider corrective action when discrepancies are identified.

During the 2013 monitoring cycle, there were five (5) block grant regulations that monitored provider policies, procedures, and practices in regards to pregnant women. Of the ninety-two (92) provider locations monitored, there were sixty-two (62) (sixty-seven percent (67%)) who were deemed fully compliant. The remaining thirty (30) (thirty-three percent (33%)) providers were placed on corrective action plans to ensure that the deficiencies that were identified were corrected.

A KCPC replacement workgroup guided the participating staff in developing a SAPT Interim Services handout. The handout was designed to be uploaded into the new KCPC for assessing providers to print out and complete for Federal priority populations to ensure SAPT Interim Services were consistent and met Federal guidelines.

Relating to Charitable Choice

As there are additional Federal regulatory requirements for any contracted agencies identified as a Charitable Choice Provider that must be followed when receiving SABG funds, the current provider contract addresses all requirements of a program that receives funding from a SABG that is part of a faith-based organization. The program may:

- Retain the authority over its internal governance
- Retain religious terms in its name
- Select board members on a religious basis
- Include religious references in the mission statements and other governing documents
- Use space in its facilities to offer Block Grant-funded activities without removing religious art, icons, scriptures, or other symbols

Faith-based programs that receive SABG funding may not use SABG funds for inherently religious activities such as the following:

- Worship

- Religious instruction
- Proselytization

The program may only engage in religious activities if the activities are offered separately, in time or location, from Block Grant-funded activities. Participation in the activities is voluntary.

In delivering services, including outreach activities, SABG-funded religious organizations cannot discriminate against current or prospective individuals based on their religious preferences. If an otherwise eligible individual objects to the religious character of the program, they must refer the individual to an alternative provider within a reasonable period of time.

Protocol states that faith-based providers require individuals sign an agreement stating they understand the requirements. This document is placed in the individual's clinical record.

Beacon monitors the records of providers to ensure compliance with these requirements.

5. Submit a project plan describing your specific approach and timetable for addressing this section.

Meridian Health Plan has an advantage in that initiating and addressing the collaborations in this section has largely already begun. The Healthiest State Initiative is moving through a redesign stage and Meridian has committed to serving on at least one committee starting in June 2015. Meridian has been working with the Value Index Score (VIS) vendor since early 2014 and will continue providing monthly encounter data unless redirected by the State. Lastly, Meridian intends on joining stakeholder meetings or workgroups for the Mental Health and Disability Services Redesign.

10.3 Incentive Programs

1. Describe your proposed provider incentive programs.

Meridian Health Plan has implemented a Provider Incentive Program to increase physician adherence to clinical guidelines to enhance the health status of Meridian's membership. All contracted PCP and OB/GYN specialties automatically participate in the program.

Meridian uses multiple formats and forums of communication to ensure providers are aware of Meridian Incentive Programs:

- **Provider Bonus** – Providers are offered bonuses as part of the PCP incentive program for getting their members in for certain preventive visits
- **HEDIS® Report Cards** – Report cards are sent to providers giving the total number of tests performed for each member and the financial incentive given
- **Action Plans** – The disease management (DM) outreach process was enhanced to include faxing of condition-specific action plans to the member's PCP and mailing a copy to the member
- **Provider Education Flyers** – Providers are given an educational flyer each month regarding HEDIS® measures

| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
|------------|------------|------------|------------|------------|------------|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
|------------|------------|------------|------------|------------|------------|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
|------------|------------|------------|------------|------------|------------|

Annually, Meridian reviews and updates the Provider Incentive Program and distributes the update in hard copy to the entire provider network. The information is maintained on the Meridian website for provider reference throughout the year. Provider bonuses are paid quarterly and analyzed annually. The PCP Incentive Program encourages providers to implement processes to ensure that care is provided and documented within the claims adjudication system. Meridian has recognized that there are restrictions on incentives to providers and that marketing is not allowed. Meridian has a formal approval process for all incentives and will comply with the restriction requirements in 42 CFR422.208 and 42 CFR 422.210.

2. Describe your proposed member incentive programs.

Meridian Health Plan is committed to implementing a consumer-directed approach to every member and has established aggressive outreach campaigns incorporating preventive, chronic disease, and educational issues that have been developed and implemented. Members are encouraged to become active in their healthcare decisions and develop healthy lifestyle behaviors. The member incentive program is primarily structured to communicate the need for an essential preventive or routine service, encourage members to seek the recommend service by providing an incentive if the member takes action, and by tracking member response to mailings as well as visits measured by claims review.

Member valuation of the incentive program is also assessed at focus groups. Acquiring anecdotal evidence of member experiences with incentives has helped Meridian identify which incentives are most valuable, motivating, and therefore effective. Meridian has adjusted incentive programs based on member feedback, switching to different gift card retailers, varying amounts according to extent and significance of service, and allowing members to receive multiple incentives if more than one essential service is completed. The member incentive program will comply with marketing provisions detailed in 42 CFR 438.104, as well as Federal and State regulations.

All new members who see their PCP within forty-five (45) days of enrollment are entered into a raffle to receive a gift card. In addition, Meridian also encourages members to use web-based resources to take ownership of their healthcare. Members are placed in a raffle for a gift card when they sign up for Meridian’s secure, online Member Portal. Within this Member Portal, members are able to request a PCP change, view their care plan (if applicable), view needed preventive services, and request health and benefit information.

Meridian also runs a raffle program to encourage members of all ages to receive preventive services. Some current Medicaid member raffles include:

- Apple iPad for women who receive an annual Pap test
- Gift card for breast cancer screening
- Gift card for cervical cancer screening
- Gift card for diabetes - HbA1c/LDL screening
- Quarterly raffle for a gift card for PCP visit within first forty-five (45) days of enrollment
- Walgreen’s gift card for diabetic retinal exam
- Monthly iPad raffle for cervical cancer screening

All interactions and incentives are tracked within the Meridian Managed Care System (MCS) and the incentive status can be viewed in the member contact record. Gift cards cannot be used towards tobacco or alcohol purchases.

| 2014 Member Gift Card Incentives | | |
|--|-----------------------|------------------|
| Requirement | HEDIS® Measure | Frequency |
| Complete Breast Cancer Screening | BCS | Weekly |
| Complete Cervical Cancer Screening | CCS | Weekly |
| Complete Chlamydia Screening | CHL | Weekly |
| Complete 6 well child visits between 0 and 15 months of life | W15 | Weekly |
| Complete one well child visit each year between 3 and 6 years of age | W34 | Weekly |

| 2014 Member Gift Card Incentives | | |
|--|----------------|---------------------------------------|
| Requirement | HEDIS® Measure | Frequency |
| Complete one well child visit each year between the ages of 12 and 21 years of age | AWC | Weekly |
| Complete Prenatal Care Visit within 42 days of enrollment to Meridian or within the 1 st Trimester | PPC | Weekly |
| Complete at least 1 blood lead screen before the child's 2 nd birthday | LSC | Weekly |
| Complete at 1 HbA1C and LDL-C blood screen per year | CDC | Weekly |
| Complete all Childhood Immunizations before the child's 2 nd Birthday | CIS | Monthly |
| Complete Postpartum visit between 21 and 56 days post-delivery <u>and</u> the 1 st well child visit | PPC W15 | Monthly |
| Complete 1 PCP visit within 45 days of enrollment to Meridian | AAP CAP | Quarterly |
| Sign up for Member Portal on www.mhplan.com | | Quarterly |
| Complete HRA within 30 days of enrollment | | Quarterly |
| Complete one well child visit between the ages of 11 and 13 years of age | AWC | 1 winner per month from July-December |
| Complete one well child visit between the ages of 14 and 17 years of age | AWC | 1 winner per month from July-December |

| 2014 Member Raffle Incentives | | |
|---|----------------|---------------------------------------|
| Requirement | HEDIS® Measure | Frequency |
| Complete one well child visit between the ages of 3 and 6 years of age | W34 | 1 winner per month from July-December |
| Complete Cervical Cancer Screening | CCS | 1 winner per month from July-December |
| Complete a Diabetic Retinal Eye Exam | CDC | Biannually - June and October |
| Complete one well child visit between the ages of 3 and 6 years of age | W34 | Annually - April |
| Complete one well child visit between the ages of 3 and 6 years of age | W34 | Annually - June |
| Complete an office visit for children between the ages of 5-13 | CAP | Annually - October |
| Complete an office visit for children between the ages of 14-17 | CAP | Annually - October |
| Complete an office visit for Children between the ages of 12-24 months | CAP | Annually - December |
| Complete an office visit for children between the ages of 25 months-6 years | CAP | Annually - December |
| Complete an office visit for children between the ages of 7-11 years | CAP | Annually - December |
| Complete an office visit for children between the ages of 12-19 years | CAP | Annually - December |
| Complete an office or ambulatory visit for adults between the ages of 20-44 years | AAP | Annually - December |
| Complete an office or ambulatory visit for adults between the ages of 44-64 years | AAP | Annually - December |

10.4 Critical Incidents

1. Describe your critical incident reporting and management system.

Meridian Health Plan has a policy in place that aims to pre-emptively detect abuse, neglect, or exploitation of a member and explains the reporting requirements (“Abuse, Neglect, Exploitation,

and Critical Incidents Reporting and Tracking”). This policy outlines the appropriate process for reporting incidents, investigating them, and tracking as well as the required timeframes for reporting. Meridian is working toward establishing a safe environment and takes the appropriate action in response to incidents which affect, or have the potential to affect the health, safety, or wellbeing of members.

Providers and Meridian staff is required to verbally report incidents to the Quality Improvement Department within twenty-four (24) hours of their knowledge of the incident and a written report must be submitted to the Quality Department describing the incident within forty-eight (48) hours of discovering the incident. If the incident includes abuse, neglect, or exploitation the provider or Meridian staff must also report the incident to the appropriate program.

Attachment 34 (Quality Review Process) in Tab 5 details the process flow for identifying and reviewing quality complaints, including critical incidents.

The Credentialing Department works with State and Federal agencies to identify previously reported incidents and work with these agencies to ensure that the appropriate follow up is completed. These incidents are reviewed by both the Credentialing Committee on a monthly basis and the Quality Improvement Committee (QIC) on a quarterly basis. Meridian will be sending a Critical Incident Report on a quarterly basis to the QIC for Iowa. If the Critical Incident Report shows that there reoccurring incidents with a provider, then swift and appropriate actions such as establishing a corrective action plan or terminating a provider contract will occur. Once the Quality Improvement Department receives a grievance, the Quality Department will send the provider a letter requesting a response within ten (10) calendar days as well as for the appropriate medical documentation which will be reviewed by the Medical Director. If it is determined that there is a quality of care issue, the case is brought forth to the Credentialing Committee and actions that can be taken include:

- Counsel the provider
- Require the provider to adhere to a corrective action with appropriate follow-up
- Disaffiliate the provider

Meridian internally tracks Critical Incident and grievances by product line and are reported to the QIC on a quarterly basis where the trends are analyzed and possible opportunities for improvement are discussed. This information is also shared with Network Development to ensure monitoring of the quality of Meridian’s provider network. The Quality Improvement Department provides this information to the State as requested.

2. Describe strategies for training staff and network providers on critical incident policies and procedures.

The Program Integrity division is overseen by Meridian’s Compliance Officer and is responsible for administration of the program and ensuring compliance with State and Federal laws, rules, and regulations. Meridian believes that the appointment of a Compliance Officer and creation of a Compliance Committee that is accountable to senior management and the implementation of compliance policies and procedures provide corporate transparency, company structure, and staff accountability. The Compliance Officer has selected a highly experienced staff with backgrounds in the investigation of pharmacy, nursing, data analysis, auditing and monitoring, and healthcare

benefits administration. Meridian believes that this broad body of experience and backgrounds produces comprehensive, superior results in the administration of a Program Integrity division.

Meridian maintains compliance and internal controls, policies, and procedures as required in 42 CFR § 438, 42 CFR § 455, 42 CFR § 456, the Affordable Care Act, and State and Federal statutes. Meridian strongly believes that diligent policy and procedure maintenance yields consistency and continuous corporate improvement. Meridian's Compliance Officer ensures that all compliance and fraud, waste, and abuse (FWA) policies and procedures are reviewed and revised at least annually, or as necessary for compliance with applicable State and Federal laws, accreditation standards, and program integrity standards.

With oversight from the Compliance Officer, Meridian's Program Integrity division constantly monitors State and Federal laws and regulations in an effort to track changes that may impact policies and procedures. Program Integrity staff also tracks any contract changes or guidance provided by State and Federal government that may affect policies and procedures. If there are changes to laws, regulations, or contracts that affect policies and procedures, the Compliance Officer immediately implements any changes. New or updated policies and procedures take effect immediately and impacted staff receives prompt education regarding any change to their job function. New or updated policies and procedures are presented at the next quarterly Compliance Committee meeting for review and approval. The Compliance Officer ensures that all current policies and procedures are available to the State upon request. Meridian also believes in an open, coordinated relationship with governing bodies and the State. Meridian constantly evaluates feedback from these governing bodies and incorporates necessary changes into policies and procedures to ensure administration of the Program Integrity division is up to State and Federal standards.

Company standards of conduct are defined in Meridian's Compliance Program policies and procedures, Compliance Program Statement, Compliance Charter, and mandatory Code of Business Conduct and Ethics (Code of Conduct). Employees are required to sign the Code of Conduct upon hire and annually thereafter. The Code of Conduct describes ethical business conduct, addresses conflicts of interest, and requires reporting of non-compliance. Compliance policies and procedures include all elements of an effective Compliance Program as outlined in 42 CFR § 438.608. The Compliance Officer is responsible for providing all Compliance Program documents to the State upon request.

Meridian has policies and procedures aimed to pre-emptively detect abuse, neglect, and critical incidents and, when necessary, coordinate with appropriate State and Federal agencies to report these incidents to ensure necessary follow up. Meridian understands that the Medicaid population is vulnerable to these incidents, particularly people with disabilities that are in a community setting. Due to this reality, Meridian has devoted resources embedded within our operations to combat these conditions in all departments.

- Physician credentialing includes review of State and Federal agencies to identify any previous reported instances, including the Office of Inspector General (OIG). These incidents are included in credentialing files and are reviewed by our Credentialing Committee. If these actions are reoccurring with a provider, Meridian will take swift action which includes, but is not limited to, corrective action plans, provider suspension, contract termination, or referral to State and Federal agencies for criminal prosecution

- Staff training includes identification strategies, how to report identified instances, and how to speak with members who have been abused, neglected, or have experienced a critical incident. This training occurs at initial hiring and annually thereafter. Employees are continuously encouraged to report any incidents that are identified and are assured that no action will be taken against the employee for reporting incidents. Employees are trained to identify physical abuse, emotional abuse, sexual abuse, self-neglect, and financial fraud. In addition, Meridian Community-Based Case Managers look for any indications that members have experienced abuse, neglect, or critical incidents at every home assessment and, if needed, take action to notify appropriate agencies
- Provider training includes identification strategies, how to report identified instances, and how to speak with members who have been abused, neglected, or have experienced a critical incident. Meridian's providers undergo training at provider orientation upon becoming contracted and annually thereafter. Through the use of newsletters and Provider Network Development Representatives, providers are encouraged to report these incidents.

In addition to the claims edits, reports, and drill down analyses that are typical of the high-level data examination upon which most program integrity divisions are based, Meridian has also implemented specialized training and procedures for our Care Coordination staff. In recent years, perpetrators of healthcare fraud have increasingly victimized the elderly and poor, two of our most vulnerable populations. Trends have shown increases in fraud in the areas of home health care, kickbacks to nursing homes for patient referrals, durable medical equipment, subjection to unnecessary medical treatments, and drug diversion. These staff members are an integral part of managing and caring for Meridian's most vulnerable population, who may be more susceptible to victimization by health care fraudsters. In addition to Meridian's vigorous Fraud, Waste, and Abuse Training Program, these staff members receive additional, specialized training and have hands-on contact with our members. Through this unique, one-on-one relationship, Meridian's Care Coordinators are able to build a trusting relationship with members while asking pointed questions regarding their options to see certain physicians; why they are receiving certain care; verifying services for which Meridian has been billed; ensuring members are not being shorted at the pharmacy and that they are receiving and taking their medications as prescribed; validating that the equipment they are receiving is necessary and matches Meridian's claims; ensuring sanitary living conditions; and that they are not victims of abuse or neglect.

The Compliance Officer serves as the designated contact for all Iowa, OIG, and any other State and Federal coordination efforts related to FWA. Upon receipt of a detected offense, the Compliance Officer directs an internal, preliminary investigation using claims data and historical provider/member contacts. If the outcome of the preliminary investigation results in a reasonable belief that FWA may have occurred, the Compliance Officer makes a referral to State that includes the original complaint, all reports and documents, and any Special Investigations Unit (SIU) staff notes. Meridian's policy is to cooperate and comply in the role of State contractor with any and all investigations with the State

At the direction of the Compliance Officer, SIU staff investigates all referrals of suspected abuse, neglect, and critical incidents. The FWA Module within the Meridian Managed Care System (MCS) maintains a Referral Management application that tracks all cases from start to completion. The Referral Management application allows for filtering of cases by:

- Who referred the case (internal employee or external entity)

- Open and closed cases
- Provider, pharmacy, or member referred for investigation
- Unique referral ID
- Date of referral

SIU staff is also able to update cases and coordinate with other departments by assigning tasks to work queues for SIU staff in Member Services, Medical Management, Claims, and Pharmacy. Any investigation actions and case developments are tracked in the FWA Module's Case Update application. This application allows SIU staff to track reporting to any local, State, Federal, or other agency, make case notes and document any findings, and attach any gathered evidence or supporting documentation.

At the direction of the Compliance Officer, SIU staff takes action including, but not limited to, reviewing historical medical and pharmaceutical claims reports, running peer-to-peer data to analyze outlier status, requesting and reviewing medical records, requesting and reviewing pharmacy documentation, analyzing provider/member to pharmacy distance ratios, conducting surveys with members, and interviewing provider staff. All case notes and actions are documented with date, time, and SIU staff electronic signature within the "Notes" section of the Case Update application. Supporting documentation includes medical records, prescription copies, claims reports, provider/member correspondence, and any other supporting documentation or attachments to the case that are logged, labeled, and electronically saved under the "Attach" section of the Case Update application.

If Meridian believes there may be a criminal violation of the False Claims Act or any other fraud statutes at any point in the investigation process, the Compliance Officer makes a referral to the State that includes the original complaint, all reports and documents gathered in the investigation process, any SIU staff notes, and a summary of significant findings. Meridian will follow all direction from the State regarding how to proceed. Meridian documents all direction from and case coordination with State and Federal agencies in the Case Update application of the FWA Module. The Compliance Officer ensures that Meridian abides by any direction received from State and Federal agencies with regard to investigative procedures.

3. Describe processes for implementing corrective action when a provider is out of compliance with critical incident reporting.

Meridian Health Plan considers providers as mandatory reporters, meaning they are expected to follow State regulations related to reporting of suspected abuse, neglect, and/or exploitation and are expected to report allegations to the appropriate program. Providers are expected to contact Meridian to give the Quality Department a verbal report of the incident within twenty-four (24) hours of their knowledge of the incident. All providers are also required to cooperate during the investigation of critical incidents, including allowing Meridian access to all requested documentation within the contractually-mandated time period for response required from the health plan to the member.

To protect the safety of the member, actions that can be taken include:

- Remove worker from the member's case
- Remove accused worker from serving all members until the investigation is complete

- Interview employees

Depending on the severity of the incident, any identified trend, or failure on the part of the provider to cooperate with any part of the investigation, the provider may be required to submit a written plan of correction to address/correct any problem or deficiency surrounding the critical incident.

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.

The Quality Improvement Department tracks and monitors all critical incidents that are reported and the tracked members are advised of their rights and to what extent reasonable accommodations were provided. All Critical Incident Reports are reported up to the Quality Improvement Committee (QIC) and to the State. Our Michigan Medicaid affiliate had reported three (3) critical incidents that were reported from the Office of Inspector General (OIG), one (1) took place in September 2014 and two (2) took place in December 2014. Meanwhile, our Michigan Medicare affiliate received one (1) critical incident from June 2014. All of the allegations were investigated and were related to abuse/neglect/exploitation and were reported to the fourth (4th) quarter QIC in January 2015. Meridian will be sending a Critical Incident Report on a quarterly basis to the QIC for Iowa. If the Critical Incident Report shows that there reoccurring incidents with a provider swift and appropriate action such as establishing a corrective action plan or terminating a provider contract.

Meridian Health Plan of Michigan Critical Incidents Report (2014 Q4)

Meridian Health Plan reports all Critical Incidents to the QIC on a quarterly basis. In fourth quarter of 2014, there were three critical incidents pertaining to the Medicaid population.

- There were three critical incidents received through OIG- one in Sept and two in Dec.
- The allegation types were all Abuse/Neglect/Exploitation.
- Actions taken included notification of the appropriate agency for all three incidents.

There was one critical incident received for MI Medicare in the same quarter.

10.5 Provider Preventable Conditions

1. Describe how you will ensure payment is not made for provider preventable conditions.

Meridian Health Plan follows Iowa's Medicare and Medicaid claims adjudication rules for its Iowa's membership, including review for provider preventable conditions on hospital facility inpatient claims and nursing facility (NF) claims and requires that as a condition of payment, all providers agree to comply with the reporting requirements in 42 CFR 447.26(d). For hospitals, the "Present on Admission" (POA) indicators are reviewed and excluded from the diagnostic-related grouper (DRG) reimbursement calculation, with additional review of claims based on outlier day and charge thresholds. In addition, Meridian has agreements in place with third party vendors who perform prospective as well as retrospective analysis on professional and

institutional claims, one of the focuses being the detection of POA indicators and diagnosis codes and treatments which are considered to be provider preventable conditions. For claims where these codes exist, payment adjustments will be applied, excluding applicable charges and days associated with the hospital acquired condition (HAC) or other provider preventable condition.

For nursing facility claims, providers are required to submit patient days attributable to provider preventable conditions as non-covered days and they will not be considered for reimbursement. Claims will be monitored for diagnosis codes that are considered provider preventable conditions and if the covered days are not adjusted to account for the patient days attributable to the provider preventable condition, a review of the records will be performed in order to determine accuracy of billing.

Meridian has programmed thousands of edits into its system to detect billing anomalies, including Medicare and Medicaid National Correct Coding Initiative (NCCI) edits, and a third party vendor is used to review professional claims on a daily basis as an additional level of review, including review of claims history for service frequency edits.

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.

11.1 Utilization Management Programs

- 1. Describe in detail your utilization management program, including how you will operate and maintain the program.**

Meridian Health Plan's NCQA-accredited Utilization Management (UM) Program is designed to monitor, evaluate, and ensure the delivery of high quality, cost-effective healthcare services to our members at the right time and in the right setting. Meridian recognizes that all utilization management strategies must be approved by the State and noticed to the community thirty (30) days prior to implementation. In addition to the behavioral health manager who will be a licensed behavioral health professional responsible for implementation of the program, Meridian will designate a long-term care professional to be involved in the implementation of the long-term care components of the program and a senior physician to provide oversight of the program.

The Meridian UM Program is comprehensive and interdisciplinary, including behavioral health and long-term care aspects. We ensure individuals receive the most appropriate, least restrictive, and most cost-effective, recovery-oriented treatments and supports that meet their identified needs and promote independence, consistent with their informed choices and preferences. Our UM Program design addresses the individual and provider's timely access to clinical staff; the consistent use of clinical criteria and treatment guidelines for decision making; the receipt of the clinical information and the timeliness of the UM decisions; notification of authorizations and non-authorizations; and the appeals process. UM decisions are based on evidence-based clinical decision support criteria, consideration of member needs, and the local delivery system. Meridian utilizes McKesson's InterQual® Criteria, a nationally recognized set of medical necessity evidence-based standards of care, developed through consensus from licensed specialists and/or primary care providers. The InterQual® Criteria are used for the following types of services:

- Acute Inpatient Services
- Skilled Nursing Facility Services
- Rehabilitation Services
- Inpatient Surgeries
- Outpatient Services
- Durable Medical Equipment
- Outpatient Physical, Speech, and Occupational Therapies

Criteria Meridian used for behavioral health clinical decision making includes:

- Beacon Health Options Internally Developed Criteria
- American Society of Addiction Medicine (ASAM)

Meridian determines medical necessity and benefits coverage during the clinical and peer clinical review processes. Clinical criteria assists UM staff to determine whether services and settings are appropriate and meet or exceed established standards of care for the member's condition.

Meridian's Medical Directors compile Utilization Review medical necessity policies to augment

the clinical decision making criteria when the circumstances, manifestations, or State mandates regarding particular conditions need to be addressed. The policies are developed in accordance with the standards adopted by nationally accredited organizations, professional organizations, and regulatory agencies and are reviewed by a physician advisory committee composed of a variety of clinical specialists. The policies are reviewed on an annual basis and updated as new treatment, applications, and technologies are adopted as generally accepted professional medical practice. Clinical criteria and policies and procedures are not intended to serve as a substitute for clinical judgment, but as guidance documents to ensure a consistent basis for application of clinical decision making. All Utilization Management policies, procedures, and criteria will be submitted to the State for approval prior to implementation. The Utilization Management Program is closely linked with quality initiatives to ensure that our members receive appropriate utilization, continuity of care, and care management.

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;

Meridian Health Plan analyzes data from multiple sources in its effort to monitor under- and over-utilization. These sources include:

- Utilization Authorization and Claims Data
- HEDIS® Data
- Physician Profile Report
- Member Complaints and Grievances
- External Quality Review Data
- Pharmacy Data
- Financial Utilization Data

This data is evaluated for patterns that may indicate inappropriate utilization and/or fraud and abuse among population groups and individual practitioners, practitioner groups, and facilities. Meridian then compares this information with other health plans as well as regional and national data. If plan-wide monitoring results fall outside the established thresholds, a focused review will be conducted. This may include, but is not limited to, practitioner or facility specific information separated by risk, delegate, specialty type, or other significant categories. If areas of deficiency are identified, the Quality Improvement Committee (QIC) will conduct an analysis of identifiable barriers or specific circumstances and make recommendations for correction of the variance.

b. Analyze emergency department utilization and diversion efforts;

Meridian Health Plan recognizes that some members regularly seek routine, non-emergent care in an emergency room setting. This behavior is detrimental to continuity of care, increases cost of care, and undermines the Medical Home concept. In response to this problem, Meridian has developed a multi-faceted approach to reduce unnecessary emergency room visits and educate members about the importance of creating and maintaining a relationship with their Medical Home. Meridian's process for managing

emergency room utilization is directed at the management of members who incur visits for primary care provider (PCP) treatable conditions. Claims for members who incur emergency room visits for chronic or ambulatory sensitive conditions are included in Meridian's predictive model program and are forwarded to Meridian's Care Coordination Program for management. Meridian's Care Coordination Program has a team dedicated to managing members with high emergency room utilization. Additionally, Meridian uses the New York University Emergency Department (NYU ED) Algorithm (developed by the New York University Center for Health and Public Service Research) to assist with identifying members who have visited the emergency room for a PCP treatable or non-emergent condition. Once identified, Meridian sends members an educational letter regarding appropriate use of emergency room services after the first emergency room visit. After the second visit, a Care Coordinator from Meridian's High-ER team follows up with the member to conduct a post emergency room assessment. The assessment identifies the reason for the emergency room utilization. During the assessment the High-ER Care Coordinator addresses transportation needs and encourages the member-PCP relationship by informing the member of their transportation benefit, assists the member in selecting another PCP if indicated, and educates the member on their preventative healthcare needs. If behavioral health, medical, or special home circumstances surface during the assessment, the High-ER Care Coordinator will refer the member to ongoing care coordination to meet their behavioral health or medical case management needs. Members incurring additional emergency room visits for PCP treatable, non-emergent conditions continue to be monitored and contacted by the High-ER Care Coordination staff. Members identified as potentially abusing narcotic are referred to the pharmacy management program. This program works with the member and the PCP to improve pain management and identify which practitioners are responsible for managed pain treatment methods such as narcotics.

c. Identify aberrant provider practice patterns;

Meridian Health Plan identifies aberrant provider practice patterns and offers education, outreach, and corrective action to those identified providers. The Meridian Finance Department provides this report, which renders detailed utilization patterns by all Meridian providers. Analysis of the report is completed on a monthly basis by the Medical Director. This analysis includes investigation of outliers for under- and over-utilization and specialty specific comparison. There is also a drill down on utilization of inpatient hospitalizations, outpatient emergency room, urgent care, and pharmacy services, type and number of referrals, and top admitting diagnosis-related groups (DRGs). Additionally, Meridian has policies to assist in the prevention of medical fraud, waste, and abuse (FWA), to monitor the compliance of participating practitioners and providers with the requirement of each State Medicaid program. These policies are applicable to all providers and practitioners in the Meridian network. Meridian will monitor, on an ongoing basis, practitioner and provider claims submissions to ensure appropriateness of billing practices and service delivery. Examples of FWA being monitored are as follows:

- Billing for services not rendered
- Billing without reporting other resources, such as private insurance companies
- Billing for a brand name drug when a generic drug is dispensed
- Billing for prescriptions not picked up or delivered to members

- Billing for unnecessary services
- Balance billing
- Billing a date of service other than the actual date the service was rendered
- Receiving “kickbacks”
- Filing fraudulent cost reports

Attachment 35 (Sample Provider FWA Report) in Tab 5 is attached as an example.

All provider and practitioner agreements will include making available upon request of Meridian and/or appropriate State or Federal departments or agencies, any and all administrative, financial, and medical records relating to the delivery of items or services for which Medicaid program funds are expended, either directly or through Meridian as the managed care contractor and payer. If it is determined by the Meridian Associate General Counsel, Compliance Officer and/or Fraud, Waste, and Abuse Committee that a full investigation is warranted, the following will occur:

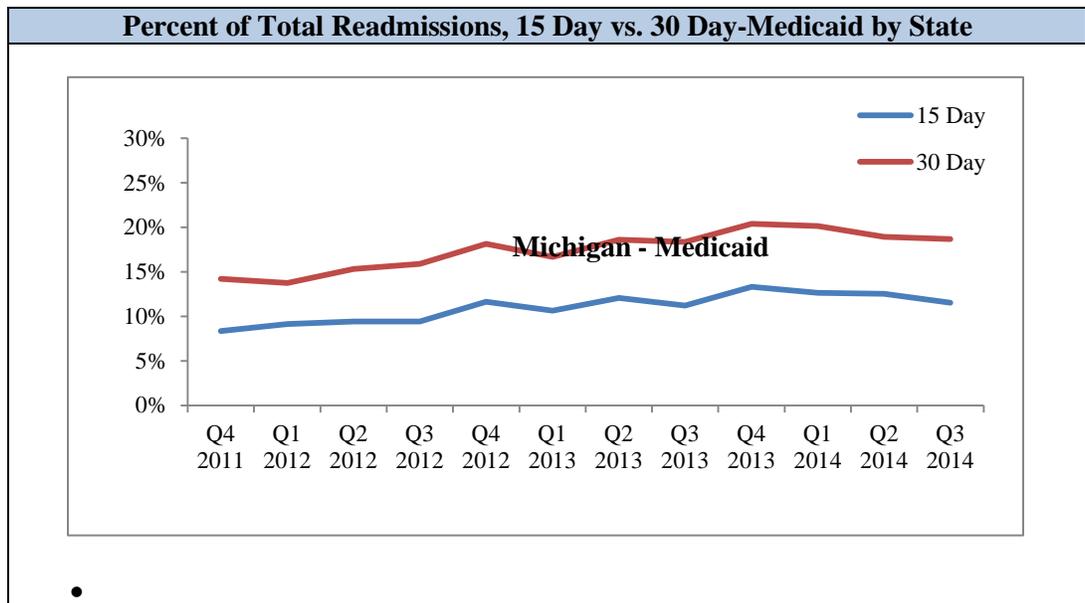
- The Associate General Counsel and will engage the Director of Provider Services, Director of Utilization Management, Care Management staff, and the Chief Medical Officer and others as needed to complete the investigation. Meridian’s legal counsel will be consulted as needed
- The investigation will include a detailed review of claims data, medical records data, and other information supplied by the provider or other parties
- If necessary, an independent third party (such as an Independent Review Organization) will be used to investigate the matter and determine medical necessity
- State or Federal departments or agencies will be notified of the full investigation, including the following information:
 - Provider name, address, phone number, Medicaid ID number
 - Source of the complaint
 - Type of provider
 - Nature of the complaint
 - Approximate range of dollars involved
 - Legal and administrative disposition of the case, including actions of law enforcement officials to which the case has been referred

d. Monitor patient data related to length of stay and re-admissions related to hospitalizations and surgeries;

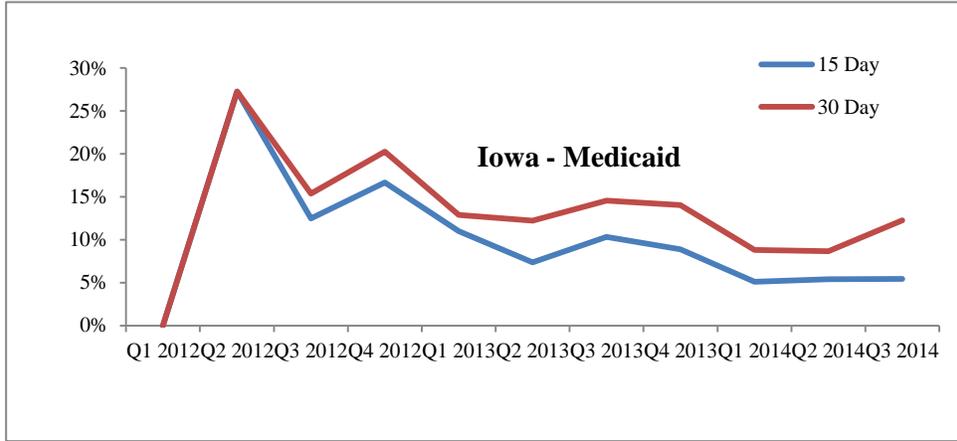
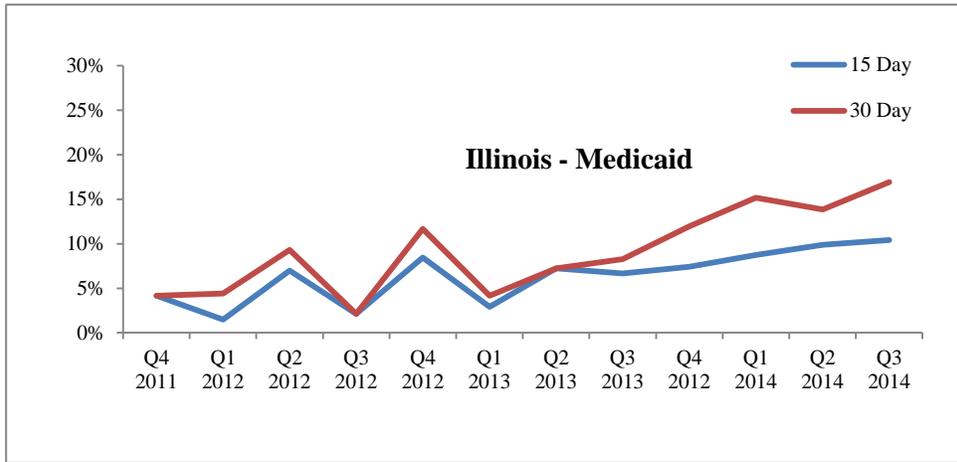
The Prolonged Length of Stay (PLOS) Report Review is required for all members who have been inpatient for fourteen (14) days or longer. The report includes relevant medical and/or admission history, reason for current admission, diagnosis and procedures that have been done during the inpatient stay, and the discharge plan. This information is presented at weekly PLOS meetings attended by a Physician Reviewer, and all Inpatient Review Nurses. The purpose of this meeting is to collaboratively discuss the current treatment plan and how the member is responding and to format a discharge plan that will prevent a readmission. Alternate levels of care are discussed, possible peer-to-peers are requested and arranged, and a transition of the care plan is discussed. The member will remain on this report until he/she has been discharged. The ongoing treatment, care plan,

and discharge plan will be discussed at each subsequent, weekly PLOS meeting. If the member is in Care Coordination, the Review Nurse will collaborate with the Care Coordinator to ensure a safe transition of care discharge plan. The Review Nurse is able to anticipate many of the members discharge needs (i.e. durable medical equipment items, skilled nursing facility placement, etc.) and have arrangements made for a smooth discharge transition.

Meridian Health Plan has implemented multiple programs that aim to control avoidable hospitalization and hospital readmissions as well as educate members on how to better manage their health care. Meridian has employed these programs with the goal of increasing quality of care for members as well as increasing cost-effectiveness. A shared goal of all of the programs described below is to ensure follow-up appointments with PCPs and specialists. These programs also assist members in establishing a medical home and assist with ensuring that medication reconciliation is completed. Meridian has instituted the Post-Discharge Follow-Up Call Program to assist members in their post-discharge care. The goal of this program is to reach the member within seven (7) days of discharge to ensure that member’s needs have been met and a follow-up appointment with their physician has been scheduled. This program also ensures that members understand their discharge instructions as well as medication reconciliation. Assistance is provided for transportation arrangements and reminder calls are placed to members to remind them of their appointments. Members are referred to case management as indicated. When a member presents for an inpatient readmission, the Utilization Management Review Nurse will monitor that patient’s stay with concurrent reviews, in addition to notifying the member’s care team to take measures to ensure a safe and appropriate discharge and prevent readmission. Additionally, quarterly readmission data is presented to Utilization Management Committee.



Percent of Total Readmissions, 15 Day vs. 30 Day-Medicaid by State



Analysis:

- For Medicaid, the fifteen (15) and thirty (30) day readmission percentages remained stable with a slight increase throughout the reported timeframe. The average fifteen (15) day readmission percentage was eleven percent (11%) and thirty (30) day readmission was seventeen point four percent (17.4%)
- The readmission rate for the Medicaid population varied throughout the reported timeframe. The average fifteen (15) day readmission rate was six point four percent (6.4%) and the average for thirty (30) day readmissions was nine point one percent (9.1%)
- For the Medicaid population, there was an overall decrease for fifteen (15) and thirty (30) day readmissions. The average fifteen (15) day readmission was ten percent (10%) and the average thirty (30) day readmission was thirteen point three percent (13.3%)

e. Assure the appropriateness of inpatient care;

To ensure appropriateness of care, Meridian Health Plan uses nationally recognized, evidence-based clinical guidelines in conjunction with policies and procedures on individualized determination processes. The Utilization Management (UM) Department administers the Inter Rater Reliability Test (IRR) to the physicians and nurses on a quarterly basis to ensure compliance with admission guidelines. The Medical Directors participate in clinical and policy making committees that impact patient care. The Audit and Remediation Group conducts quarterly physician and nurse audits to ensure compliance with current practice at Meridian, against evidenced based clinical standards of care. When making a determination of coverage based on medical necessity, Meridian seeks to obtain relevant clinical information from any reasonably reliable source. Only information necessary to certify the request will be requested and reviewed. Meridian does not request copies of all medical records on all members reviewed, nor require facilities and/or providers to numerically code diagnoses and procedures to be considered for certification, but codes may be requested, if necessary. Meridian utilizes all information relevant to an individual member's care when rendering UM decisions, including, but not limited to, consults with the treating physician, specialist, or other provider, clinical exam, history of the presenting problem, treatment plans and progress notes, office and hospital records, psychosocial history, photographs, operative and pathological reports, rehabilitation evaluations, imaging findings and diagnostic tests, clinical notes, and evaluations from other health care providers.

f. Ensure active participation of a utilization review committee;

Utilization data is presented at the Utilization Management Committee (UMC), which is chaired by the Medical Director, and meets at least quarterly. Detailed agendas, minutes, and action items are recorded and distributed to all team members. Committee membership includes both local and corporate internal leadership staff, a representative from Beacon Health Options, and a representative from Independent Living Systems. Membership on the UMC is a mandatory requirement of the staff involved and a member of the Committee will be on-site in each state. The UMC reviews utilization metrics and statistics for medical and behavioral health services and utilization trends including metrics and trends related to members receiving HCBS and other long-term care services. The UMC's goal is to set policies regarding utilization for hospitals, physicians, and non-physician practitioners to assure consistency in benefit determination while monitoring high quality care to members.

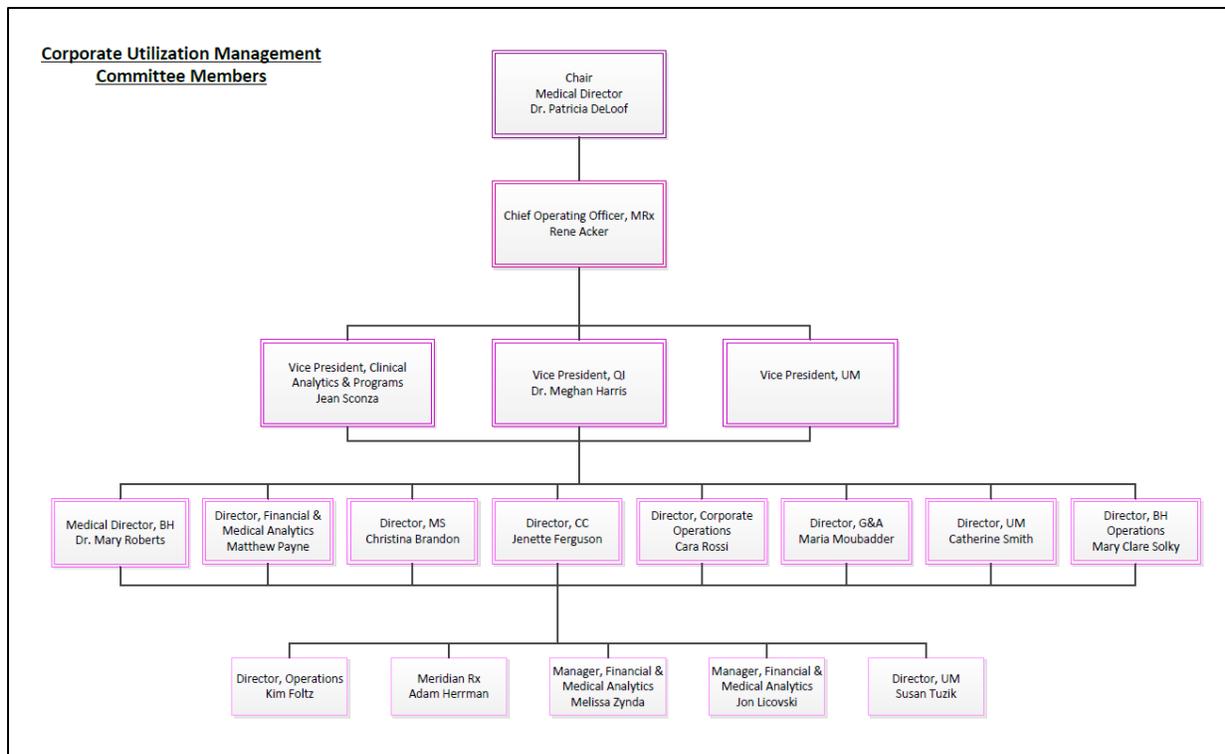
This Utilization Management Committee (UMC) identifies trends and variations and to discuss possible interventions to increase the utilization and health of Meridian's membership. The UMC continually monitors and takes necessary actions to improve the Utilization Management (UM) process in terms of quality of care, cost containment, and member and provider satisfaction. The UMC is also responsible for oversight UM delegated functions, including pharmacy and therapeutics and preparation and analysis of plan-wide and practitioner-specific statistical utilization reports. In addition, the UMC is responsible for monitoring medical necessity of the health care services provided, acting on process changes as a result of trended utilization data, following Meridian's policies and procedures that mirror industry standards and adhere to all timelines and response

requirements including the one (1) hour response to all emergency room providers, twenty four (24) hours a day, seven (7) days a week.

Utilization Management Committee membership includes the following individuals:

- Medical Director of Utilization Management
- Director of Utilization Management
- Vice President of Utilization Management
- Director of Quality Improvement
- Vice President of Performance and Quality Improvement
- Quality Improvement Junior Analyst
- Medical Directors
- Director of Claims
- Medical Director of Behavioral Health
- Director of Behavioral Health Operations
- Director of Care Coordination
- Director of Long-Term Services and Supports (LTSS)
- Manager of Clinical Services
- Pharmacist Manager
- Director of Member Services
- Director of Network Development
- Manager of Financial and Data Analysis

The UMC Organizational Chart is provided below.



The functions of the UMC include:

- Monitoring of over- and under-utilization
- Compliance with timeliness standards for denials and appeals of adverse determinations
- Denial and approval and overturn rates
- Timeliness of UM decision making
- Satisfaction with the UM process
- Establish clinical criteria for UM decision

The role of the UMC is to:

- Develop, implement, and evaluate the UM Program
- Assist in the development, implementation, and monitoring of clinical practice guidelines relating to quality of care
- Investigate, resolve, and monitor quarterly operations related to UM activities
- Review and approve UM policies and procedures annually
- Monitor appropriate levels of care and timeliness of the delivery of healthcare services
- Review UM policies and procedures for utilization by clinical and non-clinical staff
- Evaluate new and existing technology recommendations
- Coordinate quality issues identified through the UM process with the Quality Improvement (QI) Department
- Monitor effectiveness of the UM process through member and practitioner satisfaction survey results
- Monitor practice patterns of practitioners
- Assess consistency with the application of care coordination criteria
- Identify and monitor over-utilization and under-utilization of services
- Identify and monitor utilization patterns that compromise consumer health and safety, inappropriately use resources, or represent organizational risk
- Evaluate consistent use of medical necessity, including criteria used and information sources
- Review process used to approve the provision of services
- Review of initial and ongoing determinations and initial and continued service authorization decisions
- Provide support to other organizational functions
- Perform special targeted monitoring activities as required by need or regulatory mandate. Examples of targeted monitoring activities include: service-specific utilization reviews, programs length of stay, reviews of service (duration, volume, and cost), service and billing integrity reviews and provider-specific treatment pattern analysis

g. Evaluate efficiency and appropriateness of service delivery;

Meridian Health Plan has processes in place to ensure appropriate service and coverage to members, as well as to address opportunities for improvement. Meridian continuously

monitors data to detect potential under- and over-utilization and takes steps to correct the variance. Meridian receives data from a variety of sources including our proprietary Managed Care System (MCS), HEDIS® data, member complaints and grievances, external quality review data, pharmacy data, and financial utilization data. This data is reported and analyzed on a consistent basis. Reports are provided by the Finance Department and contracted hospitals on a weekly basis, which are analyzed and reported to the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC).

Other reports that are evaluated include the following:

- Inpatient Acute Care Days
- Inpatient Acute Care Discharges
- Outpatient Visits
- Emergency Room Visits/Rates/Readmissions
- Inpatient Readmissions – Unplanned and \leq Fifteen (15) Days from Prior Admission
- Selected Surgical Procedures
- Meridian HEDIS® Data
- Behavioral Health Quality
- Behavioral Health Utilization
- Behavioral Health Administration
- Behavioral Health Provider Performance
- Behavioral Health Finance
- Behavioral Health Complaints to Measure and Evaluate Care Efficacy Through Improved Health Outcomes

Analysis of utilization data includes the identification of patterns that may indicate inappropriate utilization (either under- or over-utilization) and/or fraud and abuse among population groups, individual practitioners, practitioner groups, and facilities. The UMC/QIC compares Meridian data with that of other State health plans and with national and regional data. Comparisons are used to establish acceptable ranges of utilization performance. If plan-wide monitoring results fall outside the established thresholds, a focused review will be conducted. This may include practitioner or facility specific information separated by risk, delegate, specialty type, or other significant categories as identified. If areas of deficiency are identified, the UMC/QIC will conduct an analysis of identifiable barriers or specific circumstances to make recommendations for correction of the variance. Based on weekly physician profiling and routine examination of PCP and emergency room utilization of members, Meridian uses a number of processes for the identification and addressing of areas of needed improvement. These include office visits by Medical Directors, reviewing in office data, and providing corrective action plans, which are subsequently reported to the Physician Advisory Committee (PAC). Each level of evaluation and effectiveness must be in measurable terms in order to make comparisons to previous findings. The consistent monitoring of the UM Program improves the quality of care for all members.

The Meridian Data Warehouse incorporates data from claims, enrollment, authorization, and HEDIS® to provide the end user with myriad ways to identify and impact over- and under-utilization as well as inappropriate utilization from the plan, provider group,

county, member, PCP, provider, and hospital perspectives. All key performance indicators are presented including emergency room usage, diagnosis-related groups (DRGs) and major diagnostic categories, diagnoses categories and ICD-9 codes, CPT-4 codes, NDC-pharmacy and plan-defined utilization categories. The Data Warehouse serves as a vital medical analytics tool providing refreshed data on a weekly basis.

Using a business intelligence tool, the Finance Department provides dashboards to Medical Management, Utilization Management, Compliance, Provider Services and Member Services that allow the users to see plan-wide, county, group, PCP, provider, hospital, and member utilization. Each user has their own login and ability to run reports at will, using pre-defined report prompts.

Potentially inappropriate utilization can be identified on any of the above levels through the dashboards with the capability to drill down to the member or even the claim level to determine appropriateness of the service in question. Using the dashboards, potentially high volume service providers have been identified, and in extreme cases, addressed in person. Reports are presented to those providers indicating their overuse of high-level codes or other potentially inappropriate behaviors. Whenever possible, the reports will compare the providers in question with their peer group to indicate the variance between the providers' billing practices and the norm. These provider-plan interactions have served as teaching moments to providers and have, in many cases, brought the billing patterns back within normal ranges.

h. Incorporate subcontractor's performance data;

Meridian Health Plan will include behavioral health data from Beacon Health Options (Beacon) and Independent Living Systems (ILS) in our evaluation of the Utilization Management (UM) Program. Beacon staff members will be co-located with Meridian to ensure unified services to members and providers. Meridian will collaborate with our subcontractors to establish integrated data transactions that will allow real-time monitoring of UM practices. In addition, Beacon and Independent Living Systems will supply reports and analysis related to UM performance on a regular basis. Beacon and Independent Living Systems staff will be active participants in the utilization review committee. Together, we will collaborate on opportunities for improvement and integrated action plans that provide a whole-person approach. We will implement a coordinated methodology to evaluating over- and under- utilization, emergency room utilization and diversion, practice patterns, readmissions, appropriateness of care, program management, and identification of quality of care issues.

i. Facilitate program management and long-term quality; and

The Utilization Management (UM) program's role is integrated into the Quality Improvement (QI) program through the development, collection, and maintenance of meaningful clinical indicators that establish measures of UM processes. This includes the effectiveness of the treatment provided by network providers, compliance with clinical practice guidelines, over- and under-utilization, and timeliness of utilization decision making and notification. As necessary, we will develop QI activities and projects that focus on improving performance. This includes:

- Identifying opportunities for improvement
- Monitoring clinical and service quality indicators
- Reviewing and analyzing data from indicators
- Prioritizing, based on risk assessment, the ability to impact performance and resource availability
- Establishing performance goals or desired level of improvement over current performance
- Collecting valid data of reach measure and calculating the baseline level of performance
- Annually re-measuring data for changes or improvement to the baseline level of performance
- Identifying interventions that are powerful enough to impact performance
- Analyzing results to determine where performance is acceptable and, if not, identifying the current barriers to improving performance

To ensure the ongoing progress of Quality Improvement initiatives, Meridian conducts a quarterly Quality Improvement Committee (QIC) meeting; committee membership includes both local and corporate internal leadership staff, contracted network providers, and a member of the Board of Directors (BOD). The QIC serves both as an action body which reports directly to BOD and as a coordinating committee where other committees are the action bodies. Subcommittees responsible for reporting up to the QIC include the Physician Advisory Committee (PAC), Utilization Management Committee (UMC), Credentialing Committee, and the Grievance Subcommittee, all of which include local and corporate leadership staff and physicians.

j. Identify critical quality of care issues.

The Meridian Health Plan Quality Improvement (QI) Department initiates a formal review of any clinical quality concern or complaint to ensure that all providers (practitioners and facilities) adhere to established standards of care in providing services to Meridian members.

A clinical quality concern can be initiated by a member, case manager, provider, or other health plan employee that identifies a quality concern or complaint based on the following criteria:

- Adverse event/outcome related to physical or behavioral care
- Pharmacy (drug, dosing, interactions, legal/licensing issues)
- Access
- Inappropriate utilization

Upon receipt of the concern, all pertinent and available member history is submitted. A member of the Quality Improvement clinical staff reviews the initial request, formally opens the quality review, initiates documentation on the Quality Review Form, and requests any additional records or clinical information necessary to complete the review. The Quality Review team member will complete the review based on the documentation and submits the finding to a Medical Director within five (5) to seven (7) days of receiving necessary documentation. The Medical Director reviews all materials and

requests additional information if necessary. The Medical Director determines the need for an Independent Review Organization (IRO) review, and if required, will send accordingly. Once a determination is made, findings and recommended actions will be returned to the Quality Improvement Reviewer within seven (7) days of receipt of the file. If the Medical Director recommends Physician Advisory Committee (PAC) review, the file is turned over to the Director of Quality Improvement and submitted for review at the next scheduled PAC meeting. The PAC may then refer the file to the Credentialing Committee. Recommendations from the PAC and Credentialing Committees are documented on the review form and maintained in the file. If PAC review is not recommended, the Quality Improvement Reviewer submits final review findings and recommendations to the Chief Medical Officer and closes the file. No further action is needed at this time.

Once the review is complete, the severity level of the event is determined to be one of the following categories:

- Level One (1) – Quality of Care issues related to behavior of physician. Potential actions are determined by the Credentialing Committee
- Level Two (2) – Deviations from standards and guidelines that can be measured but have no direct impact on the practitioner/patient relations (Credentialing Committee, PAC, or Medical Director decision)
- Level Three (3) – Deviation from guidelines of care or from generally accepted community medical standards which have a potential for harm (Credentialing Committee decision with potential for additional monitoring actions, pacing enrollment/disciplinary hold, or corrective action plan)
- Level Four (4) – Substandard care which results in a significant adverse effect on the member (Credentialing Committee decision with potential for reporting to State licensing bureau, initiation of termination process, or perform re-credentialing early)

When the severity level is determined, the event is assigned to one of the following outcomes:

- Termination, suspension, or limitation of credentials (Credentialing Committee decision only)
- Other Corrective Action (Credentialing Committee, PAC, or Medical Director decision)
- Track and Trend (QI Reviewer, Credentialing Committee, PAC, or Medical Director decision)
- Quality Issue Resolved
- No Action Required

All outcomes are communicated to the Credentialing Department and Director of Network Development. In addition, Meridian will notify the State of all outcomes.

3. Provide a sample UM Work Plan.

A sample UM Work Plan is provided below.

Utilization Management Work Plan 2015 Last updated <Date>

Importance Level: Low
 Medium
 High

| Utilization Management | | | | | | | | |
|------------------------|----------------------|-------------------------------|------------------|----------|-------------------|-------------|--------|----------|
| Reference # | Goal/Objective | Description of Goal/Objective | Quarterly Action | Ticket # | Responsible Party | Target Date | Status | Comments |
| 1 | Lorem Ipsum Dolor... | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |

4. Describe if any UM functions will be delegated. If any functions will be delegated, describe proposed ongoing monitoring strategies of the delegated entity.

Meridian Health Plan intends to delegate Utilization Management (UM) functions for behavioral health to our NCQA accredited partner, Beacon Health Options (Beacon) and our Long-Term Services and Supports (LTSS) services to Independent Living Systems. Beacon’s UM staff will be co-located with Meridian’s staff to ensure seamless integration of services and to provide oversight of Beacon’s processes. Compensation shall not be structured to provide incentives for the entity to deny, limit, or discontinue medically necessary covered services for any member. Activities will be regularly audited and monitored to ensure compliance. All delegated activities will meet NCQA guidelines.

Monitoring activities and will include, but are not limited to:

- Review and oversight of the UM Program
- File audit, including prior authorization, approvals, and denials
- Annual evaluation
- Development of Quality Improvement activities
- Evaluation and approval of UM and quality programs and reports

Meridian Health Plan has also executed a Letter of Intent with Independent Living Services (ILS) to administer care coordination and case management services to the LTSS population.

5. Describe the process for developing and updating practice guidelines.

Meridian Health Plan utilizes internal medical review criteria when rendering Utilization Management (UM) decisions. If Meridian internal medical review criteria are not present for a requested service, Meridian will utilize InterQual® Guidelines. Meridian internal medical review criteria are developed when utilization practice identifies opportunities that promote the development of new criteria or a revision/addition to existing practice guidelines. In compliance with 42 CFR 438.236, Meridian employs current, objective, clinical, and evidenced-based

medicine sources as a basis for development of internal medical review criteria and UM guidelines. When necessary, consultation is sought from medical review organizations, appropriate practitioners and university faculty in the development process with current knowledge relevant to the criteria under review. Meridian's Medical Policy Committee (MPC) is composed of the Chief Medical Officer, Meridian Medical Directors, and the Compliance Analyst. The committee meets at least monthly to review opportunities for new medical policies and update existing medical policies and practice guidelines.

In conjunction with the MPC, the policies are sent for review by the Medical Policy Operations Committee (MPOC). The MPOC is a subcommittee of the MPC assigned with the task of reviewing the medical policies and developing the operational processes for implementation. The MPOC includes Medical Directors, Corporate UM Director, Quality Improvement (QI), Information Technologies (IT), and Claims. The MPOC representatives are appointed on an annual basis. The MPC develops medical policies for Medicaid and Medicare members that are consistent with the Local Coverage Determinations (LCDs) and/or National Coverage Determinations (NCDs) as established by the Centers for Medicare and Medicaid Services (CMS). All policies are reviewed and approved by the MPC on an annual basis.

Following approval by the MPC, the policies are presented to the Physician Advisory Committee (PAC), comprised of Meridian Medical Directors and actively practicing physicians. Annually and as needed, the PAC reviews the criteria and recommends modifications and revisions as clinically appropriate. Following the PAC clinical recommendations, the policies are reviewed and approved by the Corporate Compliance Committee to ensure compliance with applicable contracts, corporate needs, and accreditation standards. Substantive recommendations will be re-reviewed by the MPC and PAC as needed.

Following Corporate Compliance approval, the policies are referred to the Corporate Quality Improvement Committee (QIC) and the Board of Directors for informational purposes. All practice guidelines and UM guidelines developed, changed, and adopted by Meridian Health Plan will be sent to the State and shared with providers thirty (30) days prior to implementation. All current and approved medical review criteria are distributed to UM and Medical Directors in hard copy and stored in the policy library. No policy will be effective until it has gone through this process and is determined to meet the standard of care, regulatory agency requirements, and corporate business needs. These policies will be reviewed on an annual basis.

Beacon developed behavioral health clinical practice guidelines by adopting national evidence-based practice guidelines from recognized sources such as the American Psychiatric Association Manual for Peer Review, the Diagnostic and Statistical Manual IV-Revised, American Accreditation HealthCare Commission/URAC Standards, ASAM Standards, and Health Management Strategies International. Standards of care are continually reviewed and modified based on scientific evidence, best practices, and input from respected industry sources, including providers in the network and other stakeholders.

6. Describe how your UM program will integrate with other functional units as appropriate and support the Quality Management and Improvement Program.

The Board of Directors (BOD) oversees all Quality Improvement Program (QIP) activities, including those of the Utilization Management (UM) Program. The Board of Directors has delegated responsibility for the ongoing management of the UM Program to the Utilization

Management Committee (UMC). The UMC reports to the Quality Improvement Committee (QIC) and both committees report to the Board of Directors on a quarterly basis. The UMC reports metrics and utilization statistics as well as utilization trends. All policy, procedure, and program changes require QIC approval. The UMC and QIC have external participants such as clinicians and subcontractor staff. This enhances the integration of the UM program across internal and external functional units. Beacon Health Options' (Beacon) UM and Quality Management (QM) programs will report to Meridian's Utilization Management and Quality Improvement programs. Beacon will have a representative on Meridian's UM and QI committees. Beacon will provide reporting, which will show the monitoring of services for members with special needs and diagnoses of severe mental illness or substance abuse.

The UM program's role is further integrated into the QIP through the development, collection, and maintenance of meaningful clinical indicators that establish measures of UM processes. This includes the effectiveness of the treatment provided by behavioral health network providers, compliance with clinical practice guidelines, over- and under-utilization, and timeliness of utilization decision making and notification. As necessary, we will develop QI activities and projects that focus on improving performance. This includes:

- Identifying opportunities for improvement
- Monitoring clinical and service quality indicators
- Reviewing and analyzing data from indicators
- Prioritizing, based on risk assessment, the ability to impact performance and resource availability
- Establishing performance goals or desired level of improvement over current performance
- Collecting valid data of reach measure and calculating the baseline level of performance
- Re-measuring data annually for changes or improvement to the baseline level of performance
- Identifying interventions that are powerful enough to impact performance
- Analyzing results to determine where performance is acceptable and, if not, identify the current barriers to improving performance

In conjunction with the UMC and QIC, the Utilization Management Department works hand-in-hand with the Care Coordination Department to ensure that members are receiving appropriate and quality care in alignment with the covered benefits, Long-Term Services and Supports (LTSS) programs, and quality initiatives. The focus on preventive health screens, access to care, and utilization of services are a focus of this collaboration. Contacts occur between the Care Coordination staff and the utilization staff on an ongoing basis throughout the work day. Referrals are made by UM staff to the Care Coordination Department for members that may need more assistance with managing their health care. UM staff can become aware of instances of members accessing emergency room services and other healthcare services when they really need to see and engage their PCP for assistance with chronic care, inpatient services, or a medication review. UM and Care Coordination staff evaluate care on an ongoing basis for appropriateness and identify critical quality of care issues.

7. Describe how the UM program will encourage health literacy and informed healthcare decision-making.

Meridian Health Plan actively supports members in their efforts to stay healthy and encourages wellness among all its members. This takes the form of member educational programs, member mailings, and incentives. Our Provider Services Representatives and Outreach Specialists attend community events, such as health fairs, health screening events, community baby showers, and similar programs to distribute health education materials and answer questions. At sponsor other events that provide healthcare services such as well-child exams, lead screenings, and immunizations. Meridian promotional items provided at these events share this practical, health-focused approach; instead of the usual novelty giveaways, we offer toddler cups, Band-Aid packs, tote bags, dosing spoons, diapers, baby wipes, and other useful items.

As part of Beacon Health Options' (Beacon) behavioral health UM program, individuals are treated at the point of care where they are comfortable, applying a patient-centered, strengths-based treatment approach that incorporates shared decision making. Individuals are treated holistically, using a single treatment plan that addresses both physical and behavioral health needs and helping individuals access their natural community supports based on their own strengths and preferences. Wellness and Recovery Action Plans (WRAP plans) are used as part of the UM process as one way to ensure members, providers, and clinical staff are operating under the same understanding of the wishes and desires of members. These plans have been proven to increase member satisfaction and outcomes because they are actively involved in developing the treatment and more likely to reach their individual goals. Health promotion and outreach activities related to behavioral health focus on three (3) important principles:

1. Ensuring members have the information they need to identify and access services in a timely and appropriate manner
2. Providing individuals and families with information to enhance their ability to prevent the onset or worsening of behavioral health issues
3. Improving access and kept appointments, especially for hard-to-reach members

Meridian Health Plan is committed to serving all members, communicating in the language of their choice and building literacy bridges with members without a delay in services, benefits, or treatment. Meridian's proprietary software, Managed Care System (MCS) tracks member language preference for future calls and communications, ensuring that our employees are able to collaborate with our members according to their individualized needs. MCS captures the member's primary language preference and triggers all materials sent to the member are sent in that primary language, if that non-English language is greater than five percent (5%) of our threshold, as required by the State.

This feature also allows Meridian to more efficiently search for PCPs and other providers who speak the same language, thus promoting shared-understanding and decision making

Meridian offers these services to accommodate non-English speaking members:

- A Member Services Help Line offering telephone-accessible services in over 170 languages
- In-house staff with fluency in the language of large non-English speaking member groups
- A training program that builds cultural awareness and language fluency for our employees

- A commitment to staffing diversity, especially those in daily member contact, reflecting the composition of membership
- Website content in English, Spanish, and any other languages as determined by the State

During the Welcome Call, members are informed of their ability to receive information in their preferred language if that non-English language is greater than five percent (5%) of our threshold, as required by the State. The Member Handbook and website will include this information as well.

Meridian will ensure essential communication materials, such as the Member Handbook, include taglines in prevalent languages directing members to the version of the item in the member's preferred language.

Additional consideration for alternative communication formats to promote health literacy and informed decision making include:

- A toll-free Teletypewriter (TTY) and Telecommunications Device for the Deaf (TTD) services for members with hearing or speech impairment, as well as online Live Chat service which allows members and providers to instant message with Meridian employees
- Production of materials in alternative formats (large print, Braille, audio) to assist member understanding
- Individual assistance and personalized programs for members with cognitive impairments
- A training program for Utilization Management staff to evaluate special accommodations on a case-by-case basis, with consideration for the level at which the member is able to verbalize information, the length of time the member is able to speak, and how much of the member's speech can be comprehended by others

The above needs are also tracked in MCS to ensure appropriate support is given to our members.

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.

Meridian Health Plan has an internally developed electronic system called the Managed Care System (MCS). This system is programmed per evidence-based guidelines outlined in the Healthcare Effectiveness Data and Information Set (HEDIS®) specifications, as well as internally identified metrics. Members are determined eligible from the following sources: Claims or encounters data, pharmacy data, health assessment results, utilization management data, and member and provider referrals. Meridian sends a variety of mailings regarding screenings throughout the year. This includes preventive screenings and services as well as monitoring services for different conditions, as recommended by evidence-based guidelines. Potential barriers are identified and addressed through our Health Risk Assessments (HRAs). Meridian Care Coordinators perform a Health Risk Assessment (HRA) upon enrollment to identify medical and behavioral health needs. This information is incorporated into a member's individualized care plan and used to determine needed appointments with their primary care provider (PCP), specialist providers, and behavioral health providers. The care plan is developed with the member after completion of the appropriate HRAs and includes agreed upon goals determined by the

member and Care Coordinator. If a member is not available to participate or cannot participate, an authorized member representative can participate on behalf of the member in the creation of the care plan with the Care Coordinator.

Upon completion of the HRA, the Care Coordinator communicates with the member, obtains additional information by completing additional medical status assessments, discusses the results of the HRA and stratification level, explains the stratification, and utilizes all information available to develop the care plan. The Interdisciplinary Care Team (ICT) works to set goals and the interventions to meet the goals. Once finalized, the care plan is then shared with the PCP by mail, fax, or an alert in MCS. The Care Coordinator utilizes the care plan as the tool for future communication with the ICT. A copy of the care plan and HRA are mailed to the member. Many times, these are discussed telephonically with the member as well. The Care Coordinator provides the member's PCP a written copy of the member's initial and subsequent HRAs, as well as the member's initial and updated care plan. Results of both are also available to providers via the online Provider Portal. The member is encouraged to utilize this copy of the HRA as their personalized health record and to bring their HRA and care plan to any healthcare appointments. This ensures all providers seeing the member are aware of the care plan and the goals toward which the member is striving.

If the member is unable to be contacted or refuses to participate in the Care Coordination Program, an initial individualized care plan is developed without the member's input and is shared with the PCP or usual caregiver. Communication with the PCP helps Meridian Care Coordinators obtain member information in the creation of a care plan. Information received from the PCP is added to the care plan by the Care Coordinator. The care plan is reviewed with the ICT for input. The final care plan is then discussed telephonically with the member or member's authorized representative. The agreed upon care plan is mailed to both the member and provider. MCS users are notified by an electronic alert. Additionally, ICT team members are available to the Care Coordinator for ad hoc consultations, as care is coordinated.

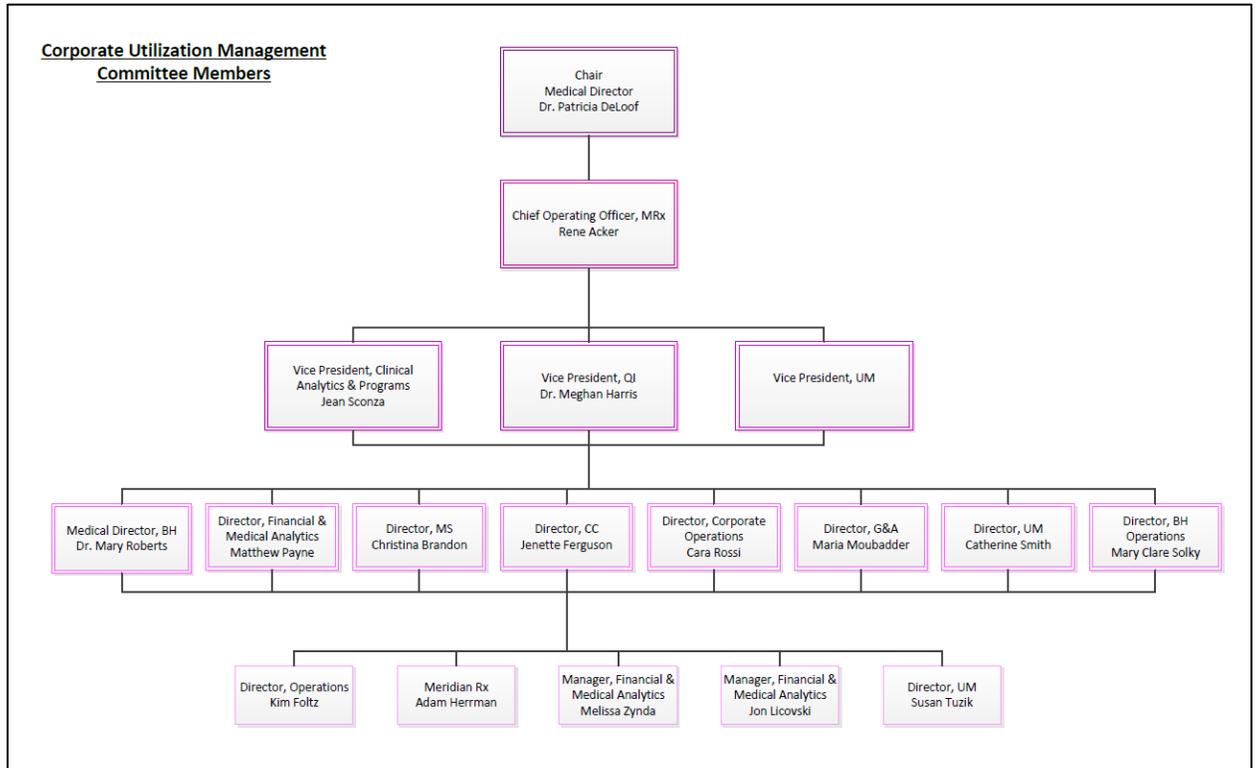
Members with complex co-morbidities and social needs may be co-managed by two (2) members of the ICT. Co-management is often needed for complex cases with severe medical conditions complicated by mental health issues. An introductory letter will be sent to members once enrolled in Care Coordination explaining the concept of the ICT and providing information on how to access any member on the team.

9. Describe your UM Committee, including proposed committee composition and tasks.

The Utilization Management Committee (UMC) is chaired by the Meridian Health Plan Medical Director and meets at least quarterly. Committee membership includes both local and corporate internal leadership staff and a representative from Beacon Health Options and Independent Living Systems. The UMC reviews and discusses utilization statistics and performance metrics and trends including behavioral health and Long-Term Services and Supports (LTSS). The UMC mission is to oversee and monitor utilization for hospitals, physicians, and non-physician practitioners to assure consistency in benefit determination while monitoring high-quality care to members. This committee is used to identify trends and variations and to discuss possible interventions to increase the utilization and health of Meridian's membership. In addition, the UMC is responsible for monitoring medical necessity of the healthcare services provided, acting on process changes as a result of trended utilization data, following Meridian policies and procedures that mirror industry standards, and adhere to all timelines and response requirements

including the one (1) hour response to all emergency room providers, twenty four (24) hours a day, seven (7) days a week.

The UMC Organizational Chart is provided below.



The functions of the UMC include:

- Monitoring of over- and under-utilization
- Compliance with timeliness standards for denials and appeals of adverse determinations
- Denial and approval and overturn rates
- Timeliness of Utilization Management (UM) decision making
- Satisfaction with the UM process
- Establish clinical criteria for UM decision

The role of the UMC is to:

- Develop, implement, and evaluate the UM Program
- Assist in the development, implementation, and monitoring of clinical practice guidelines relating to quality of care
- Investigate, resolve, and monitor quarterly operations related to UM activities
- Review and approve UM policies and procedures annually
- Monitor appropriate levels of care and timeliness of the delivery of healthcare services
- Review UM policies and procedures for utilization by clinical and non-clinical staff
- Evaluate new and existing technology recommendations

- Coordinate quality issues identified through the UM process with the Quality Improvement (QI) Department
- Monitor effectiveness of the UM process through member and practitioner satisfaction survey results
- Monitor practice patterns of practitioners
- Assess consistency with the application of care coordination criteria
- Identify and monitor over-utilization and under-utilization of services
- Identify and monitor utilization patterns that compromise consumer health and safety, inappropriately use resources, or represent organizational risk
- Evaluate consistent use of medical necessity, including criteria used and information sources
- Review process used to approve the provision of services
- Review of initial and ongoing determinations and initial and continued service authorization decisions
- Provide support to other organizational functions
- Perform special targeted monitoring activities as required by need or regulatory mandate. Examples of targeted monitoring activities include: service-specific utilization reviews, programs length of stay, reviews of service (duration, volume, and cost), service and billing integrity reviews, and provider-specific treatment pattern analysis

10. Describe any benefits which are proposed to require PCP referral and what services would be available on a self-referral process.

Meridian Health Plan members may self-refer to an affiliated, contracted provider without going through their primary care provider (PCP) or the prior authorization process for the following services:

- OB and gynecological services to include acute, chronic, preventive, and routine visits
- Routine yearly retinal eye exam for members with diabetes
- Screening mammograms
- Well woman exam
- Routine yearly prostate cancer screening, including prostate specific antigen (PSA) testing and digital rectal exam

We do not require a PCP referral for members accessing behavioral health services. However, Beacon Health Options will assist PCPs that would like help with referrals. Independent Living Systems will assist members though with referrals for services, such as environmental modifications, to ensure medical necessity.

11.2 Prior Authorization

- 1. Describe policies and procedures for processing authorization requests including when consultation with the requesting provider will be utilized.**

Medical Authorizations

In compliance with CFR 438.210(b), Meridian Health Plan follows our outlined policies and procedures for processing authorization requests for each request received. These policies and procedures are brought to the Utilization Management Committee (UMC) and the Quality Improvement Committee (QIC), which are responsible for monitoring medical necessity of the healthcare services provided, acting on process changes as a result of trended utilization data, following Meridian's policies and procedures that mirror industry standards, and adhere to all timelines and response requirements. All Meridian policies and procedures are available for review on the Meridian website. To ensure appropriateness of care, Meridian uses nationally recognized, evidence-based clinical guidelines in conjunction with policies and procedures on individualized determination processes. The Utilization Management (UM) Department administers the Inter Rater Reliability Test (IRR) to the physicians and nurses on a bi-annual basis to ensure compliance with admission guidelines. The Medical Directors participate in clinical and policy making committees that impact patient care. The Audit and Remediation Group conducts quarterly physician and nurse audits to ensure compliance with current practice at Meridian Health Plan, against evidenced-based clinical standards of care.

- **Initial Review**

Meridian Inpatient and Pre-service Review Nurses complete an Initial Clinical Review to determine the medical necessity and/or benefit compliance of requested services. Pre-established medical necessity criteria are applied during the initial clinical review. Inpatient and Pre-service Review Nurses may approve services if the review of the clinical documentation meets the specific medical necessity criteria. All denial decisions are rendered by the Medical Directors and Associate Medical Directors. Pre-service Review Nurses conduct pre-service review of select outpatient procedures, elective inpatient admissions, durable medical equipment evaluation, out-of-state requests, physical, speech, and occupational therapy, transplant evaluations, and potentially cosmetic services at the request of providers and members to determine coverage determinations. Inpatient Review Nurses conduct pre-service review of emergent admissions, inpatient rehabilitation, and skilled nursing facility care. This includes utilization review, discharge planning, and determining the appropriate level of care.

Both the Inpatient and Pre-service Review Nurses are responsible for identifying members with case management and disease management needs and referring them to the appropriate program. Pre-service Review Nurses and Inpatient Review Nurses conduct concurrent review of requests to extend currently approved courses of treatment such as physical, occupational, and speech therapies, pain management services, inpatient rehabilitation, and skilled nursing facility care.

- **Concurrent Review**

During the course of pre-service review or concurrent review, the Review Nurse will identify ongoing, continuing care needs for a member upon discharge and make arrangements with providers (e.g., home care, durable medical equipment, supplies, and/or education classes). Retrospective review decisions are rendered by the Post-

Service Appeals Committee through the post service appeals process. Review decisions for inpatient admissions, where the member has already been discharged but the review was called in within the one (1) business day in accordance with contractual requirement, are made on the basis of medical necessity and the decision communicated within seventy-two (72) hours of receipt of the notification.

- **Denial Process**

Peer Clinical Review is conducted by the Associate Medical Directors and Medical Directors to determine the medical necessity of requested services when medical necessity is not clearly met during the initial clinical review. Pre-established medical necessity criteria are applied during the peer clinical review. Meridian provides verbal notification of an impending denial and offers a peer-to-peer conversation to the attending or ordering physician with every denial notification. This notification allows the requesting physician the opportunity to provide additional information that may clarify the need for the requested services. The attending or ordering physician may request a peer-to-peer conversation over the phone, in person, or electronically. The Meridian clinical peer reviewer responds within one (1) business day of the peer-to-peer request. If the clinical peer reviewer determines to uphold the initial denial after the peer-to-peer conversation, the attending and ordering physician is informed of their appeal rights. Meridian provides attending or ordering physicians the opportunity to submit additional clinical information for reconsideration within ten (10) days of the date of the written denial notification. The clinical peer reviewer responsible for the denial determination reviews the clinical information and renders a decision within three (3) days of receipt. The attending or ordering physician will be notified of the determination within one (1) day of decision. If the review does not result in an approval, the attending or ordering physician will be informed of their appeal rights.

- **Timeframes and Notification Process**

In accordance with 42 CFR 438.210, Meridian will notify members of standard authorization decisions as required by the member's health condition. This notification will not exceed seven (7) calendar days after the request for services or the timeframe described in the executed contract. If the member or provider requests an extension or if a justified need for more information is submitted, an extension of up to fourteen (14) calendar days will be utilized. Meridian Health Plan recognizes that if there is a failure to respond within the seven (7) calendar days of receiving all necessary documentation, the authorization is deemed to be granted and the member and provider will be notified as such. In the event of an expedited authorization request, Meridian shall respond to the prior authorization request within three (3) business days of receiving all necessary documentation. If a member requests an extension or if Meridian justifies a need for additional information, an extension of up to fourteen (14) calendar days may be granted. Meridian Health Plan recognizes that if there is a failure to respond within the three (3) calendar days or fourteen (14) calendar days, the authorization is approved and all parties notified.

Exceptions to Prior Authorization and/or Referrals

UM will work with providers to ensure that appropriate, medically-necessary care is available and provided, which includes any necessary exceptions to prior authorization and referral guidelines.

Pharmacy Prior Authorization

In accordance with MeridianRx guidelines, all prior authorization requests are reviewed and decisions are rendered within twenty-four (24) hours. Once a decision is made, MeridianRx will provide a response to the submitter by telephone or other telecommunication device within twenty-four (24) hours of the request's resolution. MeridianRx is a fully operational twenty-four (24) hours a day, and seven (7) days a week organization. In emergency situations, MeridianRx allows medication overrides for medications and dispenses a minimum of a seventy-two (72) hour supply.

Behavioral Health Authorizations

The Behavioral Health authorization process will provide integrated data transactions between Meridian and Beacon Health Options (Beacon). Beacon's Master's level, licensed clinicians conduct reviews of mental health and substance use services to monitor and evaluate treatment requests and progress. Authorization protocols are provided primarily through the use of the telephonic, web-based/electronic, or paper document submission from providers.

All medical necessity behavioral health determinations are based on the application of level of care criteria approved by the State. We consider the level criteria as guidelines, not absolute standards, and consider them in conjunction with other indications of an individual's needs, strengths, and treatment history in determining the best placement for the member. In general, individuals will only be certified if they meet the specific medical necessity criteria for a particular level of care. All decisions regarding treatment, provided by our multidisciplinary team of clinicians, are made as expeditiously as the members healthcare needs require and always within the State-established timeliness standards as described above.

Clinicians collect only the information necessary to certify the admission, treatment, length of stay, or frequency or duration of services. We do not routinely request copies of all medical records on patients reviewed. Additional medical records will only be requested when there is difficulty in making a decision. We do not routinely require hospitals, physicians, or other providers to numerically code diagnoses to be considered for authorization. Authorizations are based on the clinical information gathered during the review. All concurrent reviews are based on the severity and complexity of the member's condition. A clinical evaluation for medical necessity is conducted at each concurrent review to determine when the next review will be due. Concurrent reviews are not routinely conducted on a daily basis.

Inpatient Authorizations

- **Initial Review**

Beacon will require prior authorization for all inpatient and higher levels of care for this program, with the exception of State-funded substance use disorder services. We will monitor these services retrospectively to ensure appropriate application of clinical criteria.

For services requiring prior authorization, our Utilization Management (UM) clinicians will conduct reviews to determine medical necessity based only on the information necessary to certify the admission, treatment, length of stay, and or frequency/duration of services. The authorization determination is rendered as quickly as possible and within all accreditation and regulatory timeliness standards. The clinician will assign and verbally

communicate the assigned length of stay to the provider and the attending physician and request the provider notify the individual. Written confirmation of the certification will also be sent to the individual, provider, and facility.

When a provider receives a certification for an individual's treatment, he/she is instructed to contact the clinician prior to the certification expiration date, leaving enough time for concurrent review and re-certification so as not to interrupt benefit coverage of the individual's treatment services.

- **Concurrent Review**

A concurrent review is conducted after the initial review has been completed and days have been certified based on medical necessity. Concurrent review is an ongoing process that evaluates the member's progress in treatment, necessity for continued stay at the current level of care, and discharge planning. Our clinician contacts the attending practitioner, provider utilization review department, or member's therapist to obtain clinical information by the last day certified. If criteria for medical necessity are met, our clinicians certify additional days and clinical documentation is entered into our clinical system.

- **Retrospective Review**

Retrospective reviews are conducted based on the design of customer-specific benefit plans. A request from a facility or practitioner for a retrospective review of an inpatient case may be received via letter, facsimile, or telephone and must include an explanation of the circumstances of the request. Once a certification decision is rendered, the member, practitioner, and facility are notified of the decision in writing.

- **Denial Process**

When the clinician questions the medical necessity or appropriateness of the recommended treatment or when there are quality-of-care issues, the case is referred to a Peer Clinical Review (either an M.D. or a Ph.D., depending on the level of care under review) for peer review. The Peer Clinical Review reviews the available information (e.g., documentation by the Care Manager, the medical record, and other documentation) and then speaks directly with the attending clinician to discuss the case. Peer reviews are intended to be a collegial exchange between Peer Advisors and the treating provider to reach agreement on an alternative course of treatment, or to give the treating provider an opportunity to present information that might result in approval of the requested level of care. Denials are rendered only in those situations where the Peer Advisor and the attending provider are unable to reach a consensus. In cases of denial, there are two levels of appeal available to providers in which another Peer Clinical Review or an Appeals Panel reviews the case. However, in the vast majority of cases (ninety-eight percent (98%) nationally), the Peer Advisor and attending provider reach agreement regarding the member's care.

Outpatient Authorizations

Beacon's outpatient philosophy is to match service intensity with the member's clinical presentation, to encourage goal-oriented, solutions-focused brief therapies that promote skills to enhance the member's autonomy and best functional baseline. We recommend that individuals engage in treatment as soon as they determine their level of readiness. We do not recommend nor require prior authorization for the initiation of outpatient treatment. Rather, we recommend a

three (3)-pronged approach, which includes Enhanced Outpatient Care Management, Provider Outlier Management, and Complex Case Management. We will work with the State to review and approve this strategy during the implementation period.

Under this model, we will conduct reviews in the outpatient setting based on a claims analytic model that identifies “unusual” cases that do not appear to be progressing towards resolution. Based on this identification, we then request clinical information and review for medical necessity and quality. Benchmarks of utilization have been established by diagnosis and provider.

2. Describe mechanisms to ensure consistent application of review criteria for prior authorization decisions.

To ensure the consistent application of level of care criteria, an Inter-Rater Reliability audit is conducted bi-annually to monitor reliability and validity between clinicians and with the standard. The tool is administered to all Utilization Management clinical decision-makers. Audits are scored, tabulated, and analyzed to highlight variances among individual staff or clinical teams. When results fall below target, improvement plans are developed and implemented.

Prior authorization is a key component in coordination and quality of care. Meridian Health Plan is committed to authorizing care at the least restrictive and most medically appropriate levels. This commitment results in high quality of care and improved member autonomy, provider satisfaction, and effectively controlling costs. The prior authorization process ensures that members receive services consistent with their care plan, covered services, medically necessary services, and services that are appropriate, timely, and cost efficient. In addition, prior authorization supports patient safety and cost control by minimizing or eliminating the occurrence of medication errors, duplication of services, and inappropriate service delivery. Meridian Health Plan identifies services and procedures requiring prior authorization through an annual and ongoing analysis of utilization data. These are generally high-volume, high-cost services where review of medical necessity and/or benefits would be helpful.

3. Describe processes for retrospective utilization monitoring for IDPH population services.

Meridian will not require authorization for any level of service for the IDPH population. As such, we will monitor utilization of these services retrospectively to assess compliance with both clinical and administrative requirements. This is critical to ensure the quality and appropriateness of treatment services provided to all individuals receiving IDPH-funded substance use disorder services.

As part of the retrospective review process, we will ensure compliance with the most current version of the American Society of Addiction Medicine (ASAM) criteria and conformity with professionally recognized standards of health care. The clinical focus of these reviews will be to ensure that the appropriate criteria have been met and the services provided are consistent with the services billed. The clinical review will assess the providers’ consistency in using evidence-based practices and other best practices endorsed by IDPH.

Retrospective utilization reports for the IDPH population services will be presented and reviewed during the quarterly Utilization Management Committee (UMC) meeting. The UMC’s goal is to

set policies regarding utilization for hospitals, physicians, and non-physician practitioners to assure consistency while monitoring high quality care to members.

4. Describe required staff qualifications for UM staff.

Meridian Health Plan utilizes qualified licensed health professionals to assess clinical information and render Utilization Management (UM) decisions. Appropriate licensed professionals supervise all medical necessity decisions.

The Chief Medical Officer is the senior physician, who is Board Certified and has a current license without restriction, who reports directly to the CEO/President. Responsibilities for this executive position include the development, implementation, and supervision of the UM Program, setting policies, reviewing cases, and participating in the Utilization Management Committee (UMC) meetings.

The Utilization Management Medical Director, who is Board Certified and has a current license without restriction, reports directly to the Chief Medical Officer. This designated senior position is responsible for the operational execution of the UM Program under the direction of the Chief Medical Officer. The UM Medical Director also ensures consistent medical necessity decision making and reviews requests that cannot be approved by the nursing staff. The Medical Director may render denial decisions.

Meridian Health Plan's UM Program is overseen by the Director of Utilization Management, a registered nurse, who is responsible for the administration and execution of the UM Program under the direction of the UM Medical Director. The Director of Utilization Management is responsible for strategic planning, evaluation, and continuous improvement of the UM Program, including the allocation of resources and interdepartmental coordination of activities. The Director of Utilization Management also oversees the coordination of activities needed for the UMC.

The Nurse Manager has a current license without restriction. Reporting to the Director of Utilization Management, the Nurse Manager supervises staff and serves as a resource for all UM staff while maintaining administrative responsibility for clinical processes and procedures. The Nurse Manager is responsible for monitoring the timeliness for decision making, conducting Inter-Rater Reliability, ensuring the appropriate handling of organizational determinations, and implementing policies and procedures.

The Manager of Utilization Management is responsible for the daily operational management and supervision of staff while maintaining administrative responsibilities that optimize workload and outcomes. Reporting to the Director of Utilization Management, the Manager of Utilization Management will maintain all regulatory and accreditation requirements and function cross-departmentally in the coordination of member care.

Inpatient Review Nurses have current nursing licenses without restriction. The Inpatient Review Nurses perform initial clinical review for pre-service urgent and concurrent inpatient admissions, discharge planning activities, identify cases for case management, and ensure the delivery of high quality, cost-effective medical care to members. Inpatient Review Nurses may authorize services, but cannot deny them. Inpatient Review Nurses receive urgent/emergent inpatient admission authorization requests and supporting clinical information from Meridian's automated care

system, telephonically, and through internal fax referral from the Utilization Management Care Coordinators. Supporting clinical data is reviewed against InterQual[®] guidelines and Meridian Health Plan internal medical review criteria. The Inpatient Review Nurses consult with the Medical Director for all requests requiring physician approval or for requests not meeting the guidelines and criteria for approval.

The Utilization Management Pre-Service Review Nurse team is comprised of licensed practical nurses and registered nurses with current licenses without restriction. The Pre-Service Review Nurses perform initial clinical review of prospective requests for certain outpatient procedures; inpatient admissions; durable medical equipment; out-of-state requests; and physical, speech, and occupational therapy at the request of providers and members. Pre-Service Review Nurses may authorize services, but cannot deny them. Pre-Service Review Nurses receive elective inpatient and outpatient authorization requests and supporting clinical information from Meridian's automated care system, telephonically, and through internal fax referral from the Utilization Management Care Coordinators. Supporting clinical data is reviewed against InterQual[®] guidelines and Meridian Health Plan internal medical review criteria. The Pre-Service Review Nurses consult with the Medical Director for all requests requiring physician approval or for requests not meeting the guidelines and criteria for approval.

The Transitional Case Managers are licensed practical nurses and/or registered nurses with current licenses without restriction. This position is responsible for the safe and effective transition of care for members transitioning from one acute care setting to another as the member's health status changes. Responsibilities include, but are not limited to, ensuring that authorization requests for skilled nursing facilities, inpatient acute rehabilitation, and long-term acute care hospital placements are processed. Transitional Case Managers function collaboratively with the members of the Utilization Management staff, and specifically with the Inpatient Review Nurses, Pre-service Review Nurses, Case Managers, Pharmacists, and Medical Directors to ensure for timely disposition of authorization requests and discharge planning activities.

Utilization Management Care Coordinators are non-clinical staff that are responsible for referral initiation and initial screening of prospective requests received via fax, telephone, and electronically. This team works collaboratively with other members of the Utilization Management staff to ensure that authorization requests and provider and member inquiries are handled appropriately, within established timeframes and utilizing established guidelines.

Transitional Care Coordinators are non-clinical staff responsible for coordinating member continuity of care services directed by the clinical staff. The Transitional Care Coordinators work collaboratively with other members of the Utilization Management staff to ensure that authorization requests and provider and member inquiries are handled appropriately, within established timeframes and utilizing established guidelines. This position will coordinate member care services as directed by the clinical staff and maintain accurate and timely tracking and reporting of activities performed.

Behavioral Health UM Staff Requirements

Vice President of Medical Affairs

The Vice President of Medical Affairs is the senior executive responsible for medical oversight and leadership of the utilization program and reports to the President of Beacon Health Options

(Beacon). As a member of the senior management team, the Vice President of Medical Affairs provides leadership and supervision to Beacon's panel of physicians (employed and contracted). S/he is actively involved in the implementation, supervision, oversight and evaluation of the Utilization Management (UM) program. S/he is a Board Certified licensed psychiatrist with a minimum of ten (10) years of direct clinical care and six (6) years of managed care experience.

Senior Clinical Director

The Senior Clinical Director is responsible for the clinical oversight of utilization management, care management, and disease management activities throughout Beacon's multi-state offices and contracts. The Clinical Directors of Utilization Management report to this position. The Senior Clinical Director has a minimum of ten (10) years of managed care experience and is an independently licensed clinician (minimum of Master's prepared). The Senior Clinical Director sets the strategic direction of the department for the organization.

Clinical Director of Utilization Management

The Clinical Director of Utilization Management is responsible for clinical oversight of the department. S/he ensures that utilization management processes are in compliance with policy guidelines, external regulatory requirements, and Managed Behavioral Healthcare Organization (MBHO) accreditation standards. In addition, s/he is responsible for monitoring clinical indicators, initiating corrective action plans, oversight of the clinical managers, and leading all clinical interdepartmental functions. S/he reports to the Senior Clinical Director. The Clinical Director of Utilization Management is an independently licensed (minimum of Master's prepared) behavioral healthcare clinician with a minimum of ten (10) years of combined clinical and managed care experience.

Medical Directors and Physician Advisors

The Medical Director(s) and Physician Advisor(s) are board certified licensed psychiatrists with a minimum of six (6) years combined direct behavioral health clinical and managed care experience. In addition, they are required to be actively practicing. Beacon maintains a state Medical Director as required by contract. Physician Advisors make medical necessity determinations, have the authority to deny services, provide consultations to treating practitioners, perform reviews with attending physicians at facilities, and participate in Quality Improvement (QI) activities. All of Beacon's Physician Advisors are Beacon employees and therefore not subordinate to the Medical Directors. Beacon Physician Advisors report to the Vice President of Medical Affairs.

Psychologist Advisors

The Psychologist Advisor(s) are Ph.D., Psy.D. or Ed.D. psychologists licensed for independent practice with a minimum of five (5) years combined direct behavioral health clinical and managed care experience. In addition, they are required to be actively practicing. Unless excluded by State regulation, Psychologist Advisors may deny outpatient services, including Psychological Testing, except when the requesting provider is a physician or a nurse prescriber. In those cases, a Physician Advisor must review and make a determination. Beacon Psychologist Advisors report to the Assistant Clinical Director of Outpatient Services. In addition to their primary supervisor, as a member of the Physician/Psychologist Advisor staff, this position receives additional clinical supervision by the Vice President of Medical Affairs as needed.

Assistant Clinical Directors and Clinical Managers

The Assistant Clinical Directors and Clinical Managers are responsible for the day- to-day operations of their teams, program development, and monitoring of all UM and Care Management (CM) activity. Staff in these roles are independently licensed (minimum of Master's prepared) as behavioral healthcare clinicians, with a minimum of five (5) to eight (8) years combined behavioral health clinical and managed care experience. All are involved in Quality Improvement activities and are active members in all clinical leadership committees. Clinical supervision is provided by the Directors of UM and CM.

Utilization Review Team Leads

The Utilization Review Team Lead(s) are licensed (minimum of Master's prepared) behavioral healthcare clinicians with at least three (3) years combined behavioral health clinical and managed care experience. They report to a Clinical Manager and/or Assistant Director and are responsible for the direct supervision of the Utilization Review (UR) Clinicians. They are active participants in QI activities.

Utilization Review Clinicians

The Utilization Review (UR) Clinicians are licensed Master's level behavioral or registered nurse healthcare professionals with a minimum of two (2) years of combined direct behavioral health clinical and managed care experience. UR Clinicians are assigned to UM Teams (for example, Outpatient, Continued Stay, or Prior Authorization). All clinicians are responsible for member and provider education, triage and referral, service procurement efforts, and participation in clinical and quality committees and projects as needed. Beacon focuses on the recruitment and hiring of staff that reflect specialty training in child/adolescent behavioral health, adult psychiatry, and addiction medicine. All Beacon UR Clinicians receive individual supervision from their respective clinical supervisor and weekly clinical and administrative group supervision from the Medical Director or designated Physician Advisor, in clinical rounds.

- Outpatient Team Clinicians are responsible for review of requests for outpatient services and monitoring provider performance through metrics and chart review
- Concurrent Review Team Clinicians are responsible for the medical necessity review and authorization of all acute and community-based diversionary levels of care and ensuring adequate discharge planning
- Prior Authorization Clinicians are responsible for the medical necessity review and authorization of all initial (prior authorization) requests for acute and other identified behavioral health services including collaboration with primary care providers on level of care decisions. Prior Authorization Clinicians are available twenty-four (24) hours a day, seven (7) days a week, and 365 days a year and perform all the functions needed for emergent and urgent triage and referral
- After Care (Discharge) Clinicians ensure adequate disposition planning and timely access for follow-up appointments. They monitor and manage the reporting of after-care follow-up rates weekly

Clinical Case Managers - Intensive Case Management (ICM) Clinicians

The Clinical Case Managers – Intensive Case Management (ICM) Clinicians are licensed behavioral health clinicians with the following credentials: a Master's degree or higher in a

health-related field and licensure as a behavioral health professional; a BSN with licensure as a professional and three (3) years behavioral health clinical practice; or a licensed behavioral health clinician and/or nurse who holds a certification as a Case Manager. They are responsible for tracking and managing members identified for ICM who may be high risk, high utilizing, at significant clinical risk, or under-utilizing services. All Beacon Case Managers receive individual supervision from their respective clinical supervisor and weekly clinical and administrative group supervision from a Medical Director or designated Physician Advisor in clinical rounds. Depending on State specific mandates, ICM clinicians may or may not perform UM functions. Beacon complies with all State-specific mandates regarding whether or not CM staff are prohibited from performing UM for their caseload.

5. Describe proposed utilization management clinical standards, including the use of any nationally recognized evidence based practices.

Meridian Health Plan encourages the use of evidence-based clinical practice guidelines (CPGs) by our providers. Our Quality Improvement Committee (QIC) approves and adopts CPGs for prevention, diagnosis, and management of medical and behavioral health conditions. These guidelines are developed by the nationally-recognized Michigan Quality Improvement Consortium (MQIC) and correspond with well-accepted standards of care and clinical treatments for specific conditions. MQIC guidelines are reviewed and updated every two (2) years or sooner if necessary. Once approved by MQIC Medical Directors, the CPGs are sent to the National Guideline Clearinghouse (NGC) for inclusion on the US Department of Health and Human Services Agency for Healthcare Research and Quality. NGC prepares structured abstracts for consistency of guidelines on their website.

Meridian promotes implementation of these CPGs via dissemination among practitioners and uses numerous performance measures to provide feedback to achieve consistent and high quality health outcomes for our members.

For a complete list of these guidelines please go to:
<http://www.mhplan.com/ia/providers/index.php?location=provider&page=cpgs>

Meridian allows members to seek a second opinion when there is a question regarding the diagnosis or options for surgery or other treatment options for medical conditions when requested by a member, parent, and/or legally appointed representative (in accordance with 42 CFR 438.206(b)(3)). The second opinion is conducted by a contracted qualified health care professional or a non-contracted health professional if a contracted professional is not available. No cost sharing or patient liability, including charges for missed appointments, is permitted by Meridian, providers, or subcontractors for covered services except those allowable under the law and as described in Section 5.

Beacon Health Options' behavioral health clinical standards and practice guidelines are used in collaboration with providers to help guide appropriate and clinically-effective care for a variety of complex behavioral health conditions. These guidelines represent standards of best practice for treating such complex conditions and are references for Utilization Review Clinicians and Physician Advisors during clinical reviews to ensure effective care delivery. Below is a comprehensive list of our behavioral health guidelines:

| Guideline and Source | Guideline and Source |
|---|---|
| Acute Stress Disorder and Post-traumatic Stress Disorder from the APA | Assessing and Treating Suicidal Behaviors from the APA |
| Attention Deficit/Hyperactivity Disorder for Children and Adolescents from the American Academy of Child and Adolescent Psychiatry | Generalized Anxiety Disorder from the Canadian Psychiatric Association Anxiety Guidelines with Annotation Page |
| Autism Spectrum Disorder (ASD) developed internally | Co-Occurring Disorders developed internally |
| Eating Disorder from the APA | Bipolar Disorder from the APA |
| Schizophrenia Guideline Watch from the APA with annotation | Opioid-Related Disorders from the SAMHSA Guideline – Tip 43 |
| Schizophrenia from the APA with annotation | Major Depression from the APA |
| Treating Substance Use Disorders from the APA | Transcranial Magnetic Stimulation (TMS) developed internally |
| Suboxone Treatment Guideline from SAMHSA | Treating Panic Disorder from the APA |

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.

Meridian Health Plan applies written criteria based on sound clinical evidence to evaluate the necessity of medical services by healthcare professionals with expertise in treating the member’s condition or disease and provide that Meridian shall consult with the provider requesting such authorization when appropriate. Meridian takes the individual circumstances and the local delivery system into account when determining the medical appropriateness of services. Meridian’s clinical staff utilizes decision-making criteria that are objective and based on medical evidence. Medical review criteria applicable to making utilization management decisions of requested services are developed nationally as well as internally by Meridian. The specific criteria utilized in Utilization Management (UM) decision making are available upon request to members and providers. Meridian’s medical policies are available online. The Meridian Medical Policy Committee (MPC), comprised of Meridian Medical Directors and the Compliance Analyst, meets at least monthly to review opportunities for new medical policies and update existing medical policies. All denial letters sent to members and providers include information on the criteria used in the decision and how to obtain a copy of the criteria. Annually, Meridian conducts Inter-Rater Reliability testing to evaluate the consistency with which reviewers (nursing staff and Medical Directors) involved in UM decision-making apply criteria and then act on opportunities for improvement where applicable.

Services that for which prior authorization is required include:

- Ambulance Transportation (Non-Emergent)
- Anesthesia when Performed with Radiology Testing
- Bariatric Surgery
- Cardiac/Pulmonary Rehab
- Chiropractic Services (over twelve (12) visits)
- Cosmetic, Reconstructive, or Plastic Surgery

- Durable Medical Equipment, Prosthetic Devices Medical Supplies > \$1,000 (e.g. augmentative enteral feeding device, enteral pump, communication devices)
- Elective Hospital Outpatient Surgery
- Elective Inpatient Admissions/Surgeries
- Family Planning Services
- Sterilization
- Genetic Testing
- Hearing Aids
- Home Health Care/Hospice/Infusion Therapy Services
- Pain Management
- Pregnancy Termination
- Specialty Drugs (covered under medical benefit) – e.g. Rituxun and Remicaide
- Speech, Occupational, and Physical Therapy (Evaluation does not require Prior Authorization)
- Weight Management (prior to Bariatric Surgery)

Services that require Behavioral Health Prior Authorization (with the exception of Iowa Department of Public Health-funded substance use disorder services):

- All inpatient higher level of care
- Partial hospitalization
- Residential treatment
- Intensive outpatient for this program

In accordance with 42 CFR 438.208(c) and 42 CFR 438.206(b)(2), services for which Meridian provides a standing referral include:

- Special Needs
- Women's Health

Services for which prior authorization is not required include, but are not limited to, the following:

- Emergency and Post-Stabilization Care Services (in accordance with 42 CFR 422.113), regardless of whether these services are provided by a contract or non-contract provider
- EPSDT Screening Services
- Behavioral Health Services
- Hospital Stays for Newborns and Mothers (in accordance with Newborn and Mothers Health Protection Act (NMHPA) of 1996), for up to forty-eight (48) hours following a normal vaginal delivery or for up to ninety-six (96) following a cesarean section

7. Describe your prior authorization request tracking system.

Meridian Health Plan's proprietary Managed Care System (MCS) functionality provides Meridian with a nearly paperless authorization process. Upon receipt of an authorization request, the referrals are entered directly into MCS. When a prior authorization is requested, all of the notes are electronically signed by the clinical staff with the appropriate designation. Meridian

provides prior authorization numbers to the requesting provider in addition to all information relevant to that specific authorization. This information includes, but is not limited to, name, contact number and credentials of the Meridian employees working on the authorization, the date and time of all transactions, and the cumulative time for determination. All determination information is collected in reportable fields in Meridian's proprietary MCS.

Associated clinical information is attached to the authorization record and the referral is forwarded to the appropriate Utilization Management (UM) staff for processing. All clinical review and final determinations are documented on the authorization record in MCS. Authorization determination notifications are generated and faxed electronically using MCS. This nearly paperless authorization process reduces time spent on faxes and phone calls between provider offices and Meridian. As a result, members avoid unnecessary delays in receiving needed care.

Members also receive a determination letter via US Mail. All written materials provided to members will be provided in English and Spanish and any additional prevalent languages identified at the time of enrollment. Per CFR 438.204, the State will provide Meridian the primary language of each member. In accordance with 42 CFR 438.210, Meridian will notify members of standard authorization decisions as required by the member's health condition, not to exceed seven (7) calendar days after the request for services. If the member or provider requests an extension or if a justified need for more information is submitted, an extension of up to fourteen (14) calendar days will be utilized. Meridian Health Plan recognizes that if there is a failure to respond within the seven (7) calendar days of receiving all necessary documentation, the authorization is deemed to be granted and the member and provider will be notified as such.

In the event of an expedited authorization request, Meridian shall respond to the prior authorization request within three (3) business days of receiving all necessary documentation. If a member requests an extension or if Meridian justifies a need for additional information, an extension of up to fourteen (14) calendar days may be granted. Meridian Health Plan recognizes that if there is a failure to respond within the three (3) calendar days or fourteen (14) calendar days, the authorization is approved and all parties notified.

Meridian will notify members in writing of decisions to terminate, suspend or reduce previously authorized covered services at least ten (10) calendar days before the date of action. If denial is based upon probable fraud (as detailed at 42 CFR 431.214), timeframe may be shortened to five (5) days advance notice. Meridian will notify the member no later than the date of the action under any of the exceptions from advance notice detailed at 42 CFR 431.213.

In the event of a denial of payment, in accordance with CFR 438.404(c)(2), Meridian shall give notice on the date of action. Included in this notice is the name and title of the caller, the date and time of the call, and the rationale for the denial. Following the call notification, a determination letter is sent via US Mail.

Meridian, Beacon Health Options' (Beacon) and Independent Living Systems (ILS) authorization tracking systems will be integrated. All behavioral health utilization management and care management activity will be documented in Beacon's web-enabled clinical care module and these transactions will be shared with Meridian for seamless coordinated care. Beacon's system is a fully integrated information technology platform that was specifically built to manage behavioral health services from initial eligibility through utilization/care management, claims administration,

and reporting. Providers can access the system to execute an array of administrative and clinical tasks including requesting and obtaining prior authorizations through our provider web portal.

The behavioral health clinical care module offers clinicians an enterprise-wide collaborative treatment planning and behavioral health record environment. Accessible twenty-four (24) hours a day, seven (7) days a week by our clinical staff, this system enables our clinicians to identify, authorize, and manage the delivery of the most appropriate, high quality mental health and substance abuse service for individuals—from initial point of entry through discharge. Whether information is submitted via phone, fax, or provider web portal, all clinical data provided, as well as the rationale for decisions rendered, are recorded in our clinical care module and become an integral part of the individual’s electronic record. It assigns a unique number to each authorization with information included in an authorization header file and an authorization detail file.

8. Provide sample notices of action as described in Section 11.2.7.

Meridian’s Managed Care System (MCS) displays when notices of action are sent. Following are samples of these MCS screens.





Attachment 36 (Sample Notices of Action) is provided in Tab

- 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.**

Meridian Health Plan does not elect to do this

- 10. Describe your program for ongoing training regarding interpretation and application of the utilization management guidelines.**

Our medical and behavioral health utilization management guidelines and policies are used during clinical case reviews to determine the treatment for individuals, identify issues for further review, and as teaching tools for staff and provider education. Our clinical staff references these guidelines and policies with providers during reviews, especially those focusing on complex or outlier situations. Fidelity to guidelines and ongoing training needs regarding interpretation and application of the guidelines are measured in multiple ways for both our clinical staff and network providers.

The Utilization Management (UM) Department is administering the Inter-Rater Reliability Test (IRR) to the physicians and nurses on a quarterly basis. InterQual® tips will be shared with clinical staff on a weekly basis via email, with discussion and case presentation of that specific information during the morning huddle calls. At the monthly staff meetings, a summary will be

discussed. Re-training will also be a focus at the monthly staff meetings for all clinical disciplines. The UM Department employs two (2) Nurse Educators that oversee the clinical training of all licensed employees. They conduct hands-on/classroom training, online modules, and weekly written testing for a minimum of six (6) weeks. The Nurse Educators also work with our Auditing and Remediation Team to conduct clinical audits and develop training modules based on those results. Both Nurse Educators are McKesson Certified InterQual® trainers. Meridian will have two (2) Utilization Management Trainers to implement the developed training curriculum for non-clinical staff. Therefore, two (2) clinical and two (2) non-clinical trainers will support the team. The auditing and remediation model will apply to this group also. Finally, in conjunction with the Corporate Training Department, UM will continue to partner with them to train, implement, and evaluate new corporate initiatives applicable to our team.

Additionally, all network providers receive a copy of our UM requirements through several sources, including our provider manual, the provider section of our website, annual reminders sent to providers, and site visits to high-volume providers. They are also included as part of our ongoing provider training curriculum. Our providers are held accountable for these through regular clinical reviews and quality audits.

SECTION 12 – PROGRAM INTEGRITY

Please explain how you propose to execute Section 12 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

A premier Medicaid managed care plan, Meridian Health Plan has pertinent experience in developing and maintaining program integrity safeguards. In Meridian will utilize established policies and procedures, as well as those outlined in the Iowa High Quality Healthcare Initiative (IHQHI) to protect against the potential for breaches in program integrity. These protections will include, but are not limited to, reports of suspected fraud and abuse by employees, subcontractors, providers, and others whom Meridian may do business with to fulfill the obligations of the IHQHI. Meridian will provide the State with our policies and procedures on handling issues of suspected fraud and implement the policies and procedures as written. Meridian will fully cooperate with the State's program integrity contractor in providing data, participating in ongoing communication and collaborating with both members and providers regarding program integrity issues that may impact these groups.

In accordance with 42 CFR 438.608 and 42 CFR 455, Meridian will further develop its current administrative procedures to align its program with the program integrity standards set forth in the in the IHQHI. This procedural manual will include in detail the manner in which Meridian will continue to detect fraud and abuse. Meridian's program integrity plan will be updated annually and submitted to the State for review and approval.

Meridian has included with this bid proposal a draft version of our current program integrity plan. An official draft will be submitted to the State within thirty (30) days, should Meridian be successful in obtaining a contract. The final plan, which will include any changes requested by the State, will be submitted to the State within thirty (30) days after the first submission of the plan. Any changes made to Meridian's program integrity plan will be approved by the State and updated to maintain a current version of the plan. Meridian will submit a Program Integrity activity report to the State on a monthly basis to outline Meridian's progress in attaining program integrity-related goals and objectives. The report will also include any and all of Meridian's program integrity activities and findings that may arise throughout the duration of the contract. Meridian will also include in this monthly activity report all recoupment totals for the reporting period.

A draft Program Integrity Plan is provided as Attachment 37 (Corporate Compliance and Fraud, Waste and Abuse Program) in Tab 5. Meridian's Program Integrity Plan will include the following components:

- Written policies, procedures and standards of conduct that articulate Meridian's commitment to comply with all applicable State and Federal standards. Meridian will incorporate all current and future CMS guidance, into our written policies and procedures and training materials
- Meridian will provide necessary data systems, resources, and staff to perform the fraud, abuse and other compliance responsibilities including, but not limited to, running; algorithms on claims, data analytics, predictive analytics, trending claims behavior, and provider and member profiling
- Meridian will designate a Compliance Officer and a Compliance Committee that is accountable to senior management. The Compliance Officer will meet with State audit and investigations representatives at the frequency required by the State
- Meridian will provide annual training for the Compliance Officer and all employees who will be provided to detect fraud. Training will address the False Claims Act, as directed by CMS;
- Meridian will ensure effective lines of communication between the Compliance Officer and the organization's employee are maintained

- Meridian will ensure the enforcement of standards through well-publicized disciplinary guidelines
- Meridian will provide for internal monitoring and auditing
- Meridian will provide for prompt responses to detected offenses, and for development of corrective action initiatives
- Meridian will develop and maintain written standards for organizational conduct
- Meridian will provide information on fraud and abuse identification and reporting in provider and member materials
- Meridian will establish program integrity-related goals, objectives and planned activities for the upcoming year
- Meridian will maintain compliance with 42 CFR 455 including timeframes for implementing and completion
- Meridian will coordinate with the State Program Integrity Contractor to remove incarcerated, deceased or incorrectly enrolled members or providers

Reporting Fraud and Abuse

Meridian will report possible fraud or abuse activity to the State. As demonstrated in our ability to combat fraud and abuse activity in the markets of our affiliated plans, Meridian will initiate an immediate investigation to gather facts regarding the possibility of fraud or abuse. Meridian will deliver, within two (2) days, the identification of suspected fraud or abuse activity to the State. Meridian will provide reports of its investigative, corrective, and legal activities with respect to fraud and abuse to the State in accordance with contractual and regulatory requirements. Meridian and its subcontractors will cooperate fully in any state reviews or investigations and in any subsequent legal action. Meridian will implement corrective actions in instances of fraud and abuse detected by the State, or other authorized agencies or entities. Meridian will report to the State all required information in the timeframe and manner required by the State as outlined in the Iowa High Quality Healthcare Initiative (IHQHI).

Coordination of Program Integrity Efforts

Meridian will coordinate any and all program integrity efforts with IME personnel, DPH personnel and Iowa's Medicaid Fraud Control Unit (MFCU), located within the Iowa Department of Inspections and Appeals.

Meridian, will at minimum:

- Meet monthly and as required with the State Program Integrity Unit, DPH staff, and MFCU staff
- Provide any and all documentation or information upon request to the State, the MFCU, HHS-OIG or the US Department of Justice related to any aspect of the Contract, including, but not limited to, policies, procedures, subcontracts, provider agreements, claims data, encounter data, provider records and report on recoupment actions and receivables
- Report within two (2) working days to the State Program Integrity and MFCU and any appropriate legal authorities any evidence indicating the possibility of fraud and abuse by any member of the provider network
- Provide the State and MFCU with an annual update of investigative activity, including corrective actions taken
- Hire and maintain a staff person in the Iowa offices whose duties shall be composed at least ninety percent (90%) of the time in the oversight and management of the program integrity efforts

required under the Contract. The Program Integrity Manager's duties shall include, but not be limited to:

- Oversight of the program integrity function under the Contract
- Liaison with the IME in all matters regarding program integrity
- Development and operations of a fraud control program within the Meridian claims payment system
- Liaison with Iowa's MFCU and/or the Office of the Attorney General
- Assure coordination of efforts with the State and other agencies with regards to program integrity issues
- Coordinate PI activities with other plans as directed by the State

Verification of Services Provided

Meridian actively monitors for FWA through verification of services by sending a predetermined number of Explanation of Benefit (EOB) letters to members based on the number of paid claims from the preceding month. The EOB letters instruct the member to confirm whether or not the service was actually provided. Returned forms are then processed and investigations opened if there are discrepancies between the claims data and the member's response. Meridian is also currently implementing a process to verify all in and out-of-network providers against the Social Security Death Master to prevent use of deceased providers' billing information.

Obligation to Suspend Payments to Providers

Meridian will comply with 42 CFR 455.23 by suspending all payments to a provider after the State determines that there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the State or law enforcement (included but not limited to the MFCU) has identified in writing good cause for not suspending payments or to suspend payments only in part.

Meridian will issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 CFR 455.23(b) and maintain the suspension for the durational period set forth in 42 CFR 455.23(c). In addition, the notice of payment suspension will state that payments are being withheld in accordance with 42 CFR 455.23. Meridian will not suspend payments until consulting first with the MFCU and secondly the State. Meridian will maintain all materials related to payment suspensions for a minimum of five (5) years in compliance with the obligations set forth in 42 CFR 455.23(g).

Meridian will also adhere to the following requirements:

- Meridian will afford a grievance process to providers for whom payments have been suspended by Meridian in accordance with 42 CFR 455.23
- Meridian will maintain policies and procedures to ensure that providers comply with Iowa Code 249A Subchapter II – Program Integrity including, but not limited to, application of interest related to provider overpayments
- Meridian will work with the State to develop a process for referral of providers to the State for Sanction under 441 IAC 79.2
- Meridian understand that it is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claim upon with the withhold or recoupment are based meet one or more of the following criteria:

- The improperly paid funds have already been recovered by the state of Iowa directly or through resolution of a state or Federal investigation, and or lawsuit, including, but not limited to, false claims act cases
- The funds have already been recovered by the Recovery Audit Contractor (RAC)
- When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the state of Iowa, are the subject of pending Federal or state litigation or investigation, or are being audited by the Iowa RAC

Meridian will consult with the State Program Integrity Unit before initiating any recoupment or withhold of any program integrity related funds to ensure that the recoupment or withhold is permissible. In the event that Meridian obtains funds in cases where recoupment or withhold is prohibited under this section, Meridian will return the funds to the provider.

Required Provider Ownership and Control Disclosures

Meridian will comply with all aspects of 42 CFR §§455.104, 105 and 106 as required by Federal law.

Reporting Obligations for Adverse Actions Taken on Provider Applications for Program Integrity Reasons 42 CFR §455.1002.3

Meridian will implement in its provider enrollment processes the obligation of providers to disclose the identity of any person described in 42 CFR § 1001.1001(a)(1). Meridian will forward such disclosures to the State. Meridian will abide by any direction provided on whether or not to permit the applicant to be a provider in the Iowa network. Meridian will not permit the provider into the provider network if the State or Meridian determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or CHIP, or if the State or the Meridian determines that the provider did not fully and accurately make any disclosure required pursuant to 42 CFR § 1001.1001(a)(1).

Termination of Providers

Meridian will comply with all requirements for provider disenrollment and termination as required by 42 CFR §455.416.

Enforcement of Iowa Medicaid Program Rules

Meridian will vigorously pursue fraud, waste and abuse in the Medicaid Program and notify the State Program Integrity Contractor of any provider activity which would incur a sanction under 441 IAC 79.2(249A).

1. Describe your procedures for avoiding, detecting, and reporting suspected fraud and abuse to the State.

Meridian Health Plan will conduct, at minimum, the following fraud and abuse activities:

- Meridian will regularly review and audit our operations to guard against fraud and abuse including the incorporation of Correct Coding Initiative editing in the Meridian claims adjudication process:

- Meridian maintains contracts with third party entities to conduct (1) medical necessity and/or appropriateness reviews (2) outpatient Diagnosis-Related Group (DRG) auditing and (3) inpatient code auditing. To bolster our efforts, Meridian recently implemented a pre-pay and post-pay program which specializes in the application of edits and flags designed to detect possible FWA. Since going live in February, all of Meridian's Iowa claims are sent to an outside vendor to be scrubbed and compared to peers within Meridian's provider panel as well as claims data of other carriers in Iowa.
- Meridian will assess and strengthen internal controls to ensure claims are submitted and paid properly:
 - In close collaboration with the IT Department and Meridian's Compliance Officer, Meridian has developed point-of-sale (POS) edits for both medical and pharmaceutical claims. POS edits allow Meridian to proactively deny the payment of fraudulent claims and monitor for fraudulent trends and activity. Meridian's proprietary Managed Care System (MCS) has the capability to run real-time, customized reports on medical utilization, prior authorization, and paid claims review. Meridian's Compliance Officer and designated staff work closely with the Finance and Claims Departments to create dashboards and customized reporting on a quarterly, annual and ad-hoc basis. Meridian is dedicated to assisting State and Federal law enforcement by creating customized reporting as needed to assist in determining allegations of fraud, waste and abuse.
- Educating employees, network providers, and members about fraud and abuse and how to report it:
 - The Compliance Officer oversees FWA and Compliance training for all employees. Employees receive copies of all FWA policies and procedures and undergo training within the first three days of employment regarding 42 CFR § 455, definitions, examples of FWA, FWA's severe societal implications, applicable State and Federal laws, prevention and detection methods, and required reporting. Employees also undergo a mandatory refresher course in FWA and Compliance on an annual basis. The Compliance Officer disseminates employee handbooks, newsletters, and notifications to educate employees regarding FWA and Compliance and to provide ongoing education, establish open lines of communication, encourage reporting, and convey well-publicized disciplinary guidelines. Meridian's Compliance Officer makes appearances at department meetings when the opportunity for continued education arises and upon request. Meridian's members and providers receive information regarding FWA through handbooks, manuals, and semi-annual newsletters cultivating network knowledge and awareness of FWA and encouraging prompt reporting of instances of suspected non-compliance with State, Federal and Agency guidelines. Information in the form of provider notices, updates, policy changes, provider resources, and contact information are also available on Meridian's website.
- Meridian will establish and maintain policies and procedures to attest the accuracy, completeness and truthfulness of claims and payment data in accordance with 42 CFR 457.950(a)(2):
 - Meridian also actively monitors for FWA through verification of services by sending a predetermined number of Explanation of Benefit (EOB) letters to members based on the number of paid claims from the preceding month. The EOB letters instruct the

member to confirm whether or not the service was actually provided. Returned forms are then processed and investigations opened if there are discrepancies between the claims data and the member's response. Meridian is also currently implementing a process to verify all in and out-of-network providers against the Social Security Death Master to prevent use of deceased providers' billing information.

- Meridian will ensure effective organizational resources will respond to complaints of fraud and abuse:
 - Meridian's Compliance Officer will appoint staff to sit on both the Grievance Committee and the Appeals Committee to represent the Program Integrity division. Both Committees meet quarterly and staff reviews all grievances and all appeals in an attempt to detect potentially fraudulent activity.
- Meridian has and will maintain procedures to process fraud and abuse complaints:
 - Meridian has established both a Grievance, and Appeals, Committee to address fraud and abuse complaints. Committee members meet quarterly and staff reviews all grievances and all appeals in an attempt to detect potentially fraudulent activity. Representatives designated by the Compliance officer can request additional information or actions from any departments involved in the grievance and appeal process. These staff members analyze the grievance and appeal data on a quarterly and rolling twelve (12) month basis to detect trends. If trends are detected and fraudulent activity is suspected, staff immediately notifies the Compliance Officer and initiate a preliminary investigation. Any complaints of physical or sexual abuse by a network provider we be immediately reported to the State in accordance with contractual requirements. Meridian will collaborate with State and Federal officials regarding cases of patient abuse and neglect.
- Meridian will maintain procedures for reporting information to the State in a format and timeframe designated by the State:
 - Meridian will also coordinate and collaborate with IME personnel, DPH personnel, the Iowa Medicaid Fraud Control Unit, and other plans as directed to enhance its own FWA prevention and detection activities. To facilitate this communication, and successful implementation of Iowa program integrity requirements, Meridian will maintain a full-time Program Integrity Manager at its Iowa offices to monitor and implement the program integrity program and liaison with state agencies. This individual will also be responsible for reporting information to the State as requested with the timeframe as designated by the State.
 - Meridian will report all possible fraud or abuse activity to DHS within two (2) days of identification, following a preliminary investigation. Its report will include the results of the preliminary investigation. Meridian will additionally fulfill its routine FWA reporting obligations, including reports of the number of complaints of fraud and abuse made to DHS warranting preliminary investigation, and for each such complaint the name and ID number of the affected member or provider, the source of the complaint, the nature of the complaint, the approximate dollars involved, and the final disposition of the investigation.
- Meridian will maintain procedures to monitor utilization/service patterns of providers, subcontractors, and members including, but not limited to, running algorithms on claims, predictive analytics, and trending claims behavior and recover improper payments identified by this monitoring;:

- FWA investigations are triggered by reports from a variety of sources, including State Program Integrity staff, Meridian employees such as Provider Services field representatives, and Meridian members and providers. Once a report or lead is received from any source, FWA Investigator responsibilities include data analysis of suspect claims and other information, conducting investigations, and coordinating with expert staff (including Meridian coders and Medical Management) to properly identify and address potential FWA. All reports are preliminarily reviewed and tracked on an FWA Case Tracker that reports the progress of all open reports and investigations. Preliminary investigations are performed by an FWA Investigator who reports any findings to the Associate General Counsel and/or Compliance Officer. Either the Associate General Counsel, Compliance Officer, or FWA Committee may instigate a full investigation based on the preliminary findings, or may decide to close the investigation if there is no indication of FWA. In the event of a full investigation, the Associate General Counsel, Compliance Officer, and FWA Investigator(s) engage with leadership staff in Meridian's Provider Services, Care Management, Medical Management, Claims, and other departments as necessary to complete the investigation. Investigations include detailed reviews of claims data, medical records, and other information supplied by providers or other sources.
- Meridian will continue to develop data mining techniques and conduct on-site audits to ensure program integrity and recovering improper payments as identified by data mining and onsite audits:
 - Meridian's FWA detection methods include innovative report-running capabilities, grievance and appeal data, analysis of pharmaceutical desk and onsite audit data, credentialing and re-credentialing, and referrals from trained employees, members, providers, and other community members.
- Meridian will develop and maintain written policies for all employees, including management, and for all employees of any subcontractor or agent, that provide detailed information about:
 - The Federal False Claims Act
 - Administrative remedies for false claims and statements
 - Any State laws pertaining to civil or criminal penalties for false claims and statements
 - Whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs; and (v) Meridian's policies and procedures for detecting and preventing fraud, waste, and abuse

2. Provide examples of outcomes achieved in other states regarding program integrity efforts.

Meridian Health Plan reviews and analyzes data contained in reports to monitor physician utilization patterns and reviews medical records to ensure quality. One report, "Evaluation and Management (E/M) Billing," includes only the primary care providers (PCPs) in Meridian's network of physicians. Certain reports, including Narcotic Prescribing and General Prescribing, include all physicians, both in-network and out-of-network, writing prescriptions for Meridian members.

While the program integrity efforts aforementioned describe the day-to-day activities of the FWA team, below are specific examples of high profile achievements that directly resulted from our FWA efforts:

Inappropriate Treatment by PCP

Situation:

Meridian identified an urgent care physician who was inappropriately treating members as a primary care provider; consistently up-coding by two (2) to three (3) levels, over-prescribing controlled substances, routinely prescribing the combination of pharmaceuticals known as “the cocktail” (i.e., Vicodin, Soma, and Xanax) and charging members cash for services. It was also brought to our attention that this provider encouraged patients to visit a near-by pharmacy and have them pay cash for their prescription fills. The urgent care physician also employed a security guard to keep order among the patients that lined up outside of his/her clinic every day prior to regular business hours. Patients would travel over 100 miles to see this urgent care physician.

Investigation:

As part of the investigation, Meridian requested and reviewed the member’s Medical records, in addition to the urgent care physician’s prescribing profile by Therapeutic Class. Meridian also completed member surveys on a selected number of members who received services from the provider in question. The survey asked questions pertaining to the overall quality of the provider, how they heard about the provider, if members lived far away, and why they had traveled to see this provider. Meridian also inquired about whether or not this provider ever referred them to their PCP or a specialist for further pain management, how long they would typically spend face-to-face with the provider or his/her assistant, and if the physician or his/her staff ever required the member to pay for services at his office.

Once the medical records were reviewed and the surveys were completed, a peer-to-peer occurred between the urgent care physician and Meridian’s Medical Director to address concerns about the narcotic-seeking patients and why this clinic treated patients on an on-going basis rather than having them see their own PCP. In addition, Meridian suggested that the provider be listed as a PCP if he desires to practice that way. The provider informed Meridian that he/she did not want to be listed as a PCP because the reimbursement was better as an urgent care physician, and he/she had no interest in becoming a PCP office with the attendant overhead.

Resolution:

Based on the investigation findings, this provider and the Urgent Care Clinic were referred to the Drug Enforcement Agency (DEA), Medicaid Integrity Program Section (MIPS), Department of Human Services Office of Inspector General (DHS OIG), and the Federal Bureau of Investigation (FBI). This provider was also terminated from Meridian’s network without cause.

Inappropriate Claims Submissions

In another account, Meridian identified inappropriately billed claims from a hospital. Meridian determined that on twenty (20) separate occasions, the facility unbundled routine supplies found in the floor stock that were not supported by a physician order. These unsupported supplies would be made available to all patients receiving supplies in that location. The facility also unbundled patient monitoring and nursing services that are included in the facility's daily room and board charge (i.e. daily ventilator charge, daily oxygen, Ballard set-ups, mouthwash).

Meridian also found that the facility was billing for non-covered experimental or investigational services. These services included the use of Antithrombin (Thrombate), Precedex, and Rx-Sildenafil (Viagra) two (2) mg/ml SU two point eight (2.8) mg in pediatric patients, CentriMag for Biventricular Support and related ancillary services for over six (6) hours, use of Nitric Oxide (iNO) in premature neonates born at less than or equal to thirty-four (34) weeks of gestation, and treatment with NovoSeven RT when there was no indication that the patient was diagnosed with any of the listed conditions that are treated by NovoSeven. The facility also submitted numerous charges for the treatment of hospital acquired conditions (HAI), did not always use the lowest packaged amount available of a drug (i.e. Lasix 100mg, KCL forty (40) meg and Water for Injection 1,000cc used on a neonate), and in some instances were using drugs for off-label purposes.

Meridian notified the State of Michigan about concerns with the facility using iNO in premature neonates. Discussion surrounding a policy ensued and in March 2014. Meridian implemented a policy that defined the use of iNO as investigational in all instances, including, but not limited to, adults and children with acute hypoxemic respiratory failure or for premature neonates born at less than or equal to thirty-four (34) weeks of gestation, as medically necessary to administer iNO as a component of treatment for hypoxic respiratory failure in neonates born at thirty-four (34) or more weeks of gestation.

Appropriate Use of Evaluation and Management Service Codes

Meridian recently embarked on a large project related to medical necessity of evaluation and management services (E/M Services). Meridian also reviewed multiple E/M services associated with the same providers and beneficiaries to determine the extent to which electronic or paper medical records had documentation vulnerabilities.

Meridian requested medical records from 120 providers who billed a higher than average percentage of E/M codes 99214, 99215, 99204 and/or 99205 office visits. Upon review of the medical records, Meridian notified the providers of the results, which included a summary of issues found, the level of the visit that the documentation provided had supported, and a letter inviting the provider to submit additional documentation to warrant the level of service billed. If the provider was unable to provide additional documentation, Meridian proceeded with recoupment. Providers were notified of the opportunity to rebill Meridian with the appropriate level of service and receive payment for the corrected claim.

Meridian's goal in performing audits is primarily educational. Many times, the correction of one (1) or two (2) recurring errors can change audit scores dramatically. Providers selected for audits generally are billing disproportionately higher levels of service than their peers, and the audit is

intended to be used as a tool to increase the provider's knowledge base on a subject that is often confusing and frustrating.

Identifying Outlier Utilization Trends

Appropriate Utilization of services is critical to uphold program integrity. Meridian demonstrated this commitment to program by identifying a provider who appeared as an outlier on several utilization reports. In particular, this provider was investigated for fraud, waste and abuse as it related to up-coding, over-prescribing narcotics, over-prescribing non-narcotics, and overutilization of trigger point injections. Meridian reviewed this provider's billing, prescribing, and utilization patterns.

In regards to billing, Meridian found that eighty-nine percent (89%) of new patient E/M visits were billed using high-level codes (99204 and 99205) and eighty-eight percent (88%) of established patient E/M visits were billed using high-level codes (99214 and 99215). This made the provider the second highest and highest utilizer, respectively, in 2009 when compared to Meridian's network of primary care providers. Meridian used the Current Procedural Terminology (CPT) 2010 codebook put forth by the American Medical Association (AMA) to analyze these patterns. Our results showed that this provider was spending more hours with patients than his clinic hours allowed.

When compared with all physicians, the physician in question, a provider certified in Family Practice and Osteopathic Manipulative Treatment (OMT), presented as the second highest prescriber of narcotic medication with a total of 186 narcotic prescriptions in a single month. This provider also had the highest number of prescriptions (all medications included) per utilizer (5.42 prescriptions per utilizer) for the same time period.

Upon looking further into the billing patterns, Meridian discovered that this provider had accounted for seventy-five percent (75%) of the trigger point injections administered to Meridian members, billing 210 trigger point injections over a twelve (12) month period. The second highest utilizer of trigger point injections billed for twelve (12) services during the same period. This data compared the provider's billing of trigger point injections with that of all physicians, both in-network and out-of-network, who billed for the service during the twelve (12) month period in review.

After a thorough review of medical records submitted, Meridian educated this provider on their practices through a face-to-face meeting with a Meridian Medical Director, several phone conversations, and literature, which included "*Responsible Opioid Prescribing: A Guide for Michigan Physicians*". It was determined that the education should be followed up with a utilization review, as well as a chart review, three (3) months from the date of the peer-to-peer. The findings from the follow-up showed that this provider continued to up-code, over-prescribe, and over-utilize trigger point injections.

As a result, Meridian terminated this provider from the network with cause and referred them to the Medicaid Integrity Program Section (MIPS). Meridian's referral resulted in a subpoena from the State of Michigan to testify.

3. Describe methods for educating employees, network providers and members on fraud and abuse identification and reporting.

Meridian Health Plan firmly believes that the best way to prevent fraud, waste and abuse (FWA) and non-compliance is through training and education, constant auditing and monitoring, establishing candid, open lines of communication, strong point-of-sale prevention measures, and correcting non-compliant behavior in members. To prevent FWA, Meridian has implemented and maintained comprehensive internal and external auditing measures, and interdepartmental communication about fraud, waste, and abuse. Meridian also analyzes new areas of risk in an effort to develop innovative medical and pharmaceutical point-of-sale edits to prevent the payment of fraudulent claims.

The Compliance Officer is responsible for attending any training given by the State, administering training and education, developing comprehensive internal and external auditing measures, promoting interdepartmental communication about compliance and fraud, waste and abuse, and analyzing new areas of risk in an effort to develop innovative medical and pharmaceutical point-of-sale edits to prevent the payment of fraudulent claims.

Meridian's policies and procedures define a comprehensive FWA education program for employees and the provider network. A variety of materials containing information on Meridian's FWA program are reviewed by the Compliance Officer and distributed to employees on an annual basis, including the Meridian Employee Handbook, Code of Conduct, FWA Manual, and new employee FWA training materials.

Employees receive copies of all FWA policies and procedures and undergo training within the first three (3) days of employment. For existing employees, annual completion of a CMS FWA and Compliance Training module is administered through an Adobe Captivate module. Completion is mandatory for all employees and is tracked in Meridian's corporate Learning Management System (LMS) and completion reports can be generated at any time. Employees are also trained on how to submit an FWA referral through our proprietary Managed Care System (MCS). As part of Meridian's FWA awareness activities, a short video has been developed and is available to all Meridian employees through Meridian University, our company training and education intranet site. The video walks employees through examples of FWA, what the societal implications are, applicable state and Federal laws, prevention and detection methods, and how to refer suspected FWA through MCS. In addition, employees may anonymously report FWA through MCS or through a dedicated telephone hotline. Employees are made aware of these procedures through a number of materials provided on an annual basis, including a dedicated flyer posted throughout the offices containing contact information to report FWA either through internal mechanisms or directly to the State or the Office of the Inspector General.

All employees are bound by the Code of Conduct, which is provided to and signed by every employee at hire and thereafter on an annual basis. The Code of Conduct requires employees to conduct themselves in an honest and ethical manner, to avoid conflicts of interest, report instances of non-compliance (including suspected FWA), and comply with all laws and regulations. The Code of Conduct advises employees of Meridian's policy of non-retaliation for any reports of non-compliance and also advises employees that strict disciplinary action, up to and including termination, may be imposed for non-compliant behavior.

Meridian also provides FWA training to its provider network. Education is provided through peer-to-peer discussions, discussions with Meridian Provider Services Representatives, the use of

in-service and provider bulletins (disseminated via fax), provider handbooks, summary demonstrating findings from FWA claim audits specific to each provider, and Meridian's designated provider FWA website. The FWA website is a dedicated portal for providers to educate themselves on Meridian's FWA policies and to easily report any instances of suspected FWA.

Meridian's members are also provided information and education on FWA through Meridian's easy-to-navigate member FWA website, member handbook, which is provided upon enrollment and annually thereafter, and through semi-annual member newsletters. Meridian presents FWA information in a concise and readable manner in accordance with contract requirements. Members are provided with definitions and examples of fraud, waste, and abuse; they are reminded that reports to Meridian and to the State are encouraged and can be made anonymously; and they are provided with toll-free fraud hotlines, email addresses, and physical mailing addresses of both Meridian and the State to encourage members to report fraud, waste, and abuse when they encounter it. We also send members Explanations of Benefits (EOB). These EOBs are a way for members to alert Meridian about potential discrepancies in claim billing or prescribing.

4. Describe internal controls to ensure claims are submitted and payments are made properly.

Meridian Health Plan monitors its paid claims for activity that may suggest possible fraud, waste, and abuse. Specifically, Meridian monitors its claim reports for unusual billing patterns, such as large volumes of rare or unusual claims, disproportionate use of codes appropriate for higher than normal levels of service, and inappropriate services rendered for a given member's recorded diagnosis codes. Meridian's claim systems allow the placement of claim edits that will automatically deny and flag for review certain high-risk services or providers with histories of anomalous billing practices. In these circumstances, additional medical records may be requested to support the claim. Most such instances are simple errors on the part of the provider and are corrected upon re-billing; in some cases, a face-to-face meeting is held between the provider and a Meridian Medical Director to discuss coding and documentation practices. Suspicious cases are referred to Meridian's FWA staff for review and investigation.

Analytics Department Claims Mining

Working with our Claims and Provider Services Departments, Meridian's Analytics Department performs a multitude of claims mining activities, including the following:

- Code Watches – Meridian has identified a list of codes that have a high propensity for fraud. Each month, Meridian reviews State of Iowa claims to determine whether those codes are being billed to Meridian, and if so, looks deeper into the claim. Examples of these codes include: surgery add-ons, sleep studies for children, and chiropractic services. Specific codes include 78699, which is for diagnostic nuclear medicine, and the overuse of J codes for injectable pharmaceuticals administered in an outpatient setting. To further illustrate how we analyze utilization, our Actuary has reviewed durable medical equipment (DME) billing for repeat billing and unexpected utilization, with a particular focus on wheelchair, oxygen, and prosthetics claims. The Actuary is constantly updating the code watch list with information received from various healthcare organizations alerting Meridian to new codes to monitor.

- Provider and Hospital claims – In addition to the mining performed by other Meridian departments described above, Meridian’s Analytics Department constantly monitors provider and hospital billings with a focus on outlier billing (i.e. a provider or a hospital facility that bills something differently than others).
- Trend Analysis – Meridian’s Analytics Department watches for changes in billing behavior by a specific provider or hospital. For example, if a provider bills Meridian for something that is out of its normal billing habit, we look deeper into the claim, especially if there is no change in the member’s medical status. Review of claim history is also important in analyzing trends.

5. Describe methods for verifying whether services reimbursed were actually furnished to members as billed by providers.

Every month, Meridian Health Plan generates and mails a predetermined number of EOB letters in accordance with applicable regulatory and contractual requirements (i.e. five percent (5%) random selection of all eligible paid claims for the preceding quarter) to members based on the number of paid claims. The EOB letters instruct the member to confirm whether or not an identified service was actually provided. Returned forms are then processed and investigations are opened if there is a discrepancy between the claims data and the member’s response.

In addition to monthly EOB letters, Meridian’s FWA investigators regularly run reports to identify providers who appear to be an outlier when compared to their peers. Examples of what the reports identify are:

- Providers who bill a higher than average number of E/M visits than their peers
- Providers who bill members for home visits and office visits in the same year
- Providers who bill fifteen (15) or more members in a day
- Providers who bill in three (3) or more counties in a day
- Providers who bill six (6) or more hours in a day
- Providers who bill emergency anesthesia with non-emergent diagnosis

Based on these reports, FWA Investigators will request and review medical records to verify that the services provided were medically necessary.

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.

At their foundation, Meridian Health Plan's Information Technology (IT) systems are designed to support our members and provide the highest possible quality of care. Meridian's IT systems are an integrated, person-centric, highly-involved approach to member support, designed to provide every Meridian employee with the ability to provide unparalleled guidance and support to our members.

Meridian is very proud of its industry-leading technology solution, Managed Care System (MCS). In the world of managed health care, where innovative, proprietary technologies result in significant efficiencies and improved health outcomes, Meridian is consistently ranked best-in-class. The award-winning MCS allows us to do more – and better – with less.

Meridian's internal IT staff developed MCS as a means to support the unique needs of our varied customer base without a dependence on software vendors, unpredictable release schedules, and unreliable resource availability. MCS has allowed Meridian to effectively manage our growth and expansion into new service areas while continuing to support corporate operations.

MCS is accessible to all Meridian employees and functions as the single source of truth for all member, provider, administrative, financial, and care management data. Through a secure, online portal, applicable data and functions in MCS are also accessible to members and providers and can be made available to authorized representatives and other authorized clinical or non-clinical care providers. All of our departments work from the same system and, as a result, do not have to deal with issues such as data exchanges and data incongruence that often hinder non-integrated systems. MCS is a truly integrated, full-service system.

13.1 Information Services & System

- 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.**

Meridian Health Plan's Managed Care System (MCS) is used to manage a wide range of functionality designed to fully support Iowa program requirements, including: care coordination; utilization management; claims payment; service authorization; provider network management; credentialing; grievance and appeals processing; quality management; utilization management; and submission of encounter data.

See the following diagram for an in-depth representation of our fully integrated systems.



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Because our systems are proprietary, Meridian can quickly customize technology in-house, allowing us to respond with both speed and flexibility to diverse challenges. A five-time winner of *CIO Magazine's* CIO 100 Award (2007, 2008, 2010, 2012, and 2013), Meridian was also commended by the Michigan Association of Health Plans for using technology to improve member outreach (2009, 2010, and 2011).

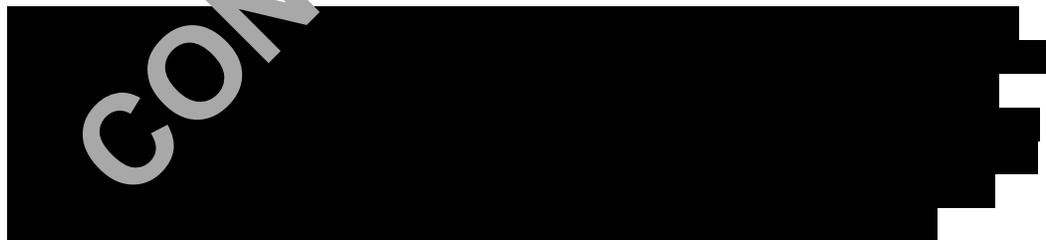
Meridian is large enough to make major investments in Information Technologies (IT), allowing us to adapt to the ever-evolving healthcare environment, yet small enough to provide truly individualized care to our members. Meridian will continue to tailor its systems and processes to meet the specific and varying needs of Iowa health care.

Meridian IT professionals have worked diligently to integrate and adapt our systems to support health initiatives in Iowa. All aspects of our systems have been reviewed and updated as necessary to meet the needs of our Iowa membership. Additionally, in anticipation of expected future membership growth in Iowa, we have not only reviewed and modified our system functionality, but also expanded and enhanced our system capacity and bandwidth so we can continue to provide unparalleled member service.

Meridian's fully integrated systems will support our Iowa members and State systems through the following areas of functionality:

- **Care Coordination** – Meridian's Care Coordination system uses evidenced-based interventions, data sharing and payment incentives to improve service delivery and engage members, families, and caregivers in healthcare decision-making for all physical, behavioral, and long term care needs. Our systems integrate encoded best practices, claims-based evidence, provider incentive systems and clinical data to ensure that we encourage and support superior member care, as reflected in our High Healthcare Effectiveness Data and Information Set (HEDIS®) rankings. This requires MCS to support collaboration across all of our systems, to maintain a central source of truth with complete, current, and accurate member data for every member.
- **Utilization Management** – Meridian is adept at data analysis, which we use to identify patterns and trends including those that may indicate inappropriate utilization (either under- or over-utilization). Analysis is also able to detect fraud, waste, and abuse among population groups, individual practitioners, practitioner groups, and facilities.

The Utilization Management Committee (UMC) and Quality Improvement Committee (QIC) compare Meridian data with national, regional, and other state health plan data. Comparisons are used to establish acceptable ranges of utilization performance.



The reports produced by our analytics team are used by our Medical Management, Utilization Management, Compliance, Provider Services, and Member Services Departments to identify inappropriate utilization. This information is invaluable when working with providers to plan the most appropriate care for our members. These provider-plan interactions have served as teaching moments to providers and are designed to return billing patterns to normal ranges. This monitoring of utilization data has also led to creative solutions to care challenges.

- **Claims Payment** – Meridian recognizes that claims payment is a significant factor in provider satisfaction and can affect member/provider interaction. Since we are a physician-operated and -owned organization, we prioritize developing and tuning our systems and processes to ensure they are reliable and do not detract from member care.

Since claims information feeds all of our other systems (Quality, Care Coordination, Member Services, Provider Network Management, Utilization Management, Finance, Compliance, etc.) and is the trigger for some of our most important work, Meridian makes it a priority to be fast and accurate with our claims processing.

See below for a diagram of Meridian’s MCS Claims Payment System.



Claims can be submitted via mail, fax, online through the Provider Portal, or directly using Electronic Data Interchange (EDI). Meridian accepts and processes claims electronically in HIPAA-standard formats. Meridian also interfaces directly with major clearinghouse vendors, such as Emdeon, Availity, Relay Health, Blue Cross Blue Shield, Networkes, and others. In addition, we actively exchange data electronically with each state in which we operate.

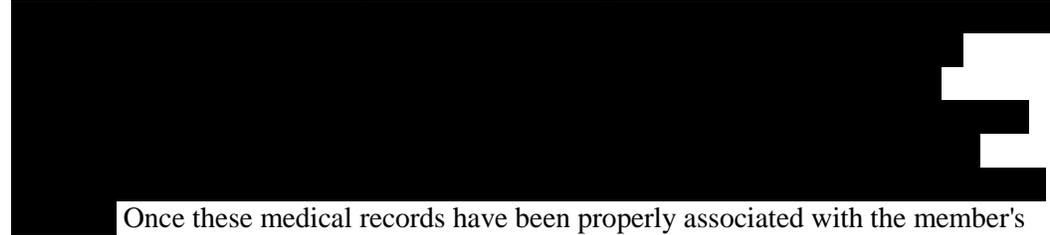
MCS applies edits to submitted claims – regardless of the way they are received – to identify errors or omissions in claim data. Edits can include, but are not limited to: checking for duplicate claim submissions; checking to see if the member has additional insurance; and making sure that the information submitted matches Current Procedural Terminology (CPT) codes, diagnosis codes, and member and provider information. Meridian is able to customize edits with just a few clicks using an interface within MCS. MCS has been updated to accept claims with ICD-10 codes as providers transition to this new code set.

The ability to quickly create claims edits allows Meridian to respond efficiently to any changes in benefits specified by the State or the Centers for Medicare and Medicaid Services (CMS). Claims Examiners review all claims that meet claims edit criteria. Once claims have gone through data validation and an examiner's review (where applicable), the claim is processed for payment. All information concerning claims is updated in real-time and posted to Meridian's online Provider Portal so providers can view the status of their claims. Finally, providers receive a detailed remittance that outlines the detail of all claims paid.

- **Service Authorization** – Meridian's service authorization process has been developed within MCS to be as streamlined and automated as possible. The diagram below depicts the authorization process.



Providers can submit authorizations with medical records, by faxing the information directly to MCS or by entering an authorization request in the online Provider Portal.



Once these medical records have been properly associated with the member's request, a Review Nurse will review the records and make a determination within twenty-four (24) hours. Once the determination is made, the Review Nurse will initiate an automated fax response to be sent back to the provider.

Meridian's service authorization system is currently configured to support Iowa programs and may be modified to accommodate any new requirements resulting from the Contract.

- Provider Network Management** – As a company founded by a physician, Meridian has always focused on building efficacy, trust, and loyalty within our provider network. Every aspect of our systems is designed to relieve administrative burden and facilitate exceptional care delivery. Our service to providers goes beyond the traditional provider services role and is intended to build a trusted partnership with the provider that removes barriers and administrative burdens so they can focus efforts on providing care to members.

Once providers are approved for the Meridian network, our Provider Network Development Representatives (PNDRs) work collaboratively to ensure that we are supportive in their care for our members. Providers have around-the-clock access to the Provider Portal in MCS, which allows providers to verify eligibility, view and submit claims, enter prior authorizations, study member data and reports, see enrollment lists, view HEDIS® bonus information, self-report, and review and approve members' individualized plans of care, among a variety of other functions and information.

Additionally, the web-based Live Chat feature offers providers and their staff secure, HIPAA-compliant direct access to Provider Services staff during normal business hours to exchange information and resolve any concerns they may have. Finally, Meridian offers an after-hours secure email system with prompt follow-up by our internal Provider Services Representatives the next business day.

Meridian's focus on minimizing prior authorizations, providing reliable claims adjudication, and delivering prompt payment successfully fosters positive relationships with our providers, which enhances the relationships between our providers and our members.

- Credentialing** – Meridian's credentialing process ensures compliance with all Federal and State safety and quality standards. Meridian follows industry-standard protocols to credential providers, including reviews of appropriate licensure, valid participation status in the Iowa Medicaid Program or other agency, appropriate insurance, background screening, and site visits or interviews.

Meridian updates our credentialing support system to interface with sources of truth as the industry evolves. Meridian has found that online, real-time sources speed up the overall process and provide timely information so that we can actively monitor our provider network. We are interested in working with the Iowa Board of Medicine, Iowa Medicaid or any other department or agency as appropriate that would be applicable sources of truth for our credentialing process.

- **Grievance and Appeals Processing** – Meridian’s Grievance and Appeals Program is fully automated within MCS. All staff is trained on and has access to the proper technology tools to document a member grievance. All grievances and appeals are automatically routed to a Grievance or Appeals Coordinator for appropriate investigation and follow-up consistent with our policies and procedures. Grievance and Appeal clinical staff is responsible for appropriately documenting cases and ensuring appropriate and timely follow-up.

MCS allows for accurate and up-to-date tracking and trending of grievances and appeals. Each grievance or appeal, whether initiated by provider or member, is documented within the request for authorization or claim to which it pertains. Grievances are reported quarterly to the Quality Improvement Committee (QIC). Appeals are reported quarterly to the Utilization Management Committee (UMC). We value member feedback and both grievances and appeals influence the revision and development of policies and procedures to ensure ongoing member and provider satisfaction.

Special Investigation Unit (SIU) staff analyzes the grievance and appeal data on a quarterly and rolling twelve (12) month basis to detect trends. If trends are detected and fraudulent activity is suspected, SIU staff immediately notifies the Compliance Officer who initiates a preliminary investigation.

- **Quality Improvement** – We believe Meridian’s corporate mission statement, “To continuously improve the quality of care in a low resource environment,” aligns with the State of Iowa’s expressed commitment to quality. Our current experience in Iowa and other states has demonstrated that our quality strategy will improve the quality of care delivered to Iowa Medicaid members.

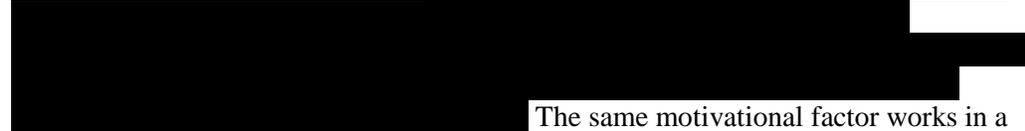
[REDACTED]

[REDACTED]

- **Encounter Data** – Meridian has developed a comprehensive encounter edit process that allows us to fully and efficiently meet encounter reporting requirements. When we originally brought Iowa Medicaid online, we were able to meet encounter reporting requirements within ten (10) days. Meridian has over seventeen (17) years of experience and consistently achieves a ninety-nine percent (99%) acceptance rate for all states in which it operates.

Each month, the Provider Services Department is responsible for monitoring the receipt of encounter data through collaboration with the Claims Department. In the event the required encounter data is incomplete or missing, the Provider Network Development Representative assigned to the specific physician group, PHO, or other clinic-type organization will follow-up with the provider to ascertain why the encounter data was not submitted.

Meridian's provider bonus program provides a monetary incentive to providers to submit encounter data in a timely manner.



The same motivational factor works in a group or office setting as the providers typically share bonuses within an office. Meridian's incentive program helps ensure that all encounters, regardless of PCP affiliation to the member, are submitted in a timely manner.

As detailed above, Meridian will support the following required Information Systems (IS) functions:

- Maintain a member database, using Medicaid State ID numbers, on a county-by-county basis which contains: (i) eligibility begin and end dates; (ii) enrollment history; and (iii) utilization and expenditure information
- Maintain county of legal residency for members; provide and update such information and provide required consumer releases
- Maintain a database which incorporates required clinical information
- Maintain information and generate reports required by the performance indicators
- Conduct claims processing and payment
- Maintain data to support medication management activities
- Maintain data documenting receipt and distribution of the capitation payment
- Maintain data on incurred but not yet reimbursed claims
- Maintain data on third party liability payments and receipts
- Maintain data on the information required to process and mail claims payment
- Maintain critical incident data
- Maintain clinical and functional outcomes data and data to support quality activities
- Maintain data on clinical reviews, appeals, grievances, and complaints and their outcomes
- Maintain data on services requested, authorized, provided, and denied
- Maintain the capacity to perform ad hoc reporting on an "as needed" basis, with a turnaround time to average no more than five (5) business days
- Maintain data on all service referrals

- Maintain all data in such a manner as to be able to generate information specific to service type, including but not limited to: (i) behavioral health services; (ii) LTSS; (iii) pharmacy; (iv) inpatient services; and (v) outpatient services
- Maintain all data in such a manner as to be able to generate information on members by age
- Provide encounter data to the State in a format specified by the State

As detailed above, Meridian will support the following general system requirements:

- Online access
- Online access to all major files and data elements within the IS
- Timely processing
- Daily file updates of member, provider, prior authorization, and claims to be processed
- Weekly file updates of reference files and claim payments

Meridian shall employ comprehensive automated edits and audits to ensure that data are valid and that Contract requirements are met. MCS tracks errors by type and frequency and maintains sufficient audit trails to allow for the reconstruction of processing events. We have an adequate system of controls and balancing to ensure that all data input can be accounted for and that all outputs can be validated.

Meridian utilizes the clinical data it receives to appropriately manage the care being provided to our members. In addition, Meridian utilizes the data in its: (i) management of providers; (ii) assessment of care being provided to members; (iii) development of new services that will increase access and improve the cost-effectiveness of the program; and (iv) implementation of evidence-based practices across the provider network.

Meridian will make data available to the State and, upon request to the Centers for Medicare and Medicaid Services (CMS). In accordance with 42 CFR 158, Subpart H, Meridian will submit all data, including encounter claims, under the signatures of either its Financial Officer or Executive leadership (i.e. President, Chief Executive Officer, Executive Director) certifying the accuracy, truthfulness, and completeness of the our data. Meridian will submit this attestation in the manner and timeframe prescribed by the State.

2. Describe data back-up processing plans including how data is stored at an off-site location.

Meridian Health Plan's Managed Care System (MCS) has a back-up and replication system that leverages the latest industry tools and technologies [REDACTED]

to provide a high level of assurance that a single event is highly unlikely to affect both locations at the same time.

Daily incremental and full weekly back-ups are performed to ensure complete data protection. [REDACTED]

All back-up files are stored and retained according to the following schedule:

| Back-up | Retention |
|-------------------|-----------------|
| Daily Incremental | Six (6) Days |
| Weekly Full | Five (5) Weeks |
| Monthly Full | One (1) Year |
| Year-End Full | Seven (7) Years |

Back-up copies of MCS production servers are created in our disaster recovery servers. This includes enrollment and eligibility data, prior authorization request data and care coordination data. In addition:



MCS conducts a full disaster recovery test annually to ensure our systems initiate in a timely manner and operate as expected.

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.

Meridian Health Plan's Managed Care System (MCS) is a repository for claims data, supplemental data entries, pharmacy, historical claims, and immunization data. These data are essential for real-time examination of HEDIS® measures. Certain measures are used for evaluation of provider management, such as controlling high blood pressure or HbA1c screenings. Others are reviewed to detect potential access to care issues or the need for member outreach. Provider status on HEDIS® measures is communicated in multiple ways.

The provider incentive program encourages awareness of member needs for routine and preventive services. Incented services align well with clinical practice guidelines promoted and provided by Meridian.

Clinical data also drive quality improvement projects (QIPs) typically targeted to a subset of the population. QIPs may be member or provider-centric, may use HEDIS® or HEDIS®-like measures, and often involve community partnerships. Projects involving members are structures assess the current and projected status of care, as well as determine whether new services or new approaches to service delivery might improve a health outcome. Past provider projects have centered on adherence to clinical practice guidelines as measured for successive years by HEDIS® performance, use of appropriate current procedural terminology codes, or by examining utilization.

For the past year, Meridian has actively supported Iowa's State Innovation Model efforts to utilize the Value Index Score (VIS). Encounter data are sent monthly to Treo. Once available, Meridian will work with Treo to ensure results are accessible to providers and adequately explained.

Meridian has also supplied specialized reports to health systems intent on improving performance. These efforts will remain a priority for Meridian if awarded in Iowa.

Utilization Management

Meridian has a comprehensive and efficient process for receiving, analyzing, and determining the disposition of authorization requests. This process uses MCS to be as streamlined and automated as possible.

Providers can submit authorizations by faxing the information directly to MCS or by entering an authorization request in the Provider Portal.

[REDACTED]

A Review Nurse will review the records and make a determination within request-specific time frames. Once the determination is made, the Review Nurse will initiate an automated fax response to be sent back to the provider.

Below is a process flow to visually depict the authorization process.



4. Submit a draft Information Systems Plan as described in Section 13.1.5.

From the earliest point in Meridian Health Plan's history, the company founders recognized the importance of Information Technology (Information Systems) and the value of maintaining current and innovative health information processes and analyses. Our success is firmly rooted in thorough information processing and procedures and our ability to stay ahead of trends and regulatory requirements, a founding principle that still drives our success and growth today.

Detailed below is Meridian's plan for 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). Meridian will maintain and update our plan in collaboration with Iowa throughout the term of the Contract.

Meridian's Information Systems Plan provides for the planning, developing, testing and implementing of new operating rules, new or updated versions of electronic transaction standards, and new or updated national standard code sets. Meridian works closely with our State partners and monitors requirements at the State and Federal level through our memberships in organizations, including Healthcare Information and Management Systems Society (HIMSS), American Health Information Management Association (AHIMA), and Workgroup for Electronic Data Interchange (WEDI). In addition, we actively participate in Federal workgroups related to healthcare data exchange. Once new requirements are identified from any of these sources, we create a project charter following Project Management Institute (PMI) guidelines.

Our project management process closely mirrors the PMI Project Management Body of Knowledge (PMBOK) process to ensure predictability and transparency. As a critical stakeholder in these updates, the State of Iowa would be included in our planning and communication plans.

Meridian has been ICD-10 enabled since August 2014, and is fully current with X12 and HL7 transaction sets.

The Meridian MCS EDI process incorporates the Sonic Enterprise Service Bus (ESB). An ESB enables us to integrate different versions of transactions, including proprietary transactions, by creating a single suite of applications that handles all mapping, translation, monitoring, notification, etc. This single suite approach alleviates the need for custom coding throughout our applications in order to handle the "nuances" of every trading partner's interpretation of healthcare data exchange standards.

Our license with Sonic includes a subscription that provides both current and historical versions of all transaction sets. Our internal EDI process converts all versions of healthcare transactions to a single internal standard that is consumed by MCS.

We have active memberships with the American Medical Association (AMA) and Washington Publishing Corporation (WPC) to receive automatic downloads of any code set changes.

Meridian's registration and verification of new and existing trading partners is a straight-forward, four (4)-step process:



Once these have been established, we mutually agree on a testing plan and, once thoroughly tested, mutually move to production data exchange.

Meridian has created and maintains a complete set of companion guides to support our trading partners. As part of our onboarding process, we distribute these to trading partners to facilitate a smooth and predictable go-live. In addition, we create what we call a Source of Truth catalog for every trading partner, which includes:

- Contact Information
- Overall Data Flow Diagram
- Interface Specs
 - Protocol
 - Security/Encryption
- File Information
 - Type & Direction
 - Metadata/Companion Guides
 - Destination/Source/Associated Programs
 - Maps/Customizations
 - Sample Data
 - Notification Scheme
- Change Requests

Meridian's staffing plan includes provisions to maintain staff dedicated to monitor data exchange activities, coordinate corrective actions for failed records or transactions, and support trading partners and business associates.

[REDACTED] We recognize that clinical data, predominantly coded to HL7 standards, is only beginning to be used within payer systems to improve care and track quality. Traditionally, clinical stakeholders have been reluctant to share raw clinical data, but we see that mindset rapidly changing. Meridian has always been and plans to always be at the forefront of any initiative that can improve quality. We are confident that we will be more than ready to leverage this information to improve care.

Additionally, we are broadening the staff of the EDI team to support maintaining our Trading Partner Source of Truth mentioned above, migrating legacy trading partner logic to our standard EDI protocol, which includes: monitoring our real-time EDI dashboard to assess the health of our interchange system; staffing our EDI Help Desk to monitor data exchange activities, coordinating corrective actions for failed records or transactions; supporting trading partners and business associates; and enhancing and refining our notification schemes so the right people have the right information at the right time. Should an issue arise, we have the systems and personnel on hand or on call to respond appropriately and resolve the issue quickly and efficiently.

Meridian is committed to maintaining compliance with all privacy policies as required by governmental agencies or State or Federal law, including all aspects of HIPAA Privacy and Security rules. Meridian has made an organization-wide commitment to the privacy and security of member information and has written policies and procedures that will be provided to the State. Meridian will incorporate any amendments to them as requested. We will provide adequate security measures for any data that is transmitted between Meridian and the State, or within our network, storage, or cache.

Meridian has designated a Privacy Officer, Security Officer and Privacy and Security Committee that meets at least quarterly to develop, implement, maintain, and modify as necessary our Privacy and Security policies and procedures that are compliant with Federal, State, and

government agency laws, regulations and guidelines. Meridian will regularly check and maintain compliance with all privacy policy changes requested by Iowa officials. The Privacy Officer and Security Officer are readily available to Meridian staff. Their contact information is circulated on a regular basis through various communication tools including, training, handbooks and newsletters to eliminate employee confusion or hesitation in the event they have questions related to their responsibilities or need to report a privacy incident as required by Meridian policy.

Meridian has implemented administrative, physical, and technical safeguards in compliance with Federal and State regulations as recorded in our written policies and procedures. Our independent auditor, Plante Moran, conducts an annual security audit of our system which includes a review of the completeness of our policies and procedures and objective test of our compliance. Our annual audit is conducted using the American Institute of Certified Public Accounts (AICPA) Service Oriented Control (SOC) report standards. Specifically, Plante Moran conducts an SSAE 16 (Statements on Standards for Attestation Engagements No. 16,) which goes beyond the now retired SAS 70 standard by not only verifying the controls and processes, but also requiring a written assertion regarding the design and operating effectiveness of the controls being reviewed. The SSAE 16 audit results in a SOC 1, Type II report. This report focuses on internal controls and includes an opinion of the accuracy and completeness of Meridian's design of controls, system, and service.

Violations to Meridian's policies and procedures are immediately reported to Meridian's Privacy and/or Security Officer, as appropriate. These violations are investigated by the Privacy and/or Security Officer, thoroughly documented, with corrective action taken as appropriate, and reported to the Privacy and Security Committee. In compliance with Federal and State laws, any incidents that constitute a breach are reported by the Privacy Officer to the Secretary of the United States Department of Health and Human Services (HHS).

As a covered entity under HIPAA, Meridian is keenly aware of its responsibilities regarding the protection of member information and has implemented policies and procedures designed to safeguard such information. Meridian's strategy for maintaining up-to-date knowledge of HIPAA-related mandates with defined or expected future compliance deadlines includes a multi-modal approach. Meridian educates its employees regularly and requires them to be cognizant of the requirements of HIPAA and implementing regulations (i.e. the Privacy Rule and the Security Rule) at all times in the performance of their job functions. Meridian fosters an environment of open communication in order to learn of privacy or security incidents and respond to them quickly and appropriately. All Meridian employees are trained upon hire and then annually thereafter regarding HIPAA, HITECH, and all relevant privacy regulations and guidelines.

In addition, Meridian works closely with our State partners and monitors State and Federal requirements through our memberships in organizations like HIMSS, AHIMA, WEDI and the like, as well as active participation in Federal workgroups related to healthcare data exchange. As new requirements are being developed and adopted, Meridian staff incorporates changes to our roadmap to remain compliant over time.

5. Describe your proposed information systems staffing model.

Meridian Health Plan uses a variety of dedicated resources to maintain an effective and collaborative Information Technologies (Information Systems) Department. The IT Organizational Structure Chart below represents Meridian staff involved in the functional

operations of IT. As shown, the IT Department is broken into various high-level subgroups comprised of [REDACTED]

[REDACTED] The IT Department also houses a variety of director-level staff members overseeing the subgroups previously stated. Each individual maintains his or her allocated areas of IT to resolve technical issues, troubleshoot system issues, monitor data exchange activities, and implement corrective actions for Meridian staff, members, and business affiliates.

[REDACTED]

Meridian maintains a dedicated EDI team, including an EDI Help Desk to monitor data exchange activities, coordinate corrective actions for failed records or transactions, and support trading partners and business associates.

An organizational chart depicting Meridian's information systems staffing model is provided as Attachment 38 (Information Systems Staffing Model) in Tab 5.

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.

Meridian Health Plan currently works well with the State of Iowa, and will continue to prioritize a collaborative relationship. Meridian will continue to monitor requirements at the State and Federal level through our memberships in organizations like HIMSS, AHIMA, WEDI and the like, to ensure that we are current and compliant with historical, current and future versions of HIPAA Transactions and Code Set requirements, at no cost to the State.

In addition, Meridian is committed to be in compliance with all privacy policies as required by governmental agencies or State or Federal law. Meridian has made an organization-wide commitment to the privacy and security of member information and has written policies and procedures that will be provided to the State. Meridian will incorporate any amendments to them as requested. We will provide adequate security measures for any data that is transmitted between Meridian and the State, or data within our network, storage, or cache.

As a covered entity under HIPAA, Meridian is keenly aware of its responsibilities regarding the protection of member information and has implemented policies and procedures designed to safeguard such information. Meridian educates its employees regularly and requires them to be cognizant of the requirements of HIPAA and implementing regulations (i.e. the Privacy Rule and the Security Rule) at all times in the performance of their job functions. Meridian fosters an environment of open communication in order to learn of privacy or security incidents and respond to them quickly and appropriately.

Meridian has implemented administrative, physical and technical safeguards in compliance with Federal and State regulations as recorded in our written policies and procedures. Our independent auditor, Plante Moran, conducts an annual security audit of our system which includes a review of the completeness of our policies and procedures and objective test of our compliance. Our annual audit is conducted using the American Institute of Certified Public Accounts (AICPA)

Service Oriented Control (SOC) report standards. Specifically, Plante Moran conducts an SSAE 16 (Statements on Standards for Attestation Engagements No. 16,) which goes beyond the now retired SAS 70 standard by not only verifying the controls and processes, but also requiring a written assertion regarding the design and operating effectiveness of the controls being reviewed. The SSAE 16 audit results in in a SOC 1 report. This report focuses on internal controls and includes an opinion of the accuracy and completeness of Meridian's design of controls, system and service.

Meridian employs the following technology to provide protections for transmission and storage of medical data:

[REDACTED]

Meridian periodically coordinates with third party technical experts to perform penetration scans and ethical hacks (remote penetration and vulnerability tests). These test the effectiveness of Meridian's Information Security implementation by attempting penetrations to MCS infrastructure and applications. The information from penetration scans and ethical hacks is used to assure and enhance MCS Security.

7. Describe your proposed electronic case management system and all information which is tracked in such system.

The Case Management (Care Coordination) system within Meridian Health Plan's Managed Care System (MCS) fully integrates with available databases in other areas of MCS (i.e. claims and utilization management (UM)). This provides Meridian Care Coordinators with efficiencies that allow them to focus on key activities to educate and promote member self-management. This system presents the Care Coordinator with a comprehensive picture of the member before initial phone contact based on previously collected data from claims and UM and creates efficiencies in the intake process and workloads.

The Care Coordination system allows users to view data from the following sources outside of the core module:

[REDACTED]

[REDACTED]

At present, pharmacy data for Iowa members are loaded into MCS monthly. Once awarded, Meridian will bring in pharmacy data obtained from Meridian's pharmacy benefit manager, MeridianRx, in addition to historical pharmacy data. MeridianRx data are imported for other state plans operated by Meridian. A comprehensive assessment must be conducted on all members in Case Management. The integration of pharmacy data makes the medication portion of the assessment more intuitive. The Care Coordinator can click a button to view prescriptions and simply highlight the current medications applicable to the assessment. This eliminates the need of typing a medication and dosage, which may or may not be accurate, removes the responsibility from the member from having to remember medications, and assists in the medication reconciliation.

Within Care Coordination, staff members are assigned to manage a particular population. The system will assign cases based on a matrix loading grid; taking into consideration the specific member data (i.e. benefit code, special condition such as pregnancy), the system will assign a team to that member. Once a team has been identified, the system looks to the coordinator level to identify a final assignment (based on county, staff qualifications). When appropriate, referrals to multi-disciplinary consultants (i.e. Behavioral Health, Pharmacy, and Nutrition) will be manually generated by the Care Coordinator or automatically generated based on assessment responses.

Meridian's Care Coordination module utilizes various initial Health Risk Assessments (internally designed based on the population) and Predictive Modeling software to stratify members with their potential risk levels (i.e. high, medium, low). Based on the resulting stratification, members are assigned (or reassigned) a coordinator based on their stratification placement (i.e. high-risk members need more intervention than medium-risk members, medium-risk members need more intervention than low-risk members). This model prioritizes member cases by potential risk, allowing the staff to appropriately handle the correct population of members based on their qualifications.

[REDACTED]

The results of this assessment, just like the internal assessments, are used to identify problems and goals for the member's care plan. Certain responses on this assessment also trigger internal staff referrals to other members of the team; for example, if a member indicates a history of behavioral health needs, a referral will generate to a Behavioral Health consultant for follow up.

Meridian's Financial Analytics Department generates member files to be run through the Predictive Modeling software. The member data used includes eligibility and demographic information, medical claims, and pharmacy claims. Files are then created both for new members to identify those with the potential highest risk as well as members who are already enrolled to identify changes in condition and risk. Members are assigned into one of four risk levels. The file generated from the Predictive Modeling software is imported into MCS, which will automatically update cases.

[REDACTED]

[REDACTED]

[REDACTED]

Each member's care plan contains a series of problems and goals.

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

When the Care Coordinator and the member complete the member's care plan, it must be reviewed and approved by the clinical Team Lead. [REDACTED]

The efficiencies built in to the care plan help staff in their daily workloads, which benefits the member. [REDACTED]

The centralization of communications in the module improves the staff and providers' ability to connect. This eliminates the need for external email or fax and removes the risk of protected health information (PHI) from being compromised. Furthermore, it supports continuity in a member's care. If the member's Care Coordinator is out of the office, another team member can easily pick up and have access to all communications; there is no need to look through another staff member's inbox.

[REDACTED]

The end result of these efforts is that Meridian is able to reach out to their members more effectively and efficiently to engage and educate them on self-management efforts and to facilitate use of the most appropriate healthcare services. This leads to improved health outcomes for the members, prevents unnecessary hospitalizations, and reduces overall healthcare costs for the State program.

8. Indicate if an Electronic Visit Verification (EVV) System is proposed and what methodologies will be utilized to monitor member receipt and utilization of HCBS.

Following execution of the Contract, Meridian Health Plan shall obtain State approval of the EVV system approach further outlined below. Meridian shall implement and adhere to the State-

approved approach. Meridian acknowledges that changes to this approach must receive the State's prior approval.

Meridian and Independent Living Systems (ILS) currently use two Electronic Visit Verification (EVV) System vendors:

- First Data Inc.
- Sansdata, Inc.

To promote seamless integration, each home-based services provider contract will use the EVV system to verify authorized service provision, member information, and authorizations electronically. This member and authorization information will be supplied directly to the EVV system from ILS and Meridian.

In order to monitor and verify member receipt and utilization of HCBS, Home Health Services, Hospice and EPSDT, the EVV system will have the capability to electronically verify the time and location of the person claiming to have provided home care services, as well as:

- Schedule and modify worker hours and services
- Allow a start-time window (allow call-in within five to fifteen (5-15) minutes of scheduled time)
- Allow an end-time window (allow call-out within five to fifteen (5-15) minutes of scheduled time)
- Provide real-time receipt of delayed service visits and missed visits
- Use participant telephone numbers (provide justification if other than the land line)
- Allow for alternate time verification arrangements when services are rendered outside the home
- Allow for alternate time verification arrangements when services are rendered outside the home
- Not be the phone of a paid staff worker
- Utilize a toll-free call-in number
- Generate bills using data recorded from the phone system
- Are secure and HIPAA compliant
- Allow for biometric identification of the person providing the services

Through the use EVV systems that employ biometric identification of the service provider, Meridian will be able to verify that the in-home provider of services is actually in the member's presence during the visit. The use of biometrics reduces the likelihood of fraudulent billing practices by allowing Meridian to identify that:

- The service was provided according to the authorized parameters
- Services were provided by the authorized, credentialed service provider, when an individual provider is authorized
- Services were timely
- Verify that the in-home provider of services is actually in the scheduled place of services during the visit episode

In addition to biometric identification, ILS has a Quality Assurance Department that reviews the delivery and utilization of services on a case-by case-basis to identify any disparities in service

delivery. To monitor the EVV vendor for utilization and to identify potential fraudulent activities, this team reviews the following vendor metrics:

- Ancillary, ambulatory, and inpatient services provided to LTC residents, while resident in, or on leave days from, a facility based on living arrangement
- Provider detail reports, by provider number, which identify the number of visits to various types of facilities by performing providers, and give details for members, including date of service, procedure code, and amount billed
- Comprehensive beneficiary and provider profiles using peer grouping methodology, calculating class group averages and standard deviations to determine outliers, and ranking providers and beneficiaries by total exception weight
- Provider profiling and Fraud and Abuse Detection reports based on:
 - Rendering provider
 - Pay-to provider
 - Referring provider
 - Billing services or other non-traditional providers.
 - Beneficiary profiling and Fraud and Abuse Detection reports based on:
 - Original member ID
 - member care plan
 - benefit packages

The ILS scheduling module captures many of the same data as the EVV vendor, allowing ILS to validate data reported by the EVV vendor.

9. Describe in detail how clinical records, as described in Section 13.1.13 will be maintained in your information system.

Meridian Health Plan's Managed Care System (MCS) was originally designed and developed as a member-centric system to support member service while also relieving administrative burden and providing care coordination and navigation for our providers. As such, all information that we receive or create that relates to a member and their care is stored and organized by member. In addition, in part to support our quality initiatives, we are constantly on the hunt for reliable and accurate sources of clinical data. The current state of state and Federal legislation, coupled with the current limitations of healthcare technology frustrate that effort.

Nevertheless, through years of effort, we now have the ability to acquire, consume and use a wide variety of patient-centric data throughout all of our various departments, including: quality improvement, care coordination, utilization management, member services, claims processing, authorization, compliance and provider services.

Specific data MCS maintains:

- [REDACTED]
- [REDACTED]

- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]

10. Submit system problem resolution plans and escalation procedures.

Meridian Health Plan works to provide superior stakeholder service across all areas of our operations. Meridian's Information Technologies (IT) Department is responsible for the development, implementation and management of the company's primary computer systems, personal computer networks and telecommunication systems. Meridian IT works to ensure that changes to systems are introduced in a controlled and coordinated manner to reduce the risk of any changes causing faults in systems or undoing changes made by other programmers. The development team participates in the change control process by identifying at-risk items early in

the development cycle, meeting regularly to review change requests and maintaining strict criteria for allowing changes.

In addition to the regular duties required to meet these responsibilities, it is periodically necessary for the Department to respond to user requests for system repairs, education or enhancements. The IT Department controls and manages this process in a manner that ensures delivery of cost effective results while maintaining efficient company operations. This is accomplished by establishing a procedure for user service requests that includes, where appropriate, approving requests, obtaining initial cost estimates and prioritizing service delivery.

Help Desk Requests

We maintain a dedicated Help Desk to address problems as they arise. If any problems occur with any system, users are instructed to notify the Help Desk.

If any service is down or functionally impaired, the Help Desk staff gathers the following information:

- Identity of caller
- Name and telephone numbers of contact
- Trouble start time
- A brief description of the nature of the problem and any other relevant information that could help in the restoration process

If an end user problem requires troubleshooting assistance, the Help Desk staff will gather all necessary information to properly diagnose the issue. Once the symptoms have been identified, the Help Desk staff will categorize the call as Tier One (1), Tier Two (2), or Tier Three (3). Computer technicians are trained on escalation procedures and know which teams are responsible for the different system components.

- **Tier One (1)** calls are defined as single user calls that the Help Desk staff can resolve on the phone with the user
- **Tier Two (2)** calls are defined as calls that the Help Desk staff is unable to handle, and that need to be escalated to the appropriate IT staff member. Our Help Desk staff are trained to know who will resolve the issue and to notify IT management staff concurrently
 - IT management, depending on the severity of the problem, will consult the team and decide on the next course of action pertaining to issue
- **Tier Three (3)** is reserved for the most complicated issues. In those instances where the problem cannot be resolved by the Tier One (1) or Tier Two (2) teams, the issue is escalated to Tier Three (3) internal support which consists of senior engineers and architects. These issues are rare and given immediate attention
 - The Tier Three (3) internal support team is responsible for resolving all problems/issues that are escalated to them. This includes contacting vendor support for those issues that cannot be fully resolved internally and need input from an external source; for example, vendor hardware or software issues

IT management will continue to update the affected end users or department directors of progress on the problem until it is fully resolved. Meridian will notify the State immediately once we identify any network hardware or software failures and sub-standard performance and will

conduct triage with the State to determine severity level or deficiencies or defects and determine timelines for fixes.

Incident Detection

Users and administrators are trained to be alert for symptoms that may indicate an intrusion into MCS and other systems. Activities and symptoms to be on the alert for include a system alarm or similar indication from an intrusion detection tool.

- Excessive virus warnings or personal firewall pop-up messages
- Unexpected system reboots and/or sudden degradation of system performance
- Unauthorized new user accounts or altered passwords
- New directories or files with unusual names
- Modification or defacement of any Meridian or MeridianRx website
- New open network ports on a system
- Unexpectedly full disk drives
- Accounting discrepancies (gaps in the accounting log in which no entries appear).
- Excessive unsuccessful logon attempts
- Unexplained attempts to write to system files or changes in system files
- Denial of service or inability of one or more users to login to an account
- Unusual time of usage
- An indicated last time of usage of a user account that does not correspond to the actual last time of usage for that user.
- Unusual usage patterns

Incident Response

When an incident is detected, the user detecting is trained to immediately notify the IT Help Desk, who will contain the potentially affected environment and follow pre-determined remediation steps to resolve completely and as quickly as possible.

MCS Change Requests

When a request for changes to MCS is entered into our ticketing and tracking system, the request is entered into a separate queue for management review. Each request is reviewed and evaluated by both IT and business unit management for feasibility and appropriateness, and to assign priority. For the requests that pass the initial gate review, the appropriate IT team works to create the project planning information so the project can be scheduled and resources planned.

- i. A Business Analyst works with the requestor, programmers and other staff as needed to develop specifications. An estimate of the number of hours it will take to complete and an estimated completion date is assigned
- ii. Application developers work with information architects to review and develop the technical design, and begin development
- iii. Developers document the unit test plan, perform unit testing and document the results
- iv. Once unit testing is complete, the change is sent for code review
- v. Once the change passes code review, it is ready for testing by the IT Quality Assurance staff. If any problems are found, the change is moved back to development

- vi. When the change passes internal IT review, it is released into UAT environment for user acceptance testing
- vii. Upon approval from user testing and the original requestor, release documentation is completed, and the change processes through release readiness review, and then promoted to production in the next release

Escalation Process

Meridian currently meets with the Iowa Department of Human Services (DHS) staff on a monthly basis to review any outstanding requests, any incident tickets and address any other items DHS chooses to escalate. Both Meridian IT and Operations Executives attend. Additionally, contact information of Meridian IT chain of command are shared and updated as our organization grows. Now that there will be more contractors, we anticipate working with staff of the DHS to revise the existing process to incorporate the new contractors into the process and develop a multi-contractor communication plan.

Meridian’s incident detection, tracking and response process is designed to include proper detection and response to security incidents, which is vital to protecting the integrity, confidentiality and availability of data and network resources. Such incidents include:

- Virus outbreaks
- Security breaches
- Failure of environmental systems
- Other exploited vulnerabilities

11. Submit sample release management plans.

Meridian Health Plan has established processes for development, testing, and promotion of system changes and maintenance. Meridian will notify the Iowa Department of Human Services (DHS) at least thirty (30) calendar days prior to the installation or implementation of “minor” software and hardware upgrades, modifications or replacements and ninety (90) calendar days prior to the installation or implementation of “major” software and hardware upgrades, modifications or replacements. “Major” changes, upgrades, modifications or replacements are those that impact mission critical business processes, such as claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, encounter data management and any other processing affecting Meridian’s capability to interface with the State or the State’s contractors. Meridian will ensure that system changes or system upgrades are accompanied by a plan which includes a timeline, milestones and adequate testing to be completed before implementation. Meridian will notify and provide such plans to DHS upon request in the timeframe and manner specified by the State.

[Redacted]

[Redacted]

[REDACTED]

Before an application can be deployed in our production environment it is required to pass Meridian's Release Readiness Review Process (RRR). This process ensures that controls for a sensitive application (Financial, Critical and/or Private) adequately satisfy the minimum requirements necessary to protect both our stakeholder's and Meridian's interests.

Meridian will adapt our development and release management processes as necessary to be fully compliant with the State's requirements including: notifying DHS at least thirty (30) calendar days prior to the installation or implementation of "minor" software and hardware upgrades, modifications or replacements and ninety (90) calendar days prior to the installation or implementation of "major" software and hardware upgrades, modifications or replacements. "Major" changes, upgrades, modifications or replacements are those that impact mission critical business processes, such as claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, encounter data management, and any other processing affecting Meridian's capability to interface with the State or the State's contractors. Meridian will ensure that system changes or system upgrades are accompanied by a plan which includes a timeline, milestones and adequate testing to be completed before implementation. Meridian will notify and provide our plans to DHS upon request in the timeframe and manner specified by the State.

A sample release management plan is provided as Attachment 39 (Sample Release Management Plans) in Tab 5.

13.2 Contingency and Continuity Planning

1. Provide a detailed disaster recovery plan and contingency and continuity planning documents.

Meridian Health Plan's disaster recovery plan encompasses all activities, processes, and resources necessary to continue to provide mission-critical business functions and processes during a disaster. Meridian's continuity planning is coordinated with information system contingency planning to ensure alignment. Our plan addresses processes for restoring critical business functions at an alternate location. Meridian's continuity activities include coordination with the State and its Contractors to ensure continuous eligibility, enrollment, and delivery of services.

Meridian will obtain state approval of the planning documents within sixty (60) days of Contract execution with the State. Meridian shall execute, adhere to, and provide the services set forth in the State-approved plan. Meridian will receive prior approval from the State before making updates to our plan. We will maintain a current version of the plan. Our plans include contingency and continuity responsibilities including, but not limited to:

- Notifying the State of any disruptions in normal business operations with a plan for resuming normal operations
- Ensuring participants continue to receive services with minimal interruption

- Ensuring data is safeguarded and accessible
- Training staff and stakeholders on the requirements of the information system contingency and continuity plans
- Conducting annual exercises to test current versions of information system contingency and continuity plans. The scope of the annual exercises will be approved by the State. Meridian shall provide a report of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercises

Meridian's contingency planning is developed in accordance with 45 CFR 164.308. Contingency plans include: (i) Data Backup plans; (ii) Disaster Recovery plans; and (iii) Emergency Mode of Operation plans. Application and Data Criticality Analysis and Testing and Revisions procedures are addressed within the required contingency plans. We will submit an official draft plan within thirty (30) days of Contract execution. A final work plan, incorporating any changes required by the State, shall be submitted to the State within sixty (60) days after official submission of the plan. Meridian will be responsible for executing all activities needed to recover and restore operation of information systems, data, and software at an existing or alternate location under emergency conditions within twenty-four (24) hours of identification or a declaration of a disaster. Meridian will protect against hardware, software, and human error. We will maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups, and disaster recovery.

Please see Attachment 40 (Corporate Business Continuity & Disaster Recovery Plan) in Tab 5.

13.3 Data Exchange

1. Describe your process for verifying member eligibility data and reconciling capitation payments for each eligible member.

Meridian Health Plan currently uses the 834 enrollment file and the capitation rate sheets to create an expected capitation amount for each eligible member in every month. The member is then matched to the payment file to show any discrepancies between expected amount and actual capitation amount. When a discrepancy is discovered, the member information is compared to the payment file to find any differences. Each variance is flagged with an issue code that shows which section of the enrollment information does not match the payment file. The file sent to the State will include a summary and detail of all issues for each program. Meridian will not modify member identifiers, eligibility categories, or other member data elements without written approval from the State.

All discrepancies will be reported back to the state within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after receiving the eligibility records. Meridian will return any capitation or overpayments to the State within forty-five (45) calendar days of discovering the discrepancy via procedures determined by the State.

Meridian will submit provider network information to the State in the timeframe and manner defined by the State. Meridian will keep provider enrollment and disenrollment information up-to-date.

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.**

Meridian Health Plan has been successfully processing public program claims for over seventeen (17) years. Listed below are some of the major features and functionality of our systems:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

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2. Describe your plan to monitor claims adjudication accuracy.

Meridian Health Plan has staff dedicated to reviews of claims processed by the Claims Examiners and will develop tailored analytical reports and metrics to monitor claims processing accuracy of auto-adjudicated claims. Controls on claims processing includes the following:

- Auditing of claims examiner processed claims: This entails pulling a random sample of five percent (5%) of claims by a claims auditor, who reviews these claims for processing accuracy. This is currently performed on a daily basis, with results recorded and

communicated to Claims management for review and follow-up of performance deficiencies.

- **Claims Analytics:** This includes the development and implementation of procedures to compare targeted claims data extracts to their corresponding pricing methodology and fee schedule for pricing accuracy. This includes but is not limited to analyzing member eligibility status versus processed claims, reviewing and reconciling post-claims processing eligibility changes to ensure that claims are not inappropriately paid outside of the member's eligibility period.
- Inpatient claims are subjected to review by a contracted third party vendor that specializes in audits and reviews of these claims. Identified processing exceptions are reviewed by Meridian staff and verified before adjustments are processed.
- Many other types of claims, including all professional claims, are subjected to internally maintained NCCI and other state-specific Medicaid edits. A third party vendor provides real-time review of these claims as well. Exceptions identified by the third party are reviewed by Meridian for accuracy, and as they are approved, they are updated to an automated edit status. Meridian monitors these edits on a weekly basis, identifying potential trends or particular provider billing issues, which results in outreach to the affected providers as needed.
- **Determination of covered benefits:** Items and services that are non-covered will be reviewed via report to ensure they are not paid, or are paid only in situations where there was a plan-approved authorization.
- **General claim denials:** Claims denials will be reviewed on an ongoing basis to identify possible erroneous or unreasonable denials, including root cause analysis and remediation as needed.

3. Describe your provider claims submission process, including provider communications addressing the provider claims process.

Meridian Health Plan accepts claims in both Electronic Data Interchange (EDI) and paper claims formats. Currently, over ninety percent (90%) of our claims are received electronically. Claims submitted via electronic data interchange (EDI) are subject to various data validation edits which detect fatal billing errors before they are accepted into the processing system. Meridian strongly promotes and encourages the use of EDI claims submissions and works with providers to convert them from paper to EDI submissions. In addition, Meridian provides network providers with access to the secure online Provider Portal with the capability of submitting claims online versus using a clearinghouse. This affords flexibility to smaller provider groups and practices, including waiver service providers, who may not have the infrastructure or technical capacity to submit through an EDI clearinghouse. Meridian receives and processes paper claims in-house, using scanning and imaging technology with optical character recognition (OCR) in order to reduce the likelihood of data entry errors, with "vertexing" (verifying text) performed by Meridian staff. Vertexer performance is audited on a daily basis for accuracy and production.

The Claims Department collaborates with the Network Development and Provider Services teams when chronic billing or claims processing issues are identified, using feedback from rejected

claims as well as provider calls. Since the Claims Department receives and responds to provider calls concerning billing or payment issues, there is an immediate feedback loop to Claims management from the staff when same or similar issues are raised with regard to billing or claims processing. For Medicaid lines of business, there is a Claims manager assigned to each state to ensure problem-focused attention to all processing their particular state. There are meetings to discuss common billing or processing issues between the various states, which results in greater resource efficiencies by addressing common issues where the same remediation impacts all lines of business in all states.

Information for providers regarding billing is found on our website at <http://www.mhplan.com/ia/providers/index.php?location=provider&page=home/claims>.

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.

Meridian Health Plan has policies and procedures in place to monitor and audit provider claim submissions. This includes controls at the point of claims submission through electronic data interchange (EDI) edits as well as more stringent internal system edits once claims satisfy EDI requirements. Examples of EDI edits include member eligibility, procedure code, diagnosis code and other national standard code set formatting and validations. Internal edits include validation of provider and member information (National Provider Identifier (NPI), member identification numbers), and date-sensitive edits for procedure codes, diagnosis codes, and National Drug Codes (NDC) for items requiring a NDC code. Subject to State-specific exceptions, Meridian accepts only standard claim forms and EDI formats. EDI exceptions are rejected and communicated to providers, and non-compliant forms are returned to the providers with an attachment identifying the specific reason(s) for rejection.

Noncompliant providers will be identified through claims analytics, focusing on both pre-claim edits at the EDI clearinghouse level as well as claim edits that identify outlier rejection edits at the provider or facility level. The Claims Department will collaborate with Provider Relations staff, providing data and other information to facilitate identification of opportunities for provider billing error remediation through outreach. This analysis includes the determination of lags between service dates and received dates of claims for the purpose of identifying billers who are submitting a higher than average number of claims exceeding a standard number of days from the date of service based on the claims and provider types.

Meridian provides a secure, online alternative for network providers to submit electronic claims in situations where it is not practical or feasible for a particular practice or type of business to submit through an EDI clearinghouse. These claims are submitted directly to Meridian, and they are subjected to various edits at the point of entry to ensure accuracy and completeness before passing through to the claims processing system.

Claim volumes and backlogs are monitored and reported on a regular basis. EDI claim files totals are compared to Production system claim totals to ensure claim load completeness. A weekly management report summarizes claim totals by product line and state based on a percentage of EDI versus paper, and management follows up with investigations when there are spikes in paper claims activity. Our EDI clearinghouse partners apply edits to incoming claims to ensure provider

billing compliance, and we will monitor EDI claim rejections in order to identify providers who may be experiencing difficulties with submitting their claims correctly.

Pended claims are monitored on a daily basis, with aging claims monitored closely for adherence to mandated processing timelines. In situations where a claim is denied due to a submission error, a HIPAA-compliant Claims Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) are applied to the claim line(s).

5. Describe your claims dispute procedures.

Meridian Health Plan understands that all claims dispute policies and procedures are subject to State review and approval. Claims processing inquiries are recorded and tracked in a system that affords the ability to categorize and analyze the issues. First, a determination is made as to whether the issue is due to a billing or data requirement for which provider education may be needed. Once the issue is determined to be a health plan error, it is analyzed to determine the root cause. The Claims Department works closely with Meridian provider liaisons to maintain communications with impacted providers during the dispute resolution process. After review, if a denial or denials are upheld and the provider does not agree with the outcome, he or she can submit an appeal that is reviewed by the Meridian appeals committee.

Claims processing issues that are not acute errors are analyzed to determine their root cause. These causes may be categorized as system or manual, specific to pricing or benefits, or impacting a subset of providers or a broad base of providers. Issues are tracked from receipt to resolution, with adjustments executed as expeditiously as possible. Meridian's claims system can reprocess claims individually or in a batch, with capabilities to efficiently adjust large volumes of claims. Typically, acute issues are resolved and claims reprocessed within the same week. Issues involving system remediation are prioritized to ensure they receive prompt attention. Claims are adjusted promptly once the system remediation is tested and promoted to the Production processing environment.

6. Describe proposed processes for collaborating with other program contracts to simplify claims submission and ease administrative burdens for providers.

Meridian Health Plan is committed to facilitating ease of claims submission, including participation with EDI clearinghouses that may not currently submit claims electronically. Meridian provides several avenues for claim submission, including agreements with several national and regional EDI clearinghouses, a secure, web-based option, and paper claims. Meridian's secure, web-based online portal allows providers to directly enter and submit paperless claims once the provider(s) are properly registered and verified. This is especially beneficial for providers who do not have relationships with EDI clearinghouses or the infrastructure to support the submission of electronic claims. Finally, Meridian offers the option of paper claims submissions.

In order to facilitate ease of claims submission for programs with dual coverage, dual-eligible members' claims are processed using a "companion claim" process, where Meridian processes the benefits under the primary coverage first, then automatically generates a linked claim under the secondary coverage for processing. The first claim is processed by adjudicating the primary coverage, and the companion claim automatically imports the primary coverage and payment

amounts as third party liability (TPL). Thus, Meridian automatically coordinates the benefits internally, and providers typically receive the linked claims on the same remittance advice.

7. Propose ideas for handling Medicare crossover claims which reduce the administrative burden on providers.

In order to facilitate ease of claims submission for dual-eligible programs, claims are processed using a “companion claim” process, where Meridian Health Plan first processes the benefits under the primary (Medicare) coverage, then automatically generates a linked claim under the secondary coverage for processing. The first claim is processed by adjudicating the primary coverage, and the companion claim automatically imports the primary coverage and payment amounts as third party liability (TPL). Thus, Meridian automatically coordinates the benefits internally, and providers typically receive the linked claims on the same remittance advice.

Meridian provides access to a wide variety of national and regional EDI claims clearinghouses to facilitate ease of claims submission, and if there is a particular clearinghouse that is not already contracted with us but will result in efficient claims submissions, we would be willing to assess and implement options that allows for the most efficient means to electronically receive and adjudicate crossover claims.

8. Describe processes for notifying providers of a member’s financial participation or cost sharing requirements.

Meridian Health Plan can adjudicate claims where a variable monthly deductible is required at an individual member level. When a member has a specific monthly financial obligation, our system will apply the member’s responsibility to the impacted service(s) as a deductible amount. This amount will be applied to the allowed amount on claims until the monthly deductible has been satisfied. When a member has cost sharing for an individual service, copays and/or coinsurance can be applied to a claim or an individual service line within a claim.

The provider remittance advice has the deductible and/or coinsurance/copay amount clearly identified as member responsibility. When a provider checks eligibility, this information is also displayed.

9. Describe processes for providing monthly prospective reimbursement to providers of IDPH funded services.

Meridian Health Plan receives an IDPH-approved payment based on a sliding fee scale. The sliding fee scale is established by IDPH using member income and family size. Meridian’s payment received is based on an annual capitated payment for each provider. The calculation for determining the annual capitated payment is the minimum number of members the provider must serve multiplied by a case rate. The case rate is a combination of each service and the projected amount that this service will be provided to IDPH substance use disorder members. Meridian pays each provider monthly, one twelfth of the annual funding due as set forth by the IDPH.

13.5 Encounter Claims Submission

- 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.**

Meridian Health Plan has developed a comprehensive encounter edit process that allows us to fully and efficiently meet encounter reporting requirements. When we originally brought Iowa Medicaid online, we were able to meet the encounter reporting requirements within ten (10) days. Meridian has seventeen (17) years of experience and consistently achieves a ninety-nine percent (99%) acceptance rate for all states in which it operates.

Each month, the Provider Services Department is responsible for monitoring the receipt of encounter data through collaboration with the Claims Department. In the event the required encounter data is incomplete or missing, the Provider Network Development Representative assigned to the specific physician group, PHO, or other clinic-type organization will follow-up with the provider to ascertain why the encounter data was not submitted. Meridian will submit encounter data by the twentieth (20th) of the month subsequent to the month for which data are reflected. All corrections to the monthly encounter data submission will be finalized within forty-five (45) days from the date the initial error report for the month was sent to Meridian or fifty-nine (59) days from the date the initial encounter data were due. The error rate for encounter data will not exceed one percent (1%).

Meridian's provider bonus program provides a monetary incentive to providers to submit encounter data in a timely manner. The bonus program is tied directly to the services rendered by the sub-capitated physicians and, while they may not receive fee-for-service payment on the claim itself, the presence of a qualifying code on that encounter would trigger a bonus payment to that primary care provider (PCP), provided the member is assigned to them. The same motivational factor would work in a group or office setting as the providers typically share bonuses within an office. Meridian's incentive program helps ensure that all encounters, regardless of PCP affiliation to the member, are submitted in a timely manner.

In addition, we have existing encounter submission processes with both LogistiCare, our Iowa transportation vendor, and Liberty Dental, our dental vendor. We will continue to work with any subcontractor we employ to maintain our current level of successful and timely submission.

Meridian will develop and implement policies and procedures, subject to State review and approval, to support encounter claim reporting. Meridian will strictly adhere to the standards defined by the State for items such as the file structure and content definitions. Meridian will submit an encounter claim to the State, or its designee, for every service rendered to a member for which Meridian has either paid or denied reimbursement.

Meridian will submit encounter claims in an electronic format that adheres to the data specifications set forth by the State and in any State or Federally-mandated electronic claims submission standards. Meridian will submit drug encounter data for adjudicated claims weekly in support of the State's drug rebate invoicing process. Meridian will submit encounter data by the twentieth (20th) of the month subsequent to the month for which data are reflected. All corrections to the monthly encounter data submission shall be finalized within forty-five (45) days from the date the initial error report for the month or fifty-nine (59) days from the date the initial encounter data were due.

Meridian has written policies and procedures to address its submission of encounter claims to the State. An initial draft plan shall be submitted with the proposal. A final work plan, incorporating any changes requested by the State, shall be submitted to the State within sixty (60) days of the official submission of the plan. Meridian will resubmit a work plan annually that addresses Meridian's strategy for monitoring and improving encounter claims submission.

Meridian has policies and procedures to ensure that encounter claims submissions are accurate. Meridian will fully comply with requirements of the audits and provide all requested documentation including, but not limited to, applicable medical records and prior authorizations. Meridian will submit a corrective action plan (CAP) and will require non-compliance remedies for failure to comply with accuracy of these reporting requirements.

Meridian has in place a system for monitoring and reporting the completeness of claims and encounter data received from providers. Meridian has in place a system for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided. Meridian will demonstrate its internal standards for measuring completeness, the results of any completeness studies, and any CAPs developed to address areas of non-compliance.

2. Describe your experience and outcomes in submitting encounter data in other states.

Meridian has over seventeen (17) years of experience and consistently achieves a ninety-nine percent (99%) acceptance rate for all states in which it operates.

13.6 TPL Processing

1. Describe your plans for coordinating benefits in order to maximize cost avoidance through the utilization of third-party coverage.

Meridian Health Plan has controls in place to identify, store, and adjudicate third party liability (TPL) data. There is a TPL information screen in the system which stores date-sensitive TPL information, including policy numbers, insurance type, and notes to communicate the types of coverage and any specific exclusion. Claims received with dates of service that fall within an identified TPL coverage period are reviewed for TPL information and, in absence of TPL information, they are rejected. Prior to the claims examiner rejecting claims, the types of items and services are considered. Since certain Medicaid services are unique (e.g. home delivered meals and waiver services), consideration is given to these benefits and the likelihood of non-coverage by a primary payer. In these situations, a determination is made to bypass the primary insurance requirement for the convenience of the provider.

We will utilize TPL information received in enrollment files with staff dedicated to verifying TPL information when discrepancies exist. In addition, we will follow-up and verify TPL information based on claims received from providers with TPL information that was not previously identified in our system.

Our system has programming in place to identify possible TPL based on certain accident and injury diagnosis codes. These codes indicate an accident or injury that could result in auto, homeowner, worker's comp, or tort liability. Claims are rejected prospectively until the provider and/or member provides information confirming non-coverage, in which case claims are paid and a determination is made to commence with post-payment recovery. We do this to ensure the member is not at risk of being prevented from receiving necessary care. Meridian participates with First Recovery Group, a third party vendor specializing in TPL cases related to auto coverage. In addition, we utilize the services of a third party partner who specializes in the identification of TPL. This information is verified before claims are rejected.

We are very experienced with Medicaid processing of Coordination of Benefits (COB) claims. Our system can compare the amount allowed and paid by the primary payer(s) and can automatically complete processing of the claim through rules that compare our plan allowed amount to the other payer paid amount, paying only the amount that exceeds the primary payer paid amount up to the lesser of the plan allowed amount or the primary payer allowed amount.

Meridian has the infrastructure in place to support the receipt and reporting of TPL information. We will have staff dedicated to the monitoring, auditing, and reporting of TPL information as needed to satisfy State TPL reporting requirements. We have various TPL identifiers in our system to properly record and report the effective and termination dates as well as the type of insurance, including the policyholder and all applicable identification information. Since we own and administer an in-house processing system, additional data elements and reporting requirements can be accommodated through customized fields and programming.

Meridian will exercise full assignment rights as applicable and shall be responsible for making every reasonable effort to determine the liability of third parties to pay for services rendered to members under the Contract and cost avoid and/or recover any such liability from the third party. Meridian has developed and implemented policies and procedures to meet its obligations regarding TPL when the third party pays a cash benefit to the member, regardless of services used, or does not allow the member to assign his/her benefits. When there is TPL, Meridian is responsible for payment of the member's coinsurance, deductibles, co-payments, and other cost-sharing expenses up to our allowed amount. Meridian's total liability will not exceed our allowed amount minus the amount paid by the primary payer. Meridian will follow all activities laid out in the Iowa Department of Human Services Medicaid TPL Action Plan, revised December 23, 2011.

Applicable liable third parties include any insurance company, individual, corporation, or business that can be held legally responsible for the payment of all or part of the medical costs of a member. Examples of liable third parties can include: (i) health insurance, including Medicare; (ii) worker's compensation; (iii) homeowner's insurance; (iv) automobile liability insurance; (v) non-custodial parents or their insurance carriers; or (vi) any individual responsible for a Medicaid participant's injury (i.e. a person who committed an assault on a participant). Meridian is able to identify trauma and accident cases where funds expended can be recovered from liable third parties and recover the funds.

Meridian will share information regarding its members with these other payers as specified by the State and in accordance with 42 CFR 438.208(b). In the process of coordinating care, Meridian will protect each member's privacy in accordance with the confidentiality requirements stated in 45 CFR 160 and 164, including confidentiality of family planning service. Meridian will report weekly any new TPL to the State to retain in the TPL system. The information collected will contain the following:

- First and last name of the policyholder
- Social Security number of the policyholder
- Full insurance company name
- Group number, if available
- Name of policyholder's employer (if known)
- Insurance carrier ID
- Type of policy and coverage

Additionally, Meridian will implement strategies and methodologies to ensure the collection and maintenance of current TPL data, for example, recoveries from direct billing, disallowance projects, and yield management activities.

2. Describe your process for identifying, collecting, and reporting third-party liability coverage.

Meridian Health Plan will utilize third party liability (TPL) information received in enrollment files, with staff dedicated to verifying TPL information when discrepancies exist. In addition, we will follow up and verify TPL information based on claims received from providers with TPL information that was not previously identified in our system. Our system has programming in place to identify possible TPL based on certain accident and injury diagnosis codes. These codes indicate an accident or injury that could result in auto, homeowner, worker's comp, or tort liability. Claims are rejected prospectively until the provider and/or member provides information confirming non-coverage, in which case claims are paid and a determination is made to commence with post-payment recovery. Meridian participates with First Recovery Group, a third party vendor specializing in TPL cases related to auto coverage.

We have several years of experience successfully processing TPL claims according to Iowa Medicaid requirements. Based on contract requirements, we can exclude certain populations or services from standard TPL processing rules and pursue post-payment recovery. Examples include prenatal care, untimely payment of child support coverage, and pediatric preventive care services. We can flag these services and, if TPL exists or is identified through the claims process but is not submitted with claims meeting the above criteria, we will flag them separately for TPL overrides and pay them, with separate reporting to pursue post-payment recovery of these claims.

TPL information can be shared with the State and we will have staff whose responsibilities include ensuring that newly identified TPL information is communicated and updated in the State's systems as required by contract. Reports will be developed as required to provide TPL information to the State.

If a member is covered by another insurer, Meridian is responsible for coordinating benefits so as to maximize the utilization of third party coverage. In accordance with 42 CFR 433.139, if the

probable existence of third party liability has been established at the time a claim is filed, Meridian will reject the claim and direct the provider to first submit the claim to the appropriate third party. When the provider resubmits the claim following payment by the primary payer, Meridian will pay the claim to the extent that payment allowed under Meridian's reimbursement schedule exceeds the amount of the remaining patient responsibility balance.

Meridian will educate network providers and include, in detailed written billing procedures, the process for submitting claims with third party liability for payment consideration.

If insurance coverage information is not available or if one of the cost avoidance exceptions described below exists, Meridian will make the payment and make a claim against the third party, if it is determined that the third party is or may be liable. Meridian will always ensure that cost avoidance efforts do not prevent a member from receiving medically necessary services in a timely manner.

Cost avoidance exceptions in accordance with 42 CFR 433.139 include the following situations in which Meridian will first pay the provider and then coordinate with the liable third party. Providers are not required to bill the third party prior to Meridian in these situations: (i) the claim is for prenatal care for a pregnant woman; (ii) the claim is for coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency and the provider of service has not received payment from the third party within thirty (30) calendar days after the date of service; or (iii) the claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program. Following reimbursement to the provider in these cost avoidance exception cases, Meridian will actively seek reimbursement from responsible third parties and adjust claims accordingly.

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.

If a member with third party liability (TPL) coverage is identified through medical and pharmacy claims data to have a chronic condition in which utilization of services is expected to be ongoing, it is cost-effective to ensure the member continues to carry the TPL coverage. Meridian Health Plan will identify members with TPL whose claims data indicates the likelihood of continuing costs based on diagnosis codes or the types of medications being dispensed and will work with the State to provide this information in a timely manner.

Meridian is responsible for identifying, collecting, and reporting TPL coverage and collection information to the State. As TPL information is a component of capitation rate development, Meridian will maintain records regarding TPL collections and report these collections to the State in the timeframe and format determined by the State. Meridian will retain all TPL collections made on behalf of its members; Meridian will not collect more than it has paid out for any claims with a liable third party. Meridian will provide to the State or its designee information on members who have newly discovered health insurance, in the timeframe and manner required by the State. Meridian will provide members and providers instructions on how to update TPL information on file and shall provide mechanisms for reporting updates and changes. Reports include, but are not limited to:

- Monthly amounts billed and collected, current and year-to-date

- Recoveries and unrecoverable amounts by carrier, type of coverage, and reason (quarterly)
- TPL activity reports (quarterly)
- Internal reports used to investigate possible TPL when paid claims contain a TPL amount and no resource information is on file
- Monthly quality assurance sample to the State verifying the accuracy of the TPL updates applied during the previous month
- Monthly pay-and-chase carrier bills

Meridian will work with IDPH and providers in developing a policy regarding IDPH eligibility for persons with insurance coverage. Third party recoveries are retained by the provider. Meridian will identify members with third party coverage who may be appropriate for enrollment in the Health Insurance Premium Payment (HIPP) program. Meridian will report members identified as potentially eligible for HIPP to the State in the timeframe and manner to be determined by the State.

13.7 Health Information Technology

1. Describe your proposed healthcare information technology (HIT) and data sharing initiatives.

The pursuit of electronic data interchanges (EDI) and integration with State healthcare information technology is a corporate priority. Meridian Health Plan has been successful at cultivating relationships within Iowa resulting in remote electronic health record (EHR) access or electronic data exchange for more than forty percent (40%) of members. Current partners include MercyCare affiliates, Unity Point, Eastern Iowa Healthcare, Broadlawns Medical Center, and Genesis Health Systems. Concurrent system use for Illinois is occurring with Unity Point and Genesis.

Meridian is using a multi-faceted approach to growing its EDI program. Quality, Provider Services, Operations and the IT Departments work collaboratively to identify opportunities for new EDI partners, Meridian's EDI team is rapidly ramping up to meet the needs of our growing company. We recognize that clinical data, predominantly coded to HL7 standards, is just beginning to be used within payer systems to improve care and track quality. Traditionally, clinical stakeholders have been reluctant to share raw clinical data, but we see that mindset rapidly changing. Meridian has always been and plans to continue to be at the forefront of any initiative that can improve quality. We plan to be more than ready to leverage this information to improve care.

Within each state that we operate, we have initiated collaboration with the statewide Health Information Exchange (HIE) initiatives. We have met with Informatics Corporation of American (ICA), the vendor for the Iowa Health Information Exchange Network (IHIN), and have started drafting plans to expand HIE activity and drive adoption across the State.

Among the initiatives discussed is an admission, discharge, and transfer (ADT) alert initiative to transfer information from emergency rooms, inpatient admissions, and discharges from hospital systems. Meridian is evaluating the value and application of ADT information for Utilization Management, Behavioral Health, Care Coordination, and Quality Improvement.

Meridian is pursuing exchanges with State laboratories. In 2014, Meridian met with the University Hygienic Laboratory to discuss opportunities for data exchange and to evaluate completeness of reporting. Communication has continued into 2015 with the assessment of screening programs. In addition, Meridian is targeting health systems and providers for potentially obtaining information for medication reconciliation and discharge summaries.

Not only does Meridian work with provider networks, HIE projects, and laboratories, but Meridian is exploring the ability to work through EHR vendors for secure access to multiple records systems.

2. Describe how you propose to interface with the Iowa Health Information Exchange.

Meridian Health Plan has been actively working with the Iowa Health Information Network (IHIN) for several years. The IHIN has the capacity for secure, encrypted messaging and the IHIN team is focused on expanding network participation. Meridian recently supported the Iowa Department of Public Health (IDPH)'s effort to add legislative language to the IHIN administrative code allowing third-party payers access to the IHIN. This ability will differentiate Iowa from other states and will preclude the need to secure direct connections with individual providers and systems. Meridian is committed to continuing an active partnership with IDPH and the IHIN project as evidenced by past engagements.

3. Describe HIT initiatives you have implemented in other states.

Quality-Based Initiatives

Meridian Health Plan has multiple initiatives in other states involving electronic exchange of health information. Electronic exchanges are functional with Medicaid program State immunization registries in all three (3) states in which Meridian operates (i.e. Michigan, Illinois, and Iowa), which is a critical step in assuring integration with statewide exchanges and disease registries. Records from the Illinois and Iowa registries contain only immunization data; however, the Michigan registry provides body mass index (BMI) and immunization data.

In Michigan, Meridian has exchange capabilities with Wellcentive, a regional records exchange for more than 20,000 members. Bronson, Henry Ford, Park Family Medical, and Integrated Health Partners are partners as well.

In Illinois, Meridian connects with the Orders of Saint Francis (OSF) medical centers, a major provider for Illinois members.

Meridian accepts electronic submission of laboratory records from Home Access Health for Illinois and Michigan members and several other laboratories including LabCorp.

Targets for implementation in Michigan, Illinois, and Iowa include systems with significant numbers of attributed lives (>1,000) and are at a state of readiness for remote records access at a minimum.

Special Projects

Meridian has collaborated with several high-volume facilities and Physician Hospital Organizations (PHO) in an effort to reduce unnecessary emergency room utilization. Review of emergency room utilization at a collaborative high-volume facility revealed that a large percentage of the members were assigned to a specific large-volume provider. Upon investigation, Meridian identified that the office saw members on a walk-in basis opposed to scheduled appointments. This particular office stated that they had to resort to this process due to a large number of appointment “no-shows.”

Meridian Provider Services, Utilization Management, and the staff from the emergency room facility met with the provider office staff and PHO. Together, they developed a plan where the provider office staff agreed to work more closely with high-emergency room utilizing members. Specific strategies included providing more member education and developing an emergency room letter, which provider office staff would send directly to members with high emergency room utilization, and an agreement to schedule appointments with members within seven (7) days of the emergency room visit. The facility emergency room Case Manager scheduled the appointments for members and reinforced the importance of attending the appointment. Transportation was also arranged.

As a result of the Collaborative Initiative:

- The rate of primary care provider (PCP) visits within seven (7) days of the emergency room visit increased from thirty-nine percent (39%) in 2009 to fifty percent (50%) in 2010
- Consequently, the rate of emergency room visits decreased from thirty-eight percent (38%) in 2009 to twenty-four percent (24%) in 2010

In addition, another large network PHO has developed a formal education program for members identified as high-emergency room utilizers, which teaches members about health plan resources, their responsibilities, the patient-centered medical home (PCMH) concept, emergent situations versus non-emergent situations, and appropriate action during those situations. Meridian follows up with members with no-show PCP appointments to educate them on the importance of the PCP visit and identify barriers to accessing their PCP. Provider access issues are also identified through receipt of monthly reports that highlight providers with higher-than-normal emergency room utilization. Finally, Meridian meets with PCPs who do not have higher-than-average member emergency room utilization appointments readily available and discusses strategies for improving access.

Sickle Cell Pilot

Meridian recently collaborated with a large Provider Health Organization (PHO) to design a strategy, influenced by the Institute for Health Care Improvement, which would combine hospital and community resources to target a high emergency room utilizing population and decrease avoidable emergency room visits. Since pain management due to sickle cell crisis was the primary driver of “preventable admissions” at this PHO emergency room facility, members with sickle cell became the target population of this intervention.

Analysis of claims data showed that although these members were being seen by a hematologist, there was no consistent care plan offered by either the hematologist or emergency room

physicians to manage member pain or prevent a sudden onset of sickle cell crisis. The following actions and interventions were implemented:

- Meridian Utilization Management (UM) staff and the facility emergency room Case Manager met with the hospital-employed hematology group, which worked closely with the local ambulatory infusion center. This meeting resulted in an agreement where the hematology group would see twenty-five (25) Meridian members with sickle cell anemia who resided in the same county
- The emergency room Case Manager attended each member's first appointment with the hematology group
- Members were initially seen weekly by the hematologist and then were transitioned to monthly appointments
- Each member was required to sign a sickle cell treatment pain management contract with the hematologist. Members agreed to:
 - Keep a pain diary and bring it to each appointment
 - Bring medications to each appointment to ensure compliance
- An emergency room care plan was developed for each member and stored in the facility's EMR, accessible to all PHO providers
- Members were required to call the hematology group prior to going to the emergency room, even if after hours, which allowed hematologists to triage the members. If a member called a hematologist, he or she was seen that day and, if necessary, treated in the ambulatory infusion center
- Members who came to the emergency room were assessed and hematologists were called to discuss next steps
- Meridian enlisted the support of the Sickle Cell Disease Association's social workers to work with each member and make home visits

Results of this intervention strategy were positive. In comparison to baseline data, there were eight (8) fewer inpatient admissions, eighteen (18) fewer observation stays and twenty-six (26) fewer emergency room visits for this population. Primary care was shifted to the hematologist's office and outpatient care and treatment, if needed, was provided in the ambulatory infusion center instead of the emergency room. Ultimately, the cost of care was dramatically reduced, while the quality of care and quality of life for our members was increased.

SECTION 14 – PERFORMANCE TARGETS AND REPORTING REQUIREMENTS

Please explain how you propose to execute Section 14 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

- 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.**

Meridian Health Plan will complete all reports included in Section 14 of the Scope of Work by the specifications set in the Reporting Manual. All data reported shall be provided within the timeframes and the format specified by the State or any approved third-party data warehouses or analytic vendor. Meridian will ensure both financial and non-financial performance data submitted to the State is accurate pursuant to Meridian Policies and State requirements. All data submitted by Meridian will be certified by our CEO, CFO or direct designate with the appropriate authority to validate the information. All data submitted by Meridian will be attested as accurate based on the best of our knowledge, information and belief of accuracy in complete truthfulness and completeness. Any updates made to the Reporting Policies and Procedures shall be implemented within Meridian's processes as required by the State. Currently, Meridian completes all reports as requested and required by the State as we serve the current Iowa Medicaid Managed Care population. Meridian accepts an audit by the State at any time regarding self-reported data and is available to meet in-person or via conference calls regarding any performance data.

Understanding the importance of a flawless transition for the Iowa Medicaid Modernization, Meridian will respond to all State requests to monitor this implementation process. Meridian looks to support the State by allowing for the adequate oversight and correction of any problems necessary and to ensure satisfactory levels of member and provider services.

Meridian fully understands and will support any additional reports or revisions to the Reporting Manual and will implement them within the thirty (30) business days allowed by the State. If at any time the State requests an ad hoc report, Meridian will provide the information accurately and within the agreed upon timeframes. Meridian is uniquely positioned to respond to all required and ad hoc reports as all information is collected in Meridian's propriety Managed Care System (MCS) and reported directly from its own integrated programs or data warehouse. Any utilization of MCS for the Financial, Member Services, Provider Network, Quality Management, LTSS, Quality of Life, Utilization, Claims, CMS or IDPH reports and performance targets is specified for each of the applicable reports indicated below.

Financial Reports and Performance Targets

- *Third Party Liability Collections*
Meridian collects all third party liability (TPL) data in MCS, and can report it as needed to satisfy regulatory reporting needs in the timeframe and format determined by the State. We currently collect and report TPL information to the State that includes the payer, payer type, amounts allowed, and amounts paid or collected by the primary payer. This can be reported by member program, and by member sub-groups within programs. TPL information is stored at the claim line level, which makes it easily reportable from our system.

- *Iowa Insurance Division Reporting*
As described in the Iowa Administrative Code r. 191-40.14(514B), Meridian currently submits an annual report for our current health plan in the State of Iowa to the National Association of Insurance Commissioners (NAIC) in the form for health maintenance organizations on or before the first day of March and verified by at least two Meridian principal officers for the preceding calendar year. Meridian shall continue to comply with all reporting requirements in the Iowa Administrative Code section. The State is also copied on all required findings with the Iowa Insurance Division.
- *Annual Independent Audit*
An annual independent audit is currently performed for Meridian with an independent certified public account firm. Meridian shall continue to complete an annual independent audit as described in Section 2.3.5 of the Scope of Work.
- *Physician Incentive Plan Disclosure*
Meridian's Physician Incentive Plan does comply with 42 CFR 422.208 and 42 CFR 422.210.
- *Insurance Premium Notice*
Meridian submits all certificates of insurance within thirty (30) calendar days after the policy renewal effective date. We shall continue timely submissions based on policy renewal dates.
- *Reinsurance*
Meridian is reinsured through an outside organization and will provide to the State all contracts as requested. Meridian provides the reinsurer with monthly updates on members over the deductible and will report to the State, as dictated by the State, all health care claims costs paid by the Meridian's reinsurer due to meeting the reinsurance attachment point.
- *Medical Loss Ratio*
Meridian operates currently in a number of states where a minimum medical loss ratio is set. Through management reports that incorporate enrollment and revenue, medical and pharmacy claims payments, and any applicable payments non claims benefit expenses, including, but not limited to, HEDIS® bonus and Patient Centered Medical Home incentive payments. Meridian is capable of tracking, on a month-by-month basis, the medical loss ratio of the plan. Meridian will maintain under this agreement, at a minimum, a medical loss ratio of eighty-five percent (85%). Any estimates for incurred, but not reported, claims payments are applied where applicable until sufficient claims run out has completed the claims history. Meridian relies upon understanding and proper interpretation of the rate setting documents in order to identify key areas where management of the member benefit will need to be focused in order to ensure compliance with the required medical loss ratio. Over- or under-utilization are tracked and areas of concern are addressed in a timely manner through clinical programs, member outreach and provider education, thus allowing Meridian to meet the minimum medical loss ratio while providing the highest quality of care to members.

Member Services Reports and Performance Targets

- **Completion of Initial Health Risk Screening**
Meridian will use all efforts to complete an initial health risk screening within ninety (90) calendar days and utilize MCS through the Assessments and Contact Log functionality. Meridian will use MCS to track each newly enrolled member to ensure at least seventy percent (70%) complete an assessment if they have been enrolled for ninety (90) continuous days. MCS will also hold documentation that Meridian conducted at least three (3) attempts to complete the screening.
- **Completion of Comprehensive Health Risk Assessment**
Meridian currently tracks and monitors comprehensive risk assessment data for several other Medicaid plans currently in operation, including the State of Iowa. This data is tracked in MCS through the assessments functionality. The data can be extracted from MCS and the approved comprehensive risk assessment tool for reporting purposes and to ensure compliance with related requirements outlined in Section 9.1.2 of the Scope of Work. The assessment shall include (i) a review of the member's claims history; (ii) contact with the member and his/her family, caregivers or representative; and (iii) contact with the member's health care providers.
- **Care Plan Development**
Meridian currently tracks and monitors care plan development for several other plans currently in operation. This data is tracked in MCS through the care plan and Contact Log functionality. The data can be extracted from MCS for reporting purposes and to ensure compliance. One 100 percent of members identified as having a potential special healthcare care need will have a care plan developed. All care plans will be updated annually.
- **Member Helpline Performance Report**
Meridian prides itself on consistently providing an excellent level of customer service. In order to ensure our call center is processing calls timely and efficiently, Meridian's Member Services Department continually monitors telephone queues, runs reports, and identifies opportunities for improvement. Meridian shall exceed the minimum service level of eighty percent (80%) for incoming calls that is calculated with this equation: $SL = ((T - (A + B)) / T) * 100$ where T= all calls that enter queue, A=calls that are answered after thirty (30) seconds, B=calls that are abandoned after thirty (30) seconds. Meridian is able to pull this daily in order to ensure we are meeting quality standards.
- **Member Enrollment and Disenrollment**
All enrollment and disenrollment data is stored in MCS and can be extracted for reporting purposes. Enrollment and disenrollment reporting is frequently accessed and utilized across all Meridian plans currently in operation. Through continuous enrollment functionality, Meridian can determine how long the members were continuously enrolled on the plan and in turn, Meridian can break out disenrollment data to show disenrollment occurring during the member's initial ninety (90) day enrollment period and disenrollment occurring after such enrollment period for cause.

- *Member Grievances Report*

Meridian through its integrated MCS captures all grievances from a single point of entry and routes them to a work queue for monitoring and processing. Each grievance is assigned a due date based on the level indicated (i.e. standard or expedited), which appears in the work queue. Escalation points exist for each level: once a grievance reaches a defined number of days/hours open without a resolution, it highlights in red and jumps to the top of the work queue for increased visibility so staff can prioritize to resolve 100 percent of grievances within thirty (30) calendar days of receipt, or three (3) business days of receipt for expedited grievances.

MCS produces an on-demand report that provides staff with current status of all grievances; this report is used for ongoing monitoring activities to ensure grievances are being triaged and processed within contractual timeframes. The report contains a summary tab that displays, for each category of grievance, the number of grievances open in each work flow state (i.e. validation and assignment, department investigation, resolution review). The detail tab displays extensive data regarding each grievance if additional information is needed.

- *Member Hearing and Appeals Report*

MCS captures both pre-service and post-service appeal requests, prompting entry of all data necessary for reporting requirements. Upon entry, the appeal case generates a record to a work queue for monitoring and processing. The appeal is assigned a due date based on the type and level of appeal initiated, which appears in the work queue. If an appeal case reaches a defined number of days/hours open without a resolution, it highlights in red and moves to the top of the work queue for increased visibility. This escalation feature allows staff to prioritize and complete 100 percent of appeals within forty-five (45) calendar days of receipt, or three (3) business days of receipt for expedited appeals. One hundred percent (100%) of appeals shall be acknowledged within three (3) business day.

MCS produces an on-demand report that provides staff with the current status of all appeals. This report is used for ongoing monitoring activities to ensure appeals are triaged and processed within contractual timeframes. The report includes detail regarding the type of appeal, original denial information, appeal initiation, reviewer, and appeal decision and notification (once the appeal has been completed).

- *Summary of Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Survey*

Meridian participates in the annual CAHPS® survey process as part of National Committee for Quality Assurance (NCQA) accreditation and annual ratings submissions. CAHPS® surveys are administered by an independent, NCQA-certified vendor to an auditor-approved sample of Meridian members. Members are asked their opinions of services received and encounters with their health plan within the six months prior to the survey.

CAHPS® allows identification of areas of high performance and where improvement is needed. Data are calculated into composite scores for comparison to the national score and into percentile rankings. As with HEDIS®, Meridian strives to reach the ninetieth (90th) percentile in all areas of member experience.

Meridian initiated its first Iowa specific Adult CAHPS® survey in 2014 to capture member experience. Meridian reached a twenty point five percent (20.5%) response rate, completing 353 surveys. There were 1,369 members who did not respond to mailings or phone calls and thirty-three (33) were determined to be ineligible. Interpreter services were used for Spanish-speaking members. (Interpreter services for Meridian members are available in over 170 languages).

Demographic data revealed solid distribution of surveys among race and ethnic group. The age of members reached was representative of the actual member population. Self-reported health status indicated most members have very good or good health, with only eighteen percent (18%) reporting fair or poor health status. Meridian Health Plan of Iowa reached the ninetieth (90th) percentile for five (5) measures, the seventy-fifth (75th) percentile for four (4) measures and two (2) measures in the fiftieth (50th) percentile (specified below). These results exceeded goals for the 2014 reporting year.

| Meridian Health Plan of Iowa – 2014 CAHPS® Performance – Key Measures | |
|--|---|
| 90th Percentile | <ul style="list-style-type: none"> • How well doctors communicate • Show respect for what you say • Listen carefully to you • Explain things so you understand • Rating of personal doctor |
| 75th Percentile | <ul style="list-style-type: none"> • Spent enough time with you • Getting needed care • Appointment with specialists • Discussing Strategies |
| 50th Percentile | <ul style="list-style-type: none"> • Got care when needed • Rating of health care |

Meridian reviews the results of the CAHPS® surveys, even member comments, to identify areas of needed improvement. Results of the survey were communicated to providers through educational documentation with State-specific results. In addition, provider satisfaction surveys were administered and results aligned with CAHPS® for department-level areas of improvement. Results of every CAHPS survey shall be submitted to the State not less than annually.

- *Member Website Utilization Report*
Meridian runs a summary report on a monthly basis to show how members are accessing our site. For example, the total number of page hits, as well as how many hits were counted for each page in the site. Meridian shall provide data regarding hits for EOB and quality information, such as immunizations and screenings. Meridian will track and report the number of members accessing these pages to the State as requested.
- *Member PCP Assignment Report*
 - *Total member enrollment count for those members under a Value Based Purchasing arrangement for the reporting period*
Meridian shall report the total member enrollment count for those members under a Value Based Purchasing arrangement for the specified reporting period. Meridian shall identify those providers associated with a Value Based Purchasing

arrangement and shall generate the enrollment report for the individual provider and/or for the provider group as a whole. Meridian shall provide the report in the format and frequency as determined by the State.

- *Total member disenrollment county for those members disenrolled from a Value Based Purchasing arrangement for the reporting period*
Meridian shall report the total member disenrollment count for those members disenrolled from a Value Based Purchasing arrangement for the specific reporting period. Meridian shall identify those providers associated with a Value Based Purchasing arrangement and shall generate the disenrollment report for the individual provider and/or for the provider group as a whole. Meridian shall provide the report in the format and frequency as determined by the State.
- *A separate, detail report showing each member assignment to their PCP, including, but not limited to, the individual PCP (name, NPI), physical location, affiliated organizational NPI(s), organizational name and organizational tax ID*
Meridian shall provide a separate, detail report showing each member assignment to their PCP, including, but not limited to, the individual PCP name and NPI, physical location, affiliated organizational NPI(s), organizational name and organizational tax ID. Meridian shall generate the enrollment report which includes the specified data for all Meridian members in the format and frequency as determined by the State.

Provider Network Reports and Performance Targets

- *Network Geographic Access Reports for Providers*
Meridian shall ensure access for 100 percent of members within the network adequacy standards outlined in Exhibit B or any additional adequacy standards developed by the State. Meridian shall comply with all requests for network geographic access reports to demonstrate the network access standards have been met.
- *Twenty-four (24) Hour Availability Audit*
Meridian routinely conducts audits, pursuant to NCQA standards, of all network providers' availability to ensure appropriate access is available to members. Meridian shall ensure 100 percent of contracted primary care providers are available twenty-four (24) hours a day, seven (7) days a week as necessary and required. If, through the audit process, Meridian identifies any primary care providers not meeting the appropriate and required accessibility standards, Meridian shall implement corrective actions plans directly with the primary care providers to ensure the standards are met.
- *Provider Credentialing Report*
Meridian has credentialed over 61,000 providers over the past three (3) years, with no provider exceeding a thirty (30) calendar day turnaround for initial credentialing. Meridian processes files in full compliance with CMS, URAC and NCQA as well as State and Federal requirements. Meridian shall provide reports which detail the timeliness and effectiveness of the Credentialing process. Meridian shall measure the timeframes for Credentialing starting once all necessary credentialing information from the Provider. Completion time will end when written communication is sent to the provider notifying them of Meridian's decision. At no time the provider credentialing of all providers will

exceed; ninety percent (90%) within thirty (30) calendar days and 100 percent within forty-five (45) days.

- *Subcontractor Compliance Summary Report*

Meridian shall submit summary reports of the quarterly formal reviews of all subcontractors in the prescribed format, including all key findings and any corrective action plans implemented.

Meridian requires subcontractor reporting on a monthly, quarterly and annual basis. Meridian monitors report submission including whether they are received timely and all information is provided. Ongoing communication is maintained with the subcontractor to obtain needed information. Compliance staff reviews the reports and complete an ongoing monitoring tracking grid for the specific performance metrics that are required. Formal reviews of metrics and report submissions occur on a quarterly basis. Subcontractor performance is summarized and reviewed by the Compliance Committee on an ongoing basis and after the aforementioned quarterly performance review.

If the Compliance Officer deems the subcontractor failed to meet performance requirements is adversely impacting member services, the subcontractor is placed on an immediate corrective action plan (CAP). If the findings are to such a level that there are serious concerns of non-compliance, the Compliance Officer will call an ad-hoc Compliance Committee to review the findings. The Compliance Committee will make the determination as to whether the subcontractor may be terminated immediately or if other actions are necessary, if permitted pursuant to the written agreement. The subcontractor is notified in writing regarding the actions that will be taken including any applicable correction action requirements. The subcontractor must submit a plan to address the deficiencies for approval. The State is informed of performance monitoring and reviews upon request and will be notified any time a subcontractor is placed on corrective action including reporting the findings of the quarterly reviews and applicable CAPs in the quarterly summary reports. The Compliance Department monitors the implementation of the CAP and ensures that the subcontractor is meeting all requirements including an improvement of any performance metrics that were not meeting the performance threshold. Upon completion of the timeframe of the CAP, Compliance staff will prepare a report summarizing the activities performed by the subcontractor and whether the subcontractor has met the terms of the CAP. If the subcontractor has satisfactorily met the terms of the CAP, the Compliance Officer will prepare the appropriate documentation to store with the subcontractor's file. The outcome of the CAP shall be reported in the quarterly summary reports to the State.

- *Provider Helpline Performance Report*

Provider calls are routed into an appropriate queue using IVR selections. Queues are monitored in order to ensure appropriate queue coverage and Telephone Service Factor (TSF). Daily, weekly, and monthly reports are run to ensure queue coverage and to identify trends in call volume, TSF, Abandonment Service Factor (ASF), and call inquiries. Meridian shall provide reports which detail the service level. Meridian shall exceed the minimum service level of eighty percent (80%) for incoming calls that is calculated with this equation: $SL = ((T - (A + B)) / T) * 100$ where T= all calls that enter queue, A=calls that are answered after thirty (30) seconds, B=calls that are abandoned after thirty (30) seconds. Meridian's goal is 100 percent for all incoming calls. Reports can be run out of MCS to identify call inquiries via contact codes. Contact codes are placed into

provider profiles in order to categorize the reason for their call. All inbound and outbound calls are recorded in MCS within the provider contact log to allow for tracking, reporting and ensuring message consistency.

Quality Management Reports & Performance Targets

Meridian Quality Management reports are used to identify opportunities for clinical or program improvement enabling review of appropriate access, level of care, quality, and utilization of program services by members and providers. Meridian shall provide information requested by the State to support quality management tracking of performance targets. Meridian currently utilizes NCQA HEDIS® and nationally recognized data to continuously improve the quality of care for our members.

Meridian HEDIS® data is pulled directly from MCS and may be viewed real-time. HEDIS® measures are essential to quality monitoring of population health. The Meridian Quality Improvement Department routinely investigates variances in rates, track longitudinal trends, comparison to performance within the State, and to other Medicaid plans nationally. A standard quality operations report is provided as Attachment 33 (Operations Report) in Tab 5.

- *Quality Management and Improvement Program Work Plan*
Quality Improvement initiatives are embedded in the culture and daily functions of Meridian. Enterprise goals consistently emphasize the criticality of providing high quality healthcare. Longitudinal planning is essential for ensuring quality improves throughout periods of growth. Experience, including established community partnerships, has been essential in determining which interventions are successful long-term, and positively impact member health.

The Meridian Quality Improvement Program operates using a continuous strategic planning cycle. State-specific plans are evaluated annually along with an accompanying work plan. The annual plan contains goals and measureable objectives which are tracked using key performance indicators (KPIs). Progress reporting on KPIs occurs weekly and helps identify areas needing focus or programmatic adjustment. The weekly report template limited to goals and objectives for the current year is provided as Attachment 31 (Quality KPIs) in Tab 5. Goals are expected to evolve over time and the department strategic plan is reviewed twice a year. Work plans are utilized to ensure daily activities are performed in support of goals and objectives. The current year sample work plan is provided as Attachment 32 (QI Work Plan) in Tab 5. Meridian shall submit an official draft plan within fifteen (15) days of Contract execution.

The Value Index Score (VIS) tool is a dynamic and valuable resource for consumers and providers. VIS indicators stretch beyond the requirements of HEDIS® and provide an encompassing picture of the provider's member attribution. Meridian participated in the early and ongoing stages of implementation of VIS in Iowa. As one of only two managed care organizations in Iowa, Meridian joined planning sessions, measurement evaluation, and provided feedback to the State on the State Innovation Model (SIM) and use of VIS. Over the past year, Meridian has routinely provided encounter data to the State for incorporation into the VIS tool, with the intent of producing provider-centric feedback on the provision of care. Results from VIS are not available at this time, though release is slated for some time in 2015. If selected, Meridian will continue its existing engagement with SIM and other value-driven initiatives as requested by the State.

- *Quality Management Committee Meeting Minutes*
Quality Improvement Committee (QIC) quarterly meetings are scheduled three (3) months in advance to ensure attendance and the State shall be notified of these meetings at least ten (10) days prior to the meeting. These meetings are also transcribed and thorough meeting minutes are recorded and sent to the State within thirty (30) days after the meeting date. The meeting minutes will reflect actions recommended and taken as detailed at the QIC and will be provided in the aforementioned reporting timeframes.
- *Care Coordination Report*
Meridian shall provide care coordination reports in accordance with the specifications outlined by the State and within timelines requested.
- *HEDIS® Report*
Meridian Health Plan of Iowa participated in the first accreditation audit and Quality Compass ranking cycle for the National Committee for Quality Assurance (NCQA) in 2014. As part of the application process, Meridian completed a roadmap of all data collection, storage, and reporting for the Healthcare Effectiveness Data and Information Set (HEDIS®). An NCQA-certified auditor conducted an on-site review of the roadmap in early spring 2014. Meridian submitted final results for 2014 to the NCQA reporting site in June 2014. The final auditor's report was obtained at that time certifying Meridian's data. The final audit report is found in Attachment 41 (NCQA HEDIS Compliance Audit) in Tab 5.

No less than annually Meridian shall conduct an annual HEDIS® audit survey and shall submit the compliance auditor's final report to the State in concert with the annual submission to NCQA. Meridian anticipates receiving performance targets from the State and shall supply data evidencing progress on performance measures as required.

- *Quarterly Health Outcomes and Clinical Reports*
 - *Behavioral Health*
Data is captured which will allow Meridian to report on the medical and pharmacy utilization of members as it pertains to (i) Follow-up after inpatient hospitalization for mental illness; (ii) readmission rates for psychiatric hospitalizations; (iii) anti-depression medication management; (iv) follow-up care for children prescribed attention deficit hyperactivity disorder (ADHD) medication; (v) diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication; (vi) adherence to antipsychotic medications; (vii) number and percentage of members receiving mental health services; (viii) number and percent of members receiving substance use disorder services; (ix) identify foster children by a common identifier, their age, diagnosis, prescribed medications; and (ix) shall identify foster children prescribed two or more psychotropic medications, psychotropic prescriptions, and diagnoses to support prescribing pattern.
 - *Children's Health*
Meridian shall report on (i) EPSDT screening rate; (ii) well-child visits; (iii) adolescent well-care visits; (iv) childhood immunization status; (v) adolescent immunization status; (vi) developmental screening for children age zero to three (0-3); and (vii) report foster children receiving EPSDT screenings.

- *Prenatal and Birth Outcomes*
Information pertinent to reporting outcomes is captured in the claims and authorization data that allow Meridian to track (i) Number of infants born between thirty-four (34) and thirty-six (36) weeks gestation; (ii) percentage of deliveries that received recommended prenatal and postpartum visit; (iii) cesarean rate; and (iv) frequency of ongoing prenatal care.
- *Chronic Condition Management*
The data warehouse and MCS capture data that allow the data analysis and clinical analytics teams to identify members with chronic conditions, such as (i) diabetes; (ii) cardiovascular conditions; (iii) HIV/AIDS; (iv) COPD; (v) asthma; (vi) chronic kidney disease; and (vii) other chronic conditions prevalent among enrolled program membership.
- *Hospitalization and ER*
Meridian Health Plan uses the NYU Algorithm to identify (i) potentially preventable admissions; (ii) hospital readmission rates; (iii) potentially preventable ER visits; and (iv) emergency room diversion.
- *Adult Preventive Care*
As with children's health, HEDIS® reporting captures adult preventive services, such as (i) cervical cancer screening; (ii) breast cancer screening; (iii) colorectal cancer screening; and (iv) adult access to preventive/ambulatory health services.

LTSS Reports and Performance Targets

- *Nursing Facilities Admission Rates/Nursing Facility Days of Care*
Meridian shall use the established State baseline data to compare and identify areas of action to ensure the decrease in the number of nursing facility, ICF/ID and PMIC admission rates and days per 1,000 members. The Clinical Analytics Team, in partnership with Medical Management shall use this data to develop programs for member outreach and intervention, as well as coordination of care to ensure that each member receives the appropriate care. Trend reporting over time shall demonstrate the decrease in the aforementioned metrics.
- *Return to Community*
Meridian currently tracks member movement as it pertains to discharge status from a nursing facility, ICF/ID or PMIC in other states. Using the State developed baseline rate, Meridian shall track the members returning to the community following discharge from these facilities and shall use the internal rates to establish clinical programs to increase the number of members who can successfully return to the community.
- *ICF/ID and PMIC Report*
As this data is captured in the system, Meridian is confident that any measures determined by the State for tracking the services performed at ICF/ID and PMICs shall be accurately reported.
- *Fall Risk Management*
Meridian shall work with providers interacting with patients in long-term care facilities to identify members at-risk for falling, and shall provide guidance on what fall risk

interventions may be appropriate. Meridian actively distributes provider education materials and provides clinical practice guidelines on its website. Meridian shall comply with the requirement to report the percentage of members in long-term care at risk for falling and those who receive intervention following a visit with a practitioner.

- *Hospital Admission after Nursing Facility Discharge*
The identification of members with a nursing facility discharge and subsequent admissions within thirty (30) days is maintained and readily available within MCS and the Meridian data warehouse. Meridian is able to track those members who had an admission within thirty (30) days of a nursing facility discharge and can compare that information to the State established baseline. Clinical programs are developed to ensure those members who need care coordination and interventions are afforded the appropriate care in order to decrease the number of admissions following a nursing facility admission.
- *Self-Direction*
Meridian currently tracks this information for all members receiving Home and Community-Based Services (HCBS). This data is tracked in MCS through the Service Level Plan and Authorization functionality. The data can be extracted from MCS for reporting purposes. Once the State establishes a baseline rate, Meridian will implement continued improvement activities with the goal of demonstrating an increase in self-directed services.
- *Timeliness of Level of Care*
Meridian currently tracks this information for all members receiving Home and Community-Based Services (HCBS). This data is tracked in MCS through the LTSS assessment functionality. A 'Reassessment Due By' field is included on the LTSS assessment screens. One hundred percent (100%) of reassessments shall be completed within twelve (12) months of the previous assessment. This data can be extracted from MCS for reporting purposes and to ensure compliance.
- *Timeliness of Needs Assessment and Reassessments*
Meridian currently tracks and monitors this information for all members receiving Home and Community-Based Services (HCBS). This data is tracked in MCS through the Enrollment and LTSS assessment functionality. One hundred percent (100%) of needs assessments shall be completed within the timeframe mutually agreed upon in contract negotiations. This data can be extracted from MCS for reporting purposes and to ensure compliance.
- *Care Plan and Case Notes Audit*
Meridian currently tracks and monitors this information for all members receiving Home and Community-Based Services (HCBS). This data is tracked in MCS through the care plan, Service Level Plan, Member Care Team, and Case Note functionality. This data can be extracted from MCS for reporting purposes and to ensure compliance. Additionally, Meridian currently participates in quarterly audits with outside auditors sub-contracted in other State Medicaid programs. The audit consists of a system walk-through that determines Meridian compliance with all items indicated in Section 14.6.10 of the Scope of Work.

- **Critical Incident Reporting**
The Quality and Performance Improvement Department tracks and monitors all critical incidents that are reported and the tracked members are advised of their rights and to what extent reasonable accommodations were provided. All Critical Incident are reported up to the Quality Improvement Committee (QIC) and to the State. Meridian shall send a Critical Incident Report on a quarterly basis to the QIC for Iowa. Meridian shall provide baseline data to the State. The Critical Incident Report shows reoccurring incidents with a provider as well as swift and appropriate action, such as establishing a corrective action plan or terminating a provider contract. The report shall also document the number, rate of incidents per member population, and type of critical incident. The QIC is charged with making recommendations when reviewing critical incidents, when appropriate, and ensuring timely and complete follow-up occurs.
- **Out of State Placements**
Meridian shall capture member information and have the ability to report on members receiving out-of-state placements.

Quality of Life Reports and Performance Targets

Quality of life indicators are essential to long-term health satisfaction and affect anticipated life expectancy. Such indicators typically include life expectancy, parsed by sex and race group and reassessed with every annual birth cohort, self-reported health status, employment status, general life satisfaction, and housing status. Data elements needed to calculate life expectancy are currently collected by Meridian; however, employment status, volunteer activities, and satisfaction are not. Housing status is collected in a Health Risk Assessment.

Meridian shall collect this data using member and provider survey tools, Health Risk Assessments, and other key quality metrics. All results shall be submitted to the State and stakeholders, and shall be submitted as part of the EQRO validation process.

Utilization of Reports and Performance Targets

- **Program Integrity Plan**
The Utilization Management Program Evaluation is reviewed and updated annually. Progress reports are reviewed and reported quarterly, consisting of documented summaries of utilization statistics including behavioral health. The Utilization Management committee is used to identify trends and variations and to discuss possible interventions for implementation to increase appropriate utilization and health of Meridian's membership.
- **Prior Authorization Report**
Utilization Management (UM) Department shall render standard authorization decisions within seven (7) calendar days of requests for service, or three (3) business days for expedited authorization decisions. UM runs daily decision Turn Around Time reports that are assessed and managed by Department leadership. All State and Federal guidelines are adhered to in relation to decision turnaround time. For pharmacy prior authorization, 100 percent of authorization decisions shall be rendered within twenty-four (24) hours of the request for service. Each quarter, Meridian shall submit a summary report of approvals, pending requests, and denials.

- Pharmacy Rebate Reporting
Meridian will support the State as it participates in the Federal supplemental drug rebate program. As such, Meridian and its subcontractors, including their affiliated pharmacy benefit manager, MeridianRx, will be prohibited from obtaining manufacturer drug rebates or other form of reimbursement on the Medicaid members.
- Pharmacy Reporting
As it relates to the pharmacy program, Meridian is able to provide reporting specific to Pharmacy Help Desk Performance, Prior Authorization (PA) Performance, PA Request Turnaround Time, the Number of Pharmacy Claims Submitted as a seventy-two (72) hour Emergency Supply, Denials (including, but not limited to, the name of the drug, the number of requests and the number of denied requests), Pharmacy Network Access, Grievance and Appeal Data, and Quality Program Data (including, but not limited to, Medication Therapy Management (MTM) Program Initiatives and Outcomes).

Claims Reports and Performance Targets

- Adjudicated Claims Summary, Claims Aging Summary, and Claims Lag Report
Meridian has procedures in place to monitor claims performance on a real-time basis, and management is apprised daily of aging claims by claim type and source. Resources are allocated as needed to ensure adjudication of all claims in a timely manner, with exceptions handled by placing special holds on claims. Our system has the capability to store a “clean” date in situations where a claim is considered complex and requires additional information in order to adjudicate the claim. Claims requiring additional information are placed in a “HOLD” status and are monitored separately, and if requested information is not received timely from providers, the claims are rejected in order to meet all required processing timelines. Meridian shall pay or deny ninety percent (90%) of clean claims within fourteen (14) days of receipt, ninety-nine point five percent (99.5%) of clean claims within twenty-one (21) days of receipt and 100 percent of claims within ninety (90) days of receipt.
- Claims Denials Reasons
Each denied claim is assigned a reason code to report why the claim was not accepted. We shall provide codes for the top ten (10) claim denials and can provide reports associated with these denials.
- CMS Reporting
Meridian shall provide any data necessary to report on Federal waiver requirements as requested by CMS, in the timeframe specified by the State and CMS.
- IDPH Reporting
The appropriate data needed to satisfy the reporting requirements can be programmed and pulled, based on IDPH specifications, through the Managed Care System (MCS) and data warehouse. Meridian shall create the reports based on specifications provided by IDPH to support the Substance Abuse Prevention and Treatment Block Grant and other reports as requested by the State.

2. Describe additional data/reports you are capable of providing that can help the State evaluate the success of the program.

Efforts to evaluate program success and member health status stretch beyond the use of HEDIS® derivation. While HEDIS® metrics are useful and allow for health plan performance comparisons; due to stringent technical specifications, they do not sufficiently characterize population differences by geographic areas, benefit plans, or other epidemiologic patterns of health.

Meridian Health Plan has extensive experience developing reports for performance improvement plans, unique population analyses, and trend reviews. Examples for any State Medicaid program include the following:

| Report | Characterization of the Medicaid Expansion Population |
|-----------------|--|
| Data | Population descriptive analyses using claims, Health Risk Assessment, and enrollment data. |
| Outcomes | Smoking prevalence exceeded forty percent (40%); high utilization was identified in middle-aged males; self-reported health status was a predictor of utilization. |

| Report | Emergency Room Performance Improvement Plan: Focus on Racial Disparity |
|-----------------|--|
| Data | Emergency room utilization data for calendar year 2014 by member and major diagnostic category. |
| Outcomes | Racial disparities were found using utilization ratios; counties with five or more visits among African Americans compared to white members were included in secondary analyses; significant racial disparities were present among pregnant women using the emergency room for pregnancy-related cause including genitourinary infections; disparities were also seen for young members receiving care for respiratory infections. |

| Report | Influenza Prevention Program |
|-----------------|---|
| Data | <ul style="list-style-type: none"> • Claims – professional and pharmacy; immunization registry • Outreach activities – provider faxes, member contacts, member education, provider education |
| Outcomes | Vaccination coverage was determined for previous seasons by place of service (most often an outpatient facility), age group, and benefit plan. Utilization of antiviral medication was tracked along with influenza-associated hospitalizations. These data will serve as a baseline for interventions in future flu seasons. |

As evidenced by the previous reports, Meridian actively uses data outside of claims such as Health Risk Assessment, enrollment, outreach, immunization, and even supplemental survey data to augment routine data sources. These data may be provided to the State to better evaluate the successes attained by Meridian.

In addition to supplemental data sources, Meridian shall continue to supply encounter data to support Treo's Value Index Score (VIS) efforts. Meridian has been an active participant in the establishment of the VIS over the past year by providing feedback on domains and measures, and in the monthly provision of data. VIS is likely to be a comprehensive and critical source of provider-centric data allowing members and providers in-depth view of quality performance. These data will also empower the State to determine program success outside of traditional reporting requirements or performance measurement.

- 3. Describe your internal operational structure that will support the compilation of the performance data and reporting processes of the programs, including:**
- a. The qualifications and experience of the staff responsible for the production and delivery of performance data to the State.**

The following departments and indicated staff are responsible for the production and delivery of performance data to the State.

Clinical Performance and Analytics

The Quality and Performance Improvement Department sits within the Division of Clinical Performance and Analytics (CPA). CPA is comprised of experienced epidemiologists, statisticians, and clinicians. The group designed Meridian Health Plan's care transformation initiative, including the use of predictive modeling to ascertain utilization behavior and targeted behavior interventions.

A comprehensive clinical analytics capability allows Meridian to use data, rather than anecdote or assumptions, to understand their member population in details. This allows targeted clinical program development based on addressing well-defined care gaps or other issues impacting related items such as adequate access to care. This approach is at the heart of developing member-centered programs and interventions to understand and address those root causes which underlie gaps in care.

The following individuals and roles lead the Clinical Performance and Analytics Team:

- *Edwin Dasso, MD, Senior Vice President of Clinical Performance and Analytics*
Heavily involved in managing clinical analytics groups and related population health program development for over two decades; he has held this role in both of the two largest managed care organizations in the US prior to joining Meridian.
- *Jean Sconza, RN, MHA, Vice President of Clinical Analytics and Programs*
Prior to joining Meridian, Ms. Sconza oversaw the Clinical Improvement & Analytics group of a national managed care organization for over a decade.

Quality and Performance Improvement

The Quality and Performance Improvement Department has a staffing structure designed to respond to changes in population composition and/or health while sustaining the highest level of quality care. The Department is led by a doctoral-level Vice President, who oversees the business units within the Department including Clinical Program

Development, Performance Improvement, Medicare Star Ratings, and State-level quality departments.

The Clinical Program Development unit is responsible for the design, coordination, monitoring, measurement, and evaluation of outreach efforts. Efforts include member outreach; education, mailings, incentives, focuses groups, telephonic contact, etc. The unit also collaborates with Network Development to refine provider education initiatives, training, and outreach. This unit performs the functions of disease management by examining the impact of outreach interventions on health status. The unit has analytic capacity to assess variance in populations using principles of epidemiology.

The Performance Improvement unit is dedicated to intensive monitoring of quality metrics, including the HEDIS®, State-specific performance measures, and population health metrics. Meridian captures multiple data sources including historical claims, demographics, claims, and Health Risk Assessment surveys. Data are accessible through MCS database extracts and through Meridian's data warehouse.

In Iowa, the Quality Department made great strides in accomplishing exceptional population health goals in a short period of time. Due to the uniqueness of each state wherein Meridian operates, quality departments specific to the State are located within local offices. Five (5) staff and a Director support the core functions of the Department. The State Quality teams prioritize population-specific health needs and frequently collaborate with community health partners. Community collaborations are essential to building and sustaining success in quality improvement.

In addition to the committee and subcommittee infrastructure, Meridian has dedicated resources to ensure all aspects of Quality Improvement are achieved.

The Quality Improvement Department includes the following staff:

- *Meghan Harris, MPH, MPA, Ed.D., Vice President of Quality and Performance Improvement*
Collaborating with the State of Iowa for many years, Dr. Harris brings a wealth of experience in improving the population health of Iowa's citizens. She has thirteen (13) years' experience leading community health programs, is an accomplished epidemiologic researcher, former professor, and holds masters' degrees in public health and public administration, and a doctorate in education leadership. Dr. Harris is a skilled collaborator cultivating relationships between Meridian and State partners, as well as employing quality data to drive decision-making.
- *C. David Smith, MD, Medical Director*
As an experienced administrator and surgeon licensed in the State of Iowa, Dr. Smith has delivered and coordinated care to Iowa residents for over thirty (30) years.
- *Amy Muhlenbruck, MSN, RN, Director of Quality Improvement*
Focused on quality care, Amy has over a decade of experience working to increase the quality of care in all settings with a focus on long-term care, hospice, facilities and outpatient clinics.

Local Quality Coordinators, HEDIS® Coordinators and a Junior Analyst support the Department leadership, work directly with Member Services, Provider Services, Care Coordination, Utilization Management, and Communications to implement Performance Improvement Projects (PIPs), related activities, and to ensure compliance.

Data Analytics

Meridian's Data Analytics Department is led by the following individuals:

- *Matthew Payne, Director of Financial and Medical Analytics*
With over ten (10) years of experience with Meridian, Mr. Payne oversees all operations in the Department.
- *Jon Licovski, Manager of Financial and Medical Analytics*
Mr. Licovski supervises a team consisting of fourteen analysts and team leads of varying levels and experience. He brings eight (8) years of experience to this role.
- *Melissa Zynda, Manager of Financial and Medical Analytics – Pharmacy & Medicare*
Ms. Zynda has been with the analytics team for five (5) years and currently oversees a team of seven (7) analysts focused on the dual members, pharmacy outcomes and quality of care.
- *Thomas Lauzon II, Manager of Data Analysis - Special Projects*
Mr. Lauzon has been with the company for six (6) years focused on data analytics and improving care.

The knowledge of our experienced leaders is filtered down to our analysts and junior analysts who create and analyze the reports. The company's employee development programs allow for growth and development of current and new employees.

Information Technology (IT)

Meridian's Information Technologies (IT) Department leadership structure supports the creation and delivery of accurate reports to the State. The IT leadership team includes:

- *Chief Information Officer*
Joining Meridian in 2014, Ms. Takai has spent the last decade as CIO of government-owned IT Departments in Michigan, California and the U.S. Department of Defense.

Educated at the University of Michigan, Takai spent thirty (30) years at Ford Motor Company, helping the company implement a global IT strategy for such departments as engineering, marketing, purchasing, supply chain and financing. She then spent several years as managing director for Electronic Data Systems and as process development director at Federal-Mogul Corp. before moving to support State IT Departments. Ms. Takai's most recent role was within President Barack Obama's administration as the CIO for the U.S. Department of Defense.

- *John Colaluca, Director IT Application Delivery*
Mr. Colaluca is responsible for directing the strategic and tactical operations of the IT Application Delivery group and all of its components including application development, solution architecture, business analysis, and application project delivery.

With over twenty-five (25) years of software application planning, design, development, implementation and support experience in health insurance IT, Mr. Colaluca's presence in the IT Department was immediately beneficial when he joined Meridian in 2011. John received his Bachelor of Business Administration from Northwood University and his Associate of Applied Science from Macomb Community College.

- *David Loo, Director of Infrastructure*
Mr. Loo is an accomplished Business and Operations Leader with extensive, global experience in achieving operational effectiveness, profit improvement, growth and client satisfaction. He has over twenty-five (25) years of experience in IT Leadership at CSC, HP and EDS plus nine (9) years of experience in the Aerospace Industry as an Aerospace Engineer and Manager. David received his Masters of Science, Aeronautics and Astronautics, from the Massachusetts Institute of Technology and his Bachelors of Science, Mechanical Engineering, from the Massachusetts Institute of Technology.

- *Mike Timm, MBA, CPIM, PMP Director Business Planning and Program Management Office - IT*
Mr. Timm specializes in creating systems that result in organizations that promote leadership, profitability and support organization goals and performance. Mike's process design and improvement, Lean Six Sigma Black Belt, and significant experience with SEI-CMM (particularly Levels Two (2) and Level Three (3)), coupled with his project management experience, supports his commitment to continuous improvement. Mike's experience includes team organization and development of leadership skills, process improvement (lean manufacturing, software development, business), and project/program management.

Mike received his Bachelor's degree from General Motors Institute (a.k.a. Kettering University) and his Masters of Business Administration from Northern Illinois University

- *Dana Ashley Green, MBA, CPA, PMP, Director of EDI*
Ms. Green has over twenty (20) years of healthcare technology management experience, especially focused on public health systems. She has led software implementations, policy and procedure initiatives and high-level, multi-stakeholder collaborations, including HIPAA transactions and privacy and security implementation for Michigan's Medicaid systems, the Office of the National Coordinator Health Information Security and Privacy Collaboration (HISPC), and the Michigan Health Information Network (MiHIN) Conduit to Care roadmap to Health Information Exchange for the State of Michigan.

Dana received her Bachelor of Business Administration from the University of Texas at Arlington and her Masters of Business Administration from Texas Christian University.

Dedicated IT business units that support State reporting include:

- *HEDIS® Team*
The HEDIS® team is an isolated group of developers, business analysts, programmers, and a project delivery lead committed to the perpetual needs of quality improvement. HEDIS® technical specifications require annual re-programming and system maintenance in order to ensure valid data. The project delivery lead has extensive experience managing IT projects and engages daily with business leads to provide HEDIS® data. These data are an essential component of performance measure reporting to the State. The lead programmer assisted in the development of the Managed Care System (MCS) and sister systems such as Merlin, used for the administration of pharmacy benefits.
- *MCS and Infrastructure*
The Managed Care System (MCS) is an OLTP, or transactional database that captures data and compiles that data into tables to be exported to or accessed by the various reporting tools. Reporting can be done directly in the system via Progress programming, or exported to the Oracle data warehouse which the Data Analysis Department uses to pull data through a user interface reporting tool.

b. The process for internal review and validation of data prior to submission to the State.

To support efficient and accurate data submission to the State, Meridian Health Plan develops a specification to pull all required fields and measures requested in a report. The specification is reviewed with team leads and department management before the logic is executed. Once the data is pulled, the approved process to complete the report is followed; the data is compiled and formatted. Once the formatted reports are complete, another round of review takes place to ensure data integrity and that proper transfer of data has taken place. Meridian consistently conducts internal reviews of data integrity by pulling samples of data and comparing to sources of truth for validity and reasonability.

4. Please provide any available Medicaid HEDIS scores in states in which you operate.

Achieving the highest percentile rankings in all quality metrics is part of the Meridian Health Plan mission to provide quality healthcare in a low resource environment. Meridian strives to be the best health plan in the State of Iowa and top ten (10) nationally as demonstrated by quality indicators including HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scored by the National Committee on Quality Assurance (NCQA); methods used by more than ninety percent (90%) of health plans. Rankings in the top ten (10) were reached by Meridian's Michigan and Illinois Medicaid programs. Meridian was ranked highest in every state of operation according to NCQA's Medicaid Health Insurance Plan Rankings 2014–2015.

Meridian was eligible to participate in the HEDIS® compliance audit for accreditation and Quality Compass reporting in calendar year (CY) 2014. In its first full year of reporting, the Iowa plan reached thirty-eighth (38th) in the country and achieved “Commendable” accreditation status.

A summary of 2014 NCQA final HEDIS® scores is provided as Attachment 33 (Operations Report) in Tab 5.

Past Performance in Iowa

Meridian has achieved significant progress on multiple HEDIS® measures in Iowa over the past several years. The first year of tracking in 2012 provided an adequate baseline for comparison, and the identification of areas where strategies were needed to improve health outcomes. Meridian performed exceptionally well in several categories. Quality Improvement (QI) staff tracked sixty-one (61) measures in 2013, including some drawn from data provided by the State of Iowa. Three quarters of sixty-one (61) measures monitored were ranked in the fiftieth (50th) percentile or higher. One-quarter were ranked in the ninetieth (90th) percentile. Statistically-significant gains were experienced in more than a dozen measures. (See table on following page for details).

Iowa Medicaid and Meridian Performance Comparison

Meridian’s performance exceeds that of MediPass and Fee for Service (FFS) within the State of Iowa, as determined by the University of Iowa Public Policy Center. A multi-year comparison showed Meridian members completed well-child visits twenty percent (20%) more often than either Medicaid plan alternative. Remarkable differences were seen with prenatal and postpartum visit rates, at sixteen percent (16%) and thirty-two percent (32%) higher than FFS or MediPass respectively. Children accessing care was more prevalent among Meridian’s membership, as was diabetes HbA1c screening at thirty-two percent (32%) above either MediPass or FFS. (See table on following page for details.)

All consumer satisfaction scores were higher for Meridian than MediPass or FFS.

Meridian’s Performance Exceeds MediPass and Fee for Service (FFS)

A multi-year comparison showed Meridian members completed well-child visits **twenty percent (20%) more often** than either Medicaid plan alternative.

Remarkable differences were seen with prenatal and postpartum visit rates, at **sixteen percent (16%) and thirty-two percent (32%) higher** than FFS or MediPass respectively.

Children accessing care was more prevalent among Meridian’s membership, as was diabetes HbA1c screening at **thirty-two percent (32%) above** either MediPass or FFS.

Multi-year comparison rankings are provided below for twenty-four (24) key HEDIS® measures.

| Measure | 2012 | | 2013 | | Year to Year Change | | |
|--|-------|------------|-------|------------|---------------------|----------|---------|
| | Rate | Percentile | Rate | Percentile | % Change | χ^2 | p-value |
| Childhood Immunizations – Combo 3 on or before 2nd birthday | 48.3% | <50th | 76.5% | 50th | 28.2% | 30.4 | 0.00* |
| Well Child- First 15 months (6+)* | 53.3% | <50th | 79.4% | 90th | 26.1% | 23.04 | 0.00* |
| Well Child 3-6 years* | 66.1% | <50th | 80.6% | 75th | 14.5% | 34.5 | 0.00* |
| Well Child – Adolescent* | 32.0% | <50th | 58.7% | 75th | 26.8% | 88.68 | 0.00* |
| Children and Adolescents’ Access to Primary Care Practitioners – 12 to 24 months | 94.9% | <50th | 99.3% | 90th | 4.4% | 20.29 | 0.00* |
| Children and Adolescents’ Access to Primary Care Practitioners – 25 months to 6 years | 85.9% | <50th | 94.0% | 90th | 8.1% | 74.12 | 0.00* |
| Children and Adolescents’ Access to Primary Care Practitioners – 7 to 11 years | 82.7% | <50th | 92.0% | N/A | 9.3% | 62.73 | 0.00* |
| Children and Adolescents’ Access to Primary Care Practitioners – 12 to 19 years | 84.3% | <50th | 94.1% | N/A | 9.8% | 77.47 | 0.00* |
| Lead Screening in Children | 74.0% | 50th | 85.8% | 75th | 11.8% | 7.85 | 0.005* |
| Timeliness of Prenatal Care | 90.4% | 75th | 96.3% | 90th | 5.9% | 0.61 | 0.44 |
| Postpartum Care | 67.3% | 75th | 74.4% | 90th | 7.1% | 1.68 | 0.196 |
| Comprehensive Diabetes Care – HbA1c Testing | 77.8% | <50th | 95.2% | 90th | 17.4% | 8.64 | 0.003* |
| Comprehensive Diabetes Care – Diabetic Eye Exam | 55.2% | 50th | 71.0% | 90th | 15.8% | 5.37 | 0.02* |
| CDC LDL Screening* | 62.6% | <50th | 77.4% | 50th | 14.8% | 3.74 | 0.053 |
| Immunizations for Adolescents* | 40.8% | <50th | 62.1% | N/A | 21.4% | 9.41 | 0.002* |
| Adults’ Access to Preventative/Ambulatory Health Services Total* | 81.7% | <50th | 91.5% | 90th | 9.9% | 69.55 | 0.00* |
| Chlamydia Screening* | 64.7% | 90th | 61.2% | 50th | -3.5% | 1.34 | 0.25 |
| Cervical Cancer Screening* | 70.7% | 50th | 76.0% | 75th | 5.3% | 7.66 | 0.0056 |

*p-value<0.05

Notes: Percentiles were taken from NCQA for each reporting year. Chi-square was calculated using the year to year comparison of hits and misses by measure.

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.

The most recent external quality review report for Meridian Health Plan's largest contract is held in the State of Michigan. In 2013-2014, Meridian's Michigan affiliate completed an external quality review. Meridian showed strengths in many areas and scored above State average in Quality standards. Overall performance was slightly below the State average at ninety-six percent (96%). See Attachment 42 (EQRO Reports) provided in Tab 6 for the auditor's final report.

An external quality review was completed for the Iowa Medicaid contract in October 2014. The time period under review was July 1, 2013-June 30, 2014. During that time period, membership grew to 46,448 members in the Temporary Assistance for Needy Families (TANF) plan, and 9,660 in the Wellness contract. Meridian scored exceptionally well on this review with a rating of ninety-eight point eight percent (98.8%); deemed proficient in all forty-seven (47) standards. This was an improvement over the previous State fiscal year rating of eighty-seven point three percent (87.3%).

SECTION 15 – TERMINATION

Please explain how you propose to execute Section 15 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

1. Describe your plan to complete the duties outlined in Section 15 in the event of contract termination or expiration.

In the event of Contract expiration or termination, Meridian Health Plan is prepared to ensure the orderly transition of our membership in a manner that does not disrupt their care or timely payment of outstanding claims to subcontractors and network providers. In a manner agreed upon by Meridian and the State of Iowa, Meridian shall 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 State.

Specifically, Meridian would serve or arrange for provision of services as directed by the State for up to forty-five (45) calendar days from the Contract Termination Date or until the members can be transferred to another program contractor, whichever is longer. Meridian shall comply with all duties and/or obligations incurred prior to the actual termination date. Meridian's centralized organizational structure allows for the winding down of corporate operations in a given state while retaining the full operational capacity necessary to administer outstanding matters using corporate resources. Meridian shall cooperate in good faith with the State and its employees, agents, and independent contractors throughout the termination process. To aid in a smooth transition process, Meridian will assign a liaison for post-transition operations and provide staff to support claims payment, member services, care coordination, and provider services.

Within sixty (60) days of a Contract execution, Meridian shall submit a written Transition Plan to the State of Iowa for approval. Meridian agrees to revise the plan as necessary in order to obtain approval by the State. In the event of Contract termination, the Meridian shall submit a Transition Plan to the State within the timeframe set forth by the State in the Notice of Termination from the State. In the event of Contract expiration, Meridian shall submit a Transition Plan at least 180 calendar days before expiration of the Contract. Meridian shall execute, adhere to, and provide the services set forth in the State-approved plan. Meridian also acknowledges that changes to the plan must receive prior approval from the State, and shall make any updates to maintain a current version of the plan.

At no expense to the State, Meridian shall transfer to the State all records related to Meridian's activities under the Contract no later than thirty (30) days after the request.

In the format and within the timeframes set forth by the State, Meridian will also provide additional information to the State, or its designated entity, including, but not limited to:

- Information on all Iowa Health and Wellness Plan members' completion of Healthy Behaviors Program requirements as described in Section 5.2 of the Scope of Work
- 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®)

Meridian's corporate offices shall also be available to participate in the External Quality Review, as required by 42 CFR 438, Subpart E, for the final year of the Contract.

As Meridian winds down operations, Meridian shall to maintain all necessary financial requirements as specified by the Contract, law, and regulation, including all insurance policies, as well as submit reports to the State every thirty (30) calendar days detailing our progress in completing our continuing obligations under the Contract. Upon completion of these continuing obligations, Meridian shall submit a final report to the State describing how completion of our continuing obligations occurred.

Meridian acknowledges that we shall be responsible for resolving member grievances and appeals with respect to dates of service prior to the day of a 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.

Meridian shall maintain the following financial responsibilities:

- 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.
- 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
- Services rendered through the day of termination or expiration of the Contract, for which payment is denied by Meridian and subsequently approved upon appeal or State fair hearing
- 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
- Submitting encounter data to the State 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

Meridian's financial and accounting staff will continue to review capitation payments for possible overpayments during and at the conclusion of the Contract term. In the event that an overpayment is discovered, Meridian will report such overpayment within thirty (30) days of discovery and provide the State with necessary assistance in any resulting investigation. Meridian shall remit payment for confirmed overpayments within fourteen (14) days of report to the State.

In addition to these financial responsibilities, Meridian shall arrange for the orderly transfer of member records, such as approved and outstanding prior authorization request and the list of members in community-based case management or care coordination, to the successor contractor(s) or another entity specified by the State. For those members whose health may be harmed by such a transfer, Meridian will ensure that such providers continue providing healthcare services until the treatment is concluded or the member can be safely transferred to another provider. If the State assigns members or responsibility to another program contractor, Meridian shall work cooperatively with, and supply program information to, any successor program contractors. For those members undergoing treatment for an acute condition, Meridian shall support continuation of care to ensure appropriate treatment.

Meridian shall work with the State to develop appropriate member and provider communication and education materials regarding the termination and transition efforts for distribution as soon as possible. Meridian shall be responsible for all expenses associated with provider notifications related to Contract termination and shall receive State approval in advance of distribution. These materials will notify members and providers of all necessary termination procedures, including the process by which members will continue to receive medical care, ongoing payment of premiums, provider transitions, and processing of authorization, grievance, and appeal requests. Members and providers will experience as seamless a transition as possible in all functional areas.

2. Provide a general end-of-contract transition plan which addresses the key components outlined in Section 15.

Any transition efforts shall begin with the development of a Transition Plan for State approval within sixty (60) days of contract execution. A Transition Plan shall be developed based on the unique needs and characteristics of the Iowa population. In the event of contract expiration, the transition plan shall be submitted at least 180 days before expiration of contract. Its development would involve the input of Meridian Health Plan leadership at the highest levels of the organization and close collaboration with the State. Meridian would designate a senior member of executive leadership at our corporate office to act as the primary liaison for transition efforts in order to guarantee continuous contact, even after local offices are reduced or closed.

Routine contact and reporting, not less frequently than every thirty (30) days, shall be maintained until all possible claims run-out has completed and obligations are fulfilled. Ad hoc communications would occur as frequently as necessary to facilitate communication regarding and resolution of any issues that may arise.

Early in the transition process, it will be necessary for the liaison to regularly coordinate with subject matter experts in various Meridian operational areas. These individuals shall be designated specifically to the transition process and shall be involved in all routine meetings and communications regarding transition until their functional area is resolved. The liaison and identified Meridian staff shall be responsible for initial and ongoing transition assistance to the State and any successor program contractors in accordance with the State's instructions.

To avoid any disruption to patient care, Meridian shall work with the State to create communication campaigns targeted to members and providers. Upon State approval of related materials, Meridian shall distribute them as agreed upon. At minimum, Meridian will perform in targeted outreach for providers engaged in intensive, active courses of treatment to members, particularly in hospitals with Meridian members with active inpatient status. Local Provider Services staff will be available to answer questions prior to the effective date of termination, after which corporate resources will be readily available to address remaining issues.

Following closure of the local office, all remaining operations can easily be performed from Meridian's corporate offices, which house claims payment, member services, care coordination, corporate provider services, utilization management, grievance, and appeal functions. These corporate teams shall support operations, and an External Quality Review, as required by 42 CFR 438, Subpart E, as required by the Transition Plan approved by the State.

Meridian shall maintain all necessary licenses and keep all necessary reserves and capital in place until it is legally permitted to withdraw them. Meridian shall cooperate with all record requests

and payment reconciliations necessary through the end of the claims run-out period, in the format and within the timeframes set forth by the State.

At the conclusion of the transition process, Meridian leadership shall submit a final progress report to the State discussing how Meridian has implemented each of the requirements of Section 15 of the Contract and any continuing obligations that may exist. Meridian will promptly comply with State requests for additional information or revisions to the final report as necessary to ensure a smooth transition and to satisfy any outstanding obligations.

Meridian has experience with an orderly and seamless transition of membership following a voluntary termination of its contract in New Hampshire in 2014. Meridian employed the above process and plan while working closely with the New Hampshire Department of Health and Human Services (DHHS) and successor program contractors to ensure efficient and smooth transfer of over 20,000 members. Disenrollment was complete within less than two (2) months. This transition included, but was not limited to, the transfer of records to DHHS and the successor program contractors information related to Meridian operations, clinical information, prior authorization requests, and lists of members in community-based case management or care coordination as well as transfer of patient records to providers who assumed transitioned members' care. Meridian continues to maintain and support our contract obligations with New Hampshire DHHS.

3.2.5.1 Experience.

3.2.5.1.1 Level of technical experience in providing the types of services sought by the RFP:

Meridian Health Plan has a high level of experience delivering the services outlined within the Iowa High Quality Healthcare Initiative (IHQHI). Our experience in managing the care of the full range of Medicaid beneficiaries, qualifies us to provide the types of services sought by this RFP. Meridian is committed to providing high-quality services in a low resources environment and offers the following credentials as testimony of our technical experience in Medicaid managed care. We have outlined our technical experience synchronizing the many facets of managed care into a high-functioning harmonious system.

Managing Care in Multiple Medicaid Markets

With over seventeen (17) years of Medicaid managed care experience, Meridian Health Plan has developed a high level of technical experience synchronizing the many facets of managed care into a high-functioning harmonious system. Meridian currently has full-risk capitated Medicaid contracts in place to provided services similar to those sought by the Iowa High Quality Health Care Initiative (IHQHI) in Illinois, Iowa, and Michigan. Currently ranked the number one (#1) Medicaid HMO in Michigan, Illinois and Iowa (according to the National Committee for Quality Assurance Medicaid Health Insurance Plan Rankings for 2014-2015), Meridian is committed to improving the value, quality, and efficiency of care for the members we serve. Based on these same rankings, nationally the Meridian affiliates in Michigan and Illinois ranked ninth (9th) and tenth (10th), and Iowa ranked thirty-eighth (38th). In addition, our Michigan affiliate earned the highest possible rating of five out of five in composite scores for Consumer Experience, Prevention, and Treatment. Our proven track record of serving Medicaid beneficiaries throughout the Midwest demonstrates our capabilities in delivering successful outcomes and reducing Medicaid program costs for taxpayers. Meridian personalizes member care and understands the complex needs of the Medicaid population.

Our mission is to continuously improve the quality of care in a low-resource environment. As a physician-owned and member-focused organization, we blend innovative proprietary technology with a commitment to premier service. We embody the “Triple Aim” concept vital to our industry:

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce the per capita cost of care

Meridian delivers outstanding quality of care while streamlining the value of care delivery. Our focus on innovative, coordinated programs allows us to tear down traditional healthcare silos. Instead, Meridian emphasizes the patient-focused delivery of services while maximizing the potential for savings. Serving as an established Medicaid managed care plan in the State of Iowa, Meridian is equipped and committed to serving the populations included in the 2015 IHQHI.

Managing Diverse Populations

Meridian Health Plan currently has full-risk capitated Medicaid contracts in place to provided services similar to those sought by the Iowa High Quality Health Care Initiative (IHQHI) in Illinois, Iowa, and Michigan. In addition to our Medicaid Managed Care Programs, Meridian is contracted with the Centers for Medicare and Medicaid Services (CMS) for two Dual Demonstration programs in conjunction with the Illinois Department of Human and Family Services and the Michigan Department of Health and Human Services (MDHHS). Similar to the services sought by the Iowa High Quality Health Care

Initiative (IHQHI), Meridian has been responsible for providing covered services to the full range of Medicaid members including:

- Aged, Blind and Disabled (ABD);
- Temporary Assistance for Needy Families (TANF);
- Supplemental Security Income (SSI);
- Sixth Omnibus Reconciliation Act (SOBRA);
- Families with Dependent Children (AFDC);
- Children's Health Insurance Plan (CHIP);
- Affordable Care Act (ACA)/Family Health Plan (FHP) Program;
- Foster children; and
- Dual eligible-Special Needs Plan (D-SNP);
- Medicare-Medicaid Alignment Initiative (Michigan/Illinois);
- Medicaid Expansion Eligible (Michigan/Illinois/Iowa)

Meridian's experience providing the full range of benefits to Medicaid members prepares us to seamlessly ensure all Iowa Medicaid members receive the covered services outlined in the IHQHI.

Care Coordination

Meridian Health Plan's Care Coordination programs focus on members with special healthcare needs and their families. The purpose is to link the member's needed services and resources in a coordinated effort, achieve better access to needed care, navigate the member through the complex healthcare system, and to increase self-management and self-advocacy skills.

Meridian's Care Coordination programs include:

- Performance of an initial health risk screening
- Placement of members in a Care Coordination Program based on assessed level of risk
- Performance of a Comprehensive Health Risk Assessment for members identified as having a special health care needs
- Care plan development
- Reassessment

The program is designed to ensure timely and thorough coordination of services across various domains, such as primary care, substance abuse, mental health, non-emergency transportation, durable medical equipment repair, dental providers, and community supports, as well as connecting providers through the exchange of relevant information so that treatment for any one of the member's needs includes recognition of their full set of needs. The goal of the program is to maximize the member's potential and provide them with optimal care. In addition the program is designed to identify members who may be overusing and/or abusing services resulting in increased quality care management across the healthcare continuum.

Members are evaluated for Care Coordination services based on an analysis of a variety of data sources including, but not limited to:

- Historical claims and prior authorizations
- Utilization management information
- Service level plan

- Changes in risk stratification
- Initial screening and Comprehensive Health Risk Assessment responses
- Laboratory results
- Pharmacy information
- Hospital discharge
- Gaps in care,
- Member/caregiver input
- Member and provider referrals
- Predictive modeling

The Meridian Care Coordination programs provide members with highly coordinated services that allow members to play an active role in their care plan. This approach allows members to maintain their independence, with the support of Meridian's Care Coordination team. Each member that is enrolled in Meridian's Care Coordination program works with our care team to develop individual goals. These goals are continuously revisited by members, providers, and care managers. This process allows members to achieve their desired health outcomes and measure their individual progress. Meridian's intent is to allow the members to be as independent in their care as possible, but more importantly serve as an advocate helping navigate members through the resources available to them. Actively participating in the care plan, Meridian members develop a sense of responsibility for their health and wellness.

Provider Network Management

Meridian Health Plan is a leader in developing Medicaid provider networks in both urban and rural areas, with extensive experience contracting in rural areas. We create exceptionally strong and lasting personal relationships with our providers, which eliminates barriers to access for our members. Through monthly face-to-face visits, we equip our providers with a vast array of technology to help them improve their administrative efficiency, allowing them to focus on delivering high-quality care. In all counties, we ensure members have access to an in-network provider for routine and preventive care and all medically necessary covered care.

Meridian currently manages provider networks in Michigan, Illinois, and Iowa. Our networks consist of primary care providers (PCP), specialists, behavioral health, Long-Term Supports and Services, hospitals, and ancillary providers. Meridian's established network of Medicaid providers in Iowa offers our members with access to over 2,400 primary care providers, over 5,200 specialists, and 87 hospitals. Our current network provides our members with access to services in 49 counties within the State. Our focus on quality and partnership is evident in this network and ensures that our members have access to the high quality of care synonymous with our performance in other states.

Meridian monitors the adequacy, accessibility, and availability of our provider network to all members, including those with special needs and cultural considerations. Meridian has not and will not discriminate against providers who serve high-risk populations or specialize in conditions that require costly treatment. We instead control costs through coordination, with any and all providers, to identify high-risk and high-cost members, and education to reduce unnecessary costs. Our network has outstanding credentials and we verify that all included are eligible to participate in Federal healthcare programs.

Quality Improvement

Quality Improvement initiatives are embedded in the culture and daily functions of Meridian Health Plan. Enterprise goals consistently emphasize the criticality of providing high quality health care. Longitudinal

planning is essential for ensuring that quality improves throughout periods of growth. Experience, including established community partnerships, has been essential in determining which interventions are successful long-term and positively impact member health.

Long-term planning is the key to a stable and successful Quality Improvement Program (QIP). Meridian embraces this process and its confident current planning efforts exceed the expectations of the State. Meridian's five-year strategic plan sets measurable goals, establishes specific objectives, identifies the strategies to be undertaken, and monitors results and assesses progress of Meridian's Iowa-specific QIP. All information related to Meridian's QIP will be made available to providers and members via the Meridian website.

Utilization Management

Meridian Health Plan's NCQA-accredited Utilization Management (UM) Program is designed to monitor, evaluate, and ensure the delivery of high quality, cost-effective healthcare services to our members at the right time and in the right setting. The Meridian UM Program is comprehensive and interdisciplinary, including behavioral health and long-term care aspects. We ensure individuals receive the most appropriate, least restrictive, and most cost-effective, recovery-oriented treatments and supports that meet their identified needs and promote independence, consistent with their informed choices and preferences.

Our UM Program design addresses the individual and provider's timely access to clinical staff; the consistent use of clinical criteria and treatment guidelines for decision making; the receipt of the clinical information and the timeliness of the UM decisions; notification of authorizations and non-authorizations; and the appeals process. UM decisions are based on evidence-based clinical decision support criteria, consideration of member needs, and the local delivery system. Meridian utilizes McKesson's InterQual® Criteria, a nationally recognized set of medical necessity evidence-based standards of care, developed through consensus from licensed specialists and/or primary care providers.

Meridian staff tracks utilization of services through Meridian's Managed Care System (MCS). Claims data is synchronized with a continuously updated "Member Service Counts" module. This module includes visit tracking of chiropractic, vision, and behavioral health services, as well as physical/occupational therapy, inpatient days, and skilled nursing facility days. Meridian staff keeps members and providers updated on the amounts remaining of those services that are limited. Meridian also uses this information for HEDIS® which allows Meridian to ensure analyze utilization and overall health of the membership. Meridian also uses health assessments to help better serve members individually to their needs by addressing their physical and behavioral health.

Meridian Health Plan analyzes data from multiple sources in its effort to monitor under- and over-utilization. These sources include:

- Utilization Authorization and Claims Data
- HEDIS® Data
- Physician Profile Report
- Member Complaints and Grievances
- External Quality Review Data
- Pharmacy Data
- Financial Utilization Data

This data is evaluated for patterns that may indicate inappropriate utilization and/or fraud and abuse among population groups and individual practitioners, practitioner groups, and facilities. Meridian then compares this information with other health plans as well as regional and national data. If plan-wide monitoring results fall outside the established thresholds, a focused review will be conducted. This may include, but is not limited to, practitioner or facility specific information separated by risk, delegate, specialty type, or other significant categories. If areas of deficiency are identified, the Quality Improvement Committee (QIC) will conduct an analysis of identifiable barriers or specific circumstances and make recommendations for correction of the variance.

Managing Behavioral Health and Long-Term Supports and Services (LTSS) Benefits

Meridian Health Plan affiliates in Michigan and Illinois currently manages the delivery of behavioral health services and Long-Term Supports and Services (LTSS). Meridian's highly integrated Behavioral Health program provides members with high quality, coordinated care that is based on individual needs. The success of the program is attributable to the coordination of the Meridian Behavioral Health Services staff, a high-quality network of behavioral health providers, the State's community mental health programs, and substance abuse coordinating agencies. Meridian ensures coordination among medical and behavioral health services that are available to members while simultaneously addressing the multiple issues that may adversely impact their functional status, risk of relapse, ability to obtain housing, and ability to resume employment or other meaningful daily activities.

The Behavioral Health, Case Management, and Care Coordination programs interface to provide members with the most appropriate care coordination for their needs. The approach of both of these programs is early identification of members and ensuring the member is routed to the proper department to ensure their needs are addressed in the most appropriate and effective manner. In some instances, this involves referring a member in Case Management to the Behavioral Health Department for a referral to behavioral health providers or referring a member with medical needs to Case Management. Behavioral Health staff assists members by providing them with referrals to behavioral health providers, assessments, interventions, and connection with available community resources.

The bi-directional coordination of behavioral and medical care is made possible by Meridian's Managed Care System (MCS), which reduces the fragmentation of the health care system for members in ways that are not feasible through less integrated programs. MCS provides comprehensive information and assessments about physical and behavioral health needs and care. This integrated system provides a real-time holistic view of each member's care and allow staff and providers to determine the impact of both types of care on outcomes.

Our LTSS Program revolves around our Care Coordination approach. This approach allows for collaboration with formal and informal providers, and caregivers to ensure transparency and cohesion in coordinating services. Meridian members are assigned based on stratification, waiver eligibility, and region to a Community-Based Case Manager who will provide case management over the phone and/or face-to-face. After assessment delivery, the care plan is developed with the member to address medical and community needs. Members are encouraged to attend the interdisciplinary care team meeting to discuss their care plan with their Interdisciplinary Care Team (ICT) and any providers or supports they wish to invite. The ICT meeting will be conducted within the first ninety (90) days of enrollment, after a significant change in condition, and annually after each reassessment.

Managing Subcontractor Relationships

Much of our success as a Medicaid managed care organization can be attributed to our commitment to quality, our strong provider relationships, and our seamless coordination with specialized service subcontractors. Meridian Health Plan develops subcontracting partnerships to provide members with professional and condition specific services they may require outside the scope of physical health services provided by our network providers. Subcontractors partnering with Meridian are held to the same standards and expectations as Meridian. Meridian has developed managerial processes to ensure our subcontractors' practices align with our contractual obligations. Services subcontracted by Meridian may include, but are not limited to, administrative services, behavioral health services, Long-Term Supports and Services (LTSS), and after-hours call services.

Member Services

Meridian Health Plan recognizes motivation for health management stems from encouraging, thorough, and accessible information supplied in multiple formats and approaches. Meridian prioritizes providing exceptional member communication through outreach as well as through operational efforts. Meridian employs a multi-pronged approach to member communication as reiteration of health communications results in better uptake and understanding. All Meridian staff is trained on member interaction and the importance of quality healthcare. Every engagement with a member is an opportunity to educate, empower, and inform. This multi-pronged approach has proven successful within the Iowa plan, as well as other states. The following are examples of member communication strategies currently in place:

- Mailings (monthly, seasonal, condition-specific, or as needed based on member contact; samples can be found in Appendix E, Member Communication and Outreach)
- Telephonic outreach (Presence automated dialing system)
 - New member welcome calls
 - Reminder calls to members identified as needing to complete a HEDIS® measure-related preventive care service
- Live Chat (online access to converse with a Member Services Representative)
- Member web portal (secure access for members to update demographic information, complete a Health Risk Assessment, request Member Handbooks, order ID cards, change PCPs, track claims, and enroll into wellness programs, etc.)
- Attendance at community events, conferences, and activities

Passive forms of communication include mailings, such as those for members with complex needs. These members receive educational information via mail on chronic disease management, preventive care, and various medical topics to provide a better understanding of medical coverage, as well as the need for ongoing care.

A critical approach for communicating with members requires Meridian presence in the community. Meridian has achieved optimum success with member engagement using community-based stakeholders. An investment in the community demonstrates Meridian's intent to go beyond the delivery of health services. Meridian has existing relationships with the Iowa Department of Public Health (IDPH), Iowa Department of Human Services (DHS), and many other entities. In working with IDPH, Meridian ensures health plan information is adequately and accurately provided to members at the time of enrollment. Local public health agencies, with support by IDPH, make essential connections with Medicaid-eligible persons. When questions around enrollment, benefits, provider or network access, and more arise, IDPH is able to refer members to the appropriate contact within Meridian. Meridian has assisted Title V clinics with payment questions, understanding provider incentives and in resolving other issues. With help from Provider Services Representatives, Community-Based Case Managers, and other field staff, Meridian is

intentional at supplying providers with preventive and routine health educational materials, suggestions for provider improvement of member health, and general understanding of member benefits.

Meridian is committed to actively participating in and supporting the communities we serve. We see this as our fiduciary responsibility, not only as a state partner but as an organization dedicated to improving the quality of care for our members. In Iowa, Meridian has sponsored the Governor's Conference on Public Health, the Iowa School Nurses Organization, and Iowa Immunization Coalition; and made donations to the Young Women's Resource Center, the American Heart Association annual heart walk, and the Count the Kicks public awareness campaign.

State-Specific Initiatives

Current initiatives conducted by the State are important to Meridian. In 2014, Meridian achieved a rate of forty-five percent (45%) electronic and remote accessibility of member records in Iowa. Meridian is committed to efficient processes that have a direct effect on the quality of services delivered. Our capabilities to electronically access our member records results in timely, detailed, and technologically driven procedures.

Meridian plays a critical role as both a contributor and leader in both advocating and promoting innovations in care. Meridian is an active member of the Iowa Maternal Health Task Force, working to collaborate and produce innovative programs to improve maternal health and care coordination. Meridian is the lead of the Iowa Primary Care Pilot Project working to improve the outcomes and efficacy of primary care to Iowa's most vulnerable populations.

Meridian recently partnered with the Iowa Department of Public Health, establishing the "Cribs for Kids" program, which provides women delivering babies in four (4) pilot counties a free crib if needed. More than half of infants that died of a sleep related cause were bed-sharing at the time of death. Identifying community specific health concerns allows Meridian to develop innovative solutions that address local needs to produce better outcomes.

Meridian's experience in managing care for a wide range of populations, relates to the plan's targeted purpose of improving access to medical, mental, and social services, the improvement of access to affordable care, coordination of care, seamless transitions across healthcare settings, and access to preventive health services all within a limited resource environment. Meridian currently provides services for over 725,000 Medicaid eligible beneficiaries. Meridian has experience administering physical health, behavioral health, and Long-Term Supports and Services (LTSS) for the full range of Medicaid members.

Providing similar services as outline in this RFP, Meridian's current programs achieve the goals as set forth in the Iowa High Quality Healthcare Initiative (IHQHI). Meridian's plans provide members with choice, by supporting comprehensive provider networks offering members a full range of primary and specialty care providers. These same network development practices ensure members have proper access to all levels of care when necessary. Meridian has developed, in accordance with industry standards, medical and clinical processes that provided members with safe, medically appropriate services. Our network providers are also held accountable for the safety of our members. Meridian's Care Coordination programs provide members with highly coordinated services that allow members to play an active role in their individual plan of care. This approach allows members to maintain their independence, while have the support of Meridian's Care Coordination team. Actively participating in the plan of care, Meridian members develop a sense of responsibility for their health and wellness.

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STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

April 24, 2015

Carrie Lindgren, Iowa Issuing Officer
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114
Bidders4MED16009@dhs.state.ia.us

RE: Letter of Reference for Iowa High Quality Health Care Initiative RFP

To Whom It May Concern:

It is with great confidence that I am recommending Meridian Health Plan as a candidate for the 2015 Iowa High Quality Healthcare Initiative. As Director of Michigan's Medicaid program, I have had the opportunity to collaborate with Meridian to support a high-performing Medicaid program. Meridian has proven to be an innovative leader in delivering high quality managed care services during their seventeen year history caring for Michigan Medicaid beneficiaries. Through consistent performance in the state of Michigan, Meridian demonstrates expertise in achieving the objectives of the Iowa High Quality Healthcare Initiative.

Improving quality and access

Meridian is ranked 9th in the nation and number one in the state of Michigan by NCQA's Medicaid Health Plan Rankings 2014-2015. Meridian meets the state of Michigan's high performance healthcare measures relevant to our beneficiaries. Meridian frequently scores number one across Medicaid health plans. In addition, the Michigan Association of Health Plans has presented Meridian with a number of Pinnacle Awards for improving quality care for members and increasing efficiency.

Promoting accountability for outcomes

Meridian has also achieved a CMS Innovations Grant to lowering the rate of preterm deliveries. On multiple occasions, Meridian has been recognized by CMS as a high performing awardee and has presented in forums to assist other organizations. On a local level, Meridian is piloting different programs throughout Michigan with organizations such as Access Alliance, CareConnect 360 (formerly known as "FRANK"), the CMS Adult Measures Grant, and the Michigan Postpartum Care Quality Improvement Project.

These achievements, along with Meridian's mission to continuously improve the quality of care in a low resource environment, echo the foundational priorities of any state Medicaid program: quality, efficiency and member satisfaction. Meridian Health Plan would be a viable partner for the state of Iowa and all Iowa Medicaid beneficiaries.

Sincerely,

Stephen Fitton, Director
Medical Services Administration
Michigan Department of Health and Human Services
Phone: 517-241-7882
fittons@michigan.gov

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201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

Charles M. Palmer, Director
Iowa Medicaid Enterprise
Hoover State Office Building
1305 E. Walnut Street
Des Moines, Iowa 50319

Dear Director Palmer,

This letter of reference is being provided in support of Meridian Health Plan as they prepare for your review of their bid to serve the Medicaid program in Iowa.

Meridian Health Plan has been a contracted health plan with the State of Illinois Medicaid program since 2008 to deliver managed Medicaid services. Meridian currently serves over 235,000 combined lives in our Family Health Plan (FHP), Affordable Care Adults (ACA), Integrated Care Program (ICP) and the Medicare Medicaid Alignment (MMAI) programs. In other words, their contracts span the entirety of our Medicaid populations – from children to adults with disabilities.

The State of Illinois' experience with Meridian Health Plan in Illinois has been positive. Meridian has consistently demonstrated a serious commitment to their contractual obligations and delivery of services to the Medicaid consumers enrolled in their plans. Meridian is very responsive to inquiries and works diligently to resolve issues when they arise. Additionally, Meridian has delivered on their commitment to quality in serving the Medicaid population in Illinois and consistently is a leader in quality outcomes.

Based on the experience of the State of Illinois' Department of Healthcare and Family Services, we are able to provide a positive reference to the State of Iowa for Meridian Health Plan. Please feel free to contact me if you have any questions or need additional information.

Sincerely,



Felicia Norwood
Director

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State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9200 FAX: 603-271-4912 TDD ACCESS: RELAY NH 1-800-735-2964

NICHOLAS A. TOUMPAS
COMMISSIONER

April 29, 2015

Ms. Carrie Lindgren
Issuing Officer
Iowa Department of Human Services
1305 East Walnut Street
Des Moines, Iowa 50319

To Whom It May Concern:

As Director of Provider Networks and Service Delivery for the New Hampshire Department of Health & Human Services, I would like to express our satisfaction with Meridian Health Plan. Meridian was one of three managed care organizations involved in the successful launch of our Medicaid Care Management program. It was clear Meridian's intentions were to ensure New Hampshire beneficiaries received the highest quality services through managed care.

Beginning operations in December of 2013, Meridian, fulfilled its contractual obligations as outlined within their contract with the state. Meridian's administrative team made commendable efforts in promoting collaboration between providers and the care management organizations. Although Meridian departed the State of New Hampshire in July of 2014, Meridian left amicably and committed to a reasonable and collaborative transition strategy.

Meridian continues to assist the Department in dissolving its operations in the least disruptive manner to our Medicaid program and beneficiaries. We continue to partner with Meridian to resolve any outstanding matters.

I would encourage the State of Iowa to consider Meridian for the 2015 Iowa High Quality Healthcare Initiative. The New Hampshire DHHS wishes Meridian all the best in the future endeavors.

Sincerely,

A handwritten signature in blue ink, appearing to read "Dawn M. Touzin".

Dawn M. Touzin, Esq.
Director, Provider Networks and
Service Delivery

The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence.

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3.2.5.1.5 Description of experience managing subcontractors, if the bidder proposes to use subcontractors.

Experience

With over seventeen (17) years of Medicaid managed care experience, Meridian has been delivering high quality, patient-centered services to the full range of Medicaid beneficiaries. Much of our success can be attributed to our commitment to quality, our strong provider relationships, and our seamless coordination with specialized service subcontractors. Meridian develops subcontracting partnerships to provide members with professional and condition specific services members may require outside the scope of physical health services provided by our network providers. Subcontractors partnering with Meridian are held to the same standards and expectations as Meridian. Meridian has developed managerial processes to ensure our subcontractors' practices align with our contractual obligations. When selected to partner with the Iowa Department of Health and Human Services, Meridian intends to initiate subcontracting relationships as outlined in section 2.2.1 of the Technical Response.

Management of Subcontractors

Prior to being approved as a delegate to perform contractually required activities, a pre-delegation evaluation is conducted which includes audits of policies and procedures, template forms, member facing materials, staff qualifications, credentials and training records, reporting capabilities, and the results of any audits conducted by regulatory or accrediting bodies. Subcontractors are required to submit personnel documentation including designated personnel resumes and job descriptions.

Documents are reviewed against the metrics and requirements of the contract and NCQA accreditation standards. Examples of metrics required of subcontractors are:

- For all subcontractors with delegated activities:
 - All staff must complete contractually required trainings prior to implementation; all newly hired staff must complete trainings upon hire and quarterly or annually thereafter depending in the specific requirement
 - All staff must be checked against the LEIE and SAM systems
- For subcontractors with a customer service call center:
 - Eighty percent (80%) of incoming calls answered within thirty (30) seconds
 - Less than five (5%) percent abandonment rate for all incoming calls
- For subcontractors with credentialing activities: All primary source verifications are conducted not more than 180 days prior to approval date
- For subcontractors handling requests for services: All notice of actions are provided to members for standard authorization decisions within a timeframe not more than seven (7) calendar days after the request for services
- For subcontractors handling grievances: All grievances were resolved within a timeframe not more than thirty (30) calendar days after the grievance was filed
- For subcontractors providing transportation services:
 - The monthly ratio of one way trips for Meridian members to Meridian member complaints must be less than one percent (1%)
 - The monthly ratio of telephone calls from Meridian members to Meridian member complaints must be less than one percent (1%)

- For subcontractors providing direct services to members, metrics include quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors

Meridian verifies provider subcontractors against the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and the General Service Administration's System for Award Management (SAM) every thirty (30) calendar days. Meridian also verifies with DHHS the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), and the Medicare Exclusion Database (the MED). Any other contractually required databases will be checked as required. Meridian terminates upon DHHS request, its relationship with any provider identified as in continued violation of law by the DHHS within thirty (30) calendar days.

Through our tenure contracting with state agencies to provide administrative services for Medicaid managed care programs, Meridian has developed a process for managing and monitoring the performance of our subcontractors and the services they provide. Meridian monitors and oversees its subcontractors and other delegated entities on an ongoing basis. All subcontractors are required to execute a Business Associate Agreement as sharing of information is necessary. Once approved to provide subcontracted services and an agreement is executed, Meridian requires its subcontractor delegates to provide ongoing reports and documentation to demonstrate compliance with Meridian, the Centers for Medicare and Managed Care Services (CMS), regulatory agencies, and contractual requirements.

Meridian has an established process for auditing and monitoring our subcontractors. Meridian's Compliance Department maintains tracking lists of all non-provider subcontractors and delegated entities and associated reports and documentation that the delegates and subcontractors are required to submit to Meridian. Meridian requires reporting on a monthly, quarterly, and annual basis. Meridian monitors these report submissions including whether they are received timely and all information is provided. Ongoing communication is maintained with the subcontractor to obtain needed information. Our Compliance Department reviews the reports and completes an ongoing monitoring tracking grid for the specific performance metrics that are required. Formal reviews of metrics and report submissions occur on a quarterly basis. Feedback is provided if the formal reviews indicate substandard performance and the performance is further reviewed by the compliance officer and compliance staff to determine if the substandard performance warrants the implementation of a corrective action plan (CAP).

In addition to quarterly formal reviews, an annual in-depth performance review is conducted to further assess the delegate's ability to perform functions. The annual review includes evaluation of staff qualifications, credentialing and training, and operations activities supporting the delegated functions. Documentation collected from the delegate or subcontractor and reviewed by Meridian includes personnel documentation, actual case file review and any template forms or policies and procedures related to the delegated function.

Subcontractor performance is summarized and reviewed by the Compliance Officer and Compliance Committee on an ongoing basis and after the aforementioned quarterly and annual performance reviews. If the compliance officer deems the subcontractor failure to meet performance requirements is adversely impacting member services, the subcontractor is placed on an immediate CAP. If the findings illustrate serious concerns of non-compliance, the Compliance Officer can convene an ad hoc Compliance Committee to review the findings. The Compliance Committee will determine the remedial or corrective actions necessary or whether the subcontract issue warrants termination pursuant to the written agreement. The subcontractor is notified of the actions required and must submit a plan addressing the deficiencies to Meridian for approval. DHHS is informed of performance monitoring and reviews as

required and will be notified any time a subcontractor is placed on corrective action. The compliance staff monitor the implementation of the CAP and ensure that the subcontractor is meeting all requirements including an improvement of any performance metrics that were not meeting the performance threshold. Upon completion of the timeframe of the CAP, the compliance staff prepare a report summarizing the activities performed by the subcontractor and whether the subcontractor has met the terms of the CAP. If the subcontractor has satisfactorily met the terms of the CAP, the compliance officer prepares the appropriate documentation to store with the subcontractor's file.

The subcontractor is notified of the CAP requirements and the timeline for a CAP submission. The Compliance staff review and approve the terms of the CAP and ensure that the subcontractor is addressing the deficiencies in performance. Upon completion of the activities described within the CAP, the Compliance staff will prepare a report summarizing the activities performed by the subcontractor and whether the subcontractor has met the terms of the CAP. If the subcontractor has satisfactorily met the terms of the CAP, the compliance officer will prepare the appropriate documentation to store with the subcontractor's file and provide an update to the Compliance Committee.

If the subcontractor has not satisfactorily met the terms of the CAP, the Compliance Officer will present a report to the Compliance Committee. The Compliance Committee will make a determination on whether to extend the CAP or to terminate the agreement. If the Compliance Committee determines that other actions should be taken, the Compliance Officer will be responsible for carrying out the Committee's request. Additional required actions may include but are not limited to regular subcontractor performance metric reporting, periodic site visits, repeat audits of policies and procedures. Ongoing full and complete investigation of all complaints or grievances related to a subcontractor would continue.

For example, if a delegate demonstrates that member grievances are not being resolved completely or in a timely fashion, the delegate would be required to identify the cause of the deficiencies, such as newly hired staff need additional training and internal monitoring. The delegate would then be required to develop a corrective action plan and documentation to address the issues, such as staff needing the training session, a schedule of trainings, and training content. Meridian would review the CAP and the materials supporting the plan, such as the training agenda, and request additional content to be added to the CAP to make the CAP acceptable.

Prior to considering the CAP resolved, the delegate would be required to provide documentation indicated the CAP activities had been completed, such as the staff attendance records. Meridian would monitor the performance metrics, such as the grievances timeliness reports and the content of the grievances resolutions to ensure the CAP has improved the performance of the subcontractor. A summary of the outcome of the CAP and the ongoing monitoring of the subcontractor would be reviewed by compliance committee.

In the rare event that Meridian must exercise its right to terminate its agreement with a subcontractor that is failing to provide services to members, a transition plan would be put in place to ensure that a member's services transition without interruption to another, qualified subcontractor. Members would be notified of the inability to obtain services from the subcontractor and be offered alternatives for services. Meridian's Member Services and Care Coordination contact information is provided to the members and these teams would also assist members with identifying and transitioning to another provider. For example, if a homecare services provider were to fail to provide the care as prescribed for the member, and fail to sufficiently implement a corrective action plan, an alternative homecare service provider would be identified and the member would be notified of the alternatives and offered a choice of those providers available. The members assigned care coordinator or care manager would reach out to both the member and the agency and facilitate the transitions of care including authorizing services as needed. The State

would be informed of the initial corrective action plan that was implemented and the outcome of the failed corrective action plan.

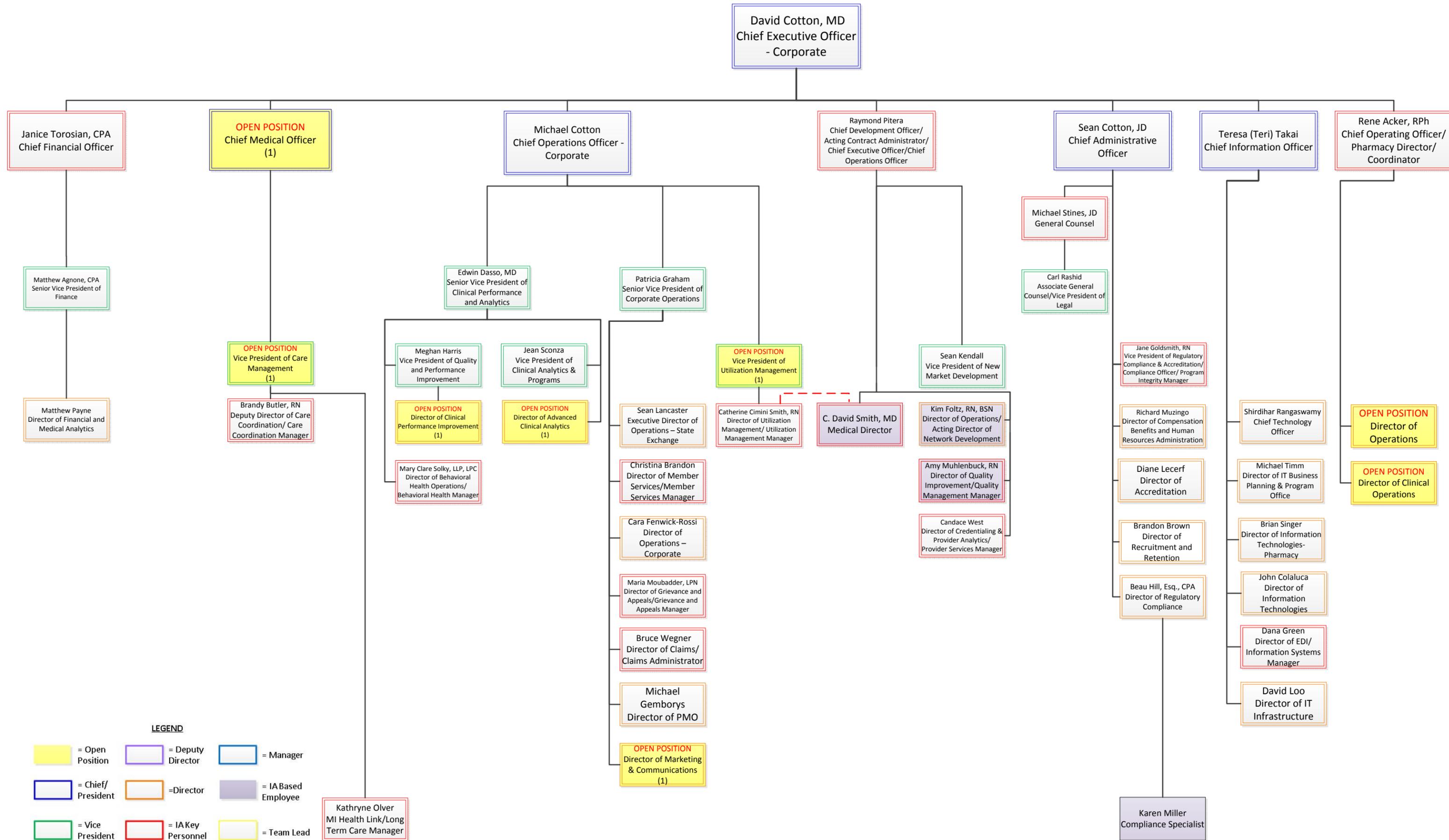
Examples of Meridian's experience with Subcontractors

Meridian Health Plan subcontracts services where greater expertise is needed to deliver the highest level of care in accordance with our contractual obligations to the state. Whether affiliated or not, Meridian takes all measures necessary to extract the best performance possible from its subcontractors. This includes working closely with subcontractors to implement processes aimed at achieving the greatest level of integration. Dependent on contractual obligations Meridian has standard subcontracting relationships that are consistent along all product lines and others that are state specific, based on services within the scope of the contract. Meridian's current subcontractors provide services that range from administrative duties such as claims processing, member enrollment and eligibility verification, quality improvement activities, provider recruitment and education, and authorizations, and other industry specific services. Meridian also manages subcontracted services such as translation services and after-hours-call services. Contractors that directly impact member's access to information and services are regularly audited and reviewed to ensure members receive timely, high-quality services.

Specific to the duties outlined in the Iowa High Quality Healthcare Initiative (IHQHI), Meridian has experience managing subcontractors who are delegated to oversee members needing specialized services such as behavioral health. Meridian's sister company, Meridian Health Plan of Michigan currently delegates the oversight of behavioral health services to a regional prepaid inpatient health plan responsible for insuring Meridian members receive services in accordance with their benefits package. This subcontracting relationship provides Meridian members with regionally specific benefit management services, in an individualized and highly coordinated manner.

Keeping in line with the goals of the Iowa High Quality Healthcare Initiative (IHQHI), Meridian has established processes for seamlessly integrating our subcontractors into our service delivery for members and providers. Meridian has experience managing a diverse group of subcontractors and will hold accountable, each subcontractor, for their activities and performance. All activities and reporting requirements, quality improvement goals, sanctions, and penalties for inadequate performance, shall be documented in a written agreement between Meridian and the subcontractor. In the event that Meridian identifies inadequate performance, Meridian shall take corrective action. Subcontractors will be held to all contractual and RFP requirements as Meridian.

Meridian Health Plan of Iowa - Tables of Organization - Overall Operations (including Key Personnel)

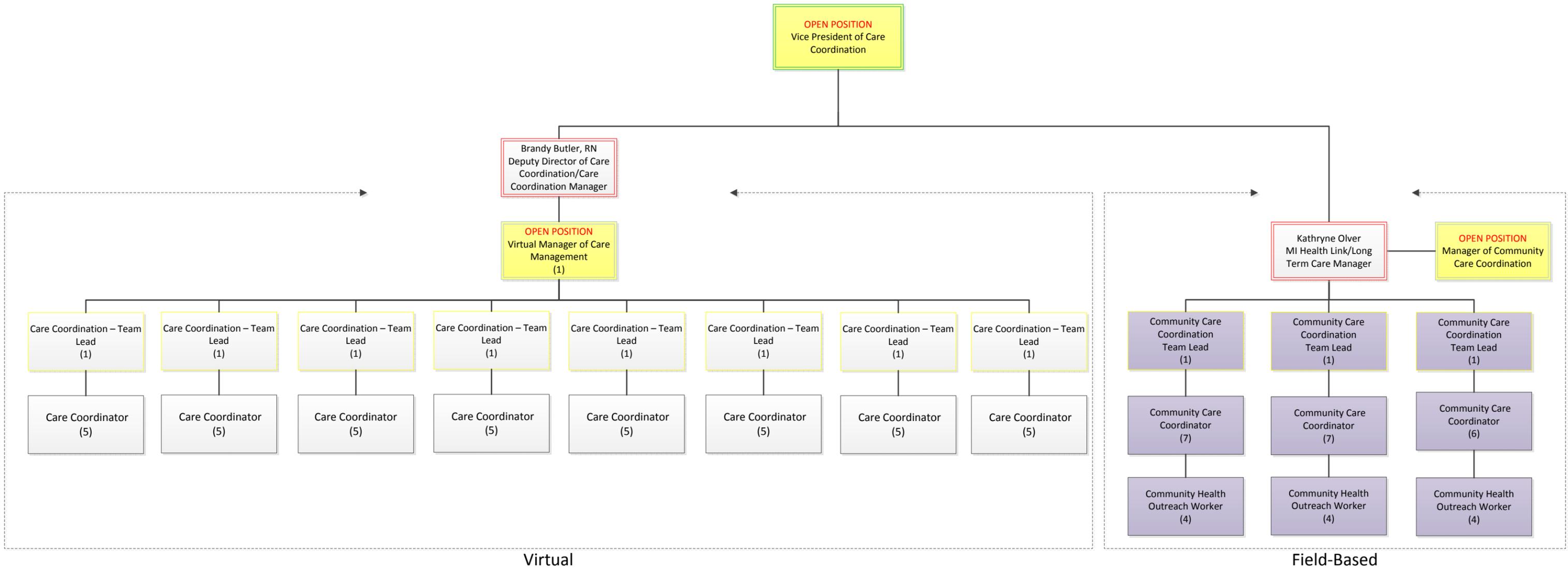


- LEGEND**
- = Open Position
 - = Deputy Director
 - = Manager
 - = Chief/President
 - = Director
 - = IA Based Employee
 - = Vice President
 - = IA Key Personnel
 - = Team Lead

Charts assume plan membership of 150,000 members.

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Meridian Health Plan of Iowa - Tables of Organization - Staff who will provide services under the RFP



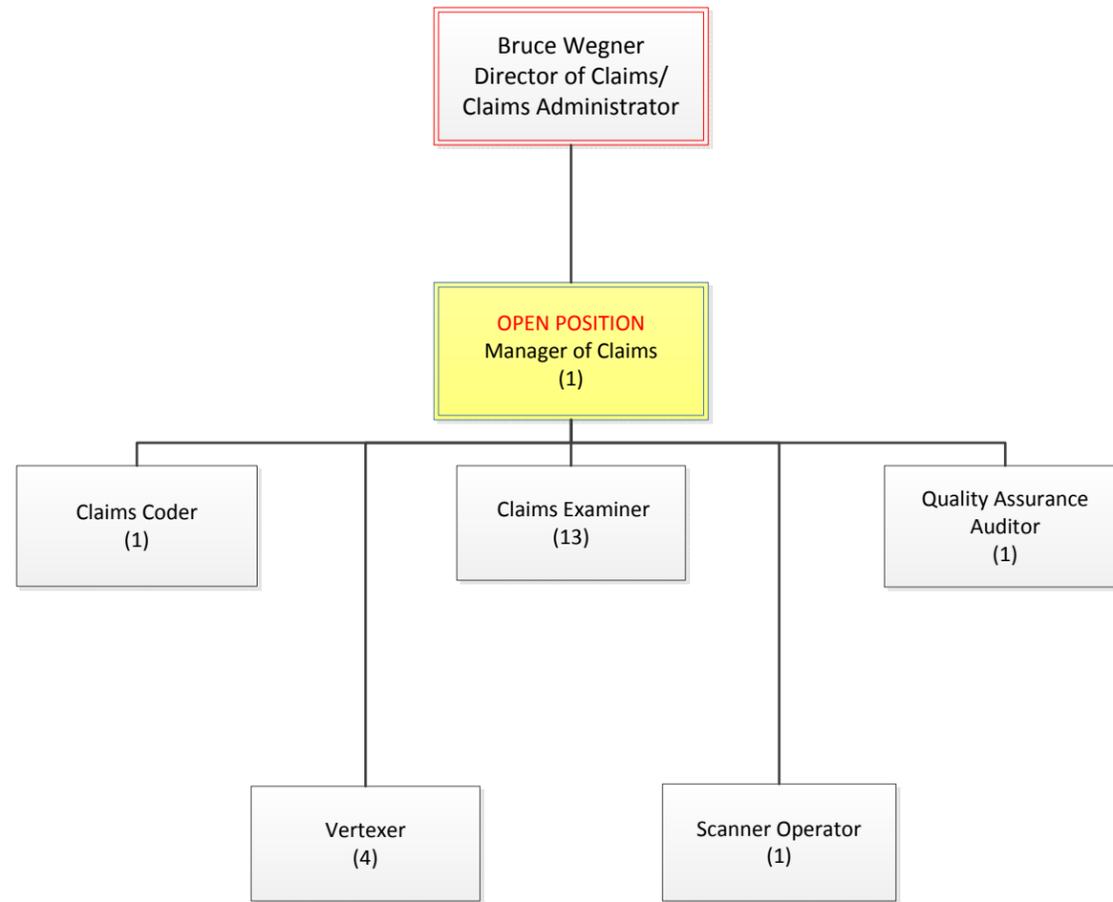
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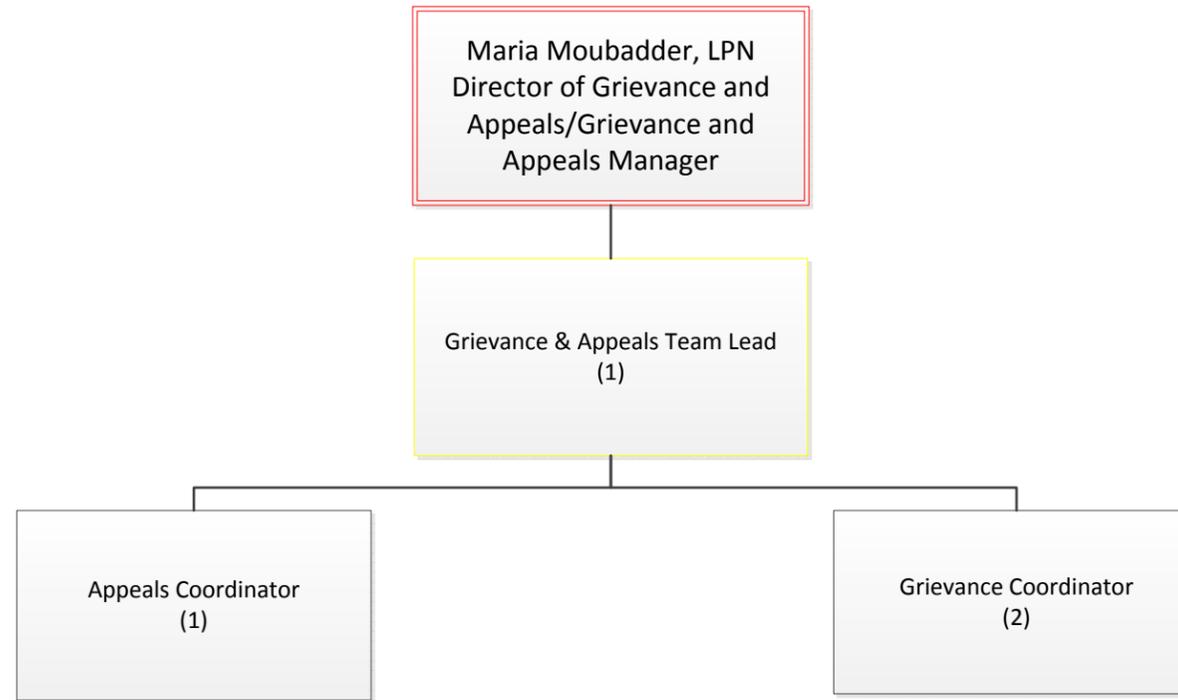
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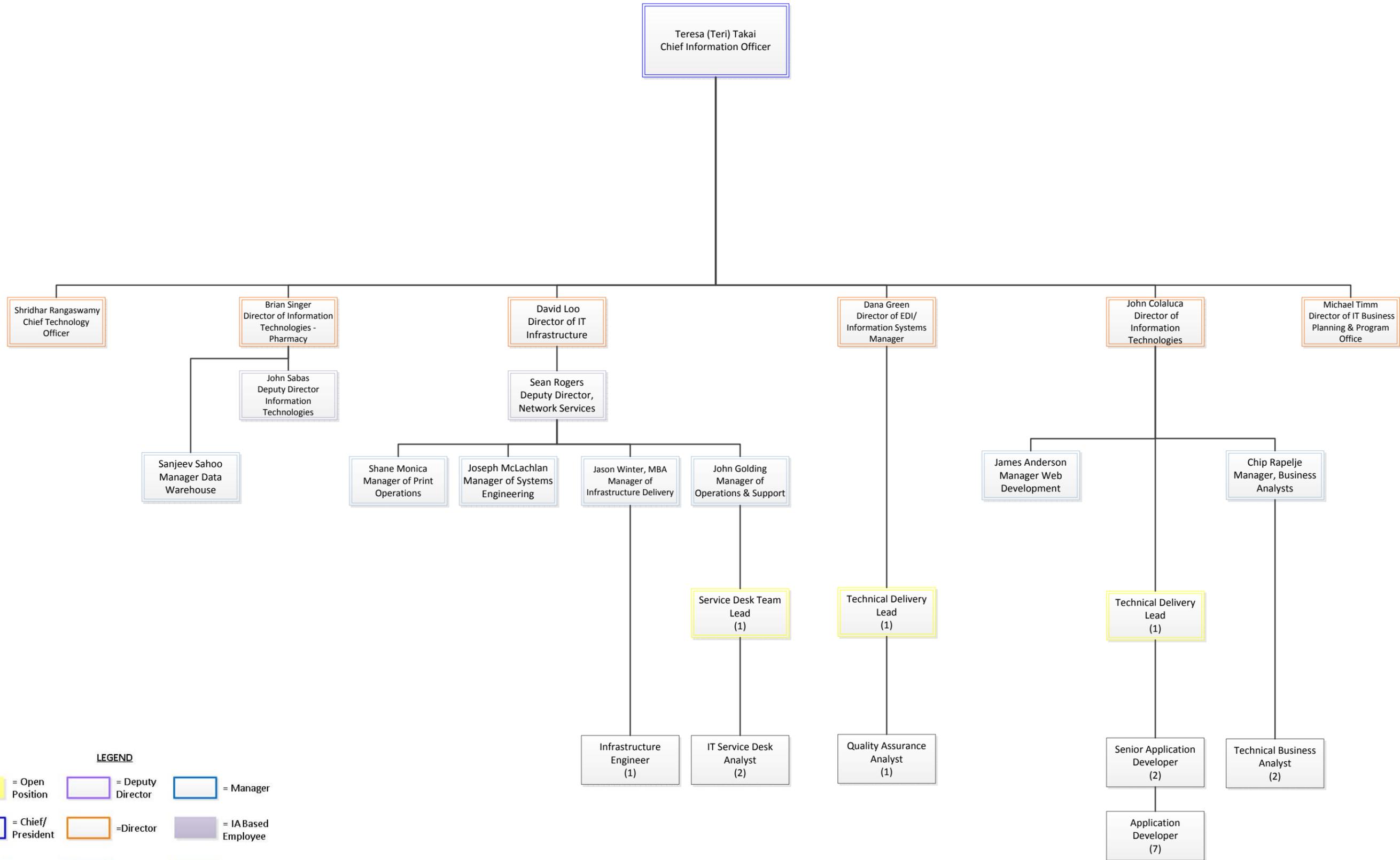


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Meridian Health Plan of Iowa - Tables of Organization - Staff who will provide services under the RFP



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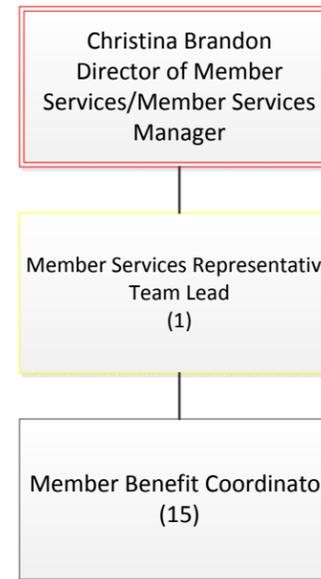
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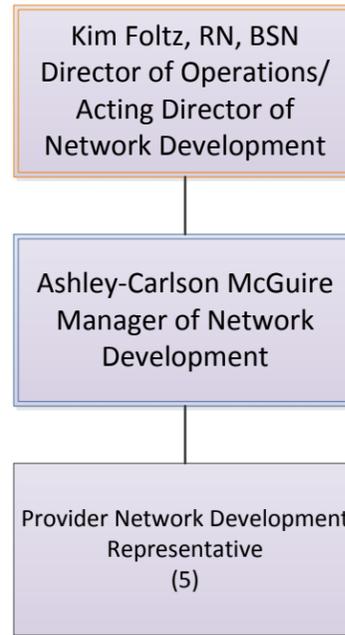
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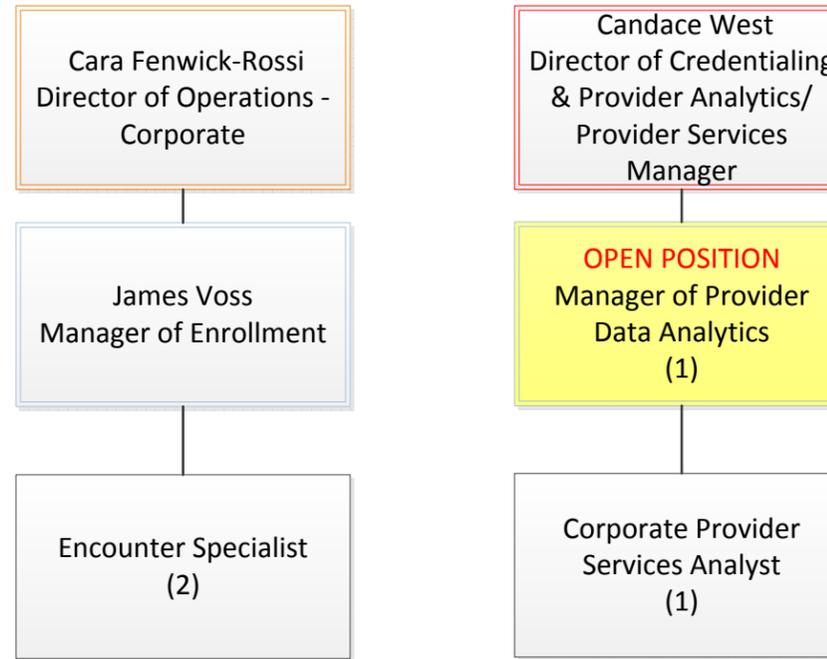
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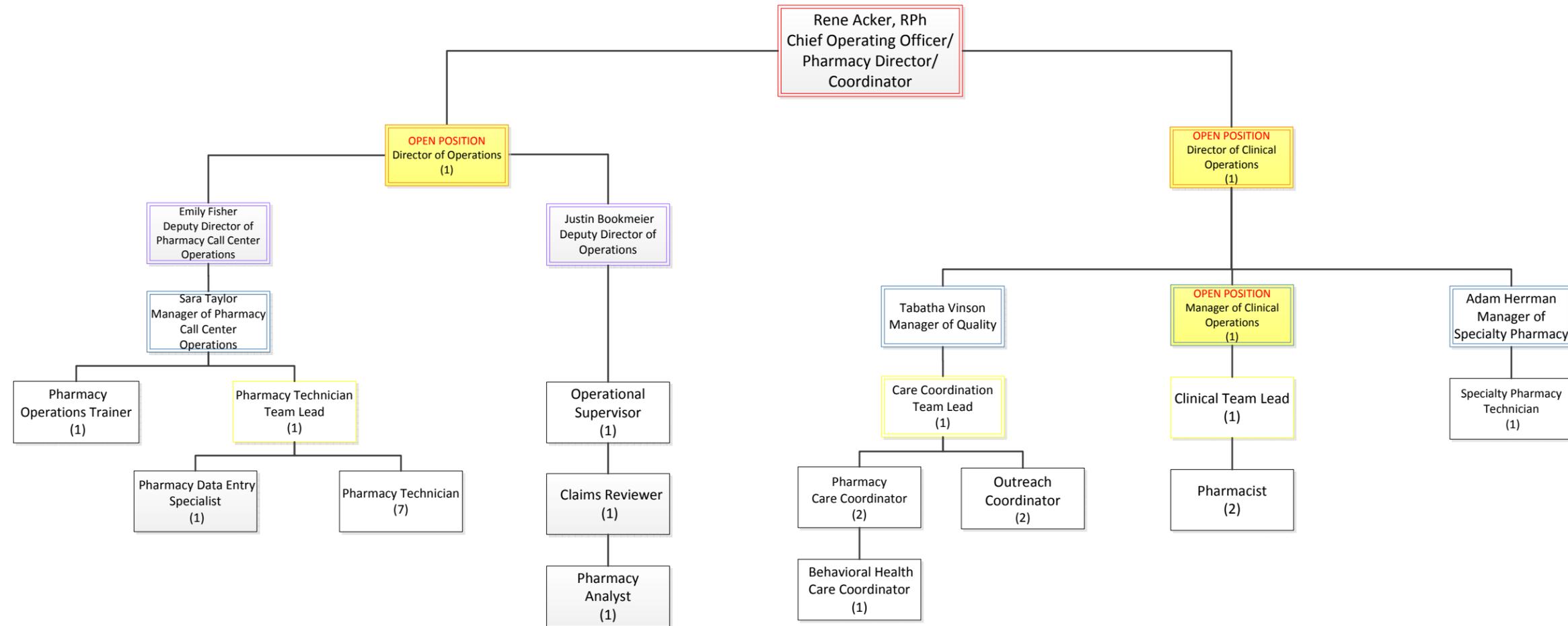
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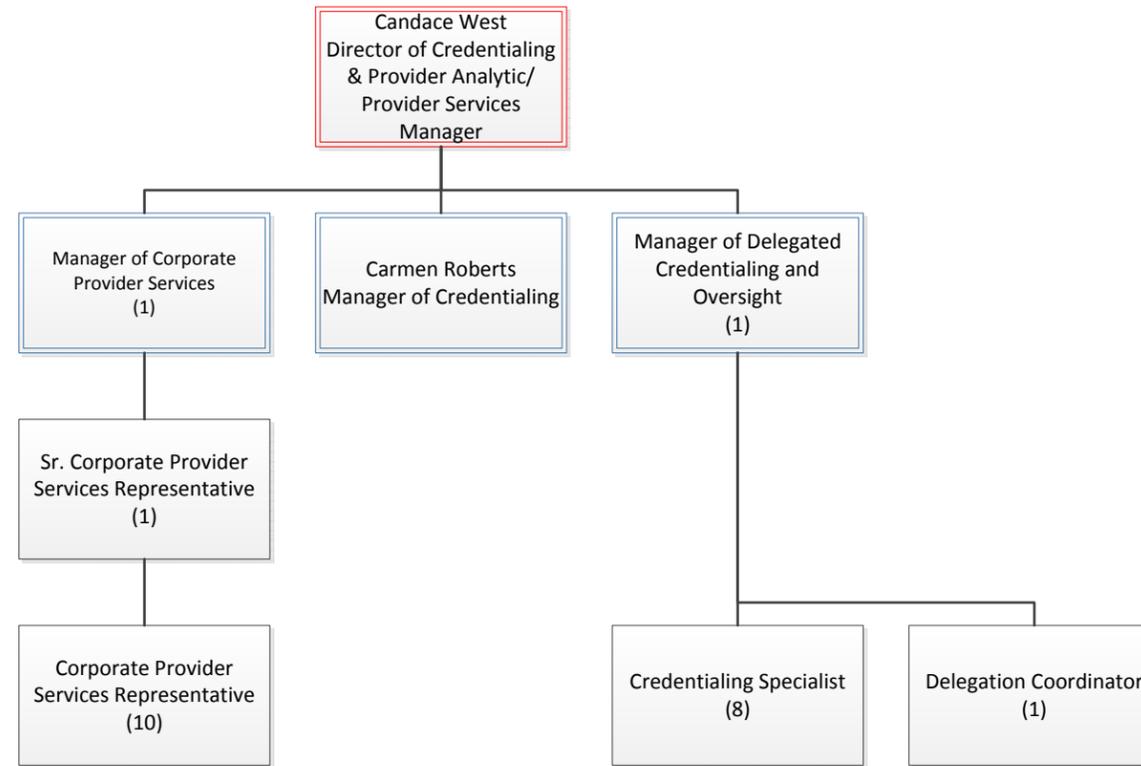
Meridian Health Plan of Iowa - Tables of Organization - Staff who will provide services under the RFP



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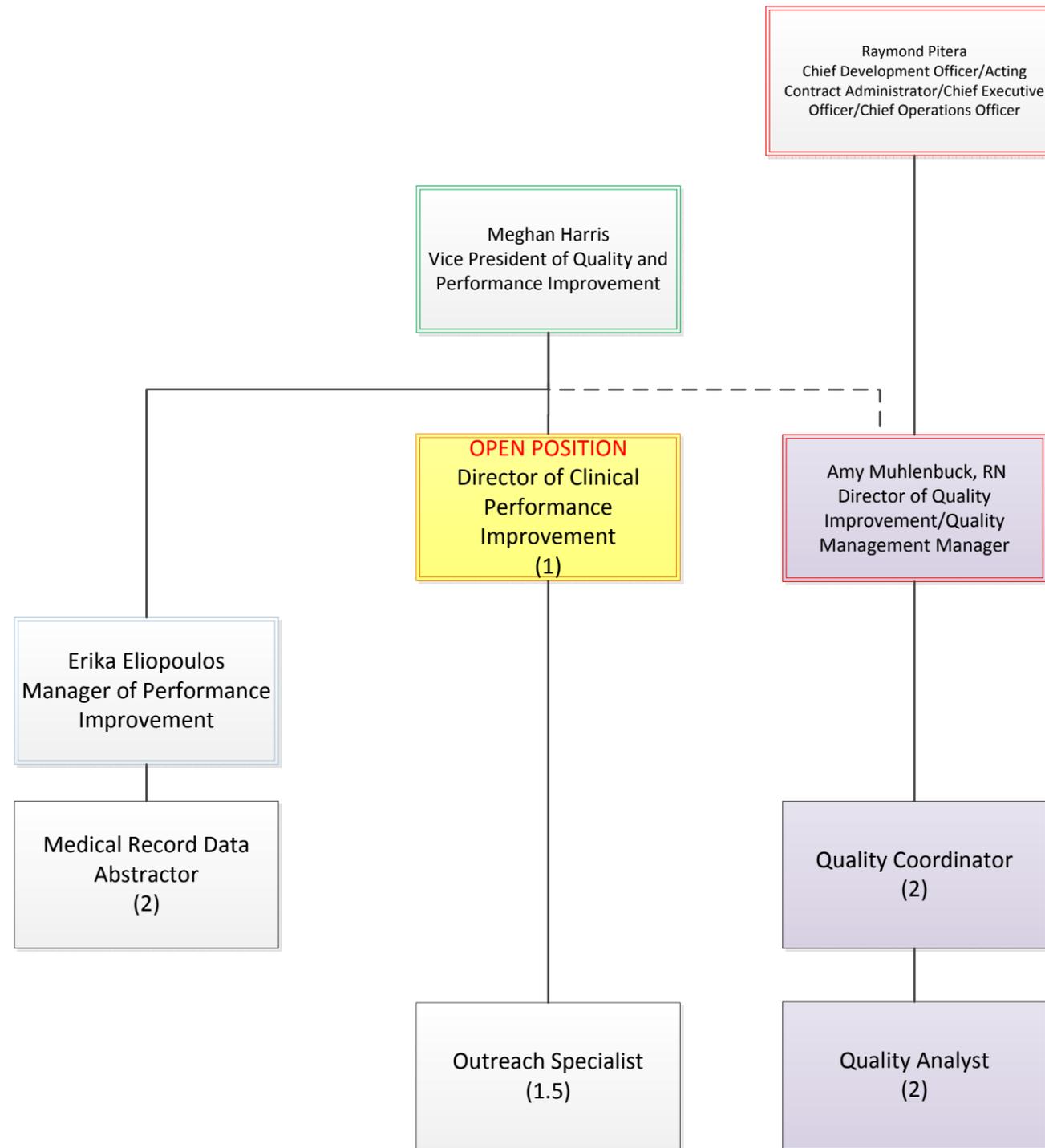
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Meridian Health Plan of Iowa - Tables of Organization - Staff who will provide services under the RFP



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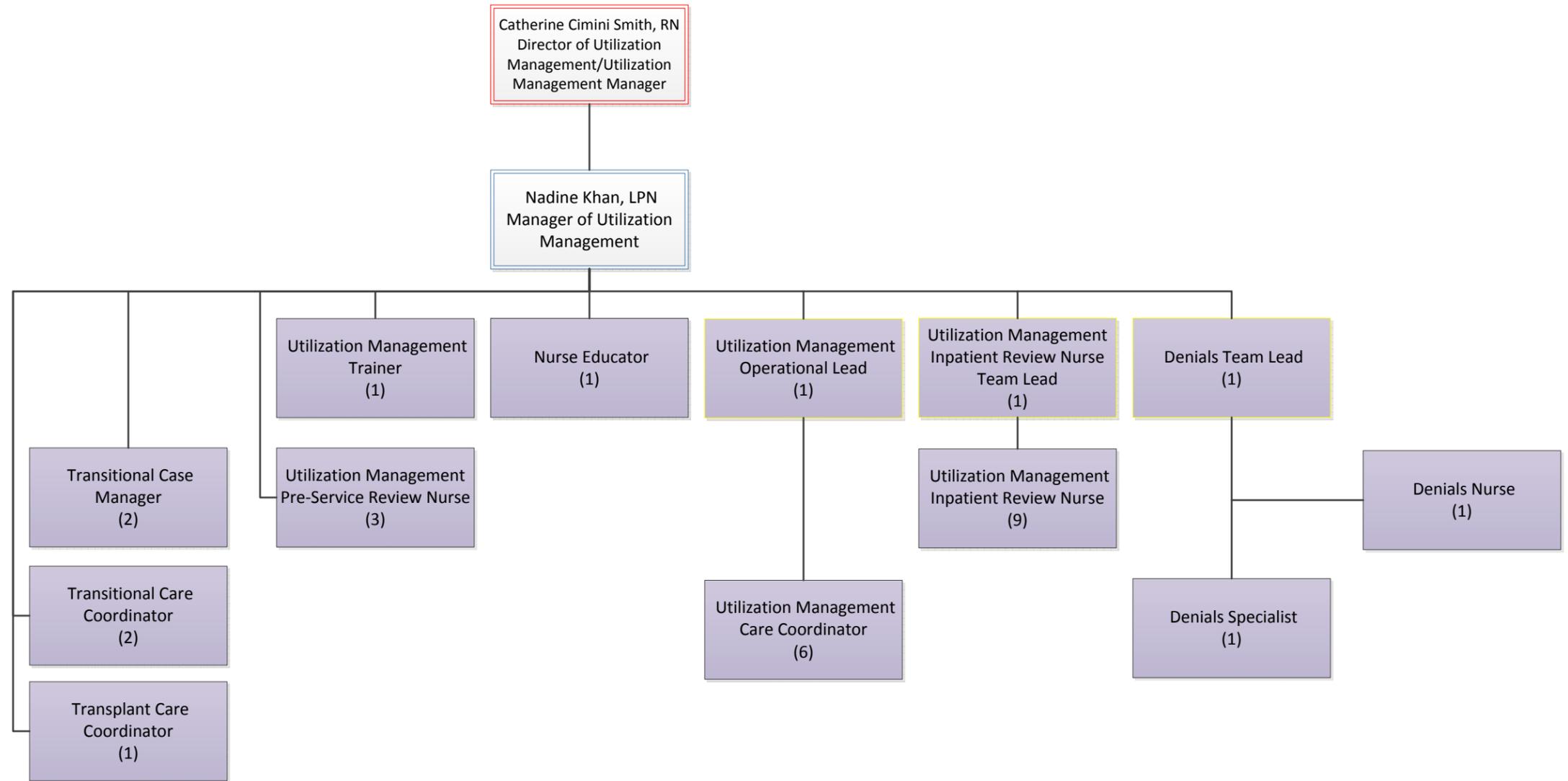
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Meridian Health Plan of Iowa - Tables of Organization - Staff who will provide services under the RFP



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3.2.5.2.2 Names and Credentials of Key Corporate Personnel.

| Key Personnel | | |
|----------------------|-------------|--|
| Name | Credentials | Role on Project |
| Acker, Rene | RPh | Chief Operating Officer/Pharmacy Director/Coordinator |
| Agnone, Matthew | CPA | Senior Vice President of Finance |
| Brandon, Christina | | Director of Member Services/Member Services Manager |
| Brown, Brandon | | Director of Recruitment and Retention |
| Butler, Brandy | RN | Deputy Director of Care Coordination/Care Coordination Manager |
| Colaluca, John | | Director of Information Systems |
| Cotton, David | MD | Chief Executive Officer - Corporate |
| Cotton, Michael | | Chief Operations Officer - Corporate |
| Cotton, Sean | JD | Chief Administrative Officer |
| Dasso, Edwin | MD | Senior Vice President of Clinical Performance and Analytics |
| Fenwick Rossi, Cara | | Director of Operations - Corporate |
| Foltz, Kim | RN, BSN | Director of Operations/Acting Director of Network Development |
| Gemborys, Michael | | Director of Project Management Office |
| Genaidy, Ashraf | | Director of Advanced Clinical Analytics |
| Goldsmith, Jane | RN | Vice President of Regulatory Compliance & Accreditation/Compliance Officer/Program Integrity Manager |
| Graham, Patricia | | Senior Vice President of Corporate Operations |
| Green, Dana | | Director of EDI/Information Systems Manager |
| Harris, Meghan | MHP, MPA | Vice President of Quality and Performance Improvement |
| Hill, Beau | Esq., CPA | Director of Regulatory Compliance |
| Kendall, Sean | | Vice President of Business Development |
| Lancaster, Sean | | Executive Director of Operations - State Exchange |
| Lecerf, Diane | | Director of Accreditation |
| Loo, David | | Director of IT Infrastructure |
| Miller, Karen | | Compliance Specialist |
| Moubadder, Maria | LPN | Director of Grievance and Appeals/Grievance & Appeals Manager |
| Muhlenbruck, Amy | RN | Director of Quality Improvement/Quality Management Manager |
| Muzingo, Richard | JD | Director of Compensation, Benefits & HR Administration |
| Olver, Kathrynne | SST | Manager of Care Coordination - MI Health Link/Long Term Care Manager |
| Payne, Matthew | | Director of Financial and Medical Analytics |
| Pitera, Raymond | | Chief Development Officer/Acting Contract Administrator/Chief Executive Officer/Chief Operations Officer |
| Rangaswamy, Shridhar | | Director of Information Systems - Pharmacy |

| Key Personnel | | |
|-------------------------|--------------------|--|
| Name | Credentials | Role on Project |
| Rashid, Carl | JD | Associate General Counsel/Vice President of Legal |
| Sconza, Jean | RN | Vice President of Clinical Analytics & Programs |
| Smith, C. David | MD | Medical Director |
| Smith, Catherine Cimini | RN | Director of Utilization Management/Utilization Management Manager |
| Solky, Mary Clare | MA, LLP, LPC | Director of Behavioral Health Operations/Behavioral Health Manager |
| Stines, Michael | JD | General Counsel |
| Takai, Teresa (Teri) | | Chief Information Officer |
| Timm, Michael | | Director of IT Business Planning & Program Office |
| Torosian, Janice | CPA | Chief Financial Officer |
| Wegner, Bruce | | Director of Claims/Claims Administrator |
| West, Candace | | Director of Credentialing & Provider Analytics/Provider Services Manager |

| Board of Directors | |
|---------------------------|--|
| Name | Title |
| David Cotton | Chief Executive Officer - Corporate |
| Michael Cotton | Chief Operations Officer - Corporate |
| Sean Cotton | Chief Administrative Officer |
| Jon Cotton | President/Chief Operating Officer - Michigan |

3.2.5.2.3 Information About Key Project Personnel

| | |
|---|---|
| Position | Contract Administrator/CEO/COO (Scope of Work 2.9.3.1) |
| Name | Raymond Pitera |
| General Description | This position is responsible for overseeing the entire operations of the Contractor. This position has full and final responsibility for contract compliance |
| Qualifications | MD/MBA/MHA/MPA or equivalent is required. Minimum of 7-10 years of progressive management position and experience in senior management positions in health care, managed care, or medical administration is required. |
| Number of Years Experience in their Field | 21 years experience |
| Proposed Location Where Position will be based | Iowa |

| | |
|---|---|
| Position | Medical Director(Scope of Work 2.9.3.2) |
| Name | Carl David Smith, MD |
| General Description | This position is responsible for oversight of all clinical functions, including but not limited to, disease management and care coordination programs, the development of clinical care guidelines and utilization management. This position is also responsible for coordination and implementation of the Quality Management and Improvement program, as well as directs the internal utilization management committee. |
| Qualifications | Current unrestricted license as Doctor of Medicine or Osteopathy for Iowa is required. Current board certification in designated specialty is preferred. Three (3) to five (5) years experience in managed care and medical management of health plans or in medical programs administration is required. 5 years post graduate experience in direct patient care is required. Strong experience in developing and/or implementing practice guidelines is required. Experience in providing care to a Medicaid population is preferred. |
| Number of Years Experience in their Field | 29 years of experience |
| Proposed Location Where Position will be based | Iowa |

| | |
|---|--|
| Position | Chief Financial Officer (Scope of Work 2.9.3.3) |
| Name | Janice Torosian |
| General Description | This position is responsible for overseeing the budget, accounting systems and financial reporting for the program. |
| Qualifications | Bachelor's Degree in Accounting is required; CPA or MBA is preferred. Minimum of five (5) years experience in the health care industry is required. At least two (2) years experience in a managed care setting is required. |
| Number of Years Experience in their Field | 32 years experience |
| Proposed Location Where Position will be based | Out-of-State, Corporate Office - Michigan |

| | |
|---|--|
| Position | Compliance Officer/Program Integrity Manager (Scope of Work 2.9.3.4 and 2.9.3.15) |
| Name | Jane Goldsmith, RN |
| General Description | This position is the primary liaison with the State (or its designees) to facilitate communications between the Agency, the State's contractors and the Contractor's executive leadership and staff. The individual in this position must maintain a current knowledge of federal and state legislation, legislative initiatives and regulations that may impact the program. Responsible for oversight of the Contractor's special investigations unit (SIU) activity. This position will serve as the liaison between the Contractor and state agencies, law enforcement, and federal agencies. This position must be informed of current trends in fraud, waste, and abuse as well as mechanisms to detect such activity. |
| Qualifications | Bachelor's degree in health care or related field is required. A minimum of five (5) years experience in a Medicaid Managed Care Program or five (5) years experience in public sector services such as Medicare, Medicaid, Community Health, Public Health or Social Services is preferred. |
| Number of Years Experience in their Field | 15 years experience |
| Proposed Location Where Position will be based | Out-of-State, Corporate Office - Michigan |

| | |
|---|--|
| Position | Pharmacy Director/Coordinator (Scope of Work 2.9.3.5) |
| Name | Rene Acker, RPh |
| General Description | This position is responsible for oversight and coordination of all Contractor and Pharmacy Benefit Manager (PBM) pharmacy requirements including drug rebate. This position must attend the Agency Pharmaceutical & Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Commission meetings. |
| Qualifications | Current unrestricted license in the state of Iowa as a Pharmacist and Controlled Substance licenses in good standing are required. At least five (5) years of experience in managed health care or pharmacy programs is required. Previous management and supervisory experience is required. Previous experience in patient care is required. Previous experience as a Medicaid Pharmacy Director or equivalent Medicaid pharmacy experience, inclusive of drug rebate is required. |
| Number of Years Experience in their Field | 18 years experience |
| Proposed Location Where Position will be based | Out-of-State, Corporate Office - Michigan |

| | |
|---|---|
| Position | Grievance & Appeals Manager (Scope of Work 2.9.3.6) |
| Name | Maria Moubadder, LPN |
| General Description | This position manages the Contractor's grievance and appeals process, ensuring compliance with processing timelines and policy and procedure adherence |
| Qualifications | Current licensure to practice as a Registered Nurse or a Licensed Practical Nurse in the designated State, without restriction or Bachelor's degree in a healthcare related field is required. Three (3) to five (5) years of experience, education and/or certifications in utilization management, case management or other appropriate health care specialty is required. Two (2) to five (5) years of experience with Medicare Appeals and Grievances is required. Experience working with physicians and clinicians in appeals and grievances is required. |
| Number of Years Experience in their Field | 23 years experience |
| Proposed Location Where Position will be based | Out-of-State, Corporate Office - Michigan |

| | |
|---|--|
| Position | Quality Management Manager (Scope of Work 2.9.3.7) |
| Name | Amy Muhlenbruck, RN |
| General Description | responsible for overseeing the Contractor's Quality Management and Improvement program and ensuring compliance with quality management requirements and quality improvement initiatives. |
| Qualifications | Bachelor's degree in nursing or a related field is required. Current license to practice as a Registered Nurse, Physician, or Physician's Assistant or a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (HCQM) by the American Board of Quality Assurance and Utilization Review Physicians in the state of Iowa. Three (3) to five (5) years experience in quality improvement activities is required. |
| Number of Years Experience in their Field | 22 years experience |
| Proposed Location Where Position will be based | Iowa |

| | |
|---|---|
| Position | Utilization Management Manager (Scope of Work 2.9.3.8) |
| Name | Catherine Smith, RN |
| General Description | This position manages all elements of the Contractor's utilization management program and staff under the supervision of the Medical Director. This includes, but is not limited to functions related to prior authorization, medical necessity determinations, concurrent and retrospective reviews, and other clinical and medical management programs. |
| Qualifications | Current licensure to practice as in the designated State, without restriction, as a licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations is required. Three (3) to five (5) years of experience, education and/or certifications in utilization management, case management or other appropriate health care specialty is required. A minimum of one year supervisory experience is required. |
| Number of Years Experience in their Field | 21 years experience |
| Proposed Location Where Position will be based | Out-of-State, Corporate Office - Michigan |

| | |
|---|---|
| Position | Behavioral Health Manager (Scope of Work 2.9.3.9) |
| Name | Mary Clare Solky |
| General Description | Responsible for ensuring that the Contractor's behavioral health operations, which include the operations of any behavioral health subcontractors, are in compliance with the terms of the Contract. This position 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. |
| Qualifications | Current, unrestricted licensure in the state of Iowa as a behavioral health professional, such as a psychologist, psychiatrist, social worker, psychiatric nurse, marriage and family therapist or mental health counselor, is required. Bachelor's degree in a health care related field with strong related experience or additional Fellow designation from the Academy of Healthcare Management (AHM) with is required. A minimum of five years professional operations management experience is required. Experience in operational program design, implementation and process improvement is required. Experience in data management, interpretation and presentation design in required. Five (5) years managed care management experience is required. Public sector managed care or services management experience is preferred. Previous personnel management and supervisory experience is required. |
| Number of Years Experience in their Field | 29 years experience |
| Proposed Location Where Position will be based | Out-of-State, Corporate Office - Michigan |

| | |
|---|---|
| Position | Member Services Manager (Scope of Work 2.9.3.10) |
| Name | Christina Brandon |
| General Description | Responsible for oversight of the member services functions of the Contract, including, but not limited to, member helpline telephone performance, member e-mail communications, member education, the member website, member outreach programs, development, approval and distribution of member materials. This position must oversee the interface with the State or its subcontractors regarding such issues as member enrollment and disenrollment. |
| Qualifications | Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is required. Minimum of 5 years of customer service experience is preferred. Experience in a call center setting for inbound and outbound calls is required. One year supervisory experience in a call center operation is strongly preferred. Background and experience in a managed care setting is strongly preferred. Project management experience is required. Experience and comfort with public speaking are required. |
| Number of Years Experience in their Field | 15 years experience |
| Proposed Location Where Position will be based | Out-of-State, Corporate Office - Michigan |

| | |
|---|--|
| Position | Provider Services Manager (Scope of Work 2.9.3.11) |
| Name | Candace West |
| General Description | Responsible for the oversight of the provider services function of the Contract. This includes, but is not limited to, the provider services helpline, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing the provider manual and education materials and developing provider outreach programs. This position is responsible for ensuring that all of the Contractor's provider services operations are in compliance with the terms of the Contract. |
| Qualifications | Bachelor's degree in business administration, healthcare administration, communications, marketing or other related field is required. 3-5 years previous experience in a provider services role is required. Prior experience in a managed care setting is strongly preferred. Prior call center experience is preferred. |
| Number of Years Experience in their Field | 16 years experience |
| Proposed Location Where Position will be based | Out-of-State, Corporate Office - Michigan |

| | |
|---|--|
| Position | Information Systems Manager (Scope of Work 2.9.3.12) |
| Name | Dana Green |
| General Description | This position serves as the liaison between the Contractor and the Agency, or its designee, regarding encounter claims submissions, capitation payment, member eligibility, enrollment and other data transmission interface and management issues. This position is responsible for ensuring all information system security and controls, program data transactions, data exchanges other information system requirements are in compliance with the terms of the Contract, and all data submissions required for federal reporting. |
| Qualifications | Bachelor's degree in Computer Science or a related field or an equivalent combination of education, training and experience. Five (5) years' experience managing people or leading project teams, including proven experience providing effective coaching and feedback to team members. Three (3) years' proven track record of technical expertise in IT, including EDI Operations, application management experience or production system responsibilities. Proven track record of delivering high quality products and services resulting in highly satisfied customers. Experience working with vendors to deliver on business needs. |
| Number of Years Experience in their Field | 13 years experience |
| Proposed Location Where Position will be based | Out-of-State, Corporate Office - Michigan |

| | |
|---|---|
| Position | Claims Administrator (Scope of Work 2.9.3.13) |
| Name | Bruce Wegner |
| General Description | Responsible for ensuring prompt and accurate provider claims processing in accordance with the terms of the Contract. |
| Qualifications | Bachelor's Degree or Fellow designation from the Academy for Healthcare Management (AHM) is required. Three (3) to five (5) years of previous claims management experience is required. Previous experience in a leadership role is required. |
| Number of Years Experience in their Field | 26 years experience |
| Proposed Location Where Position will be based | Out-of-State, Corporate Office - Michigan |

| | |
|---|--|
| Position | Care Coordination Manager (Scope of Work 2.9.3.14) |
| Name | Brandy Butler, RN |
| General Description | Responsible for oversight of the Contractor's care coordination and community-based case management programs. This position will be responsible for overseeing care coordination and community-based case management teams, care plan development and care plan implementation. |
| Qualifications | Bachelor's degree in health related field or Fellow designation from the Academy of Healthcare Management (AHM) is required. Master's degree in nursing, health care administration or related field is preferred. Three (3) to five (5) years of experience in utilization management, with additional case management experience preferred. Previous experience in managed care and Medicaid programs. Previous management and supervisory experience. |
| Number of Years Experience in their Field | 12 years experience |
| Proposed Location Where Position will be based | Out-of-State, Corporate Office - Michigan |

| | |
|---|--|
| Position | Long Term Care Manager (Scope of Work 2.9.3.16) |
| Name | Kathryne Olver, SST |
| General Description | Responsible for oversight of the Contractor's implantation of the state's community based and facility programs. This position is also responsible for overseeing long-term care provider reviews, utilization reviews, member satisfaction surveys, and member health and welfare. |
| Qualifications | Bachelor's degree in a healthcare related discipline such as Nursing, Social Work, Healthcare Administration, Counseling, Special Education, Sociology, Psychology, or Gerontology; or Fellow, Academy for Healthcare Management (AHM) Designation is required. 3 to 5 years' experience in management of community-based program/agency, project management, health promotion, and community assessments, or program development. A minimum of at least 5 years of experience in long term care policy. Must have a comprehensive understanding of CMS rules and regulations. Experience in working with the Medicaid and/or Medicare populations. Experience in a managed care setting and/or direct experience in the delivery of community services and/or care coordination, discharge planning, or behavioral health or long term care services. At least 1 year of leadership/management experience is preferred. Experience with billing codes including CPT and/or ICD-9. |
| Number of Years Experience in their Field | 18 years experience |
| Proposed Location Where Position will be based | Out-of-State, Corporate Office - Michigan |

| | |
|---|---|
| Position | Director of Operations (Scope of Work 2.9.3.17) |
| Name | Kim Foltz, RN, BSN |
| General Description | Responsible for representing Meridian Health Plan of Iowa in operational matters. This position assists the Contract Administrator/Chief Executive Officer/Chief Operations Officer in providing overall direction and guidance to Iowa specific departments, interfacing with designated corporate departments. This position is also designated as the primary point of contact with the Agency for delivery system reform activities, including managing a specific project plan and reporting on activity and progress towards identified goals. |
| Qualifications | Bachelor's degree is required. At least five years of progressive management experience is required. Three to five years of experience in a Medicaid Managed Care Program or in public sector services such as Medicare, Medicaid, Community Health, Public Health or Social Services is preferred. Strong managed health care knowledge. Knowledge of Medicaid Managed Care guidelines. Knowledge of plan policies and procedures. Familiarity with healthcare laws, regulations and standards. Working knowledge of the National Committee for Quality Assurance (NCQA), URAC or general accreditation policies and procedures. Working knowledge of Healthcare Effectiveness Data and Information Set (HEDIS®) requirements. Working knowledge of the Privacy and Security Health Insurance Portability and Accountability Act (HIPAA) regulations. Knowledge of coding and reimbursement systems, risk management and performance improvement is helpful. |
| Number of Years Experience in their Field | 20 years experience |
| Proposed Location Where Position will be based | Iowa |

3.2.5.4 Termination, Litigation, and Investigation.

- **List any contract for services that the bidder has had that was terminated for convenience, non-performance, non-allocation of funds, or any other reason for which termination occurred before completion of all obligations under the contract provisions.**

Upon its request to withdraw, and mutual agreement by both parties regarding such withdrawal, Meridian Health Plan affiliate Granite Care- Meridian Health Plan of New Hampshire, Inc.'s contract with the New Hampshire Department of Health and Human Services was terminated for reasons of convenience. Meridian continued to fulfill its contractual obligations during the transition period.

- **List any occurrences where the bidder has either been subject to default or has received notice of default or failure to perform on a contract. Provide full details related to the default or notice of default including the other party's name, address, and telephone number.**

Neither Meridian Health Plan nor its affiliates have been subject to any of the events listed in this question in the past five (5) years.

- **List any damages, penalties, disincentives assessed, or payments withheld, or anything of value traded or given up by the bidder under any of its existing or past contracts as it relates to services performed that are similar to the services contemplated by this RFP.**

Neither Meridian Health Plan nor its affiliates have been subject to any of the events listed in this question in the past five (5) years.

- **List and summarize pending or threatened litigation, administrative or regulatory proceedings, or similar matters related to the subject matter of the services sought in this RFP.**

Neither Meridian Health Plan nor its affiliates are subject to any pending or threatened litigation, administrative, or regulatory proceeding, or similar matter related to the subject matter of the services sought in this RFP in the past five (5) years.

- **List any irregularities that have been discovered in any of the accounts maintained by the bidder on behalf of others. Describe the circumstances of irregularities or variances and detail how the issues were resolved.**

Neither Meridian Health Plan nor its associates have had irregularities in any of the accounts maintained by it on behalf of others in the past five (5) years.

- **List any details of whether the bidder or any owners, officers, primary partners, staff providing services or any owners, officers, primary partners, or staff providing services of**

any subcontractor who may be involved with providing the services sought in this RFP, have ever had a founded child or dependent adult abuse report, or been convicted of a felony. Staff providing services shall include anyone having contact with members or member data.

To the best of its knowledge, information, and belief, neither Meridian Health Plan nor any of its affiliates or subcontractors, nor any owners, officers, primary partners, or staff providing services of Meridian, its affiliates, or subcontractors, have had a founded child or dependent adult abuse report of been convicted of a felony.

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Care Coordinator

Reports To: Virtual Manager of Care Coordination

Position Summary:

This position coordinates care for high risk populations identified by the clinical team leader. This position must work cooperatively with multidisciplinary care teams that may include: the member's PCP, specialists, social worker/behavioral health specialist and community resource contacts, while functioning with professional autonomy under the supervision of their Manager/Director. This position is field based or office based depending upon the needs of the membership and/or management recommendation.

Essential Functions:

- Maintain ongoing tracking and appropriate documentation on referrals to promote team awareness and ensure member safety.
- Conduct complete, timely and accurate Health Risk Assessments (face-to-face or telephonically), including current member demographic information.
- Assemble information concerning member's clinical background and referral needs, and per referral guidelines provides appropriate clinical information to PCP and specialists.
- Assists members in problem solving potential issues related to the health care system, such as need for transportation, interpreters, etc.
- Be the system navigator and point of contact for members and families, with members and families having direct access for asking questions and raising concerns.
- Identify and utilize cultural and community resources.
- Ensure referrals are addressed in a timely manner.
- Remind members of scheduled appointments.
- Provides follow up with member/family when member transitions from one setting to another. Completes post hospital discharge follow-up: Medication reconciliation data collection, PCP or specialist follow up appointments.
- Assists with scheduling appointments for Healthcare Effectiveness Data Information Set (HEDIS) measures the member needs.
- Seeks to resolve any concerns about care delivery or providers
- Acts as a liaison and member advocate between the member/family, physician and facilities/agencies.
- Must create and maintain strong communication with the members' integrated care team.
- Must create a relationship with the member working towards their optimal overall health and well-being by facilitating transitions of care for members through individual meetings in person and by phone.
- Create and update a personalized, member centered plan of care involving the members PCP, family/caregiver, Social Worker/Behavioral Health specialists and other specialists as needed to evaluate the individuals' needs, goals, and plan of action.
- Closely monitor members' medical history and any changes through initial screenings and comprehensive assessment of the members needs during their coordination of care.
- Coordinates community resources and benefits
- Maintains HIPAA standards and confidentiality of protected health information; and
- Takes the overall population under the care of the Team Lead or Social Worker and works under their direction to stratify them by risk into the population that will be worked with each month.
- Perform other duties as assigned.

Job Requirements:

Education:

- Bachelor's degree with a concentration in healthcare or related field is required;
- Fellow, Academy for Healthcare Management (AHM) Designation is preferred

Experience:

- Six months to one year of customer service experience or related health care industry experience is required.

Knowledge:

- Must demonstrate customer focused interpersonal skills to interact in an effective manner with practitioners, the interdisciplinary health care team, community agencies, members, and families with diverse opinions, values, and religious and cultural ideals.
- Must also demonstrate the ability to work autonomously, follow through with delegated tasks and be directly accountable for deliverables.
- Must have leadership qualities including time management, verbal and written communication skills, listening skills, problem solving and decision-making, priority setting, work delegation and work organization, as well as strong customer service focus, teamwork orientation and resourcefulness in problem solving.

Skills:

- Demonstrates excellent communication – both verbal and written
- Excellent interpersonal and facilitation skills

Abilities:

- Must have the ability to affect change, work as a productive and effective team member and adapt to changing needs/priorities

Care Coordination Team Lead

Reports To: Virtual Manager of Care Coordination

Position Summary: This position is responsible for specific functions within the Care Coordination portion of the Utilization Management department. This position oversees the care for high risk populations and oversees a team of care coordinators to ensure assessment of members clinical and psychosocial status, interdisciplinary team approach, education of members in the area of self-management is achieved. This position also provides first line clinical direction to the care coordination staff and refers to Manager of Care Coordination when necessary.

Essential Functions:

- Review predictive model report of each member assigned to their team. Review with care coordinator all cases assigned to team for management.
- Direct member contact of members referred by care coordinator for clinical issues and or medication reconciliation.
- Perform post inpatient calls on all members assigned to team
- Discuss challenging cases with Medical Director assigned to team. Provides recommendations to care coordinators regarding consultation to behavioral health, nutrition, and pharmacy.
- Oversee workloads by monitoring each care coordinators work list queue to ensure there is a balance of cases by acuity level and referral type of case. Discuss variances that may be identified in team member case load/performance with manager; such as: overdue tasks/cases.
- Provide front line direction to care coordination staff and consult with manager as appropriate for input.
- Identify cases that require team conferences with the nurse reviewer, team lead, behavioral health, nutrition, pharmacy, appropriate managers, and Medical Director assigned to the team to develop a care plan that will be entered into MCS.
- Provide for ongoing clinical training and education of all staff based on needs assessments done with each staff member to determine areas where more training is required. Coordinate such training with the Manager.
- Work in collaboration with Manager and Trainer to develop job aides for the care coordination staff.
- Acts as a liaison with other MHP departments in relation to care coordination issues.
- Assists Manager in the creation of the agenda for the monthly care coordination team meetings.
- Facilitates weekly team meetings with team members to perform case reviews together.
- Participates in QIA activities and adheres to all regulatory guidelines and standards.
- Consistently demonstrates compliance with HIPAA regulations, professional conduct, and ethical practice.
- Assists with special projects or departmental process improvement efforts, as needed.
- Maintains HIPAA standards and confidentiality of protected health information; and consistently demonstrate compliance with HIPAA regulations, professional conduct and ethical practice
- Perform other duties as assigned.

Job Requirements:

Education:

- Current license (without restriction) to practice as a Licensed Practical Nurse or Registered Nurse in the designated State is required.

Attachment 1 (Care Coordination/Long-Term Services and Supports Job Descriptions)

Experience:

- A minimum of 1 year case management/disease management experience.

Knowledge:

- Knowledge of managed care
- Knowledge of case management processes including tools and techniques for identification, stratification and management of high-risk members.
- Must possess working knowledge of MDCH regulations

Skills:

- Excellent organizational and critical thinking skills
- Excellent people skills
- Skilled in conducting telephone based nursing assessments
- Excellent written and verbal communication skills

Abilities:

- Must be able to relate to and work with ill, disabled, elderly, emotional upset and at times, hostile members
- Must possess the ability to make independent decisions when circumstances warrant such action.
- Ability to prioritize and coordinate member care needs
- Ability to manage multiple tasks simultaneously
- Ability to work collaboratively and effectively with diverse groups
- Ability to function as part of an interdisciplinary team

Virtual Manager of Care Coordination

Reports To: Deputy Director of Care Coordination/Care Management Manager

Position Summary: This position has direct supervision over the Virtual MI Health Link Care Coordination teams and is responsible for providing leadership, direction and implementation of all aspects of the Care Coordination and SNP Model of Care and Compliance program. The Manager is responsible for ensuring the integration of evidence based clinical guidelines into member interventions; providing staff education both individually and on a group level; serves as the liaison for staff with the medical management leadership team; and participates with Disease Management in identification of members at risk for certain disease states.

Essential Functions:

- Provides direct management to the MI Health Link Care Coordination teams, including but not limited to hiring, monitoring workload, performance evaluations and disciplinary action
- Administers quality and phone audits among all staff members to evaluate the consistency with which professionals involved in Care Coordination MHP criteria, Evidence Based Practice Guidelines and state contract criteria in decision making and acts on opportunities to improve consistency when applicable and follow MHP policies and procedures.
- Provides reports to the Director/Deputy Director of Care Coordination on the status of special projects
- Coordinates, monitors, and evaluates the activities of the various Care Coordination teams involved in managing the care of MI Health Link Care Coordination team. This may include, but is not limited to collaborating with physicians, family members, other managed care workers, social workers, public health departments, community mental health, inpatient case managers, discharge planners, and ancillary providers to ensure an optimal level of functional status and wellness
- Establishes multiple case finding mechanisms and population specific assessment tools, identifies and assesses individuals through Predictive Model with catastrophic, complex or chronic risk factors who meet established criteria for entry into the Care Coordination program.
- Is responsible for the development and maintenance of MHP protocols and policies specific to Care Coordination and the SNP model of care.
- Monitors staff interactions with physicians and other ancillary providers to establish a plan of care and desired outcomes/goals based on an HRA that includes including bio/psycho/social assessment data
- Proactively initiates auditing and monitoring of the timeliness of care coordination interventions designed to optimize patient outcomes/goals and address barriers, including patient and family response and compliance with the care plan.
- Utilizes professional judgment and critical thinking to assist staff in working with members in overcoming barriers to goal achievement
- Evaluates and reports the effects of care coordination process on the targeted patient populations including the identification and reporting of quality issues
- Utilizes critical pathways, published care management guidelines, knowledge of current medical practices, and MHP preventive and clinical practice guidelines to instruct both the Team Leads and Care Coordinators on how to manage the member in Care Coordination program

Attachment 1 (Care Coordination/Long-Term Services and Supports Job Descriptions)

- Work closely with the team leads of the various types of care coordinators regarding any escalated requests in the FWA module in MCS.
- Review care coordination processes to provide Director/Deputy Director with an individual assessment of compliance risk, internal control and the overall effectiveness and efficiency of the process.
- Works with the IS department to develop needed collection and reporting resources
- Conducts cost benefit analysis of the Care Coordination Program
- Assists Director/Deputy Director with budgeting and strategic planning
- Collaborates closely with the Disease Management, Quality Management, Utilization Management, Member Services, Information Services, Pharmacy, Claims, and Provider Services in the development of protocols and practice guidelines designed to standardize care practices and care delivery
- Seeks out opportunities to participate in and improve HEDIS, CAHPS, National Committee for Quality Assurance (NCQA) or general accreditation and QIA initiatives
- Consistently demonstrates compliance with HIPAA regulations, professional conduct, and ethical practice
- Some travel may be required
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree is required. Master's degree is preferred.
- Case Manager Certification is preferred.

Experience:

- Five years management experience in health care or related field preferred.
- Experience in discharge planning, home health care, community health or managed care is required.

Knowledge:

- Advanced knowledge and experience in health care management
- Knowledge of managed care
- Knowledge of the Care Coordination process including tools and techniques for identification, stratification and management of high-risk clients

Skills:

- Excellent organizational and critical thinking skills
- Skilled in developing and managing databases for tracking member caseloads

Abilities:

- Ability to provide leadership and garner commitment to team function
- Ability to prioritize and coordinate member care needs
- Skilled in conducting telephone based nursing assessments
- Ability to manage multiple tasks simultaneously
- Ability to work collaboratively and effectively with diverse groups
- Ability to function as part of an interdisciplinary team

Manager of Community Care Coordination

Reports to: Vice President of Care Coordination

Position Summary: This position is responsible for the community care coordination program overseeing the services provided by plan community-based care coordinators and community health outreach workers. The care coordinators and community health outreach workers are responsible for assessing the member's needs; and facilitating, promoting and advocating for the member's ongoing self-sufficiency and independence. Additionally, the care coordinator and community health outreach workers are responsible for sustaining the natural supports of the member, offers person-centered care planning, service coordination and support services for members receiving long-term care (LTC) and home and community (HCBS) services. This includes but is not limited to assessing the availability of natural supports, representative or family members to ensure the ongoing and physical and behavioral health of those natural supports.

Essential Functions:

- In collaboration with the leadership, assist in the development and implementation of community relations strategic plan. Build positive relationships with community and regulatory stakeholders.
- Directly manage all community outreach staff including, but not limited to, hiring, training, scheduling, monitoring workload, conflict resolution, conducting performance evaluations, and implementing performance improvement and disciplinary actions, when necessary
- Track and trend under and over-utilization of services to identify opportunities for improvement, followed by implementation of policies and procedures to initiate and monitor the community care coordination activities
- Oversee workload needs on a concurrent basis including monitoring staff production metrics, auditing assessments and member plans of care according to respective policies and procedures. Daily prioritization of staffing assignments for optimizing impact on department production
- Monitor the performance of the care coordination team leaders and provide constructive feedback and opportunities for improvement.
- Conduct regular evaluation of the care coordination program, including, but not limited to; timely review of the member's plan of care with the interdisciplinary team, collaborative review and reassessment of the member's plan of care as defined and coordination of the member services.
- Responsible for coordination and presentation of information for administrative hearings and State reviews
- Conducts inter-rater reliability tests and audits among clinical staff. Evaluates the consistency of utilization management decision making based on MPM developed criteria and InterQual and acts on opportunities to improve consistency, when applicable
- Responsible for developing a strong working relationship with the Care Coordination staff and with all of MHP's corporate care coordination staff and other internal teams to encourage a cooperative sharing of ideas and support
- Facilitate, promote, and coordinate post-acute care within the most appropriate care setting through on site care management activities in post-acute care facilities
- Develop and implement guidelines of community care coordination for admission and discharge criteria, as well as care plan documentation guidelines
- Identify and track care coordination and HEDIS and performance outcomes
- Provide on-going coaching and counseling to all staff

Attachment 1 (Care Coordination/Long-Term Services and Supports Job Descriptions)

- Create culturally appropriate health education, information, and outreach in community-based settings
- Develop and maintain all community activities that are included in the QIP, Work Plan, QIC meetings, and policies and procedures
- Conduct quality audits of Care Coordination staff activities in accordance with respective policies and procedures
- Manages the NCQA, URAC, or general accreditation and all initiatives, activities, and efforts for reporting and maintaining performance rates
- Monitor and track compliance with HIPAA regulations, professional conduct, and ethical practice
- Assist in the development of multidisciplinary community training and education programs for internal and external customers
- Analyze outcomes on community-related measures to identify potential barriers, interventions, and opportunities for improvement

Job Requirements:

Education:

- Bachelor's degree in a healthcare related discipline such as Nursing, Social Work, Counseling, Special Education, Sociology, Psychology, or Gerontology, master's preferred.
- Fellow, Academy for Healthcare Management (AHM) Designation

Experience:

- 3 to 5 years' experience in management of community-based program/agency, project management, health promotion, and community assessments, or program development
- Experience in working with the Medicaid and/or Medicare populations
- Knowledge of Illinois Home and Community Based Services.
- Experience in a managed care setting and/or direct experience in the delivery of community services and/or care coordination, discharge planning, or behavioral health or long term care services.
- At least 1 year of leadership/management experience is preferred
- Experience with billing codes including CPT and/or ICD-9
- Working knowledge of accreditation standards of NCQA, URAC, or general accreditation and the Healthcare Effectiveness Data Information Set (HEDIS)

Skills:

- Excellent customer service and interpersonal communication skills
- Excellent written and verbal communication skills
- Telephone service skills

Abilities:

- Ability to work independently and collaboratively with a team
- Ability to prioritize work and function under time constraints

Community-Based Case Manager

Reports to: Long Term Care Manager / Manager of Community Care Coordination

Position Summary:

This position coordinates care for high risk populations identified by the clinical team leader. This position must work cooperatively with multidisciplinary care teams that may include: the member's PCP, specialists, social worker/behavioral health specialist and community resource contacts, while functioning with professional autonomy under the supervision of their Manager/Director. This position performs appropriate assessments, organizes, collects, reviews and reports health and social information through member home visits and phone outreach, while demonstrating multicultural sensitivity and effective communication skills with members. This position follows established safety protocols in the community setting, as well as established preventive and disease management programs for health promotion and education, while delivering culturally appropriate information regarding the availability of health and community resources that will reduce barriers to care. This position is field based.

Essential Functions:

- Serve as the direct personal contact in the community with assigned Meridian Health Plan (MHP) members
- Develop and maintain relationships with key individuals in the community and act as an advocate to linkages or referrals to improve health, social, and environmental conditions for MHP members
- Maintain ongoing tracking and appropriate documentation on referrals to promote team awareness and ensure member safety.
- Conduct complete, timely and accurate Health Risk Assessments (face-to-face or telephonically), including current member demographic information and other clinical assessments/reassessments as identified by clinical judgment or Manager/Director.
- Assemble information concerning member's clinical background and referral needs, and per referral guidelines provides appropriate clinical information to PCP and specialists.
- Assists members in problem solving potential issues related to the health care system, such as need for transportation, interpreters, etc.
- Be the system navigator and point of contact for members and families, with members and families having direct access for asking questions and raising concerns.
- Identify and utilize cultural and community resources.
- Ensure referrals are addressed in a timely manner.
- Remind members of scheduled appointments.
- Provides follow up with member/family when member transitions from one setting to another. Completes post hospital discharge follow-up: Medication reconciliation data collection, PCP or specialist follow up appointments.
- Seeks to resolve any concerns about care delivery or providers
- Acts as a liaison and member advocate between the member/family, physician and facilities/agencies.
- Must create and maintain strong communication with the members' integrated care team..
- Must create a relationship with the member working towards their optimal overall health and well-being by facilitating transitions of care for members through individual meetings in person and by phone.
- Create and update a personalized, member centered plan of care involving the members PCP, family/caregiver, Social Worker/Behavioral Health specialists and other specialists as needed to evaluate the individuals' needs, goals, and plan of action.

Attachment 1 (Care Coordination/Long-Term Services and Supports Job Descriptions)

- Closely monitor members' medical history and any changes through initial screenings and comprehensive assessment of the members needs during their coordination of care.
- Coordinates community resources and benefits
- Develop and maintain a report system for outcomes
- Ability to work flex hours, including evenings and weekends, is mandatory
- Maintains HIPAA standards and confidentiality of protected health information; and
- Perform other duties as assigned.

Job Requirements:

Education:

- Current license (without restriction) to practice as a Registered Nurse in the designated State is required; or
- Must have a BSN, or have BA/BS degree in social science, social work or related field. One year of program experience, which is defined as assessment, provision and/or authorization of formal services for the elderly, may replace one year of college education up to and including 4 years of experience replacing a baccalaureate degree; or
- Be an LPN with one year of program experience, which is defined as assessment, provision and/or authorization of formal services for the elderly; or
- Ability to possess a valid State of Iowa driver's license and to travel is required. Any MHP employee who uses a motor vehicle in the course of their duties representing MHP must be compliant with Iowa State Motor Vehicle laws and must follow the policy that pertains to Driver's License Requirements as a condition of employment.
- Prior experience with population preferred

Knowledge:

- Must demonstrate customer focused interpersonal skills to interact in an effective manner with practitioners, the interdisciplinary health care team, community agencies, members, and families with diverse opinions, values, and religious and cultural ideals.
- Must also demonstrate the ability to work autonomously, follow through with delegated tasks and be directly accountable for deliverables.
- Must have leadership qualities including time management, verbal and written communication skills, listening skills, problem solving and decision-making, priority setting, work delegation and work organization, as well as strong customer service focus, teamwork orientation and resourcefulness in problem solving.
- Meet all training requirements as specified by the designated State

Skills:

- Demonstrates excellent communication – both verbal and written
- Strong organizational and follow up skills; specifically working with Inner City, Suburban and Rural neighborhood members
- Excellent interpersonal and facilitation skills

Abilities:

- Must have the ability to affect change, work as a productive and effective team member and adapt to changing needs/priorities

Community Health Outreach Worker

Reports To: Long Term Care Manager / Manager of Community Care Coordination

Position Summary:

This position is responsible for performing duties independently and as part of the Care Coordination Team. This position organizes, collects, reviews and reports health and social information through member home visits and phone outreach, while demonstrating multicultural sensitivity and effective communication skills with Medicaid members. This position follows established safety protocols in the community setting, as well as established preventive and disease management programs for health promotion and education. This position delivers culturally appropriate information regarding the availability of health and community resources that will reduce barriers to care.

Essential Functions:

- Serves as a consultant on Meridian Health Plan (MHP) care coordination teams.
- Participate in Interdisciplinary care team meetings as indicated.
- Serve as MHP's community liaison and maintain relationships with key individuals in the community and serve as an advocate by coordinating linkages or referrals to improve health, social, and environmental conditions for MHP members
- Serve as a resource for providers' taking part in the grant by tracking down members who they are unable to reach
- Coordinate and perform duties of communicating the mission and role of MHP to community associations, senior groups, ethnic clubs and groups, and churches.
- Serve as the direct personal contact in the community with MHP members who are unable to be reached through phone calls
- Conduct member assessments
- Educate and assist identified MHP members about behaviors that can enhance their health successfully navigating the health system
- Facilitate access to preventive and disease management health services
- Manage difficult to reach and non-compliant MHP members
- Conduct Field Assessments and Quality Reviews
- Develop a plan of management associated with health care goals for each MHP member addressing the diverse needs in a culturally appropriate way
- Develop and maintain a report system for outcomes
- Communicate MHP member issues requiring interventions to appropriate MHP departments and providers
- Ability to work flex hours, including evenings and weekends, is mandatory
- Ability to possess a valid State of Iowa driver's license and to travel is required. Any MHP employee who uses a motor vehicle in the course of their duties representing MHP must be compliant with Iowa State Motor Vehicle laws and must follow the policy that pertains to Driver's License Requirements as a condition of employment.
- Maintains confidentiality and uses only the minimum amount of protected health information (PHI) necessary to accomplish job related responsibilities
- Perform other duties as assigned

Job Requirements:

Attachment 1 (Care Coordination/Long-Term Services and Supports Job Descriptions)

Education:

- Bachelor's degree in social work, social sciences or counseling or four years of case management experience; or a Bachelor's degree in a human services field such as Child, Family and Community Services, Early Childhood Development, Guidance and counseling, Home Economics – Child Family Services, Human Development Counseling, Human Service Administration, Human Services, Pastoral Care, Pastoral Counseling, Psychology, Public administration, Rehabilitation Counseling, Social Science, Social Services/Social Work, Sociology, or Fellow designation from the Academy of Healthcare Management (AHM) is preferred

Experience:

- Proven two (2) years of experience working with diverse populations, community or faith based organizations. Health care setting experience preferred
- Bilingual in English/Spanish preferred

Knowledge:

- Knowledge of State social service agencies and community resources
- Knowledge of health education, motivational strategies, and an empathetic manner working with the underserved
- Knowledge of Peoria and its residents
- Knowledge of healthcare business preferred

Skills:

- Excellent verbal and written communication skills, including conflict resolution skills
- Strong organizational and follow up skills; specifically working with Inner City, Suburban and Rural neighborhood members
- Good computer knowledge skills

Abilities:

- Ability to collect and report outcomes verbally and in writing
- Ability to maintain confidentiality and assume accountability
- Proven ability to work in a self-directed manner, off-site with minimum supervision or field support

Community Care Coordination Team Lead

Reports To: Long Term Care Manager / Manager of Community Care Coordination

Position Summary: This position is responsible for specific functions within the Care Coordination portion of the Utilization Management department. This position oversees the care for high risk populations and oversees a team of care coordinators to ensure assessment of members clinical and psychosocial status, interdisciplinary team approach, education of members in the area of self-management is achieved. This position also provides first line clinical direction to the care coordination staff and refers to Manager of Care Coordination when necessary. This position is field based with field visits to members, healthcare facilities or to assess field care coordinators' function as needed/directed by Director.

Essential Functions:

- Review predictive model report of each member assigned to their team. Review with care coordinator all cases assigned to team for management.
- Direct member contact of members referred by care coordinator for clinical issues and or medication reconciliation.
- Perform post inpatient calls on all members assigned to team
- Discuss challenging cases with Medical Director assigned to team. Provides recommendations to care coordinators regarding consultation to behavioral health, nutrition, compliance, behavioral health. Oversee workloads by monitoring each care coordinators work list queue to ensure there is a balance of cases by acuity level and referral type of case. Discuss variances that may be identified in team member case load/performance with manager; such as: overdue tasks/cases.
- Provide front line direction to care coordination staff and consult with manager as appropriate for input.
- Identify cases that require team case conferences with the nurse reviewer, behavioral health, nutrition, compliance staff, appropriate managers, and plan physician to develop a care plan that will be entered into MCS.
- Provide for ongoing clinical training and education of all staff based on needs assessments done with each staff member to determine areas where more training is required. Coordinate such training with the Care Coordination Clinical Trainer and Manager.
- Work in collaboration with Manager and Trainer to develop job aides for the care coordination staff.
- Acts as a liaison with other MHP departments in relation to care coordination issues.
- Assists Manager in the creation of the agenda for the monthly care coordination team meetings.
- Facilitates weekly team meetings with team members to perform case reviews together.
- Participates in QIA activities and adheres to all regulatory guidelines and standards.
- Consistently demonstrates compliance with HIPPA regulations, professional conduct, and ethical practice.
- Assists with special projects or departmental process improvement efforts, as needed.
- Perform other duties as assigned.

Job Requirements:

Education:

- Current license (without restriction) to practice as a Registered Nurse in the designated State is required

Attachment 1 (Care Coordination/Long-Term Services and Supports Job Descriptions)

- BSN or Master's degree in social science, social work or related field is required.
- One year of program experience, which is defined as assessment, provision and/or authorization of formal services for the elderly, may replace one year of college education up to and including 2 years of experience replacing a baccalaureate degree; or
- Ability to possess a valid State of Iowa driver's license and to travel is required. Any MHP employee who uses a motor vehicle in the course of their duties representing MHP must be compliant with Iowa State Motor Vehicle laws and must follow the policy that pertains to Driver's License Requirements as a condition of employment.
- Prior experience with population preferred

Knowledge:

- Must demonstrate customer focused interpersonal skills to interact in an effective manner with practitioners, the interdisciplinary health care team, community agencies, members, and families with diverse opinions, values, and religious and cultural ideals.
- Must also demonstrate the ability to work autonomously, follow through with delegated tasks and be directly accountable for deliverables.
- Must have leadership qualities including time management, verbal and written communication skills, listening skills, problem solving and decision-making, priority setting, work delegation and work organization, as well as strong customer service focus, teamwork orientation and resourcefulness in problem solving.

Skills:

- Demonstrates excellent communication – both verbal and written
- Strong organizational and follow up skills; specifically working with Inner City, Suburban and Rural neighborhood members
- Excellent interpersonal and facilitation skills

Abilities:

- Must have the ability to affect change, work as a productive and effective team member and adapt to changing needs/priorities

Claims Coder

Reports To: Manager of Claims

Position Summary: This position must accurately analyze and code Medicare insurance claims in accordance with nationally recognized coding guidelines through evaluation of medical records. Properly assign appropriate clinical diagnosis and procedure codes. Act as a coding resource to other staff.

Essential Functions:

- Analyzes medical information from medical records. Accurately codes diagnostic and procedural information in accordance with national coding guidelines and appropriate reimbursement requirements. Consults with medical providers to clarify missing or inadequate record information and to determine appropriate diagnostic and procedure codes. Provides thorough, timely and accurate assignments of ICD9 and/or CPT4 codes, MS-DRGs, APCs, POAs and reconciliation of charges.
- Audits documentation to verify coding accuracy and to identify missing information
- Assure compliance with coding rules and regulations according to regulatory agencies for state Medicaid plans, Center for Medicare Services (CMS), Office of the Inspector General (OIG) and the Health Care Financing Administration (HCFA), as well as company and applicable professional standard
- Researches insurance questions about codes and charges
- Provides information to providers regarding billing, account status and payment inquiries
- Research and resolution of coding projects as assigned.
- Research and implement revisions to Rules and Regulations which govern inpatient & outpatient physician coding
- Attend seminars related to Coding and Compliance and education of new Payment Systems
- Serve as a coding resource for internal departments
- Attend meetings as necessary to provide information relating to coding and compliance
- Inform Management of trends identified through the review and validation process
- Provide related weekly, monthly and year end reports of audit findings
- Serve as a liaison with external auditors for corporate audits
- Facilitate physician education and coordinate coder education
- Perform other duties as assigned.

Job Requirements:

Education:

- High School Diploma is required.
- Bachelor's Degree or Fellow Designation from the Academy of Healthcare Management (AHM) is preferred
- One of the following certifications:
 - Registered Health Information Administrator (RHIA)
 - Registered Health Information Technician (RHIT)
 - Certified Coding Specialist (CCS); or
 - Certified Professional Coder (CPC) in an active status with American Health Information Management Association or American Academy of Professional Coders.
- Will consider experience in lieu of certification/degree.
- CCS required within 6 months of employment.

Attachment 2 (Claims Job Descriptions)

Experience:

- 2-3 years of experience in a medical office setting or similar environment
- Demonstrated successful completion of medical terminology course
- Previous Medicare coding, auditing, billing or claims payment experience required

Knowledge:

- Thorough knowledge of CPT4, ICDCM, HCPCS, Medicare, Medicaid, and insurance guidelines
- Working knowledge of claims policies and procedures
- Knowledge of reimbursement methods and rates
- Personal computer skills and software packages including Microsoft Office, Excel and Word, and mail merge capabilities

Skills:

- Strong organizational, planning, analytical and communication skills
- Excellent analytical and problem solving skills
- Excellent interpersonal skills necessary to interact with all levels of personnel

Abilities:

- Ability to problem solve
- Ability to develop a team based attitude toward accomplishing goals within the department

Claims Examiner

Reports To: Manager of Claims

Position Summary: This position is responsible for processing claims in a highly efficient manner meeting or exceeding claims production and quality goals.

Essential Functions:

- Process claims in accordance with the plan benefits, authorization requirements, coordination of benefits, subrogation, and state insurance mandates
- Meet or exceed claim production goals as set by management while meeting or exceeding the department quality goals
- Maintain a quality level of 96% or better
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma is required.
- Pursuit of a Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is preferred.

Experience:

- At least two years of previous experience in claims processing is required.

Knowledge:

- Knowledge of Managed Care.
- Solid understanding of the full adjudication process
- Knowledge of medical terminology, ICD-9, and CPT-4 codes

Skills:

- Interpersonal skills
- Strong written and verbal communication skills
- Team-building skills
- Flexibility
- Effective problem-solving skills
- Research and follow-through skills
- Analytical thinking
- Organizational and team skills

Abilities:

- Ability to handle multiple priorities
- Ability to communicate clearly
- Ability to maintain a professional and pleasant demeanor

Manager of Claims

Reports To: Director of Claims

Position Summary: This position coordinates and supervises activities within the Claims Department under the direction of the department director. Ensures that claims are processed accurately and timely in compliance with claims processing requirements as indicated in the Claims Policy and Procedure guidelines. Resolves customer inquiries promptly and courteously.

Essential Functions:

- Direct activities of claims department. Ensure that staff members maintain adequate expertise in claims processing, eligibility, and policy interpretation, while meeting or exceeding production and accuracy standards.
- Review and advise on those claims with the highest complexity and sensitivity, and those that exceed claims examiners payment authorizations
- Identify requirements for future training needs
- Interface with internal and external personnel to resolve issues and inquiries
- Handle Third Party Liability investigations and complete necessary reporting to the State
- Administer and adhere to company and department policies and procedures
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's Degree or Fellow designation from the Academy for Healthcare Management (AHM) is preferred.

Experience:

- Previous experience in a leadership role is required.

Knowledge:

- Knowledge of all aspects of claims processing
- Thorough knowledge of CPT and ICD-9 coding
- Knowledge of claims policies and procedures
- Working knowledge of PC applications

Skills:

- Strong organizational, planning, analytical, and communication skills
- Excellent interpersonal skills necessary to interact with all levels of personnel

Abilities:

- Ability to problem solve

Scanner Operator Job Description

Reports To: Manager of Claims

Position Summary: This position is responsible for overseeing all incoming and outgoing mail. This includes internal interoffice mail delivery as well as external mail. Ensure appropriate use of postage machine and related supplies. This position operates digital image scanning equipment to capture images and generate associated text following established scanning and quality control procedures.

Essential Functions:

- Operate digital image scanning equipment to capture images and generate associated text
- Follow established scanning and quality control procedures in producing digital files in specified format for further processing
- Conduct quality checks by verifying electronic images on the screen and correcting any scanning malfunctions
- Perform cleaning and daily maintenance of scanners
- Ensure claims are a priority item sorted and delivered timely
- Batch claim forms for scanning
- Handle outgoing mail including operating the scanner
- Sort and distribute all incoming mail to the correct person/department
- Deliver returned mail to the correct person/department (“Return to Sender”)
- Collect and post all outgoing mail daily
- File all Mail Routing Forms daily
- Collect all interdepartmental mail and deliver to the correct person/department
- Assist each department with mass mailings
- Assist in keeping storage rooms organized. Help monitor inventory of envelopes, letterhead and shipping supplies on a weekly basis.
- Assist in support and maintenance of the Pitney Bowes postage machine. Reports, funding refills, scheduling service, etc.
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma is required.

Experience:

- Previous claims processing experience is preferred.
- PC experience is required.
- Demonstrated mechanical aptitude is required

Knowledge:

- Basic knowledge of general office operations
- Knowledge of postage rates and prior use of postage meter preferred
- Basic knowledge of Managed Care preferred
- Basic computer knowledge
- Basic knowledge of the claims processing workflow preferred
- Knowledge of scanning hardware and software is preferred

Attachment 2 (Claims Job Descriptions)

Skills:

- Organizational and team skills
- Filing and sorting skills
- Mechanical aptitude

Abilities:

- Ability to identify healthcare industry standard claim forms
- Ability to meet deadlines in a fast paced environment
- Exhibits sense of urgency for all job duties
- Ability to communicate clearly
- Professional and pleasant demeanor
- Driver's license, safe driving record and proof of insurance
- Ability to lift 30 to 50 pounds on a continuous basis

Quality Assurance Auditor Job Description

Reports To: Manager of Claims

Position Summary: This position coordinates and conducts the activities of the Claims Quality Assurance Program. Ensures that claims are processed accurately and in compliance with quality assurance requirements. Complies with State requirements for processing inpatient facility claims in a timely and accurate manner. Updates Claims Processing Manual as needed and identifies training needs within the Claims Department.

Essential Functions:

- Conduct audits of Claim Examiners' work product to ensure that staff meet or exceed accuracy standards
- Review and process inpatient facility claims
- Handle incoming and outgoing claim department phone calls
- Assist in the review of Auto Audit reports to identify potential payment errors, Third Party Liability claims and case management situations
- Identify requirements for future training needs and report to claims management
- Identify and update changes and additions needed to the claims processing manual
- Assist with Third Party Liability investigations, recovery and necessary reporting to the State
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree or Fellow designation from the Academy for Healthcare
- Management (AHM) is required.

Experience:

- Experience in conducting audits of medical insurance claims is required.
- Experience in processing inpatient Medicaid facility claims is required.

Knowledge:

- Excellent knowledge of CPT and ICD-9 coding
- Knowledge of claim policies and procedures
- Working knowledge of PC applications
- Knowledge of all aspects of claims processing

Skills:

- Strong analytical, organizational and communication skills
- Good problem solving skills
- Good interpersonal skills necessary to interact with all levels of personnel

Abilities:

- Ability to prioritize work process

Vertexer Job Description

Reports To: Manager of Claims

Position Summary: The Vertexer is responsible for processing claims in an effective and efficient manner meeting claims production and quality goals.

Essential Functions:

- Compare scanned documents to image to ensure accuracy of data
- Meet or exceed claim production goals as set by management while meeting or exceeding the department quality goals
- Operate scanner
- Open and sort incoming mail by document type
- Batch claim forms for scanning
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma is required.
- Pursuit of a Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is preferred.

Experience:

- At least one year of previous experience in claims processing is required.

Knowledge:

- Basic knowledge of Managed Care
- Knowledge of claims processing

Skills:

- Interpersonal skills
- Strong written and verbal communication skills
- Flexibility
- Research and follow-through skills
- Organizational and Team Skills

Abilities:

- Ability to handle multiple priorities
- Ability to communicate clearly
- Professional and pleasant demeanor

Program Director

Position Summary: The Program Director is responsible to Meridian Health Plan of Iowa for the overall contractual, sub-contractual, reporting and operational management of the program.

Essential Functions:

- Ensuring contract compliance and execution of all deliverables
- Supporting coordination of member care for behavioral health services
- Defining and executing strategic goals, ensuring contractual, regulatory, and delegation agreement compliance
- Actively cultivating key stakeholder relationships to advance Beacon's standing on behalf of its current client base and to support business expansion and retention efforts
- Fostering business development opportunities and strategic relationships in the region
- Partnering with advocacy and key provider groups
- Ensuring all contractual reporting requirements
- Overseeing comprehensive reporting and analysis of program utilization, cost, quality, and related performance indicators
- Attending relevant client and external meetings, as necessary, to deliver exceptional customer service and to execute on defined strategic goals
- Direct supervision of co-located staff
- Monitoring NCQA/URAC compliance and quality outcomes
- Serving as primary liaison to service center operations
- Other duties as assigned

Job Requirements:

Education:

- A master's degree with four to five years of behavioral health managed care experience
- Experience with financial and clinical data analysis

Experience:

- Leadership skills and supervisory experience, including the ability to develop team performance
- Excellent written and oral communication skills

Abilities:

- Self-motivated, able to prioritize multiple issues, excellent organizational skills, ability to track multiple projects/tasks and follow through as needed
- Ability to manage and coordinate with internal and external departments
- Able to work collaboratively with internal staff and external agencies
- Must be detail oriented; able to work independently in an ever changing environment

Inter-Agency Liaison

Position Summary: The Inter-Agency Liaison will represent Beacon and Meridian Health Plan at the regional agency level to ensure coordination with state and regional agencies.

Essential Functions:

- Developing relationships and partnerships with state and regional agencies and systems serving children, adolescents, adults, and families
- Collaborating with and providing technical assistance for agency partners in navigating the health care system in Iowa
- Representing Beacon and Meridian Health Plan on task forces involving other agencies and systems serving, children, adolescents, adults and families
- Problem resolution between agencies, providers, members and families
- Developing, implementing, evaluating, and revising policies and procedures related to the delivery and coordination of care for members involved with other state agencies.
- Coordinating with stakeholder and provider agencies to identify training and education needs
- Coordinating and participating in visits to various agencies, facilities, and schools to provide information to increase interagency collaboration
- Other duties as assigned

Job Requirements:

Education:

- Bachelor's degree; master's degree preferred

Experience:

- Three to five years of experience in related field

Knowledge:

- Strong understanding of managed care and health care operations

Abilities:

- Ability to remain detail-oriented while managing multiple tasks and priorities
- Excellent communication (verbal and written) and interpersonal skills

Database Developer

Position Summary: The Database Developer is primarily responsible for providing decision support through reporting and data analysis supporting Beacon's internal and external data/information customers. In addition, the Database Developer is responsible for the operation and maintenance of the activities necessary to ensure the timely production and dissemination of accurate reports, data and management information

Essential Functions:

- Conducting data analysis, designing and developing standardized management reporting tools
- Conducting ongoing requirement analysis for data needs for department/account managers and customers
- Creating data/reports specifications for IT technical for development
- Ensuring that the reports are created and generated accurately in a timely manner for review, analysis and subsequent submission to the customers
- Conducting project based data analysis and ad-hoc reporting
- Analyzing and evaluating requests for reports and develop procedures to extract data from the various data sources and the corporate data warehouse using report writers and data extract tools
- Participating in the data warehouse design and development team
- Conduct training and implementation of the reporting system
- Other duties as assigned

Job Requirements:

Education:

- A bachelor's degree in computer science or related field

Experience:

- Four to six years of hands-on report development

Knowledge:

- Knowledge of relational databases design and tuning

Skills:

- Proficiency in report documentation and auditing procedures
- Proficiency in Microsoft SQL Server Development (T-SQL, DTS)
- Excellent communication (oral and written) and interpersonal skills

Abilities:

- Ability to communicate complex information in simple terms
- Ability to handle multiple priorities and meet aggressive deadlines

Claims/Encounter Processing Analyst

Position Summary: The Claims/Encounter Processing Analyst is responsible for reviewing and completing the weekly claims batch, while ensuring claims are processing in accordance to claims policies and procedures and payment guidelines.

Essential Functions:

- Reviewing and making appropriate adjustments, reversals, and recoupment and following-up on over payment collection with providers
- Identifying potential claims problems and making recommendations to the claims manager
- Providing assistance with research of all claims-related correspondence and memorandums included but not limited to: inquiries/complaints received by senior management, referrals by both the provider and provider services, and other miscellaneous inquiries
- Assuring monthly delegation reports are pulled, reviewed, and provided to the health plan on time
- Identifying any updated rates or changes in the fee schedule that may impact claims and report those changes to both staff and management
- Works closely with Claims Management Staff on special or priority cases. Will be accountable for timely response and resolution of those cases
- Reporting any system issues with claims adjudication and/or processing
- Interpreting and applying all applicable policy, procedures, and guidelines
- Reviewing and finalizing all edits messages, and makes appropriate phone calls when needed
- Other duties as assigned

Job Requirements:

Education:

- High school diploma (or equivalent)

Experience:

- Minimum of four to five years of claims adjudication and auditing experience in managed care environment
- Prior experience with online claims adjudication and encounter processing system

Knowledge:

- Working knowledge of medical terminology

Skills:

- Excellent organizational and time management skills

Case Manager

Position Summary: The Case Manager triages, assesses, and manages members referred to intensive case management (ICM) including those who may be high-risk, high utilizers, at significant clinical risk, or under-utilizing services.

Essential Functions:

- Independent assessment of members enrolled in ICM
- Managing, coordinating care, tracking, and reporting on all assigned ICM members
- Telephonic collaboration with members, including urgent calls
- Telephonic collaboration and coordination with providers and state agencies, including community supports and resources
- Utilization review for designated ICM members
- Participating in systems meetings, as needed
- Collaboration with medical and social care managers
- In-person outreach and engagement of members, as needed

Job Requirements:

Education:

- Case managers must have a current, valid, and unrestricted licensure for practice with at least one of the following required:
 - Master's degree or higher in a health related field and independent licensure as a behavioral health professional
 - BSN with licensure as a professional

Experience:

- A minimum of five years of years of direct services, preferably in a behavioral health setting

Knowledge:

- Advanced level of PC skills required

Skills:

- Excellent prioritization and organization skills
- Strong interpersonal skills and good written and verbal communication skills

Manager, Utilization Review

Position Summary: The Manager, Utilization Review is responsible for the supervision and oversight of specific utilization management staff and programs, concentrating on areas of new program identification, workflow development, and ensuring consistency and accuracy of utilization management process, team productivity, and process improvement.

Essential Functions:

- Direct supervision of utilization review clinicians
- Participating in the identification of specialized clinical programs to address unmet needs
- Identifying and monitoring trends in utilization management and quality
- Assisting the Clinical Director, Utilization Review in the interpretation of utilization management metrics for the organization and individual programs
- Overseeing utilization management processes with regards to specialty programs to ensure compliance with policy guidelines, external regulatory requirements, and URAC/NCQA accreditation standards
- Assisting staff in the application of level of care criteria
- Establishing workflows for the overall management of high-risk members including case management referrals, discharge planning, and aftercare
- Participating in the development of utilization management standard operating procedures
- Other Duties as assigned

Job Requirements:

Education:

- A master's degree in psychology, counseling, social work or related field
- A current, valid, unrestricted license in behavioral health or nursing

Experience:

- At least three to five years of combined direct behavioral health, supervisory, and/or managed care experience

Skills:

- Must be detail-oriented, and have excellent written and verbal communication skills

Abilities:

- Ability to understand and interpret utilization management metrics as well as identify new utilization management metrics
- Demonstrated understanding of continuous quality improvement
- Ability to prioritize multiple issues and track multiple projects/tasks

Manager, Case Management

Position Summary: The Manager, Case Management works to ensure that care management processes are in compliance with Beacon's policy guidelines, external regulatory requirements and URAC accreditation standards. The Manager, Case Management concentrates on workflow development and enhancement, consistency and accuracy of care management processes, team productivity and process improvement. The Manager, Case Management maintains a positive interaction with internal and external customers, supporting the overall goals of Beacon and the clinical department.

Essential Functions:

- Identifying opportunities to streamline workflows that result in accurate, high quality production standards
- Assisting local office managers in identifying training opportunities and other resources to local case managers to ensure consistent and efficient programming
- Overseeing quarterly case management audit process and reporting
- Overseeing physician advisor case management weekly rounds process
- Participating in the annual evaluations of disease management and case management programs and the development of care management reporting
- Working with the Clinical Director, Case Management and implementation team to support development and implementation of case management programs for external customers
- Attending and participating in clinical, quality improvement meetings as designated
- Working closely with clinical and quality management and improvement on URAC and NCQA initiatives
- Other duties as assigned

Job Requirements:

Education:

- A master's degree or higher or RN
- A current, valid, unrestricted independent license in behavioral health or nursing (RN) and practice within the scope of their licensure

Experience:

- Minimum of two years of combined direct behavioral health clinical and managed care experience

Abilities:

- Demonstrated work experience meeting strict deadlines and established cycle times through effective prioritization and follow-up skills.

Utilization Review Clinician

Position Summary: The Utilization Review Clinician performs utilization review and initial authorization determination of behavioral health services provided in inpatient, diversionary, and outpatient care settings using appropriate medical necessity level of care criteria and ensuring policy and procedure guidelines, external regulatory requirements, and URAC/NCQA accreditation standards are met.

Essential Functions:

- Performs telephonic care review and authorization determinations for prospective, concurrent and discharge review with psychiatric and substance treatment facilities as assigned
- Determines appropriate level of care related to mental health and substance use treatment for members based on medical necessity level of care criteria
- Consults with physician advisors when requests for services do not meet medical necessity criteria
- Interacts with physician advisors to discuss clinical/authorization questions, alternative treatment options and concerns regarding specific cases
- Provides information to members and providers regarding mental health and substance abuse benefits and community treatment resources
- Identifies and refers high risk members to care management
- Recognizes quality of care issues and reports them appropriately through internal and external processes
- Interacts with providers and facilities in a professional, respectful manner
- Demonstrates thorough understanding of product lines and benefit structure for all contracts assigned
- Assists with NCQA, URAC, and other quality improvement initiatives
- Other duties as assigned

Job Requirements:

Education:

- A master's degree in psychology, counseling, social work or related field
- A current, valid, unrestricted license in behavioral health or nursing

Experience:

- Three to five years of combined behavioral health clinical and managed care experience

Knowledge:

- Knowledge of current behavioral health principles, procedures, and treatment protocols

Skills:

- Strong interpersonal skills and good written and verbal communication skills

Aftercare Coordinator

Position Summary: The Aftercare Coordinator supports the clinical administrative departments in a variety of functions focused on ensuring members have appropriate and timely access to care. The Aftercare Coordinator works closely with members and providers, requiring excellent customer service and communication skills. The Aftercare Coordinator develops a good understanding of Beacon's provider network to be able to assist members and Beacon staff with the referral process. The Aftercare Coordinator strives to meet all contractual and regulatory timeframes related to the functions of the job.

Essential Functions:

- Performs aftercare duties including:
 - Member reminder calls, provider follow-up calls, and facilitating member mailings
 - Providing clear documentation/outreach to ensure Beacon is meeting its HEDIS/QARR standards
 - Review and audit aftercare appointment screens in the system to ensure these are being completed with accurate/complete information
- Secures appointments for members in need of urgent and routine appointments, working directly with providers and members to secure appropriate type of appointment requested
- Serves as a backup support for other administrative duties within the clinical department
- Other duties as assigned

Job Requirements:

Education:

- A high school diploma (or equivalent), college degree preferred

Experience:

- Two to three years of experience in an administrative support, customer service, or similar position, and/or skill set

Abilities:

- Ability to multi-task, work well under pressure, and in fast-paced environment

After Hours Clinician

Position Summary: The After Hours Clinician is responsible for facilitating triage, including referral, utilization management and referral and access to behavioral health services to members, providers, and facilities during afterhours, weekends, and holidays.

Essential Functions:

- Provides weekend, afterhours, holiday coverage for triage and referral for members, facilities and providers
- Remains accessible by cell phone Monday-Friday 5:00 pm- 8:30 am; weekend and holidays 24 hours per day
- Responds to all calls needing any clinical referral and triage decisions
- In the case of an emergency, the clinician validates and assesses the nature of the emergency situation and informs the member about how to proceed
- Conducts prior authorization for acute and diversionary services during after-hours, and have supervisory and physician advisor support available.
- Advises providers or members to call on the next business day for all routine requests.
- Gives verbal authorization and quotes eligibility disclaimer
- Documents all information in the system or on a member authorization form
- Enters all calls on in afterhours log and submits information to Utilization Manager Supervisor on the next business morning.

Job Requirements:

Education:

- A master's degree in psychology, counseling, social work or related field
- A current, valid, unrestricted license in behavioral health or nursing

Experience:

- Three to five years of combined behavioral health clinical and managed care experience

Knowledge:

- Knowledge of current behavioral health principles, procedures, and treatment protocols

Skills:

- Strong interpersonal skills and good written and verbal communication skills

Community-Based Support Coordinator

Position Summary: The Community-Based Support Coordinator is responsible for coordinating behavioral health, physical health, and long-term services and support services as part of the member's interdisciplinary care team.

Essential Functions:

- Establishing relationships and effectively engaging members and providers through telephonic communication to obtain necessary information and facilitate care in multiple settings
- Ensuring high quality community-based member care through appropriate allocation of member services and resources
- Assisting members in navigating the network of community-based services and information
- Monitoring and evaluating effectiveness of the care plan to ensure member/caregiver satisfaction with services
- Acting as a resource to staff in the planning and delivery of member care
- Assisting in collection of data for quality improvement activities that support performance improvement
- Identifying barriers and developing innovative solutions to ensure quality care
- Other duties as assigned

Job Requirements:

Education:

- Master's degree or higher, or RN
- A current, valid, unrestricted license in behavioral health or nursing

Experience:

- Minimum of two years of combined direct behavioral health clinical and managed care experience

Knowledge:

- Managed care and state-specific expertise and knowledge of community resources

Abilities:

- Demonstrated work experience to influence and negotiate to effectively manage member care and health care outcomes
- Ability to meet strict deadlines and established cycle times through effective prioritization and follow-up skills

Peer Support Specialist

Position Summary: The Peer Support Specialist empowers members to define and pursue their own recoveries, connect them to community-based resources, and work collaboratively with the clinical team as part of the member's interdisciplinary care team.

Essential Functions:

- Providing telephonic and face-to-face support to members and families from “someone who’s been there” to understand their issues and offer support and information
- Assisting members in articulating their personal goals for recovery and identifying the skills, strengths, supports, and resources to aid them in achieving those goals
- Assisting members in navigating the system, filling out applications, explaining member rights, and learning about self-advocacy skills
- Engaging and educating members and their families to connect with support services, community resources, and advocacy assistance
- Serving as an adjunct to the clinical team to enhance the members’ treatment by identifying resources, access to care issues, barriers to care, and gaps in service
- Conducting training for all staff and providers, members, and other stakeholders across the state on member and family perspectives
- Building, developing, and maintaining positive and collaborative relationships with providers and member and family organizations in the community
- Performing a wide range of tasks to assist members in regaining independence within the community and mastery over their own recovery process

Job Requirements:

Education:

- Certification as a Peer Specialist

Experience:

- Lived experience and achieved a significant level of personal recovery
- Two to five years of work experience within the behavioral health delivery system and an understanding of managed care concepts as they relate to prevention, education, and outreach activities

Skills:

- Insight and maturity to be a guide and mentor
- Good communication and organizational skills

RN – Hotline Clinician

Position Summary: The RN – Hotline Clinician handles crisis calls, making appropriate referrals and connecting members with regionally-based crisis services and resources.

Essential Functions:

- Providing telephonic triage and crisis intervention to callers
- Aiding members in increasing their coping skills to address current crisis issues
- Locating appropriate services and linking callers with the service
- Locating appropriate service and links caller with the service
- Ensuring appropriate documentation is available for follow-up
- Participating in scheduled staff meetings and trainings
- Other duties as assigned

JOB REQUIREMENTS:

Education:

- A license as a Registered Nurse (RN)

Experience:

- Three to five years of combined behavioral health clinical and managed care experience

Knowledge:

- Knowledge of current behavioral health principles, procedures, and treatment protocols

Skills:

- Strong interpersonal skills and good written and verbal communication skills

Practice Transitioning Coach

Position Summary: The Practice Transitioning Coach is responsible for leading multi-disciplined practice transformation and practice performance improvement initiatives to improve quality, efficiency, and utilization.

Essential Functions:

- Designing practice transformation plans and implementing appropriate training modules to assist practices in achieve contractually required transformation milestones
- Monitoring practice's progress in achieving milestones and ensure practice accountability for successful completion
- Consulting and guiding practices on developing innovative solutions to practice organization and structural challenges to achieve desired program outcomes
- Bringing best practice experience and connecting practices with other high performing practices to spur innovation
- Analyzing key cost, utilization, and quality data and interpreting results to assess performance of the practice, identifying strategies for improvement to include specific outcomes and metrics to monitor progress to a goal, and provide feedback and recommendations for improvement
- Guiding practices in identifying care management opportunities and adjusting processes to prioritize interventions to achieve clinical and cost outcomes
- Meeting regularly with practices to review available practice reports, presenting practice performance synopsis, and identifying opportunities for improvement
- Facilitating efficient, effective practice improvement meetings,
- Other duties as assigned

Job Requirements:

Education:

- A bachelor's degree or equivalent experience

Experience:

- Demonstrated experience in analyzing health care practice performance data and identifying opportunities for improvement and innovation
- Health care quality improvement and practice management experience

Skills:

- Excellent verbal, written, presentation, and group facilitation skills
- Strong critical thinking skills necessary to evaluate and respond to practice challenges and related team dynamics

Abilities:

- Ability to convey complex or technical information in simple terms

Clinical Learning Specialist

Position Summary: The Clinical Learning Specialist is responsible for developing and coordinating delivery of clinical training for all clinical staff.

Essential Functions:

- Developing training curriculums for all clinical components of Beacon's training programs
- Planning and facilitating clinical staff training on role-based workflows and software
- Delivering in-person or WebEx/video conference trainings on key clinical topics
- Maintaining collaborative relationships with subject matter experts, business analysts, and other key personnel to regularly enhance the clinical training curriculum to incorporate changes to Beacon's model of care
- Maintaining statistics around training, adoption, satisfaction, and certification
- Other duties as assigned

Job Requirements:

Education:

- Bachelor's degree; master's degree preferred
- Clinical licensure preferred, but not required

Experience:

- Extensive experience leading classroom style training sessions and distance-style training
- Experience developing training using various mediums including printed documentation interactive computer-based training, workbook-style self-paced training, web-based training (WBT), video training, and other mediums, as needed
- Hands on experience consulting with internal customers to identify needs and determine training objectives

Skills:

- Strong written and oral communications skills and a working knowledge of design principles

Integrated Care Nurse

Position Summary: The Integrated Care Nurse is responsible for providing whole-person (behavioral health, physical, health, and LTSS) care management services to members, facilitating an integrated approach to care delivery with providers, health homes, members, their families, and community agencies and services.

Essential Functions:

- Ensure the member's interdisciplinary care team participates in developing the person-centered care plan, using face-to-face, telephonic, and written communications
- Engaging and working with members to assess their needs and strengths and incorporating their views, recommendations, and preferences in the care plan
- Ensuring referrals to medical/LTSS/behavioral health specialists result in timely appointments and two-way transition of useful member information
- Managing and tracking tests, test results, assessments, referrals, and outcomes
- Obtaining reliable and timely information about medical/LTSS/behavioral health services to ensure safe and effective transitions across care settings
- Assisting members in developing wellness strategies and self-management skills to effectively access and use services
- Motivating and educating members and their families, as appropriate, to engage in treatment planning, shared decision making with providers, and self-management of chronic physical and behavioral health conditions
- Assuring compliance with privacy, security, and other federal and state regulations
- Other duties as assigned

Job Requirements:

Education:

- A License as a Registered Nurse (RN)

Experience:

- Three to five years of combined behavioral health clinical and managed care experience

Knowledge:

- Knowledge of current behavioral health principles, procedures, and treatment protocols

Skills:

- Strong interpersonal skills and good written and verbal communication skills

Financial Reporting Analyst

Position Summary: The Financial Reporting Analyst is responsible for general ledger reporting, including variance analysis, funding allocations, deposit reconciliation, and accounts receivable reconciliation in order to provide accurate financial reports and analyses to support management decision-making.

Essential Functions:

- Processing and tracking funds and payments, including authorized amounts, matching invoices to authorized amounts, invoicing appropriate agency for services, and notification to claims reconciliation staff upon receipt of funding
- Working closely with finance staff to ensure proper payments are made to providers
- Maintaining and analyzing general ledger to trial balance in preparation of financial reporting requirements
- Preparing financial statements, balance sheets, and cash flow statements, including variance analysis and labor cost reporting
- Preparing scheduled financial reports and forecasts for management review
- Analyzing, reconciling, and explaining indirect expense reports;
- Assisting with contract audits
- Monitoring invoice payment process, including check authorizations, cost allocations, production, and disbursement;
- Preparing and tracking of capital and fiscal budget
- Researching inquiries related to departmental expenses, as needed
- Other duties as assigned

Job Requirements:

Education:

- Bachelor's degree in finance, accounting, or related field

Experience:

- Two to five years of experience in related finance position, or the equivalent combination of education, training, and/or experience

Skills:

- Excellent communication (verbal and written) and interpersonal skills

Abilities:

- Ability to handle multiple priorities and meet aggressive deadlines

Human Resources Specialist

Position Summary: The Human Resources Specialist is responsible for providing day-to-day support in variety of human resources activities, functions, and operations.

Essential Functions:

- Acting as the initial point of contact between employees and the human resources department regarding human resources-related inquiries via e-mail, phone, or face-to-face interaction
- Maintaining personnel files in compliance with applicable state and federal requirements
- Responding to both written and verbal employment verification requests
- Responding to unemployment claims in accordance with company policies and procedures
- Conducting new hire orientations for employees company-wide both electronically and in-person
- Processing new hire paperwork including I-9s and payroll documents
- Entering data for new hires into system and online learning portal
- Processing and distributing various reports through the payroll system
- Providing support on various audits of employee or human resources-related data
- Maintaining listing of active licenses for all clinical staff and ensuring compliance with licensing requirements
- Supporting annual EEO-1 filing and internal affirmative action plan
- Coordinating employee events including benefit meetings, employee appreciation initiatives, and corporate functions
- Other duties as assigned

Job Requirements:

Education:

- High school diploma (or equivalent)

Knowledge:

- Basic knowledge of human resources systems, policies and procedures, and legal and regulatory environments

Skills:

- Excellent communication (verbal and written) and interpersonal skills

Abilities:

- Ability to remain detail-oriented while managing multiple tasks and priorities
- Ability to process and protect highly confidential information

Manager, Information Systems

Position Summary: The Network Manager is responsible for managing the behavioral health provider network, identifying and engaging new/existing providers to enhance services, negotiates rates and level of agreements or contract language.

Essential Functions:

- Identifying network needs and potential providers for recruitment
- Negotiating rate changes and contract terms with network providers
- Securing executed agreements with all existing in- and out-of-network providers
- Performing reimbursement analyses on providers that are outside of targeted rate schedules or performance standards and strategizing about cost reductions, member needs, and quality improvement
- Working with providers to further their understanding of performance specifications and standards
- Reviewing and drafting suggested provider contract changes and overseeing resolution of all changes
- Performing site visits on behalf of the credentialing team
- Working with legal department to ensure contract language is in compliance with all state and federal regulatory standards, as well as NCQA standards
- Collaborating with other departments to address and resolve operational issues related to negotiated contract language
- Other duties as assigned

Job Requirements:

Education:

- A bachelor's degree required; master's degree in business administration, public administration, or public health preferred

Experience:

- At least two years of health care contracting experience

Knowledge:

- Understanding of finance and contract language essential

Skills:

- Must have excellent communication and negotiation skills

Fraud and Abuse Investigator

Position Summary: The Fraud and Abuse Investigator is responsible for conducting fraud and abuse audits of provider and subscriber medical data, claims, and system reports and developing documentation to substantiate findings.

Essential Functions:

- Analyzing enrollment, contract documents, provider/subscriber medical claims history, health insurance benefits, external data banks and other documents to make decisions as to the possible existence of fraud and/or abuse
- Conducting detailed offsite audit/investigations with interviews
- Researching provider/subscriber claims activity, operations manuals, data systems, and medical policies to identify control deficiencies and non-compliance and to detect fraudulent/abusive activities
- Ensuring audits are conducted in a timely manner and results in an overall achievement of targeted financial recoveries
- Maintaining case investigative files to preserve as potentially discoverable material, including boilerplate, original correspondence, and detailed technical writing of reports and synopses
- Providing litigation support for civil/criminal court proceedings by collaborating with internal departments/external agencies
- Maintaining lines of cooperation/communication with external agencies that pursue fraud and abuse cases
- Assisting with updating and providing fraud and abuse training to employees
- Other duties as assigned

Job Requirements:

Education:

- Associate's degree and three to four years work experience in claims, fraud, or auditing in managed care environment; bachelor's degree preferred

Knowledge:

- Working knowledge of legal, investigative, accounting procedures, data processing systems, auditing, claims processing and systems, medical reviews, and appeals

Member Services Representative

Position Summary: The Member Service Representative is the front line interface to members and providers seeking information about behavioral health benefits. The Member Service Representative assists callers by providing benefit and eligibility information and referrals to network providers. The Member Service Representative transfers clinical calls to clinicians, as defined in the transfer protocol. In addition, the Member Service Representative is responsible for completing specified assignments that assist the department in meeting contractual goals.

Essential Functions:

- Adhering to telephone performance requirements for call response times and abandonment rates
- Educating callers about behavioral health services and benefits
- Responding to questions about eligibility, benefits, and procedures for accessing behavioral health services
- Verifying member benefits and eligibility through health plan computer access, phone and e-mail
- Entering complete member information into system and sending our completed authorizations to providers
- Working with health plan and providers to effectively coordinate member's care
- Outreaching to new members that have been identified with behavioral health needs
- Responding to requests for referrals to network providers
- Determining which calls need to be transferred to a clinician, as defined by established protocols, including emergency call procedures
- Attending all department and general staff meetings
- Forwarding member and provider complaints per health plan guidelines

Job Requirements:

Education:

- A high school diploma (or equivalent)

Experience:

- One to two years of experience in a call center or customer service setting
- Experience in an ACD environment preferred

BH Medical Director

Position Summary: The BH Medical Director provides leadership and direction for clinical services, including identification of potential quality indicators.

Essential Functions:

- Provides clinical review for outlier cases
- Provides direct clinical supervision, as needed
- Conducts peer reviews
- Conducts clinical denial reviews and determinations as per delegation agreements
- Provides consultation and peer review, as needed
- Conducts clinical triage
- Facilitates authorization and denial determinations per delegation agreements
- Identifies of potential quality care issues
- Development, implementation, and interpretation of clinical-medical policies and procedures that are specific to behavioral health or can be expected to impact the health and recovery of individuals with behavioral health issues conditions
- Ensure strong integration of physical and behavioral health care services in conjunction with the health plan and medical management staff
- Clinical peer review recruitment and supervision
- Provider education, training, and orientation to promote adoption of evidence-based practices
- Behavioral health provider quality profile design and data interpretation
- Development and implementation of the behavioral health sections of the QM/UM Plan, including serving as the chairperson of behavioral health committees for QM/UM and peer review
- Administration of all behavioral health QM/UM and performance improvement activities, including grievances and appeals
- Attendance at regular health plan leadership and medical director meetings

JOB REQUIREMENTS:

Education:

- A current, unrestricted license to practice psychiatry in the state and Board Certification in Psychiatry

Experience:

- Minimum five years of post-graduate experience with patient care
- Minimum five years of experience with psychiatric/chemical dependency utilization management, preferably in a managed care and/or hospital setting
- Excellent written and communication skills
- Experience with staff supervision

Skills:

- Basic level of PC skills required

Credentialing and Data Specialist

Position Summary: The Credentialing and Data Specialist is responsible for credentialing and re-credentialing behavioral health providers and ensuring processes and protocols are in place to maintain credentialing file accuracy according to contractual and NCQA standards.

Essential Functions:

- Entering data related to applications and provider network changes into our system in an efficient and accurate manner
- Maintaining accurate records regarding files for facilities, programs, and providers
- Responding to provider questions and concerns in a professional and timely manner
- Assisting in development and maintaining the application and credentialing program reports
- Assisting in the resolution of outstanding credentialing and maintenance issues
- Communicating provider issues with clinical, claims, and other departments, as necessary
- Participating in quality improvement activities to ensure credentialing processes and other provider activities meet NCQA and contractual standards
- Other duties as assigned

Job Requirements:

Education:

- High school diploma (or equivalent); bachelor's degree preferred

Experience:

- Two to three years of experience in behavioral health environment
- Previous credentialing experience

Skills:

- Strong organizational skills and attention to detail

Manager, Network

Position Summary: The Network Manager is responsible for managing the behavioral health provider network, identifying and engaging new/existing providers to enhance services, negotiates rates and level of agreements or contract language.

Essential Functions:

- Identifying network needs and potential providers for recruitment
- Negotiating rate changes and contract terms with network providers
- Securing executed agreements with all existing in- and out-of-network providers
- Performing reimbursement analyses on providers that are outside of targeted rate schedules or performance standards and strategizing about cost reductions, member needs, and quality improvement
- Working with providers to further their understanding of performance specifications and standards
- Reviewing and drafting suggested provider contract changes and overseeing resolution of all changes
- Performing site visits on behalf of the credentialing team
- Working with legal department to ensure contract language is in compliance with all state and federal regulatory standards, as well as NCQA standards
- Collaborating with other departments to address and resolve operational issues related to negotiated contract language
- Other duties as assigned

Job Requirements:

Education:

- A bachelor's degree required; master's degree in business administration, public administration, or public health preferred

Experience:

- At least two years of health care contracting experience

Knowledge:

- Understanding of finance and contract language essential

Skills:

- Must have excellent communication and negotiation skills

Manager, Provider Relations

Position Summary: The Manager, Provider Relations is responsible for leading the provider support strategy for Beacon, building and refining a structured provider support function and navigating nuances of each market, including regulatory requirements for each state.

Essential Functions:

- Working directly with providers, clients, and internal departments including network development, account management, members services, clinical, and operations administrative support
- Mentoring and developing a team of provider relations representatives
- Building and refining provider support protocols and workflows
- Reporting monthly department performance
- Providing oversight and support for provider-related projects
- Providing subject matter expertise and completing tasks for implementation projects
- Identifying and implementing process improvements
- Providing oversight of all provider issue resolution
- Ensuring compliance with regulatory and NCQA requirements
- Developing and maintaining quality-related policies and procedures
- Providing oversight of claims denial rates to identify and implement opportunities for provider training
- Developing and executing strategies to increase electronic transaction rates across the provider network
- Managing and leading all provider events
- Managing and coordinating the production of various reports and requests
- Other duties as assigned

Job Requirements:

Education:

- A bachelor's degree business, public administration, or public health desired

Experience:

- At least two years of health care contracting, behavioral health experience strongly preferred

Knowledge:

- Understanding of finance and contract language

Skills:

- Strong written and oral communication skills, including ability to negotiate

Abilities:

- Professional demeanor and good public relations abilities

Provider Relations Specialist

Position Summary: The Provider Relations Specialist serves as Beacon's representative to the provider community, implementing regional-based strategies to meet local and statewide clinical, quality and network improvement goals through established positive relationships with providers, state agency stakeholders, and members.

Essential Functions:

- Building, developing, and maintaining positive relationships with local community providers, hospital administrators, other key local services providers to identify system of care issues, planning and implementing solutions and working towards established goals of the program
- Assisting in the identification of service level gaps and addressing recruitment opportunities
- Overseeing regional network performance improvement and implementing with providers statewide
- Working with clinical, operations, and IT teams to identify and resolve provider/systems issues and review network performance strategies
- Developing and implementing provider analysis and reporting tools
- Reviewing and summarizing all profiling data including demographic, utilization, and quality data by provider to identify provider strengths and opportunities for improvement
- Sharing best practice information with provider strengthen quality of the network
- Actively outreaching and training providers to ensure compliance with access and availability
- Identifying and resolving provider issues by researching causes and working with clinical, operations, and IT teams
- Scheduling, leading, and reporting on provider site visits
- Other duties as assigned

Job Requirements:

Education:

- Bachelor's degree

Experience:

- Prior network and customer service experience

Knowledge:

- Strong understanding of managed care and health care operations

Skills:

- Excellent communication (verbal and written) and interpersonal skills

Abilities:

- Ability to remain detail-oriented while managing multiple tasks and priorities

Network Contract Manager

Position Summary: The Network Contract Manager is responsible for oversight of new procurement activities including making contact with new/existing providers, negotiating rates, development letters of agreement, and securing executed contracts with in- and out-of-network providers.

Essential Functions:

- Identifying network needs and potential providers and pursuing network agreements
- Negotiating and re-negotiating rates within identified financial parameters
- Performing analysis on providers that are outside of targeted rate schedules or performance standards and strategizing about cost reductions, member needs and quality interventions
- Identifying opportunities for cost savings related to the network contracting process
- Working with providers to further their understanding of performance specifications and standards
- Reviewing and drafting suggested changes and overseeing resolution of all proposed changes to letters of agreement and provider services agreements
- Participating in provider meetings, trainings, and site visits
- Participating in continuous quality improvement activities
- Strategizing with network team to ensure access and availability of providers to meet current standards
- Collaborating with other departments to address and resolve operational issues related to negotiated contract language
- Other duties as assigned

Job Requirements:

Education:

- A master's degree in business administration, public administration, or public health

Experience:

- At least two years of health care contracting

Knowledge:

- Understanding of finance and contract language

Skills:

- Strong written and verbal communication skills and ability to negotiated

Manager, Provider Partnerships

Position Summary: The Manager, Provider Partnerships, is primarily responsible for interfacing with a strategic subset of Beacon's network of community providers, building strategic partnerships and bringing an analytic mindset to discussions with providers.

Essential Functions:

- Serves as direct contact point for a subset of Beacon providers, generally the largest and/or most important in a specific region, and be the "face" of Beacon for those providers
- Serves as a "concierge" for strategic providers as they need help and access to Beacon, including receiving inbound questions from provider, filtering question to proper internal audience at Beacon, and either facilitate or deliver the responses from the Beacon team back to the provider
- Serves the same "concierge" role for any direct provider query or request, even for those outside of the strategic designation, to ensure there is "no wrong door" for a provider to access assistance from Beacon
- Leads meetings with strategic providers, to include set number of meetings per provider, per year
- Analyzes strategic provider reports around cost, utilization, and outcomes, and prepares reports to share with providers that detail provider performance over time, highlighting key areas of focus
- Maintains accountability for the monitoring and interpretation of provider utilization data, to include overseeing data analysis to understand root cause of any outlier utilization and engaging providers to discuss and help remedy outlier utilization; for clinical issues, surface issues to Beacon's local or service center clinical teams and participate in helping to address concerns
- Crafts annual strategic plan for each strategic provider partner with measurable goals for each calendar year
- Works with account management team to ensure provider activities are in line with Beacon priorities
- Liaises with clinical team to be knowledgeable regarding UR and care management programs and services, to be able to answer or appropriately triage provider questions
- Identifies innovative provider programs and gathers information on program structure, function, efficacy and outcomes to share with Beacon innovation warehouse
- Solicits annual feedback from providers regarding Beacon partnership and prepares annual regional report on regional provider perspectives
- Shares health plan-specific provider performance to educate health plan clients about provider performance, with a focus on utilization outliers
- Helps identify opportunities for innovative pilot programs, to include program development, implementation, launch, and efficacy and outcomes measurements
- Assists with provider orientations and provider training events in the region; trainings and orientations will be led by the network operations team
- Closely collaborates with the network operations team to ensure contracting, credentialing and other network operations are completed within necessary timelines and that there is a fluid bi-directional sharing of information
- Provides input into rate increase evaluation process led by network operations
- Other duties and projects as assigned

Job Requirements:

Education:

- A master's degree in business administration, public administration, public health, or behavioral health
- Independently licensed behavioral health clinicians strongly considered

Attachment 3 (Behavioral & Physical Health Job Descriptions)

Knowledge:

- Knowledge of managed care, analytics, performance improvement, and clinical skill preferred

Skills:

- Strong execution and follow-up skills, analytic skills, ability to multi-task are essential
- Professional demeanor, strong written and oral communication skills needed

Grievance and Appeals Coordinator

Position Summary: The Grievances and Appeals Coordinator is responsible for managing grievances and appeals functions including screening and processing member/provider complaints, disposition of investigation requests, and grievances and appeals training.

Essential Functions:

- Coordinating all levels of complaints, grievances, and appeals to ensure timeliness and compliance with state and client standards
- Producing necessary documentation for all grievances and appeals decisions
- Assisting in design and maintenance of applicable databases for complaints/appeals and other ad hoc quality management projects
- Maintaining sound customer relations while researching and gathering complaints, grievances and appeals information
- Reviewing investigation reports, approving corrective actions plans, issuing decision letters, and completing follow-up on corrective action plans
- Other duties as assigned

Job Requirements:

Education:

- A bachelor's degree

Experience:

- At least five years of experience working in a health care-related industry
- At least one year of experience in quality management/utilization management preferred

Skills:

- Strong customer service orientation
- High degree of organizational and written/verbal communication skills

Abilities:

- Ability to meet deadlines
- Ability to maintain positive customer relations

Manager, Quality

Position Summary: The Manager, Quality is responsible for the oversight and implementation of the quality program, implementing and monitoring the annual quality work plan, identifying barriers and opportunities for improvement, and applying continuous quality improvement principles to ensure continued success of quality activities.

Essential Functions:

- Supervising Quality Analysts and conducting periodic assessment of program effectiveness
- Conducting performance improvement activities and reporting on key quality indicators
- Assisting with research, reporting, and data analysis focused on NCQA and URAC accreditation activities and ensuring ongoing compliance with accreditation standards
- Participating in quality improvement activity teams and assisting in the development and refinement of quality improvement activities using NCQA standards
- Contributing to the development of new quality policies and procedures and overseeing key departmental activities to further department goals
- Assisting in all areas of quality improvement through the company, including preparing and presenting staff trainings related to quality
- Analyzing current process and developing new workflow documents for quality and clinical programs to improve efficiency, accuracy, and compliance
- Developing ongoing report specifications and overseeing all internal and external quality management reporting and regional quality management activities
- Other duties as assigned

Job Requirements:

Education:

- Master's degree or equivalent in behavioral health, public health, or related field

Experience:

- At least three years of experience with data analysis, reporting writing, and quality improvement

Skills:

- Ability to communicate complex information in simple terms
- Excellent communication (oral and written) and interpersonal skills

Abilities:

- Ability to handle multiple priorities and meet aggressive deadlines

Quality Analyst

Position Summary: The Quality Analyst works with the quality department and other staff on quality improvement activities, analyses, and reporting of key quality indicators.

Essential Functions:

- Researching, reporting, and data analysis focusing on NCQA and URAC accreditation activities (e.g., demographic analysis of service utilization patterns, trend reports)
- Providing support to Ombudspersons for reporting requirements
- Support and evaluating clinical, service, and quality programs and activities
- Analyzing and reporting on HEDIS/QARR measures and participating on HEDIS committees
- Supporting clinical and quality teams in the analysis and reporting of periodic performance data, including monthly, quarterly, semi-annual, and annual analyses
- Assisting in member satisfaction surveys, including working with selected vendors and writing the annual report
- Regularly reviewing and updating key performance indicator data for the oversight of clinical and quality performance and reporting results to appropriate quality committees
- Assisting with the outpatient and inpatient treatment record review process, supporting clinical teams on analysis, reporting, and follow-up of treatment record review performance data
- Attending provider advisory council meetings, as assigned, and presenting summary information on quality data and initiatives
- Other duties as assigned

Job Requirements:

Education:

- Bachelor's degree in behavioral health or related-field; master's degree preferred

Experience:

- At least two years of experience with data analysis, reporting writing, and quality improvement

Skills:

- Ability to communicate complex information in simple terms
- Excellent communication (oral and written) and interpersonal skills

Abilities:

- Ability to handle multiple priorities and meet aggressive deadlines

Quality Improvement Coordinator

Position Summary: The Quality Improvement Coordinator formulates quality improvement activities, analyses, and reporting of key quality indicators and accreditation activities

Essential Functions:

- Monitoring core processes, analyzing data, and developing action plans to meet established goals and objectives, with a focus on NCQA accreditation activities
- Formulating quality indicators and educating internal staff on status of quality indicators and trends
- Making recommendations for systemic quality improvement initiatives
- Communicating with clients and regulatory quality management staff to develop quality improvement projects and evaluate and communicate results
- Developing short- and long-term strategies to improve health care outcomes through data interpretation, data management, literature review, and other means of investigation and research
- Assessing impact of provider performance strategies and revise methodologies accordingly
- Assisting in the planning and execution of process improvement studies to increase efficiency and productivity

Job Requirements:

Education:

- A bachelor's degree in behavioral health, healthcare administration, or related field required; master's degree preferred

Experience:

- Three years of experience in healthcare, behavioral health preferred
- Experience in data analysis, quality improvement activities; experience with NCQA strongly preferred

Skills:

- Excellent analytical and communication skills

Abilities:

- Must be detail oriented, able to work independently in a flexible environments, able to handle multiple tasks in an efficient manner

Data Analyst

Position Summary: The Data Analyst is responsible for providing decision support through reporting and data analysis, as well as timely production and dissemination of accurate reports, data, and management information.

Essential Functions:

- Conducting data analysis, design, and development of standardized management reports
- Conducting ongoing requirement analysis for data needs for internal and external stakeholders
- Creating functional and technical specifications based on business requirements and needs
- Developing data flows, pseudo-code, report mockups, and validating business requirements
- Ensuring that algorithms and reports are created and generated accurately in a timely manner for review, analysis, and subsequent submission to clients
- Conducting project-based data analysis and ad hoc reports
- Developing test scripts for unit testing and user acceptance testing
- Analyzing and evaluating requests for reports and developing procedures to extract data from various data sources and the data warehouse using report writers and data extract tools
- Conducting training and implementation of the reporting system
- Other duties as assigned

Job Requirements:

Education:

- A bachelor's degree in information systems or equivalent work experience

Experience:

- Four to six years of experience in a reporting, business intelligence environment

Knowledge:

- Knowledge of relational databases and data warehouse

Skills:

- Proficiency in report documentation and auditing procedures
- Proficiency in Microsoft SQL Server Development (T-SQL, stored procedures), Crystal Reports, Cognos Reports Studio, and SSRS
- Excellent communication (verbal and written) and interpersonal skills

Abilities:

- Ability to communicate complex information in simple terms
- Ability to handle multiple priorities and meet aggressive deadlines

Help Desk Analyst

Position Summary: The Help Desk Analyst supports, monitors, tests, installs, and troubleshoots hardware and software problems related to local area networks, PC, and peripheral equipment.

Essential Functions:

- Providing first line response for users requiring assistance with information technology issues and problems
- Responding to requests for technical assistance by phone, e-mail, and/or using a help desk management system
- Tracking issues to resolution, updating the internal knowledgebase and/or communicating learnings with relevant business units
- Escalating more involved issues to the appropriate Tier 2 and Tier 3 support teams
- Updating daily status reports and shift handover reports
- Acting as a liaison between customers and technical escalation teams
- Providing a single view to the organization for information technology-related problems
- Other duties as assigned

Job Requirements:

Education:

- Bachelor's degree in computer science, management information systems, or related field

Experience:

- Three to five years of experience in technical environments

Knowledge:

- Knowledge of the ITIL methodology, change management, and risk management processes
- Familiarity with common office productivity software applications

Skills:

- Excellent communication (verbal and written) and interpersonal skills
- Excellent judgment skills to be able to properly evaluate situations and immediately provide effective solutions

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Appeals Coordinator

Reports To: Director of Grievances and Appeals/Grievance and Appeals Manager

Position Summary: This position requires advanced knowledge of all lines of business for MHP including Medicare, Commercial and National Committee for Quality Assurance (NCQA), URAC or general accreditation requirements to collaboratively work with other MHP departments and proactively respond to and resolve member appeals within established timeframes. This position is responsible for coordinating appeals from receipt to resolution. Investigates member appeals in accordance with federal and state laws and department policies regarding quality and timeliness by maintaining accurate and timely tracking and reporting of all regulatory and accreditation requirements.

Essential Functions:

- Coordinates all appeal requests
- Serves as a liaison in corresponding and communicating with providers and members and/or member's authorized representative
- Work with the Appeals Team Lead to identify and document the reason for the appeal in MCS
- Investigate and collect documentation related to the appeals and summarize in MCS
- Maintain all documentation associated with the processing and handling of appeals to comply with regulatory standards while maintain an accurate and complete appeals record in MCS
- Assist Medical Directors with preparing documentation for Independent external review
- Draft appeal letter templates
- Track and log all appeal data components as required by federal and state laws and department policies
- Regularly provide written reports of compliance with appeal standards
- Identify and implement process improvement opportunities
- Function as a liaison between the Utilization Management department and the Member Services Case Specialists
- Document user requirements for MCS systems development
- Analyze the data elements appeal reports
- Draft and update policies and procedures pertaining to appeals
- Remain updated on all relevant policy changes made by MHP
- Remain updated on all relevant regulatory and accreditation reporting requirements and policy changes
- Perform other duties as assigned

Job Requirements:

Education:

- Associate's degree is required
- Bachelor's degree or Fellow designation from the Academy of Healthcare Management (AHM) is preferred

Experience:

- A minimum of one to two years experience as a Utilization Management Specialist or one to two years of related health industry experience is required

Knowledge:

- Knowledge of managed care, Medicaid and Medicare guidelines

Attachment 4 (Grievance & Appeals Job Descriptions)

- Thorough knowledge of the authorization process
- Understanding of NCQA, URAC or general accreditation requirements for Utilization Management and appeals

Skills:

- Excellent verbal and written communication skills
- Basic computer skills
- Telephone service skills

Abilities:

- Ability to be patient and courteous to all members and providers in all situations
- Ability to work in teams

Testing Requirements

- Successful completion of the Online Medicaid Managed Care Course

Grievance Coordinator

Reports To: Director of Grievances and Appeals/Grievance and Appeals Manager

Position Summary: This position is responsible for informing and educating plan members on the process to properly submit a formal grievance. The Grievance Coordinator investigates and resolves member grievances pursuant to Meridian Health Plan's (MHP) policies and procedures, its regulatory and its accreditation requirements to include, but not limited to, meeting all required timeframes.

Essential Functions:

- Monitor the grievance work list on a daily basis
- Provide notification of new grievances to appropriate department staff for investigation
- Generate grievance acknowledgement and resolution letters
- Conduct grievance investigation and follow up as appropriate
- Documents all grievances in an accurate and timely manner per policy, related follow-up activities and final outcomes in designated systems while concurrently maintaining secure, comprehensive and clearly defined files
- Provides timely assistance to members in filing a formal grievance and ensures that members are advised of their appeal rights
- Prepare for and attend Grievance Subcommittee and conduct necessary follow up based on recommendations of committee members
- Conduct monthly follow up with members who file grievances
- Assist Director in preparing committee and State complaints/grievances reports
- Assemble Administrative Hearing files by gathering relevant documents and communicating with the Administrative Tribunal
- Maintains strict confidentiality of member information in accordance with Caidan/HIPAA Privacy Policies
- Performs other duties as assigned

Job Requirements:

Education:

- High school diploma is required.
- Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is preferred.

Experience:

- One to three years of experience in a Managed Care setting is preferred.
- Two years of experience with MHP's Managed Care System (MCS) is preferred.
- Experience entering data into the CRM system is required.

Knowledge:

- Working knowledge in Microsoft Office applications (Outlook, Word, Excel, etc.)
- Knowledge of customer relations and team participation

Skills:

- Accuracy in data entry
- Grammar and punctuation skills
- Competency in telephone handling

Attachment 4 (Grievance & Appeals Job Descriptions)

- Demonstrated written and verbal communication skills

Abilities:

- The ability to work within multiple departmental teams and successfully identify and resolve issues relating to enrollment and eligibility
- The ability to manage and coordinate multiple time sensitive tasks

Grievance and Appeals Team Lead

Reports To: Director of Grievances and Appeals / Grievance and Appeals Manager

Position Summary: This position is responsible for management of the Grievance and Appeals division of the health plan. Successfully maintains regulatory and accreditation status with regard to appeals letters and grievance resolutions. Responsible for the writing and final editing of all letters sent out for appeals and grievances. This position ensures that each employee that is part of the grievance and appeals process meets their timeline with a 100% accuracy rate.

Essential Functions:

- Responsible for managing all aspects of the grievance and appeals processes within the department to promote consistency and accuracy within the processes and compliance with NCQA, URAC or general accreditation, regulatory requirements and HIPAA guidelines
- Supervises the training of new staff and signs off on all staff when they have completed training and are ready for the phones
- Ensures staff meets all relevant regulatory requirements and comprehends and complies with best practices, professional standards, internal policies, and procedures
- Supervises, analyzes and coordinates the daily grievance and appeals activities to ensure departmental goals are met with regards to timeliness, accuracy and consistency of medical decisions
- Recognizes opportunities to improve the quality of care/services and activities to continually strive to improve outcomes
- Responsible for providing expertise or general support in reviewing, researching, investigating, negotiating and resolving all types of grievances and appeals
- Communicates with appropriate parties, issues, implications and decisions. Analyzes and identifies trends for grievances and appeals
- Coordinates with the quality department on all quality of care cases
- Ensures that existing clinical documentation accurately reflects the service needs of the members on all cases where an Appeal or Fair Hearing has been initiated
- Responsible for clinical coordination and presentation of information for administrative hearings and state external reviews
- Reviews and participates in all grievances and appeals that go to the state fair hearings. Assists with the preparation and ground work for each hearing maintaining a better than 99% reached verdict in favor of the health plan
- Daily prioritization of workflow assignments for optimizing impact on department production
- Responsible for each IRO supporting the health plan's decisions and ensures that they meet the critical time lines
- Works with the IT department on MCS development issues as it pertains to grievances and appeals
- Prepares, with the department assistant, each second level Pre-Service appeal and/or grievance. Materials are prepared when the call to the member is placed
- Assists the Member Service department and State Director of Operations with the member complaints
- Updates Pharmacy and Behavioral Health departments of relevant changes to the appeal and grievance policy and procedures
- Investigates relevant complaints; researches and provides written summary to support the health plan's decision

Attachment 4 (Grievance & Appeals Job Descriptions)

- Reviews weekly post service appeals; investigates each case and prepares summary with review for each case
- Provide ongoing training and education to the staff through one-on-one and classroom settings regarding InterQual, medical policies, NCQA, URAC or general accreditation, regulatory requirements and other necessary job-related skills
- Utilize professional knowledge, MHP knowledge and pertinent resources or use the appropriate reporting structure to solve problems and issues as identified
- Maintain strict confidentiality of employee and organizational information in accordance with MHP, HIPAA and State privacy regulations
- Trains new staff as needed
- Perform other duties as assigned

Job Requirements:

Education:

- Current licensure to practice as a Registered Nurse or a Licensed Practical Nurse in the designated State, without restriction

Experience:

- Three to five years of experience, education and/or certifications in utilization management, case management or other appropriate health care specialty

Knowledge:

- Knowledge of MHP's mission and operational structure
- Knowledge of managed care, particularly utilization management processes
- Knowledge of Medicare and Medicaid guidelines, medical necessity and benefit structure
- Knowledge of NCQA, URAC or general accreditation requirements and guidelines for utilization management, denials and appeals

Skills:

- Demonstrated leadership skills
- Organizational skills
- Excellent written and verbal communication skills
- Demonstrated clinical knowledge and expertise

Abilities:

- Ability to prioritize work load
- Ability to work as part of a team while meeting individual goals and objectives
- Ability to identify, develop and implement process improvements

Infrastructure Engineer

Reports to: Manager of Infrastructure Service Delivery

Essential Functions:

- Work with internal build-out teams and room integrators to ensure consistency of builds.
- Participate in site surveys and needs analysis meetings
- Participate in generating final equipment lists based on needs analysis
- Provide installation quality assurance
- System set up and troubleshooting
- Train staff in equipment and meeting set up

Job Requirements:

Education:

- Bachelor's degree in related field or equivalent work experience preferred

Experience:

- Experience with videoconferencing equipment from vendors such as Polycom, Cisco, LifeSize, or Vidy.
- Sound structure, microphone, and speaker configuration, design, and selection.
- Experience with audio DSP and room engineering
- Troubleshooting experience
- Experience in room acoustic evaluation
- Experience with VoIP and networking protocols such as SIP, RTP, WebRTC.
- Experience with device control APIs, including IR blasting solutions.
- Experience with A/V over IP protocols.
- Experience with Crestron and AMX

Knowledge:

- Product Knowledge of Audio & Video Conferencing systems.
- Understanding of equipment interoperability.

Skills:

- Excellent communication skills and experience working with executives

Service Desk Team Lead

Reports to: Manager of Operations & Support

Position Summary: Supports, monitors, tests, and troubleshoots all hardware and software problems pertaining to hardware and system applications. Works with applications/OS support personnel to install all hardware and software products for local and remote users.

Essential Functions:

- Assume the role as Team Lead of all IT Operations/Service Desk Support. Responsibilities include but are not limited to:
 - Supervise employee workload; provide overall direction, coordination and evaluation
 - Report employee production and quality details to the manager
 - Assist employees if problems arise and offer assistance when decision making is involved
 - Advise employees how to improve work procedures
 - Ensure high levels of customer satisfaction with delivered services
- Perform hardware installation, troubleshooting and repairs on PC's and printers
- Handle network, operating system, software support, and issues
- Provide service desk telephone support to end users on software applications, including internally developed programs, MS Office Suite, Windows, Internet, and all other products
- Provide service desk telephone hardware support to end users, including PC desktops, laptops, printers, check scanners, and network interface of equipment
- Coordinate the resolution of problems and issues with the appropriate vendors and internal staff
- Install and configure workstations
- Provide monitoring of all system peripherals
- Ensure all daily production work is complete (daily file extracts and loads, daily tape backups, etc.)
- Assist with planning and execution of upgrades and software implementations
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree in computer related area is required.

Experience:

- Over five years' experience in information systems or related field is preferred.
- Versed with various operating systems and application software is a requirement.
- Direct repair experience with PC'S, laptops, servers, printers, plotters and peripheral devices etc. is required.

Knowledge:

- Knowledge of commonly used concepts, practices, and procedures within a particular field
- Working knowledge and skill of troubleshooting and repairing PCs, laptops, and printers
- Additional knowledge in the following areas: Microsoft Windows XP, 7 and Microsoft Office suite

Attachment 5 (Information Technologies Job Descriptions)

Skills:

- Strong hardware repair skills
- Strong troubleshooting, process and documentation skills
- Excellent telephone etiquette and command of the English language

Abilities:

- Ability to work independently and exercise judgment in decision making
- Able to work on multiple projects/priorities in a deadline-driven environment
- Must be able to remain calm in pressure situations and adapt quickly to change
- Able and willing to travel occasionally

IT Service Desk Analyst

Reports to: Manager of Operations & Support

Position Summary: This position supports, monitors, tests, and troubleshoots all hardware and software problems. Works with applications and operation system support personnel to install hardware and software products for local and remote users.

Essential Functions:

- Perform hardware installation, troubleshooting and repairs on PC's and printers
- Handle network, operating system, software support, and issues
- Provide service desk telephone support to end users on software applications, including internally developed programs, MS Office Suite, Windows, Internet, and all other products
- Provide service desk telephone hardware support to end users, including PC desktops, laptops, printers, check scanners, and network interface of equipment
- Coordinate the resolution of problems and issues with the appropriate vendors and internal staff
- Install and configure workstations
- Ensure all daily production work is complete (daily file extracts and loads, daily tape backups, etc)
- Assist with planning and execution of upgrades and software implementations
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma is required. Bachelor's degree or associate's Degree in computer-related field or pursuit of job-related certifications is required.
- Must pass the MHP Analyst Assessment.

Experience:

- A minimum of two years' experience in information systems or related field is preferred.
- Versed with various operating systems and application software is a requirement.
- Direct repair experience including PC'S, laptops, servers, printers, plotters and peripheral devices etc. is required.

Knowledge:

- Knowledge of commonly used concepts, practices, and procedures within a particular field
- Working knowledge and skill of troubleshooting and repairing PCs, laptops, and printers
- Additional knowledge in the following areas is preferred: Microsoft Windows XP, 7 and Microsoft Office suite

Skills:

- Strong hardware repair skills
- Excellent telephone etiquette and command of the English language

Abilities:

- Ability to work independently and exercise judgment in decision making
- Able to work on multiple projects/priorities in a deadline-driven environment
- Must be able to remain calm in pressure situations and adapt quickly to change
- Able and willing to travel occasionally

Technical Delivery Lead

Reports to: Director of EDI/Information Systems Manager

Position Summary: This position is responsible for planning, managing, and delivering complex Information Technologies projects on time, within budget, and with high quality. This role creates the project plans encompassing all IT delivery elements including but not limited to requirements gathering, business and system analysis, business requirements quality assurance and approval, solution design, system and application configuration, application construction, quality assurance testing, application turnover, implementation, and post-implementation support. The Technical Delivery Lead drives collaboration with the business area(s), IS, and technology vendors to ensure that all project participants are effectively communicating and executing tasks as specified in the project plan.

Essential Functions:

- Manage multiple projects of small to large size and risk concurrently
- Responsible for initiating, planning, executing, controlling, and closing complex application and system implementation projects using structured project management methodology and processes
- Lead the development of strategic plans for projects of high business complexity
- Develops detailed project plans, resource, work, and cost estimates, critical path assessment, budgets and schedules, including goals, risks, and resource allocation
- Oversee client/customer/vendor relations to ensure that service expectations are met or exceeded
- Monitors project metrics for significant deviations in quality, cost, or schedule
- Monitors and reports all project risks and issues; leads mitigation and resolution efforts to limit risks; escalates as needed
- Prepares regularly scheduled project status reports
- Organize, lead, and document project meetings
- Assists in establishing, enabling, and improving project management methodologies, procedures and policies
- Coaches and mentors individuals on the project teams and provides feedback on performance to their leaders
- Performs other duties as assigned

Job Requirements:

Education:

- Bachelor's or master's degree in computer science, information technology, engineering, business administration or related field

Experience:

- Three to five years leading the project delivery of complex enterprise application systems, distributed applications, web applications, and system integration solutions
- Three to five years project leadership in a deadline driven environment
- Three to five years using SDLC methodologies such as Agile, RUP, Waterfall, etc.
- Three to five years working with technology vendors
- System and/or Business Analysis experience preferred
- Application development experience preferred
- Health Care experience preferred
- Process improvement experience preferred

Attachment 5 (Information Technologies Job Descriptions)

Knowledge:

- Microsoft Office including Word, Excel, Visio, Project, PowerPoint, and Outlook
- Project Management Institute's standards and terminology

Skills:

- Strong project management, leadership, and organization skills
- Excellent verbal and written communication skills

Abilities:

- Candidate must be thorough and detail-oriented
- Able to work on multiple priorities in a deadline-driven environment
- Must be able to remain calm in pressure situations and adapt quickly to change
- Must have the ability to work independently and with minimal supervision

Quality Assurance Analyst

Reports to: Director of EDI/Information Systems Manager

Position Summary: This position is responsible for planning, and executing the Quality Assurance testing of software application releases. The Quality Assurance Analyst assists in the development and documentation of testing strategies, test cases, and test plans. The QA Analyst also performs Functional Testing, User Acceptance Testing (UAT), System Integration Testing (SIT), End-to-End Testing (E2E), and /or Regression Testing, and records test results for each test case and release per approved plans.

Essential Functions:

- Assist in the development of quality assurance and testing policies, standards and procedures
- Assists the Manager in test planning and execution tasks
- Coordinates with Business Analysts and IT Technical Delivery Leads to complete testing specifications and release requirements
- Prepares testing estimates for project and non-project releases
- Prepares test strategies for each application release
- Assist in the creation of Test Plans including UAT, SIT, E2E, and Regression
- Coordinate with IT Technical Delivery Leads on project test planning and test execution schedule
- Coordinate with Business testers and IT Technical Delivery Leads to schedule and execute UAT testing
- Design, develop and execute test strategies/plans; debug and troubleshoot; collaborate with test resources on proper and testing procedures,
- Perform QA status reporting to the Manager of Business Analysis & Quality Assurance
- Assist in the coordinate of defect tracking, defect triage activities, and issue resolution for all assigned projects.
- Ensure that all system tests are successfully completed and documented and all problems are resolved prior to any production releases
- Support all quality initiatives that are implemented during each phase of the system development life cycle
- Initiate risk management and escalation when necessary

Job Requirements:

Education:

- Bachelor's or master's degree in computer science, information technology or related field is required.
- Must pass the MHP Analyst Assessment.

Experience:

- Two to four years testing distributed and web applications
- Two to four years test case creation
- Two to four years development of test programs and scripts
- Two to four years working under SDLC methodologies such as Agile, RUP, Waterfall, etc.
- Two to three years using formal testing tools
- Health Care experience preferred

Knowledge:

- Microsoft Office including Word, Excel, Visio, Project, PowerPoint, and Outlook
- Experience with defect tracking tools (Jira, QC, etc.)

Attachment 5 (Information Technologies Job Descriptions)

Skills:

- Demonstrated success as a self-starter
- Strong verbal and written communication skills
- Candidate must be thorough and detail-oriented

Abilities:

- Able to work on multiple priorities in a deadline-driven environment
- Must have the ability to work independently and with minimal supervision
- Willingness to learn and quickly adapt to changing requirements

Sr. Application Developer

Reports to: Director of Information Technologies

Position Summary: The position is responsible for analyzing, and modifying programming systems and components, which includes the coding, testing, debugging and installation of code to support the organization's various software applications. This includes developing detailed specifications and testing strategies for both new programs and software enhancements.

- Application Developer must work according to approved requirements and work to detailed specifications and/or design document(s).
- Works with limited direct supervision.
- Primary job functions require exercising some independent judgment.
- Relies on instructions and pre-established guidelines to perform the functions of the job.

Essential Functions:

- Develops, modifies and maintains assigned programs.
- Unit tests the operation of developed programs and documents results.
- Reviews user requirements and performs analysis, design, implementation and installation related to new software developed and/or acquired.
- Assists with the planning and organization of department work.
- May provide lead support for programming tasks in support of IT development projects.
- Performs simultaneous activities in support of Information Technologies software programming projects.
- Relies on experience and judgment to plan and accomplish goals.
- Performs a variety of programming and development tasks.
- Ensures that deliverables meet or exceed functional, technical, and performance requirements.
- Troubleshoots and resolves production issues.
- Works on more complex programs under the direction of technical Team Lead or Architect.
- Submits for code review and approval all software modifications.
- May guide or mentor other development staff or student interns.
- Takes ownership of the projects and tasks assigned.
- Provides on-call support as assigned.
- Consistently meets task deadlines while maintaining high quality standards.
- Accurate time entry for all hours worked.
- Other related duties as assigned.

Job Requirements:

Education:

- Bachelor's degree in a related area is required.

Experience:

- A minimum of 4 to 8 years of experience in the field or in a related area is required.

Technical Knowledge:

- Knowledge of commonly-used concepts, practices, and procedures such as:
- See Appendix
- Working knowledge of web services technology and SOA practices a plus.

Preferred Industry Experience:

- Health Insurance - Medicare, Medicaid a plus.
- Health Care – Provider, laboratory, clinical research, pharmaceutical.

Skills:

- Strong technical and analytical, problem-solving skills.
- Excellent code debugging skills.
- Strong system design and development skills.
- Good oral and written communication ability.
- Excellent attention to detail.
- A certain degree of creativity and latitude is required.

Abilities:

- Ability to troubleshoot and manage problems independently
- Ability to work collaboratively with users to understand business requirements.
- Ability to collaborate with other IT Professionals to achieve common project goals.
- Ability to integrate multiple inter-related aspects of the system for a comprehensive approach to design.
- Able to work on multiple projects/priorities in a deadline-driven environment.

Application Developer

Reports to: Director of Information Technologies

Position Summary: This position is responsible for analyzing, and modifying programming systems and components, which includes the coding, testing, debugging and installation of code to support the organization's various software applications.

- Application Developer must work according to approved requirements and work to detailed specifications and/or design document(s).
- Works under immediate supervision.
- Primary job functions do not typically require exercising independent judgment.
- Relies on instructions and pre-established guidelines to perform the functions of the job.

Essential Functions:

- Develops, modifies and maintains assigned programs.
- Unit tests the operation of developed programs and documents results.
- Reviews user requirements and performs analysis, design, implementation and installation related to new software developed and/or acquired.
- Ensures that deliverables meet or exceed functional, technical, and performance requirements.
- Troubleshoots and resolves production issues.
- May work on more complex programs under the direction of higher level staff, technical Team Lead or Architect.
- Submits for code review and approval all software modifications.
- May guide or mentor junior level development staff or student interns.
- Takes ownership of the projects and tasks assigned.
- Provides on-call support as assigned.
- Consistently meets task deadlines while maintaining high quality standards.
- Accurate time entry for all hours worked.
- Other related duties as assigned.

Job Requirements:

Education:

- Bachelor's degree in a related area is required.

Experience:

- A minimum of 2 years of experience in the field or in a related area is required.

Technical Knowledge:

- Knowledge of commonly-used concepts, practices, and procedures such as:
- See Appendix
- Working knowledge of web services technology and SOA practices a plus.

Preferred Industry Experience:

- Health Insurance - Medicare, Medicaid a plus.
- Health Care – Provider, laboratory, clinical research, pharmaceutical.

Skills:

Attachment 5 (Information Technologies Job Descriptions)

- Strong technical and analytical, problem-solving skills.
- Strong technical knowledge and development skills.
- Good oral and written communication ability.
- Excellent attention to detail.

Abilities:

- Ability to troubleshoot system issues.
- Ability to work collaboratively with users and IT team members to understand business requirements.
- Ability to collaborate with other IT Professionals to achieve common project goals.
- Able to work on multiple projects/priorities in a deadline-driven environment

Technical Business Analyst

Reports to: Director of Information Technologies

Position Summary: This position is primarily responsible for requirements gathering, requirements analysis, impact assessment, and creation of Business Requirements documents for system development projects of various size and complexity. The Business Requirement documents are at a detailed level, including functional requirements, use cases, testing strategy, and functional solution design. This position collaborates with Delivery Leads, Vendors, Technical resources, Project Management Office., and Business Leads on a regular basis throughout the project delivery lifecycle. The Technical Business Analyst is responsible for adhering to corporate software development standards and methodologies. Secondary responsibilities include creation and maintenance of various types of documents, testing support, issue investigation, analysis, and resolution, and assisting in responding to new corporate initiatives as needed.

Essential Functions:

- Leads the collaboration with the business and/or external clients to define scope of a new project, documents risk and assumptions, assists in developing the delivery approach, and assists with work estimation
- Liaison with business customers to identify and define needed system software requirements/specifications
- Responsible for the use case definition and functional systems design
- Participates in and facilitates system design workshops with the business community to solicit and document business and functional requirements (e.g. Use Case Creation)
- Researches, reviews and analyzes existing processes and develops strategies for enhancements
- Performs business process analysis and modeling
- Performs data mining, analysis, and mapping
- High level of participation in architecting the logical design of the system with the developers, including screen design and specifications, data modeling, and documentation of logical processing flows
- Participates in/leads screen design and specifications
- Responsible for facilitating/brokering communication between the business customers and the technical team
- Establishes and maintains traceability between artifacts in accordance with program guidelines
- Communicates with development and QA teams regularly to ensure accurate understanding and interpretation of requirements
- Collaborates with QA teams in the execution of User Acceptance Testing (UAT)
- Assists in the preparation of user training documentation and may conduct training sessions
- Coordinates and performs tests, including end-user reviews, for modified and new processes/systems
- Provides post implementation support including problem triage, analysis, and resolution
- Manage business requirements documents throughout all project phases
- Assist project delivery lead in the creation and maintenance of project related documents (project status sheets, project plans, timelines, etc.)

Attachment 5 (Information Technologies Job Descriptions)

- Perform analysis and impact assessment for new corporate initiatives
- Perform “ad hoc” technical writing and project management assignments as required
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor’s degree required or in lieu of Bachelor’s degree, five (5) years of experience in programming or business/systems analysis at senior or advanced levels in addition to the requirements listed below
- Must pass the MHP Analyst Assessment.

Experience:

- Three (3) years’ experience in information technology as a business/systems analyst, programmer, or designer required
- At least two years’ experience in large scale system implementation efforts following a standard software development lifecycle approach
- Experience with business and technical requirements analysis, business process modeling/mapping, methodology development and data modeling (requirements management with Use Cases desired)
- Strong knowledge of industry standard development methodologies and technologies
- Proven experience in client requirements/needs analysis and ability to interpret those requirements as they pertain to existing company systems/processes is required
- Minimum 2 years’ experience working with data structures including relational databases, XML, fixed length, and delimited files
- Data mining, analysis, definition and data mapping experience
- Knowledge of systems development required, developer experience preferred
- Health care experience preferred

Skills:

- Ability to create systematic and manual operations procedures in both technical and user-friendly language
- Strong facilitation skills
- High proficiency with MS Office (Word, PowerPoint, Excel, Visio, Project, Publisher)
- Exceptional communication skills (verbal and written)
- Extreme attention to detail
- Advanced skills in technical writing and capability in authoring clear and concise process-orientated technical documentation
- Excellent interpersonal skills including the ability to work with both internal and external customers and all levels of the organization required.
- Strong organizational skills with the ability to handle multiple projects and timelines with minimal supervision required
- Strong problem solving and conflict management skills including the ability to minimize conflict and find mutually acceptable resolutions required
- Experience in interrogating data structures and databases; two (2) years of SQL query writing experience preferred

Abilities:

Attachment 5 (Information Technologies Job Descriptions)

- Ability to consistently solicit and adhere to work-related priorities, while balancing multiple projects simultaneously
- Ability to work both in a team environment and independently
- Ability to be self-motivated, adaptable, hands-on, and display demonstrated ability to multi-task and troubleshoot

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Marketing Coordinator

Reports to: Manager of Communications

Position Summary: This position works closely with the Manager of Communications to coordinate the development, implementation, documentation and evaluation of all marketing initiatives. Assists in the development of marketing strategies and supports direct execution of campaigns and materials with the goal of increased market share.

This job summary and the accountabilities listed in no way state or imply that these are the only duties to be performed by the individual(s) holding the position described. The individual(s) may be required to follow other instructions or perform other duties and tasks requested by his or her supervisor, consistent with the description of the position, department, and company objectives.

Essential Functions:

- Coordinates with the Manager of Communications to develop, implement and evaluate external and internal marketing strategies and initiatives
- Work with Regulatory and Compliance Departments to ensure all marketing communications are compliant with federal, state and regulatory guidelines
- Develop and maintain a comprehensive digital system to order and track all marketing materials and merchandise
- Create and maintain data analysis strategies and ROI reporting formats for marketing strategies
- Assist in development of training materials for marketing initiatives
- Collaborate with other organizations, agencies, vendors and/or community groups in developing marketing materials and campaigns, as appropriate
- Create reports, forms, correspondence and other materials, as necessary
- Proofread materials for accuracy and neatness
- Assist with preparing external mailings for marketing campaigns
- Consistently demonstrate compliance with HIPAA regulations, professional conduct and ethical practice
- Maintain communications guidelines for all written and internet communications. This includes the style, format, font type and size, branding, and standardization of materials.
- Oversight and approval of the print proof process to ensure that the quality of the product for distribution meets the communication guidelines
- Maintain strict confidentiality of employee and organizational information
- Foster a participatory and collegial team atmosphere in interactions with others; act as a role model to other staff
- Ability to travel to other markets, as necessary
- Perform other duties as assigned

Qualifications:

Education:

- Bachelor's degree in Marketing, Communications, Business, Health Care Administration or related field is preferred

Experience:

- 2-4 years of experience in marketing, communications, public relations, social media management and/or project management; healthcare experience is a plus

Attachment 6 (Marketing Job Descriptions)

- Strong experience and competence in data analysis is preferred

Knowledge:

- Knowledge of managed care principles
- Knowledge of State Managed Medicaid, Medicare and commercial health care as well as national healthcare initiatives
- General knowledge of quality and process improvement strategies
- General knowledge of National Committee for Quality Assurance (NCQA) or URAC accreditation
- General knowledge of Adobe Creative Suite software preferred

Skills:

- Excellent written and verbal communication skills; write concise and grammatically correct business correspondence and reports, speak one-on-one or in groups to obtain information, explain policies and procedures, and champion department and corporate initiatives
- Strong organizational skills; coordinate material, information and people in a systematic way to optimize efficiency and minimize duplication of effort, often changing from one task to another of a different nature
- Strong time management skills including the ability to handle multiple ongoing tasks with changing priorities
- Strong editing abilities; proofread and edit content in a variety of formats
- Research skills
- Excellent computer skills including Microsoft Office, Excel, PowerPoint, Visio and Access
- Demonstrated initiative, resourcefulness, creativity, and self-motivation
- Strong public speaking skills a plus

Abilities:

- Ability to manage, coordinate and anticipate needs for multiple complex projects and tasks and meet deadlines consistently
- Ability to manage projects through completion with minimal oversight
- Ability to design and edit documents for a variety of audiences and at a variety of reading levels, including 6th grade reading level for the Medicaid population
- Ability to create materials that reflect the brand image of the company and create a positive impression with clients
- Ability to work independently in a fast-paced environment and support team initiatives
- Ability to interface effectively with all levels of employees, and stakeholders

Member Services Manager

Reports to: Senior Vice President of Corporate Operations

Position Summary: This position is responsible for oversight of the member services functions including, but not limited to, member helpline telephone performance, member e-mail communications, member education, the member website, member outreach programs, development, approval and distribution of member materials. This position also oversees the interface with the State or its subcontractors regarding such issues as member enrollment and disenrollment.

Essential Functions:

Member Services:

- Supervise and schedule departmental activities to ensure expected productivity levels are maintained and all calls are answered within 30 seconds with a service rate of 98%
- Establish staffing schedules to ensure that inbound and outbound call center activities are designed to meet company and member service goals relating to Healthcare Effectiveness Data Information Set (HEDIS) measures
- Perform quality monitoring on inbound and outbound calls and follow up with staff who are not meeting MHP's expectations
- Assist the department Director and Deputy Director with:
 - Weekly reports for inbound and outbound call productivity based on the bonus and incentive program
 - Implementation and documentation of disciplinary actions according to company policies and procedures
 - Performance reviews
- Complete bi-weekly payroll to include bonus payouts
- Educate members and providers on member benefits and member rights and responsibilities
- Educate staff, members, and providers on fraud, waste and abuse and HIPAA policies and procedures and processes
- Coordinate the tracking of guardianships and HIPAA privacy forms with the Privacy Officer
- Educate members and providers on Meridian policies and procedures regarding access to care, the grievance and appeals process and eligibility guidelines
- Annually assist Director and Deputy Director with review of department policies and procedures; Make updates as necessary.
- Ensure that all Job Aids, Policies and Procedures and any resource material used by staff are the appropriate version and available to staff at all times
- Acts as a liaison between providers and members on all issues
- Work with the department Director and Deputy Director to ensure member satisfaction and timely resolution of grievances and appeals
- Understand the system used to track and trend all provider and member inquiries, concerns, and complaints and appeals
- Update and educate staff on all member, provider and administrative policy changes made by Meridian or the State
- Address department related issues submitted by other Meridian departments
- Conduct Weekly Audit meeting with Team Leads. Review any failed audits with Team Lead and staff member.
- Review Bi-Weekly Team Meeting agendas and Meeting Minutes
- Attend meetings as requested by the Department Director and Deputy Director
- Perform other duties as assigned

Attachment 7 (Member Services Job Descriptions)

Job Requirements:

Education:

- Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is required.

Experience:

- Minimum of 5 years of customer service experience is preferred.
- Experience in a call center setting for inbound and outbound calls is required.
- One year supervisory experience in a call center operation is strongly preferred.
- Background and experience in a managed care setting is strongly preferred.
- Project management experience is required.
- Experience and comfort with public speaking are required.

Knowledge:

- Working knowledge in Microsoft Office applications (Outlook, Word, Excel, etc.)
- Knowledge of call center operations
- Managed Care and Iowa Medicaid knowledge is an asset
- Knowledge of continuous quality improvement strategies and practical application methodologies

Skills:

- Strong leadership skills
- Demonstrated customer service skills
- Excellent interpersonal communication skills
- Excellent verbal and written communication skills
- Strong team building skills

Abilities:

- Ability to manage multiple priorities in an effective manner
- Ability to motivate and supervise member service staff to meet company and departmental goals
- Ability to develop presentations

Member Services Representative Team Lead

Reports To: Member Services Manager

Position Summary: This position is responsible for the daily oversight of the Member Services Team, with an emphasis on productivity, monitoring, and supervising the Member Services Representative staff.

Essential Functions:

- Works with the Member Services Manager to schedule the representative's breaks/lunches
- Supervises the training of new staff and signs off on all staff when they have completed training and are ready for the phones
- Answers questions from the representatives as needed
- Performing quality audits on a weekly basis for Member services staff and addressing failed audits with employees
- Conduct monthly audit meetings for Member Services staff addressing failed and passed audits with employees
- Works with the Member Services Manager to schedule PTO time for department staff
- Works with the Member Services Manager to supervise and schedule departmental activities to ensure expected productivity levels are maintained and all calls are answered within 30 seconds with a service rate of 98%
- Works with the Manager of Member Services to perform quality monitoring on inbound and outbound calls and follow up with staffs who are not meeting MHP's expectations
- Assists the department director/manager with: Weekly reports for inbound and outbound call productivity based on the bonus and incentive program
- Educates members and providers on member benefits and member rights and responsibilities
- Coordinate and run Outreach Campaigns for Member Services and other CMC Departments
- Test all aspects of the auto dialer system to ensure it is functioning properly
- Participate in state specific HEDIS Committees as it relates to HEDIS outreach
- Develop appropriate reports including analysis for inbound and outbound call productivity and goals
- Coordinates with QI to ensure that the system and outreach staff are obtaining Healthcare Effectiveness Data Information Set and preventative care at an optimum level
- Mail member ID cards, educational postcards and all other member information as needed
- Welcome new members to MHP monthly and ascertain member medical needs to ensure a smooth transition to the MHP network
- Acts as a liaison between providers and members on all issues
- Along with the Member Services Manager updates and educates staff on all member, provider and administrative policy changes made by MHP or the State of Iowa
- Educate Member Services staff on all updates to training materials
- Hold monthly agenda meetings with employees to update them on changes in the department
- Coach employees on production reports and expectations
- Maintains and updates training materials as needed
- Understand and be able to maneuver through the MHP member handbook
- Provide "CMC Factor" customer service to members and internally to MHP
- Performs other duties as assigned

Attachment 7 (Member Services Job Descriptions)

Job Requirements:

Education:

- High School Diploma is required.
- Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is preferred.

Experience:

- Must have a minimum of four years of customer service/call center experience.
- One year supervisory experience required

Knowledge:

- Knowledge of customer relations and team participation.
- Working knowledge in Microsoft Office applications (Outlook, Word, Excel, etc.).

Abilities:

- Able to motivate and supervise Member Services staff to meet all company and departmental goals.
- Must be able to work a flexible schedule, including weekends and evenings.

Skills:

- Excellent supervisory skills with a strong emphasis on employee motivation, coaching, and mentoring.
- Excellent verbal and written communication skills.
- Organizational skills and the ability to manage multiple interrelated tasks.

Member Benefit Coordinator

Reports To: Member Services Manager

Essential Functions:

- Conduct inbound/outbound telephonic contact with members in a professional manner and maintain phone stats according to departmental goals
- Educate members and providers on members benefits, rights and responsibilities
- Educate members and providers on Meridian Health Plan (MHP) policies and procedures regarding access to care, grievance and appeal process and eligibility process
- Consistently demonstrates compliance with HIPAA regulations, professional conduct and ethical practice
- Provide “Meridian Factor” customer service to members, providers, and internally to all Caidan Management Staff
- Act as a liaison between providers and members on all issues
- Remain updated on all member and provider policy changes made by MHP or the State
- Welcome new members to MHP monthly and ascertain member medical needs to ensure a smooth transition to the MHP network
- Performs accurate data entry into MHP systems and software programs
- Understand and be able to maneuver through the MHP member handbook
- Work with transportation and PCP office to schedule members’ appointments as needed
- Make appropriate referrals to other departments when necessary
- Assist members through Live Chat
- Cross train on all other product lines of MHP to provide assistance as needed
- Process Member Data Changes, State File Changes, and Member Services Faxes in a timely fashion
- Complete follow up calls to members and providers
- Assist with training new representatives
- Assist with special projects or department process improvement efforts, as needed
- May represent MHP in the community at outreach events such as health fairs, etc.
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma is required.
- Pursuit of Associate’s degree, Bachelor’s degree or Fellow designation from the Academy for Healthcare Management (AHM) or job-related certification is preferred.

Experience:

- Six months to one year of customer service experience or related health care industry experience is required.

Knowledge:

- Basic knowledge of managed care or Medicaid programs is helpful.
- Familiarity with Medical Terminology is preferred.

Skills:

- Excellent verbal and written communication skills are required.
- Intermediate computer skills are required.

Attachment 7 (Member Services Job Descriptions)

Abilities:

- Ability to effectively and clearly communicate with callers is required.

Director of Network Development

Reports To: Contract Administrator/CEO/COO

Position Summary: This position is to actively oversee the development and maintenance of a provider network for the health plan that is capable of delivering all basic, specialty, and ancillary health services to the health plan's enrollees in its contracted service areas.

Essential Functions:

- Direct the process of identifying specific providers in Meridian Health Plan's contracted service area, based on review of the network area, for inclusion in the Meridian Health Plan provider network
- Actively seek service area expansion consistent with Meridian Health Plan's targeted goals
- Develop and implement a program for contacting providers, introducing them to Meridian Health Plan and supplying them with contracting and credentialing information
- Monitor and ensure the collection of signed contracts, applications and other necessary credentialing documents and submit them to the Credentialing Coordinator for processing
- Develop and implement an Orientation Program for all providers who meet the credentialing requirements and who are recommended for acceptance by the Credentialing Committee. The orientation should include:
 - Complete education regarding Provider Services Policies and Procedures including authorizations and referrals, claims, encounters, provider utilization reports and the complaint and grievance procedures
 - A review of the financial arrangements, including capitation or fee-for-service, covered services, reimbursement rates, payment schedules and risk sharing arrangements
 - The process for reporting feedback to other Meridian Health Plan departments
- Manage the ongoing servicing of providers as deemed necessary by the provider or Meridian Health Plan, to ensure that a positive relationship is maintained between Meridian Health Plan and its providers
- Prepare all required State and Governing Body data submissions and reports as they pertain to the provider network
- Prepare departmental information for DCH and all State mandated site reviews
- Develop and manage the distribution of provider information such as Provider Bulletins, Provider Newsletter and Provider Manual
- Ensure communication and coordination between the Provider Services Department and other Meridian Health Plan departments
- Manage provider complaints and grievances as necessary. Ensure that concerns are addressed in a timely and thorough manner as described in the Provider Manual.
- Ensure that Provider Network Specialists are properly educated and able to complete their assigned tasks
- Oversee the provider contract negotiation process carried out by Provider Services Specialists. Ensure adherence to all financial guidelines
- Perform other duties as assigned

Attachment 8 (Network Development & Management Job Descriptions)

Job Requirements:

Education:

- Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is required.

Experience:

- Three to five years of previous experience in a provider services role is required.
- Experience contracting providers in a Medicaid managed care environment is required.
- Previous management or supervisory experience is desirable.

Knowledge:

- Thorough knowledge of Meridian Health Plan's mission and its operational structure
- Thorough knowledge of Meridian Health Plan's contracts including Primary Care, Specialty Care, Ancillary Care, Hospital and Organizational Master
- Thorough knowledge of basic reimbursement methods and rates
- Thorough knowledge of Meridian Health Plan's provider policies and procedures as described in the Provider Manual
- Thorough knowledge of geographic areas in which Meridian Health Plan is licensed to operate, including, types of providers in the area, relationships between providers (PO, PHO, independent), key providers/decision makers, enrollee demographics and other competing health plans

Skills:

- Follow-up and follow-through skills
- Strong organizational skills
- Excellent written and verbal presentation skills
- Excellent customer service and interpersonal skills

Abilities:

- Ability to work as part of a team while meeting and maintaining individual goals and objectives
- Ability to organize and manage other personnel

Manager of Network Development

Reports To: Director of Operations/ Acting Director of Network Development

Position Summary: This position is to create an educated and comprehensive provider network in all assigned territories. The preferred candidate will have experience contracting with Hospitals, PHOs, large provider groups, and individual practitioners for Medicaid, Medicare and Commercial Networks.

Essential Functions:

- Manage the external Provider Network Development Representatives staff and monitor their daily activities through ongoing communication and periodic audits. Ensure sufficient frequency of meetings and communication to meet the needs of MHP and its providers. At a minimum, ensure monthly visits to each PCP office and facilitate quarterly meetings with Hospital Providers.
- Ensure that Provider Network Development Representatives are properly educated and able to complete their assigned tasks. Conduct random monthly field oversight with each Provider Network Development Representatives to ensure that a positive relationship is maintained.
- Manage provider complaints and grievances jointly with internal staff as necessary. Ensure that all provider concerns are addressed in a timely and thorough manner as described in the Provider Manual and all policies and procedures.
- Develop and implement an Orientation Program for all providers who meet the credentialing requirements and who are accepted by the Credentialing Committee. The orientation should include:
 - Complete education regarding applicable MHP policies and procedures including authorizations and referrals, claims/encounters, provider utilization reports and the complaint and grievance procedures
 - Utilization of the MCS Provider Portal system as a tool to enhance the provider's practice
 - A review of the financial arrangements, including capitation or fee-for-service, covered services, reimbursement rates, payment schedules, bonus programs and risk sharing arrangements
 - The process for reporting feedback to other MHP departments
- Coordinate the development and distribution of provider education information such as the Provider Manual, Provider Bulletins, Provider Newsletters, etc.
- Coordinate and oversee education and communication with providers related to quality improvement and outreach initiatives, such as lead screening, Healthcare Effectiveness Data and Information Set (HEDIS), health fairs, disease management and other projects as necessary
- Ensure the effective and ongoing collaboration between the Provider Services Department and other MHP departments such as Member Services, Utilization Management, Quality Improvement, IT and Claims
- Represent the Provider Services Department at all Monthly Manager Meetings and additional internal Meridian Health Plan Meetings, as necessary. Attendance at all weekly Provider Service Department meetings is mandatory.
- Assist in preparing departmental information for State mandated site reviews and National Committee for Quality Assurance (NCQA), URAC, or general accreditation site visits, as necessary
- Perform other duties as assigned

Attachment 8 (Network Development & Management Job Descriptions)

Job Requirements:

Education:

- Bachelor's degree in business administration, healthcare administration, communications, marketing or other related field is required.

Experience:

- 3-5 years previous experience in a provider services role is required.
- Previous experience managing an external staff is required.

Knowledge:

- Thorough knowledge of MHP's mission and its operational structure
- Thorough knowledge of basic reimbursement methods and rates
- Thorough knowledge of MHP's provider policies and procedures as described in the Provider Manual
- Thorough knowledge of geographic areas in which MHP is licensed to operate, including types of providers in area, relationships between providers (PO, PHO, independent), key providers/decision makers, enrollee demographics and other competing health plans
- Knowledge of MHP's reimbursement methods including Primary Care, Specialty Care, Ancillary Care, Hospital and Organizational Master

Skills:

- Follow-up and follow-through skills
- Strong organizational skills
- Excellent communication and inter-personal skills
- Strong computer skills, including working knowledge of Microsoft Office and MHP's Managed Care System

Abilities:

- Ability to communicate clearly and concisely both orally and via written documents
- Ability to work as part of a team while meeting and maintaining individual goals and objectives
- Ability to organize and manage other personnel
- Ability to travel within the state, with limited overnight travel required

Provider Network Development Representative

Reports To: Manager of Network Development

Position Summary: This position is to create an educated and comprehensive provider network in all assigned territories.

Essential Functions:

- Prospecting to potential providers for inclusion in the Meridian Health Plan (MHP) Provider Network
- Coordinating the entire contracting process for all potential providers, including prospecting, negotiation, credentialing and orientation
- Collecting all practitioner and ancillary signed contracts, applications and necessary credentialing information. Ensuring MHP's credentialing standards are maintained.
- Educating providers on MHP's provider policies and procedures
- Increasing Healthcare Effectiveness Data and Information Set (HEDIS) scores in the assigned territory
- Special projects related to provider development and education
- Provider network reporting for State expansion requirements
- Assist contracted MHP providers with access to the Provider Portal. Provide ongoing education on the use and tools of the Provider Portal
- Provide exceptional customer service to our Provider Network.
- Complete change forms and top sheets when needed to update Provider changes and or additions in MCS (complete and submit appropriate documentation for proper set up in MCS)
- Provide training for Level 1 staff
- Provide training and mentoring for Provider Network Development Representatives in other states
- Perform other duties as assigned

Job Requirements:

Education:

- High School Diploma is required.
- Pursuit of Associates degree, Bachelors degree or job-related certification preferred.

Experience:

- One to three years of provider services or managed care experience is required.

Knowledge:

- Thorough knowledge of Practitioner, Hospital, and Ancillary Agreements
- Thorough knowledge of credentialing requirements for all providers
- Thorough knowledge of managed care reimbursement methods
- Thorough knowledge of Medicaid managed care, reimbursement, and Medicaid/Medicare guidelines

Skills:

- Computer skills, including working knowledge of Excel and Oracle software
- Follow up skills, with a "do whatever it takes" attitude
- Organizational skills

Attachment 8 (Network Development & Management Job Descriptions)

Abilities:

- Ability to communicate clearly and concisely both orally and in writing
- Ability to work as part of a team while maintaining and exceeding individual goals and objectives

Manager of Provider Data Analytics

Reports To: Director of Corporate Provider Services and Credentialing/Provider Services Manager

Position Summary: This position is to assist the Director of Corporate Provider Services and Credentialing in the day to day operations and auditing of the Corporate Provider Service department and to oversee the Corporate Provider Services Analyst staff to maintain a complete and accurate provider network in all MHP service areas.

Essential Functions:

- Complete and submit weekly production reporting for the Corporate Provider Services and Credentialing departments.
- Provide subject matter expertise within the department for assigned topics or projects
- Conduct weekly auditing of the integrity of data entered into the Managed Care System, including duplicate entries
- Identify and promptly correct any data entry errors or inconsistencies within the Managed Care System
- Oversee routine auditing of provider files including applications, contracts and facility site reviews in electronic and hard copy form, as well as the exporting of provider data and coordinating with the Credentialing and Finance departments
- Ensuring MHP's credentialing standards are maintained as well as maintaining accurate provider data through update forms and claim information
- Reporting of contracted providers through spreadsheets and provider directories
- Performing and preparing analysis of provider data for committees and meetings
- Oversight of monthly network access reports for all MHP lines of business
- Responsible for the oversight of the creation of various reports used to ensure compliance with state and federal requirements and ensure compliance with requirements of all national and State regulatory agencies, including NCQA, URAC, CMS or general accreditation
- Coordinate dissemination of provider network and credentialing compliance information to other Caidan Management Departments
- Coordinate preparation for regulatory accreditation reviews of provider network and credentialing activities
- Maintain strict confidentiality of employee and organizational information in accordance with HIPAA and State privacy regulations
- Occasional special projects related to provider services, quality improvement coordination and data management
- Assist with planning, development and implementation of projects/activities of the Corporate Provider Services department to support corporate operations Assist with the training and mentoring of the Corporate Provider Services and Credentialing teams
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree in business administration, healthcare administration, communications, marketing or other related field is preferred.

Attachment 9 (Performance Data Reporting & Encounter Claims Submission
Job Descriptions)

Experience:

- 3-5 years previous experience in a provider services role is required.
- Prior experience in a managed care setting is strongly preferred.

Knowledge:

- Advanced knowledge of MHP's philosophy and organizational structure
- Thorough knowledge of MHP's provider policies and procedures as described in the Provider Manual
- Thorough knowledge of geographic areas in which MHP is licensed to operate, including, types of providers in area, relationships between providers (PO, PHO, independent) and key providers/decision makers
- Understanding of Healthcare Effectiveness Data Information Set (HEDIS) reporting and HIPAA regulations
- Thorough knowledge of MHP's contracts including Practitioner, Ancillary, Hospital and Delegated Agreements
- Knowledge of basic reimbursement methods and rates
- Knowledge of managed care, including but not limited to, guidelines, reimbursement and competitors

Skills:

- Strong organizational and project management skills
- Strong customer service skills, including follow-up and follow through skills
- Computer skills including working knowledge of software products: Word, Excel, Oracle, Publisher, Quest Analytics

Abilities:

- Ability to communicate clearly and concisely both orally and via written documents
- Ability to work as part of a team while meeting and maintaining individual goals and objectives
- Ability to organize and manage the activities of other personnel
- Ability to prioritize workload and respond to multiple competing deadlines

Corporate Provider Services Analyst

Reports To: Manager of Provider Data Analytics

Position Summary: This position is responsible for research and analysis of all Caidan Managements current and potential lines of business with an emphasis on expansion of Caidan Management Company through new customer development and increased market share for Meridian Health Plan, Meridian Advantage and MeridianRx. This position also provides support activities as well as assisting in reporting and specific projects for the Corporate Provider Services Department.

Essential Functions:

- Complete and provide analysis of access availability reporting for all Caidan Management current and potential lines of business
- Assist in identifying and analyzing requests for proposals and assist in successful responses for Meridian Health Plan, Meridian Advantage and MeridianRx
- Assist in Prospecting and generating leads of potential providers
- Creation of formal proposals and presentations working closely with the Communications Department, Director of Provider Network Development and Director of Corporate Provider Services and Credentialing
- Complete and submit weekly production reporting for the Corporate Provider Services and Credentialing departments.
- Conduct weekly auditing of the integrity of data entered into the Managed Care System, including duplicate entries
- Identify and promptly correct any data entry errors or inconsistencies within the Managed Care System
- Complete routine auditing of provider files including applications, contracts and facility site reviews in electronic and hard copy form, as well as the exporting of provider data and coordinating with the Credentialing and Finance departments
- Ensuring MHP's credentialing standards are maintained as well as maintaining accurate provider data through update forms and claim information
- Reporting of contracted providers through spreadsheets and provider directories
- Performing and preparing analysis of provider data for committees and meetings
- Responsible for the oversight of the creation of various reports used to ensure compliance with state and federal requirements
- Assure compliance with requirements of all national and State regulatory agencies, including NCQA, URAC, CMS or general accreditation
- Assist in special projects assigned by the Executive Team

Job Requirements:

Education:

- Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is required.

Knowledge:

- Thorough knowledge of CMC's mission and its operational structure
- Thorough knowledge of managed health care industry
- Thorough knowledge of CMC's provider policies and procedures

Attachment 9 (Performance Data Reporting & Encounter Claims Submission
Job Descriptions)

Skills:

- Follow-up and follow-through skills
- Strong organizational skills
- Excellent communication, analytical and financial skills
- Strong writing and presentation skills.
- Strong knowledge of MS office, Excel, Access

Abilities:

- Ability to communicate clearly and concisely both orally and via written documents
- Ability to work as part of a team while meeting and maintaining individual goals and objectives
- Leadership capabilities, self-motivation and outstanding ability to sell
- Oral and written communication skills
- Current driver's license and willingness to travel
- Computer skills with MS Office, databases, Internet searches, etc.

Manager of Enrollment

Reports To: Senior Vice President of Corporate Operations

Position Summary: This position is responsible for maintaining the entire enrollment process. The Manager of Enrollment will oversee a team that is tasked with preparing, processing and maintaining new member or group enrollments. The Manager of Enrollment will analyze and report on the transactional data and production of the Enrollment team. The Manager of Enrollment will act as the liaison between Operations/ Enrollment and other internal departments as well as external clients and vendors as it relates to the Plan's Enrollment, Eligibility and Premium Billing standards and workflows.

Essential Functions:

- Ensure all transactions are processed according to CMS guidelines.
- Ensure policy and work flow incorporates a view of transactions from a member perspective and that actions taken enhance the member experience.
- Conduct ongoing analysis of performance for continuous process improvements, improved efficiency, and improved customer satisfaction.
- Provide management with overall status reports, including any issues that may impact the organization.
- Conduct assessment of current operations, developing and implementing short-and long-term improvements, maintaining regulatory compliance, and working with appropriate functional areas to implement tactical and strategic initiatives.
- Develop and monitor performance reports, including member notifications to assure turnaround times are met.
- Manage the team(s) to meet operational and program performance metrics consistent with the client(s) services and level agreements ("SLA").
- Manage floor operations to guarantee success in meeting all operations effectiveness and efficiencies measurements, including, but not limited to, work queues, manual transaction reply codes, error codes, membership reconciliation: MMR, MPWR, LIS/LEP and other CMS files.
- Responsible for managing the daily workflow for the department to ensure understanding and execution of strategies to meet client SLA's.
- Provide guidance on escalated customer service calls.
- Responsible for ensuring supervisory staff is effectively communicating results, targets and strategies to team members.
- Set, Maintains and reviews productivity goals.
- Performs periodic reviews to improve quality and efficiencies in the department. Recommend changes to processes accordingly.
- Maintain department policies and procedures in coordination with supervisory staff, director of operations and compliance department.
- Work with Compliance audit department on CMS releases and internal quarterly audit findings.
- Ensure corrective action plans are executed as a result of compliance and quality assurance audits.
- Work with IT and/ or Program Manager on system enhancement requirements and user acceptance testing.

Attachment 9 (Performance Data Reporting & Encounter Claims Submission
Job Descriptions)

Job Requirements:

Education:

- Bachelor's degree is required.

Experience:

- Minimum of 3 years of experience in Medicare eligibility and enrollment work.
- Experience with CMS audits preferred.

Knowledge:

- Broad knowledge of Medicare regulations and guidance including, but not limited to the Medicare Managed Care Manual and the Medicare Prescription Drug Benefit manual.
- In-depth experience with Medicare operations within a managed care organization.

Skills:

- Strong organization skills.
- Strong analytical skills.
- Strong leadership and management traits and ability to work in a collaborative environment effectively.
- Strong computer skills, including Microsoft Office suite, especially Excel, Word and PowerPoint.
- Excellent written, verbal, presentation skills and inter-personal skills.

Abilities:

- Must be able to interact with a variety of organizational areas within the organization.
- Ability to motivate others toward achievement of common goals
- Ability to track issues to ensure they are resolved from beginning to end within an appropriate time frame.

Encounter Specialist

Reports To: Manager of Enrollment

Position Summary: This position is responsible for encounter data submission, monitoring, resubmission, and error mitigation along with all other procedures relating to the enrollment/disenrollment process for all lines of business within Caidan Management Company (CMC).

Essential Functions:

- Oversees the preparation, processing and maintenance of encounter data for all lines of business
- Monitors encounter data transactions in order to identify any issues with load and processing
- Serves as the subject matter expert with encounter data and reconciliation for the organization
- Verify 5010 834 compliance is being met while maintaining data integrity
- Works closely with EDI to test and verify any changes made in processing
- Notifies EDI if a file is not received, or the file is not as expected
- Works closely with IT to test and verify any changes made in processing
- Notifies IT if a submission, or the file is not as expected
- Serves as the subject matter expert regarding companion guides for files and processing
- Reports encounter and reconciliation trends and issues to leadership on a weekly basis
- Understands State and CMS encounter data and reconciliation mechanisms
- Responsible for notifying leadership of any encounter issues
- Responsible for reporting potential edits that would streamline process for encounters
- Completes all projects as needed for other members of the department when researching encounter or reconciliation issues
- Responsible for collecting and transmitting data elements specified by CMS for the purpose of encounter data
- Monthly financial reconciliation and issue identification
- Maintains strict confidentiality of member information in accordance with Caidan/HIPAA Privacy Policies
- Performs other duties as assigned

Job Requirements:

Education:

- High school diploma is required.
- Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is preferred.

Experience:

- One to three years of experience in a Managed Care setting is preferred.
- Two years of experience with MHP's Managed Care System (MCS) is preferred.
- Medicare experience preferred

Knowledge:

- Working knowledge in Microsoft Office applications (Outlook, Word, Excel, etc.)
- Knowledge of 5010 834 Formats and Companion Guidelines
- Knowledge of customer relations and team participation

Attachment 9 (Performance Data Reporting & Encounter Claims Submission
Job Descriptions)

Skills:

- Accuracy in data entry
- Grammar and punctuation skills
- Competency in telephone handling
- Demonstrated written and verbal communication skills
- Multi-tasking and prioritizing tasks at hand

Abilities:

- The ability to work within multiple departmental teams and successfully identify and resolve issues relating to enrollment and eligibility
- The ability to manage and coordinate multiple time sensitive tasks

Pharmacy Analyst

Reports To: Deputy Director of Operational Analytics

Position Summary: This position provides varied, complex and confidential management and operational analysis in support of the department. This position is responsible to gather, analyze, and manage the data needs of MeridianRx. The position helps to develop and communicate technical specifications that are necessary to meet the regulatory, management, quality and clinical data needs. As necessary the position will also be responsible for providing operational support for the pharmacy department. This includes responding to internal and external requests for assistance with authorizations, medication profiles and other clinical and operational pharmacy processes.

Essential Functions:

- Assist pharmacy technician staff in data retrieval and analysis, patient communications (mail, FAX, phone), and other duties as identified
- Assist providers with obtaining clinically appropriate medications for members via the prior authorization process
- Ensure accurate data entry and tracking of provider requests
- Collaborate with the client's utilization review, case management, and member services staff to ensure appropriate resource allocation and utilization by all members
- Assist in resolution of member issues related to pharmacy prescriptions
- Act as a liaison between MeridianRx and clients
- Request and maintain relevant client records, including medication prior authorizations, prior authorization appeals, telephone statistics and monthly utilization reports. Provide analysis and trending to the clients, where appropriate
- Maintain internal reporting and trending, including monthly drug spend, fraud waste and abuse findings, and staff productivity
- Respond to requests for standard medication profiles/utilization reports as requested by client
- Prepare quarterly status reports for the Pharmacy and Therapeutics Committee
- Provide support to client clinical and non-clinical departments to determine needs, resolve problems, improve processes and promote effective drug therapy
- Have knowledge of commonly-used concepts, practices and procedures within the pharmacy operations
- Assist department Care Coordinators with cases as needed
- Perform assigned tasks according to established guidelines
- Ensure compliance with all company, state and federal rules and regulations
- This position will spend at least 25% of their time on Quality Improvement projects and analysis
- This position may require:
 - Update formulary, both Medicaid and Medicare, as needed
 - Manage online formulary and formulary tools
 - Monitor First Data Bank data changes
 - Respond daily to after-hours voicemails from members and providers
 - Manage Manufacturer Disputes
 - Provide Medication Pricing
 - Manage Audit Reporting
 - Coordinate with analysts, Director and Manager of pharmacy to maintain compliance of URAC standards
 - Coordinate with analysts to implement and achieve quality improvement initiatives

Attachment 10 (Pharmacy Job Descriptions)

- Assist in the collection of Healthcare Effectiveness Data and Information Set (HEDIS) data
- Manage information on intranet site
- Monitor claim alerts and track for fraud and abuse; report any possible fraud or abuse to appropriate manager
- Track Medicare transition claims, mail member notification letter and assist members with a smooth transition to formulary medications
- Receive PDE response file and review for error correction
- Upload required Medicare documents to HPMS and Acumen
- Remain updated on all member and provider policy changes made by CMS
- Take incoming/outgoing calls to assist members and providers with the appeals process
- Assist with all Administrative Hearing Requests; Develop informational review packets to be review by the Director of Pharmacy and Chief Medical Officer
- Assist with all OFIR requests
- Create and mail all member and provider appeal letters
- Train new staff members on the appeal process
- Perform onsite and/or desktop pharmacy audits
- Prepare pharmacy audit materials for committee review
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree in health care related field or a Fellow Designation from the Academy of Healthcare Management is required
- Must pass the MHP Analyst Assessment.

Experience:

- At least one year experience in a professional office environment and/or customer call center is required
- Experience in a Managed Care environment is preferred

Knowledge:

- Basic knowledge of drug products, dosage forms and usage, as well as retail pharmacy operations
- Knowledge of medical and pharmaceutical terminology
- Knowledge and/or experience in work teams

Skills:

- Excellent customer service and interpersonal communication skills; maintains professional demeanor
- Computer/data entry skills; proficient in data warehouse, database, word processing and spreadsheet applications
- Detail-oriented with strong organizational skills
- Telephone service skills

Abilities:

- Ability to work with minimal management oversight on multiple projects with competing priorities
- Ability to prioritize work and function under time constraints
- Ability to work with confidential information
- Ability and desire to work in a team atmosphere

Behavioral Health Care Coordinator

Reports to: Manager of Quality

Position Summary: This position works collaboratively with the Member Services, Utilization Management and Quality Improvement Departments. The position assigns members to appropriate providers for assessment and counseling and is responsible for ensuring that those services are handled appropriately.

Essential Functions:

- Manages and arrange for behavioral health services for our most at risk and vulnerable members with mental health impairments (including but not limited to chemical/SA issues, and SPMI).
- Provides smoking cessation interventions to members enrolled in MHP smoking cessation program, if assigned.
- Conducts complete, timely and accurate Behavioral Health Assessments (telephonically).
- Identifies needed mental health referrals, and pre-referral guidelines, while providing appropriate and timely clinical information to the member's PCP and specialists.
- Assist members in solving access to care issues, such as coordinating transportation, interpreters, cultural resources and community resources.
- Works with the PCP, specialist, HHC and DME vendors, and other participants in the member's care to establish a plan of care with desired outcomes/goals based on HRA data including biological, psychological and social assessments
- Uses multiple case finding mechanisms and population specific assessment tools to identify and assess individuals with catastrophic, complex or chronic risk factors who meet established criteria to receive BH Care Coordination. Assigns level of care (risk) based on established protocols.
- Manages telephone inquiries by logging into appropriate phone queue and handling or forwarding calls as needed
- Receives and organizes authorization requests via fax or telephone
- Enters demographic data into MCS making certain that all data fields are correct and all necessary CPT, ICD-9 and diagnostic codes are entered. Utilizes appropriate resources or contacts provider offices to clarify information as needed.
- Forwards corporate authorization requests and accompanying behavioral healthcare information to the Behavioral Health Case Manager
- Faxes processed requests back to appropriate provider offices
- Makes outgoing calls to members to conduct outreach related to MHP behavioral health priorities
- In conjunction with the Behavioral Health Care Coordinator Team Lead, acts as a resource for other staff with respect to criteria and benefit interpretation including the correct and consistent application of procedural practices established by MHP
- Regularly meets or exceeds team and individual production goals
- Perform other duties as assigned

Attachment 10 (Pharmacy Job Descriptions)

Job Requirements:

Education:

- Bachelor's degree in Social Work, psychology, nursing or health services related field or Fellow, Academy for Healthcare Management (AHM) designation is required.

Experience:

- At least one to two years of customer services experience or related health care industry experience is required.

Knowledge:

- Must possess working knowledge of DCH regulations
- Knowledge of managed care
- Knowledge of case management processes including tools and techniques for identification, stratification and management of high-risk clients

Skills:

- Excellent organizational and critical thinking skills
- Skilled in developing and managing databases for tracking member caseloads
- Skilled in conducting telephone based assessments

Abilities:

- Ability to prioritize and coordinate member care needs
- Ability to manage multiple tasks simultaneously
- Ability to work collaboratively and effectively with diverse groups
- Ability to function as part of an interdisciplinary team
- Must be able to function independently and have flexibility, personal integrity, and the ability to work effectively with residents, staff, and support agencies

Pharmacy Care Coordinator

Reports to: Manager of Quality

Position Summary: This position is responsible for providing operational support for the Coordination of Care Team. This includes responding to internal and external requests for assistance with authorizations, medication profiles and other clinical pharmacy processes. This position will also coordinate activities and provide oversight of the Pharmacy Benefits Manager (PBM).

Essential Functions:

- Serve as a medication information and formulary resource within the Care Coordination Teams
- Set appropriate goals, barriers and follow up dates for all members that are reviewed
- Follow in track all members that are being discharged from inpatient stays facilitating access appropriate discharge medications
- Review all cases with notations, assessment, and documentation of all Care Coordination activities
- Review Prior Authorizations for members in their Care Coordination Team
- Deny Prior Authorizations based on strict criteria for members in their Care Coordination Team
- Act as a backup and answer incoming calls in the Pharmacy and Medicare Part D queue
- Review and approve denial, appeal, and intervention letters
- Have knowledge of commonly-used concepts, practices and procedures within pharmacy operations
- Provide excellent customer service to all callers, at all times
- Perform assigned tasks according to established guidelines
- Ensure compliance with all company, state and federal rules and regulations
- Perform other duties as assigned

Job Requirements:

Education:

- High School Diploma or GED is required
- * Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is preferred; or

License:

- Licensed Pharmacy Technician who has completed a Certified Pharmacy Technician training program or equivalent board certification is required

Experience:

- One to three years of related experience and/or training in pharmacy prior authorization and pharmacy technician processes in a managed care setting is required.

Knowledge:

- Expert knowledge of drug products, dosage forms and usage, as well as retail pharmacy operations is preferred
- Knowledge of medical and pharmaceutical terminology
- Knowledge of managed care and authorization processes
- Knowledge and/or experience in work teams

Attachment 10 (Pharmacy Job Descriptions)

Skills:

- Excellent customer service and interpersonal communication skills; maintains professional demeanor
- Computer/data entry skills; proficient in data warehouse, database, word processing and spreadsheet applications
- Detail-oriented with strong organizational skills
- Telephone service skills

Abilities:

- Ability to work with minimal management oversight on multiple projects with competing priorities
- Ability to prioritize work and function under time constraints
- Ability to work with confidential information
- Ability and desire to work in a team atmosphere

Claims Reviewer

Reports To: Manager of Pharmacy Call Center Operations

Position Summary: This position is responsible for providing operational support for the MeridianRx pharmacy department. This includes responding to internal and external requests for assistance with authorizations, medication profiles and other clinical and operational pharmacy processes.

Essential Functions:

- Assist client's providers with obtaining clinically appropriate medications for the client's members via the prior authorization process
- Ensure accurate data entry and tracking of provider requests
- Enter new Prior Authorizations from the fax queue in PBM & MCS
- Answer incoming calls in the Pharmacy and Medicare Part D queue
- Collaborate with the client's existing utilization review, case management, and member services staff to ensure appropriate resource allocation and utilization by all members
- Assist in resolution of member issues related to pharmacy prescriptions
- Act as a liaison between MeridianRx, providers, and the client
- Respond to client requests for standard medication profiles/utilization reports
- Review and approve denial, appeal, and intervention letters
- Review and analyze all incoming claims to ensure the claims pay out or reject appropriately
- Provide support to clients clinical and non-clinical departments to determine needs, resolve problems, improve processes and promote effective drug therapy
- Have knowledge of commonly-used concepts, practices and procedures within pharmacy operations
- Provide excellent customer service to all callers, at all times
- Perform assigned tasks according to established guidelines
- Ensure compliance with all company, state and federal rules and regulations
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma or GED is required.

Licensure:

- Registered Pharmacy Technician who has completed a Certified Pharmacy Technician training program or equivalent experience is preferred.
- Enrollment in a certification program at time of hire and completion of certification program within one year is preferred.

Experience:

- At least two years of related experience and/or training in pharmacy prior authorization and pharmacy technician processes is preferred

Knowledge:

- Expert knowledge of drug products, dosage forms and usage, as well as retail pharmacy operations is preferred
- Knowledge of medical and pharmaceutical terminology
- Knowledge of managed care and authorization processes

Attachment 10 (Pharmacy Job Descriptions)

- Knowledge and/or experience in work teams

Skills:

- Excellent customer service and interpersonal communication skills; maintains professional demeanor
- Computer/data entry skills; proficient in data warehouse, database, word processing and spreadsheet applications
- Detail-oriented with strong organizational skills
- Telephone service skills

Abilities:

- Ability to work with minimal management oversight on multiple projects with competing priorities
- Ability to prioritize work and function under time constraints
- Ability to work with confidential information
- Ability and desire to work in a team atmosphere

Pharmacy Data Entry Specialist

Reports to: Manager of Pharmacy Call Center Operations

Position Summary: This position is responsible for providing operational support for the MeridianRx pharmacy department. This includes responding to internal and external requests for assistance with authorizations, medication profiles and other clinical and operational pharmacy processes.

Essential Functions:

- Enter coverage determination requests in both MERLIN and MCS
- Coordinate with pharmacists to quickly render a decision on requests close to their expiring timeframe
- Develop a plan to reduce the amount of steps taken when entering a prior authorizations by completing the coverage determination request on the first step
- Develop tools to determine when requests should be approved or denied
- Monitor and process redeterminations, direct member reimbursement requests and universal claim form requests
- Collaborate with Manager of Pharmacy Call Center when creating new innovative ideas to enhance the PBM system
- Perform timely entry of data into systems, validating data accuracy and preventing erroneous or duplicate entries
- Propose recommendations to procedures and workflow to enhance quality and productivity
- Proactively send out pharmacy letters to meet compliance requirements
- Have knowledge of commonly-used concepts, practices and procedures within pharmacy operations
- Perform assigned tasks according to established guidelines
- Ensure compliance with all company, state and federal rules and regulations
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma or GED is required.

Licensure:

- Registered Pharmacy Technician who has completed a Certified Pharmacy Technician training program or equivalent experience is preferred.
- Enrollment in a certification program within the first 60 days of employment is required
- Completion of certification program within six (6) months is required

Experience:

- Six (6) months to One (1) year of related experience and/or training in pharmacy prior authorization and pharmacy technician processes is preferred

Knowledge:

Knowledge of drug products, dosage forms and usage, as well as retail pharmacy operations is preferred

- Knowledge of medical and pharmaceutical terminology
- Knowledge of managed care and authorization processes
- Knowledge and/or experience in work teams

Attachment 10 (Pharmacy Job Descriptions)

Skills:

- Excellent customer service and interpersonal communication skills; maintains professional demeanor
- Computer/data entry skills; proficient in data warehouse, database, word processing and spreadsheet applications
- Detail-oriented with strong organizational skills
- Telephone service skills

Abilities:

- Ability to work with minimal management oversight on multiple projects with competing priorities
- Ability to prioritize work and function under time constraints
- Ability to work with confidential information
- Ability and desire to work in a team atmosphere

Pharmacy Operations Trainer

Reports To: Manager of Pharmacy Call Center Operations

Position Summary: This position coordinates training for MeridianRx. This position must work cooperatively with multiple teams that may include: the Pharmacy Care Coordination Team, Clinical Operations, Call Center Operations, MeridianRx Network Development Team, Information Systems and all internal and external clients. This position also will serve as the liaison between CMC Corporate Training and MeridianRx on-site training.

Essential Functions:

- Training of all new hire employees in broad MeridianRx Overview
- Coordination and training of all new employees in Call Center Technical and Clinical Operations
- Coordination and training of Prior Authorization MERLIN Processes
- Training of Member and Provider Appeals
- Review of Grievance Module
- Overview and Coordination of MTM (level as appropriate for position)
- Overview of FWA and audit triggers for Network Pharmacies
- Overview and Coordination of Pharmacy Care Coordination (level as appropriate for position)
- URAC Overview and PBM Standards
- Member safety and High Risk Member Training
- Retrospective analysis for specific Clients
- Intervention Letter Module Creation and Review Training
- Formulary Training all LOB
- Medicare Training on all lines, including MMAI, PDP, MAPD, SNP
- Star Ratings and HEDIS training as related to Pharmacy Operations
- Transition Module Training for LOB
- Letters Module and Creation Training
- Overview of Medical Benefit Medication Programs and all processes
- Assists members in problem solving potential issues related to the health care system, such as need for transportation, interpreters, help new staff understand services of all clients, including waiver related programs
- Must create and maintain strong communication with all MRx Departments including Operations, Clinical, Finance, Network and Sales and develop training aids that support implementation of new programs across all departments.
- Maintains HIPAA standards and confidentiality of protected health information; and
- Assists with training new Care Coordination staff as related to Pharmacy
- Act as a Subject Matter Expert (SME) on all Client Specific Programs
- Work with training department to develop new training materials.
- Conduct training sessions to instruct new hires and current staff on all aspects of the department to meet accreditation standards.
 - New hire care coordination training for new employees in collaboration with the training department.
 - Work in conjunction with the departmental managers to identify areas where additional training for staff is required and assist with such training
 - Act as the super user of the department for other CMC staff
- Document training sessions and all materials to meet accreditation and corporate standards.

Attachment 10 (Pharmacy Job Descriptions)

- Create testing to evaluate retention of training by staff
- Assist in updating training checklists annually
- Provide feedback to the leadership team on status of training and staff comprehension.
- Make recommendations to implement improved processes
- Work in collaboration with Management team to develop job aides for the care coordination staff.
- Perform other duties as assigned.

Job Requirements:

Education:

- High School Diploma or GED is required.
- Bachelor's Degree in a healthcare related field is preferred

Licensure:

- Licensed Pharmacy Technician who has completed a Certified Pharmacy Technician training program or equivalent board certification is preferred

Knowledge:

- Must demonstrate customer focused interpersonal skills to interact in an effective manner with new and current staff.
- Must also demonstrate the ability to work autonomously, follow through with delegated tasks and be directly accountable for deliverables.
- Must have leadership qualities including time management, verbal and written communication skills, listening skills, problem solving and decision-making, priority setting, work delegation and work organization, as well as strong customer service focus, teamwork orientation and resourcefulness in problem solving.

Experience:

- At least three or more years of customer service experience or related health care industry experience is required.
- Experience in Call Center Operations is required.

Skills:

- Demonstrates excellent communication – both verbal and written
- Excellent interpersonal and facilitation skills

Abilities:

- Must have the ability to affect change, work as a productive and effective team member and adapt to changing needs/priorities

Outreach Coordinator

Reports to: Manager of Quality

Position Summary: This position is responsible for providing operational support for the MeridianRx pharmacy department for all outbound communication. This includes but is not limited to outbound letters and/or calls concerning quality improvement, HEDIS, Medicare required communications, and impact analysis.

Essential Functions:

- Assist pharmacy operations staff in data retrieval, analysis, and patient communications including mail, Fax, phone.
- Provide outreach and engagement services to our members related to HEDIS and Medicare Star Ratings.
- Obtain and record necessary data required to improve HEDIS and Star Ratings outcomes.
- Provide support to various pharmacy departments by conducting outbound communications to assist with impact analysis outreach.
- Assist in resolution of member issues related to pharmacy prescriptions
- Conduct Medicare outreach
- Reach out to prescribers offices to obtain supporting statements or coverage determination requests as needed
- Act as a liaison between MeridianRx, providers, and the client
- Have knowledge of commonly-used concepts, practices and procedures within pharmacy operations
- Provide excellent customer service to all members, providers, and customers at all times
- Perform assigned tasks according to established guidelines
- Ensure compliance with all company, state and federal rules and regulations
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma or GED is required.

Licensure:

- Registered Pharmacy Technician who has completed a Certified Pharmacy Technician training program or equivalent experience is preferred.
- Enrollment in a certification program within the first 60 days of employment is required
- Completion of certification program within six (6) months is required

Experience:

- Six (6) months to One (1) year of related experience and/or training in pharmacy prior authorization and pharmacy technician processes is preferred

Knowledge:

Knowledge of drug products, dosage forms and usage, as well as retail pharmacy operations is preferred

- Knowledge of medical and pharmaceutical terminology
- Knowledge of managed care and authorization processes
- Knowledge and/or experience in work teams

Attachment 10 (Pharmacy Job Descriptions)

Skills:

- Excellent customer service and interpersonal communication skills; maintains professional demeanor
- Computer/data entry skills; proficient in data warehouse, database, word processing and spreadsheet applications
- Detail-oriented with strong organizational skills
- Telephone service skills

Abilities:

- Ability to work with minimal management oversight on multiple projects with competing priorities
- Ability to prioritize work and function under time constraints
- Ability to work with confidential information
- Ability and desire to work in a team atmosphere

Pharmacy Technician

Reports to: Manager of Pharmacy Call Center Operations

Position Summary: This position is responsible for providing operational support for the MeridianRx pharmacy department. This includes responding to internal and external requests for assistance with authorizations, medication profiles and other clinical and operational pharmacy processes.

Essential Functions:

- Assist client's providers with obtaining clinically appropriate medications for the client's members via the prior authorization process
- Ensure accurate data entry and tracking of provider requests
- Enter new Prior Authorizations from the fax queue in PBM & MCS
- Answer incoming calls in the Pharmacy and Medicare Part D queue
- Collaborate with the client's existing utilization review, case management, and member services staff to ensure appropriate resource allocation and utilization by all members
- Assist in resolution of member issues related to pharmacy prescriptions
- Act as a liaison between MeridianRx, providers, and the client
- Respond to client requests for standard medication profiles/utilization reports
- Review and approve denial, appeal, and intervention letters
- Provide support to clients clinical and non-clinical departments to determine needs, resolve problems, improve processes and promote effective drug therapy
- Have knowledge of commonly-used concepts, practices and procedures within pharmacy operations
- Provide excellent customer service to all callers, at all times
- Perform assigned tasks according to established guidelines
- Ensure compliance with all company, state and federal rules and regulations
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma or GED is required.

License:

- Licensed Pharmacy Technician who has completed a Certified Pharmacy Technician training program or equivalent experience is preferred.
- Completion of certification program within six (6) months or a defined timeframe as designated by COO is required

Experience:

- At least two years of related experience and/or training in pharmacy prior authorization and pharmacy technician processes is preferred
- Knowledge:
- Expert knowledge of drug products, dosage forms and usage, as well as retail pharmacy operations is preferred
- Knowledge of medical and pharmaceutical terminology
- Knowledge of managed care and authorization processes
- Knowledge and/or experience in work teams

Attachment 10 (Pharmacy Job Descriptions)

Skills:

- Excellent customer service and interpersonal communication skills; maintains professional demeanor
- Computer/data entry skills; proficient in data warehouse, database, word processing and spreadsheet applications
- Detail-oriented with strong organizational skills
- Telephone service skills

Abilities:

- Ability to work with minimal management oversight on multiple projects with competing priorities
- Ability to prioritize work and function under time constraints
- Ability to work with confidential information
- Ability and desire to work in a team atmosphere

Pharmacist

Reports to: Manager of Clinical Operations

Position Summary: This position is responsible for providing clinical pharmacy services for MeridianRx. Coordinates the distribution of clinical drug and disease information and educates providers and staff regarding appropriate use of pharmaceutical treatment regimens.

Essential Functions:

- Improves quality of service to members by providing prior authorization of formulary drugs, developing programs to provide optimal pharmaceutical care to patients, participating in dispute resolution of drug utilization review, measuring and documenting improvements in patient care, and/or improving claim adjudication for proper provider reimbursement
- Collaborates with other medical management team members in developing treatment guidelines and demonstrates the impact of these guidelines
- Participates in the maintenance of the non-formulary exception program
- Participate and review in the utilization management process, including authorizations, denials and appeals.
- Participates in formulary development and management
- Monitors prescribing patterns of participating physicians. Makes recommendations to physicians to improve medication regimens as appropriate.
- Participates in the development and maintenance of processes that incorporate pharmacy data and clinical information obtained in the pharmacy authorization process into client Healthcare Effectiveness Data and Information Set (HEDIS) reporting
- Responds to provider and member questions regarding the pharmacy benefits program.
- Assist with drug recall and alert communication and safety program.
- Assists with the preparation and distribution of communication materials between the plan and participating providers
- Assists the pharmacy care coordinator with drug information and review of complex cases.
- Participates in the preparation of state-required reports for review and submission at the Pharmacy and Therapeutics Committee meetings
- Perform MTM to our Clients members.
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's in Pharmacy is required.
- PharmD or graduate degree is required.
- Residency and/or Board Certification is preferred

Licensure:

- Current unrestricted Pharmacist and Controlled Substance licenses in the designated state and in good standing are required.

Experience:

One to two years of experience in managed health care or pharmacy programs is required.

- Previous experience in Medicaid programs is strongly preferred.

Attachment 10 (Pharmacy Job Descriptions)

Knowledge:

- Knowledge of the National Committee for Quality Assurance (NCQA), URAC or general accreditation standards for managed care organizations as they relate to pharmacy programs and delegation
- Knowledge of pharmacy utilization management processes and documentation
- Familiar with clinical program components, formulary designs, and prescription drug benefit trends

Skills:

- Excellent written, verbal and presentation skills
- Excellent inter-personal and team building skills
- Strong computer skills, including Microsoft Office (Word, Excel, PowerPoint)
- Strong analytical and data interpretation skills

Abilities:

- Ability to work cooperatively with peers and subordinates
- Ability to motivate others toward achievement of common goals
- Ability to think creatively to resolve common barriers and issues

Specialty Pharmacy Technician

Reports to: Manager of Specialty Pharmacy

Position Summary: This position is responsible for providing operational support for the MeridianRx pharmacy department. This includes responding to internal and external requests for assistance with authorizations, medication profiles and other clinical and operational pharmacy processes.

Essential Functions:

- Assist client's providers with obtaining clinically appropriate medications for the client's members via the prior authorization process
- Answer incoming calls in the Pharmacy and Medicare Part D queue
- Ensure accurate data entry and tracking of provider requests
- Enter new prior authorizations from the fax queue in PBM & MCS
- Collaborate with the client's existing utilization review, case management, and member services staff to ensure appropriate resource allocation and utilization by all members
- Assist in resolution of member issues related to pharmacy prescriptions
- Act as a liaison between MeridianRx, providers, and the client
- Respond to client requests for standard medication profiles/utilization reports
- Have knowledge of commonly-used concepts, practices and procedures within pharmacy operations
- Provide excellent customer service to all callers, at all times
- Collaborate with Specialty Pharmacy Team Lead and Pharmacist with specialty related medications
- Review high cost and specialty medications
- Perform assigned tasks according to established guidelines
- Ensure compliance with all company, state and federal rules and regulations
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma or GED is required.

Licensure:

- Registered Pharmacy Technician who has completed a Certified Pharmacy Technician training program or equivalent experience is preferred.
- Enrollment in a certification program within the first 60 days of employment is required
- Completion of certification program within six (6) months is required

Experience:

- Six (6) months to One (1) year of related experience and/or training in pharmacy prior authorization and pharmacy technician processes is preferred

Knowledge:

Knowledge of drug products, dosage forms and usage, as well as retail pharmacy operations is preferred

- Knowledge of medical and pharmaceutical terminology
- Knowledge of managed care and authorization processes
- Knowledge and/or experience in work teams

Attachment 10 (Pharmacy Job Descriptions)

Skills:

- Excellent customer service and interpersonal communication skills; maintains professional demeanor
- Computer/data entry skills; proficient in data warehouse, database, word processing and spreadsheet applications
- Detail-oriented with strong organizational skills
- Telephone service skills

Abilities:

- Ability to work with minimal management oversight on multiple projects with competing priorities
- Ability to prioritize work and function under time constraints
- Ability to work with confidential information
- Ability and desire to work in a team atmosphere

Manager of Corporate Provider Services

Reports To: Director of Credentialing and Provider Analytics / Provider Services Manager

Position Summary: This position assists the department director in the day to day operations of the Corporate Provider Service department and oversees the Corporate Provider Services Representatives staff to maintain a complete and comprehensive provider network in all MHP service areas.

Essential Functions:

- Coordinate all incoming provider communications, phone, claims questions, mail, online chat and provider portal, including the education of providers on MHP's provider policies and procedures
- Assist with planning and development activities of the Corporate Provider Services department
- Provide training and mentoring of the Data Management staff
- Assist the Director of Corporate Provider Services and Credentialing with planning and implementing special projects to support corporate operations
- Provide subject matter expertise within the department for assigned topics or projects
- Oversight of new provider data entry in the Managed Care System
- Oversee the maintenance of provider files including applications, contracts and facility site reviews in electronic and hard copy form, provider changes and system updates, as well as the exporting of provider data and coordinating with the Credentialing and Finance departments
- Oversee the collection of all practitioner and ancillary signed contracts, applications and necessary credentialing information.
- Ensuring MHP's credentialing standards are maintained as well as maintaining accurate provider data through update forms and claim information
- Work collectively with the Manager of Provider Data Analytics to ensure accurate reporting of contracted providers through spreadsheets, provider directories and weekly production reporting for the Corporate Provider Services Representatives.
- Performing and preparing analysis of provider data for committees and meetings
- Occasional special projects related to provider services, quality improvement coordination and data management
- Assure compliance with requirements of all national and State regulatory agencies, including NCQA, URAC, CMS, or general accreditation
- Maintain strict confidentiality of employee and organizational information in accordance with HIPAA and State privacy regulations
- Initiate workgroups and meetings to develop productive communication and customer service pathways.
- Maintain and develop, where necessary, the MHP training manuals, policy, procedures and job aids
- Oversee the Corporate Provider Services phone queue
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree in business administration, healthcare administration, communications, marketing or other related field is required.

Attachment 11 (Provider Services & Provider Enrollment Job Descriptions)

Experience:

- 3-5 years previous experience in a provider services role is required.
- Prior experience in a managed care setting is strongly preferred.
- Prior call center experience is preferred

Knowledge:

- Advanced knowledge of MHP's philosophy and organizational structure
- Thorough knowledge of MHP's provider policies and procedures as described in the Provider Manual
- Thorough knowledge of geographic areas in which MHP is licensed to operate, including, types of providers in area, relationships between providers (PO, PHO, independent) and key providers/decision makers
- Understanding of Healthcare Effectiveness Data Information Set (HEDIS) reporting and HIPAA regulations
- Thorough knowledge of MHP's contracts including Practitioner, Ancillary, Hospital and Delegated Agreements
- Knowledge of basic reimbursement methods and rates
- Knowledge of managed care, guidelines, reimbursement and competitors

Skills:

- Strong organizational and project management skills
- Strong customer service skills, including follow-up and follow through skills
- Computer skills including working knowledge of software products: Word, Excel, Oracle, Publisher

Abilities:

- Ability to communicate clearly and concisely both orally and via written documents
- Ability to work as part of a team while meeting and maintaining individual goals and objectives
- Ability to organize and manage the activities of other personnel
- Ability to prioritize workload and respond to multiple competing deadlines

Senior Corporate Provider Services Representative

Reports To: Manager of Corporate Provider Services

Position Summary: This position is responsible for assisting with the activities of Corporate Provider Services Representative under the direction of the Manager of Corporate Provider Services. The position requires provider services, and contracting subject matter expertise. This position works closely with the Corporate Provider Services Representatives, Credentialing, Claims, Finance and Provider Network Development Representative to assure timely and accurate entry of provider demographic, contract affiliation, and fee schedule information into the health plan system. Responsible for researching claims processing guidelines, provider contracts, fee schedules and system configurations to determine root cause of payment error. The senior will represents Corporate Provider Services in the manager's absence.

Essential Functions:

- Train, mentor, and manage the Provider Services Team in cooperation with the Manager of Corporate Provider Services
- Act as lead contact with Network Management Representatives and Provider Service Representatives to facilitate issues regarding providers that need resolution
- Responsible for monitoring Provider Services phone queue
- Oversight of the activities of other Corporate Provider Service Representatives, including prioritizing duties
- Actively identifies opportunities for departmental efficiencies and implements new processes and procedures
- Provide back-up support for manager as administrative and customer liaison by taking necessary action and responding to inquiries in a timely manner
- Prospecting and responding to potential providers for inclusion in the MHP Provider Network
- Coordinating the entire contracting process for all potential providers, including prospecting, negotiation, credentialing and orientation
- Reviews all applications, provider requests and supporting documentation for accuracy and completeness and adds the information to the file according to policy, in a prompt, timely manner as directed per contractual guidelines
- Maintain knowledge of the credentialing requirements of all national, CMS and State agencies, including National Committee for Quality Assurance (NCQA), URAC, or general accreditation and support the Credentialing Manager in fulfilling credentialing department expectations
- Assist Manager of Corporate Provider Services conduct weekly auditing of the integrity of data entered into the Managed Care System, including duplicate entries
- Identifying and promptly correcting any data entry errors or inconsistencies within the Managed Care System
- Occasional special projects related to provider services
- Collecting all practitioner and ancillary signed contracts, applications and necessary credentialing information. Ensuring MHP's credentialing standards is maintained.
- Provide exceptional customer service to our Provider Network.
- Complete necessary forms to update Provider changes and or additions in MCS (complete and submit appropriate documentation for proper set up in MCS)
- Enters new provider data, provider demographic and contract affiliation information into the Managed Care System.
- Facilitate network expansion efforts by working closely with the Business Development Team
- Provide oversight and delegation of department workload
- Perform other duties as assigned

Attachment 11 (Provider Services & Provider Enrollment Job Descriptions)

Job Requirements:

Education:

- High school diploma is required.
- Pursuit of a Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is preferred.

Experience:

- Three or more years of managed care or provider services data management experience is required.

Knowledge:

- Strong Leadership Skills
- Knowledge of MHP's philosophy, organizational structure and plan overview
- Knowledge of MHP's Practitioner, Hospital and Ancillary Agreements
- Knowledge of managed care, credentialing, reimbursement and competitors
- Knowledge of MHP's provider manual, including policies and procedures
- Ability to perform independently, handle multiple projects simultaneously and problem solve
- Microsoft Office Suite knowledge (Outlook, Word, Excel, PowerPoint, Access)
- Ability to communicate comfortably and effectively with all levels of a healthcare organization, within both the corporate and regional market environments
- Ability to multitask and work in a fast-paced environment
- Excellent verbal and written communication skills
- Strong follow up skills, with a "do whatever it takes" attitude

Abilities:

- Ability to communicate clearly and concisely both orally and in writing
- Ability to work as part of a team while maintaining and exceeding individual goals and objectives
- Professional and pleasant demeanor
- Ability to prioritize workload

Corporate Provider Services Representative

Reports To: Manager of Corporate Provider Services

Position Summary: Under the direction of the Manager of Corporate Provider Services this position provides provider servicing and contracting subject matter expertise. This position works closely with the, Credentialing, Claims, Finance, Provider Data Analytics and Provider Network Development Representative to assure timely and accurate entry and resolution of provider demographic, contract affiliation, and fee schedule information into the health plan system. Responsible for researching provider claims issues, provider contracts, fee schedules to determine root cause of payment error.

Essential Functions:

- Reviews all applications, provider requests and supporting documentation for accuracy and completeness and adds the information to the file according to policy, in a prompt, timely manner as directed per contractual guidelines.
- Maintain knowledge of the credentialing requirements of all national, CMS and State agencies, including National Committee for Quality Assurance (NCQA), URAC, or general accreditation and support the Credentialing Manager in fulfilling credentialing department expectations
- Responsible for answering the Provider Services phone queue
- Occasional special projects related to provider services
- Prospecting and responding to potential providers for inclusion in the MHP Provider Network
- Collecting and data entry all practitioner and ancillary signed contracts, applications and necessary credentialing information ensuring MHP's credentialing standards is maintained.
- Provide exceptional customer service to Provider Network for all States while receiving or making provider calls.
- Complete necessary forms when needed to update Provider changes and or additions in MCS (complete and submit appropriate documentation for proper set up in MCS)
- Enters new provider data, provider demographic and contract affiliation information into the Managed Care System.
- Process information for updates to information and analyze by applying knowledge and experience to ensure appropriate information has been provided.
- Assist with network expansion by working closely with the Business Development Team
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma is required.
- Pursuit of a Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is preferred.

Experience:

- At least one years of managed care or provider services experience is preferred.

Knowledge:

- Basic knowledge of MHP's philosophy, organizational structure and plan overview
- Thorough knowledge of MHP's credentialing standards and contracting requirements
- Knowledge of National Committee for Quality Assurance (NCQA), URAC or general accreditation requirements and how they directly relate to the function of the position

Attachment 11 (Provider Services & Provider Enrollment Job Descriptions)

- Basic knowledge of the managed care industry

Skills:

- Organizational and team skills
- Follow up skills, with a “do whatever it takes” attitude
- Proficiency in scanning and attachment of electronic files
- Efficient computer and data entry skills, including knowledge of software products: MCS, MS Word and Excel

Abilities:

- Ability to communicate clearly and concisely both orally and in writing
- Ability to work as part of a team while maintaining and exceeding individual goals and objectives
- Professional and pleasant demeanor

Manager of Credentialing

Reports To: Director of Credentialing and Provider Analytics / Provider Services Manager

Position Summary: This position is responsible for coordinating the credentialing and re-credentialing activities of the health plan. The position interfaces with the Quality, Finance, Information Technologies, Corporate Provider Services, Provider Data Analytics and Network Development departments to assure that MHP's credentialing process meets National Committee for Quality Assurance (NCQA), URAC, CMS, or general accreditation standards and when applicable those of the contracted state agencies.

Essential Functions:

- Act as primary coordinator in screening applications, credentials, and support materials for practitioners and providers including Primary Care Providers, Specialists, Mental Health Practitioners, Hospitals, Ancillary Providers, and others interested in participating as part of MHP's Network
- Assist in the monitoring of department work for fraud, waste and abuse and reporting of any suspected activities to the appropriate regulatory authority
- Work collectively with the Manager of Delegated Credentialing and Compliance to ensure coordinated activities of the Credentialing teams
- Coordinate activities relating to credentialing including the development of related correspondence, filing of all submitted materials and verification of completeness of Practitioner and Provider applications
- Maintain credentialing workflow process with all involved parties and departments.
- Initiate workgroups and meetings to develop productive communication and customer service pathways.
- Maintain and develop, where necessary, the MHP credentialing manuals and databases
- Coordinate re-credentialing activities
- Coordinate the production of materials for Credentialing Committee meetings and report to regulatory agencies
- Attend Credentialing Committee meetings and present applicants for review
- Assure compliance with requirements of all national and State regulatory agencies, including NCQA, URAC, CMS or general accreditation
- Coordinate dissemination of credentialing compliance information to other Caidan Management Departments
- Oversee the maintenance of provider files including applications, contracts and facility site reviews in electronic and hard copy form, as well as the exporting of provider data and coordinating with the Corporate Provider Services and Finance departments
- Ensure MHP's credentialing standards are maintained as well as maintaining accurate provider data through update forms and claim information
- Coordinate preparation for regulatory accreditation reviews of credentialing activities
- Maintain strict confidentiality of employee and organizational information in accordance with HIPAA and State privacy regulations
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma is required.
- Bachelor's degree or Fellow designation from the Academy for Healthcare Management is required.

Attachment 11 (Provider Services & Provider Enrollment Job Descriptions)

Experience:

- Previous credentialing experience in a managed care or hospital environment is required.

Knowledge:

- Knowledge of Caidan Management's mission and operational structure
- Knowledge of all regulatory agency credentialing requirements including CMS, NCQA, URAC or general accreditation, OFIR, DCH and IDHFS
- Knowledge of MHP's provider contracting process

Skills:

- Strong organizational skills
- Excellent verbal and written skills

Abilities:

- Ability to prioritize work load
- Ability to communicate clearly and concisely in oral and written communications
- Ability to work as part of a team while maintaining and meeting individual goals and objectives
- Ability to develop and implement workflow for department
- Current driver's license and willingness to travel

Credentialing Specialist

Reports To: Manager of Delegated Credentialing

Position Summary: This position is responsible for assisting with the activities of the credentialing department under the direction of the Manager of Delegated Credentialing.

Essential Functions:

- Review application data for accuracy and completeness and input into the MCS system
- Monitor application documentation for fraud, waste and abuse and report any questionable items to the Manager of Credentialing
- Create form letters, requests, inquiries and other correspondence under the direction of the manager and arrange appropriate, HIPAA approved delivery
- Maintain filing system and documentation tracking system for all credentialing information
- Schedule necessary site-visits and maintain accurate tracking of all audit events per facility
- Assist in site-visits and audits progressing to performing independent site-visits to meet department needs
- Support the Manager of Credentialing in preparing for Credentialing Committee meetings and assist in the maintenance of the meeting minutes and documentation books
- Acquire and maintain knowledge of the credentialing requirements of all national and State agencies, including National Committee for Quality Assurance (NCQA), URAC or general accreditation and support the Credentialing Manager in fulfilling credentialing department expectations
- Maintain strict confidentiality of employee and organizational information in accordance with HIPAA and State privacy regulations
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma is required.
- Pursuit of a Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is preferred.

Experience:

- One to two years of experience processing credentialing and re-credentialing applications and/or managed care experience is preferred. Previous experience in an office setting is required.

Knowledge:

- Basic knowledge of MHP's mission and operational structure
- Basic knowledge of the credentialing process
- Basic understanding of NCQA, URAC or general accreditation credentialing requirements

Abilities:

- Ability to prioritize work load
- Ability to manage details and maintain excellent documentation
- Ability to work as part of a team while maintaining and meeting individual goals and objectives

Attachment 11 (Provider Services & Provider Enrollment Job Descriptions)

Skills:

- Organizational skills
- Customer service and telephone skills
- Oral and written communication skills
- Current driver's license and willingness to travel
- Computer skills with MS Office, databases, Internet searches, etc.

Manager of Delegated Credentialing and Oversight

Reports To: Director of Credentialing and Provider Analytics / Provider Services Manager

Position Summary: This position is responsible for the oversight and management of the delegated credentialing and compliance team. Responsible for all health plan audits for credentialing, developed corrective action plans and resolve all delegated entities. This position is responsible for coordinating the credentialing and re-credentialing of delegates of the health plan. The position interfaces with the Quality, Finance, Information Technologies, Compliance, Legal, Corporate Provider Services and Network Development departments to assure that MHP's credentialing process meets National Committee for Quality Assurance (NCQA), URAC, CMS or general accreditation standards and when applicable those of the contracted state agencies.

Essential Functions:

- Manage, coordinate and participate in the delegated agreement process from inception to completion with Delegated Provider Groups, including conducting annual delegated audits.
- Track and maintain communication with the delegated provider groups to ensure compliance with the delegated agreements.
- Participate in the development of the delegation strategy in coordination with the Network Development, conduct and record meetings and provide regular status reports to the leadership team.
- Manages delegated credentialing and re-credentialing activities to ensure accuracy and compliance with NCQA, CMS, URAC, state specific credentialing standards and defined policies/regulations
- Prepare/participate in Credentialing Committee meetings
- Manage auditing of appropriate provider data, review due diligence documents and document all credentialing in appropriate files/records.
- Manage assignments, work flow and establishes priorities on a daily basis for employees within the delegated Credentialing team.
- Work collectively with the Manager of Credentialing to ensure coordinated activities of the Credentialing teams
- Develop and maintain policies and procedures for department processes and revise as needed
- Oversight of delegated provider data entry in the Managed Care System
- Conduct weekly auditing of the integrity of credentialing data entered into the Managed Care System and promptly correct any credentialing data entry errors or inconsistencies within the Managed Care System
- Oversight of Scanning Operations of Credentialing files, ensuring quality checks and compliance
- Oversee the maintenance of delegated provider files including applications, contracts and site reviews in electronic and hard copy form, as well as the exporting of provider data and coordinating with the Credentialing and Finance departments
- Ensure MHP's credentialing standards are maintained as well as maintaining accurate provider data through update forms and claim information
- Reporting of contracted providers through spreadsheets and provider directories
- Occasional special projects related to provider services, quality improvement coordination and data management
- Monitor department work for fraud, waste and abuse and report any suspected activities to the appropriate regulatory authority, and ensure compliance with all required reporting requirements.
- Oversight of monthly sanction, and exclusion monitoring and reporting
- Maintain delegated credentialing workflow process with all involved parties and departments.

Attachment 11 (Provider Services & Provider Enrollment Job Descriptions)

- Maintain and develop, where necessary, the MHP credentialing manuals and databases
- Coordinate necessary site-visits
- Assure compliance with requirements of all national and State regulatory agencies, including NCQA, URAC, CMS or general accreditation
- Coordinate dissemination of credentialing compliance information to other Caidan Management Departments
- Coordinate preparation for regulatory accreditation reviews of credentialing activities
- Maintain strict confidentiality of employee and organizational information in accordance with HIPAA and State privacy regulations
- Perform other duties as assigned
- Travel Required

Job Requirements:

Education:

- High school diploma is required.
- Bachelor's degree or Fellow designation from the Academy for Healthcare Management is required.

Experience:

- Previous credentialing experience in a managed care or hospital environment is required.

Knowledge:

- Knowledge of Caidan Management's mission and operational structure
- Knowledge of all regulatory agency credentialing requirements including NCQA, URAC, CMS or general accreditation,
- Knowledge of MHP's provider and delegated contracting process

Skills:

- Organizational skills
- Excellent verbal and written skills

Abilities:

- Ability to prioritize work load
- Ability to communicate clearly and concisely in oral and written communications
- Ability to work as part of a team while maintaining and meeting individual goals and objectives
- Ability to develop and implement workflow for department
- Current driver's license and willingness to travel

Delegated Credentialing Coordinator

Reports To: Manager of Delegated Credentialing and Oversight

Position Summary: The primary role of this position is to coordinate all delegated credentialing functions, including pre-assessments and annual audits by evaluating potential and existing delegated entities for compliance with national credentialing requirements, ensuring that they meet both regulatory compliance and quality standards. The Delegation Credentialing Coordinator joins and works collaboratively with the MUCH group (Iowa United Credentialing Healthcare Forum) and other states shared annual delegation audits to ensure compliance with our contracted entities. The Delegation Credentialing Coordinator also will be responsible for monitoring provider network of any sanctions, exclusions or other adverse actions taken against providers by any state, federal, or nationally recognized source. Travel required.

Essential Functions:

- Enter provider information into MCS accurately
- Responsible for reporting audit outcomes and delegation monitoring results to management
- Serve as a key contact for communications and ensure compliance with performance metrics
- Maintains familiarity with all delegated credentialing agreements and each plan's requirements
- Complete annual or more frequent if required on-site or desktop audits if required
- Coordinate monthly delegate reporting according to the reporting schedule
- Interface with the health plan's functional departments to address any service related issues
- Provides reports to health plans in accordance with delegation agreements. Maintains accurate and up-to-date training materials, guides, resources and tools for the Credentialing Department
- Ensures timely completion of the initial and annual review process as required by insurance carriers, including hosting on-site audits and/or submitting credentialing files and credentialing policies and procedures to insurance company credentialing representative
- Maintains internal files including electronic copies of delegation agreements, ancillary applications
- Ensures all Credentialing policies are compliant with company guidelines and standard, NCQA, URAC, CMS and delegation agreements
- Proposes updates to credentialing policies and procedures when deemed necessary
- Review application data for accuracy and completeness and input into the MCS system when necessary
- Enter practitioner information into the Integrated Querying and Reporting Service (IQRS) to facilitate the querying of the NPDB/HIPDB
- Monthly review of practitioner network for expired licenses and follow up on any lapsed or expiring licenses
- Monitor application documentation for fraud, waste and abuse, investigate adverse findings and report any questionable items to the Manager of Delegated Credentialing and Auditing and Health Plan Fraud, Waste and Abuse Committees, and Quality Improvement Committees
- Maintain filing system and documentation tracking system for all credentialing information
- Serve as lead audit coordinator for data entry and credentialing files
- Schedule and travel to perform necessary site-visits and delegated audits nationally for MHP
- Maintain accurate tracking of all audit events per facility and complete organizational assessments in accordance with NCQA requirements
- Assist with the production of routine reports, including analyzing information prior to sending outside the department for accurate and complete information

Attachment 11 (Provider Services & Provider Enrollment Job Descriptions)

- Participation in NCQA preparation and readiness as requested
- Maintain knowledge of the credentialing requirements of all national and State agencies, including National Committee for Quality Assurance (NCQA), URAC, CMS or general accreditation and support the Credentialing Manager in fulfilling credentialing department expectations
- Maintain strict confidentiality of employee and organizational information in accordance with HIPAA and State privacy regulations
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma is required.
- Pursuit of a Bachelor's degree or Fellow designation from the Academy for Healthcare Management is preferred.

Experience:

- Two to five years of credentialing experience in a managed care setting, including processing credentialing and re-credentialing files is preferred.

Knowledge:

- Thorough knowledge of MHP's mission and operational structure
- Thorough knowledge of the credentialing process
- Comprehensive understanding of CMS, NCQA, URAC or general accreditation credentialing requirements

Abilities:

- Ability to prioritize work load
- Ability to work independently with minimal supervision
- Ability to manage details and maintain excellent documentation
- Ability to work as part of a team while maintaining and meeting individual goals and objectives
- Ability to travel as needed

Skills:

- Strong organizational skills
- Excellent customer service and telephone skills
- Strong written and verbal communication skills
- Current driver's license in the State of Michigan and willingness to travel
- Computer skills with MS Office, databases, Internet searches, etc.

Director of Quality Improvement/Quality Management Manager

Reports to: Contract Administrator/Chief Executive Officer/Chief Operations Officer

Position Summary: This position is responsible for achieving and maintaining the quality and performance goals of Meridian Health Plan. Leads, coordinates, and ensures documentation of quality improvement, accreditation, and regulatory activities for the health plan. Develops and implements a comprehensive corporate strategy to ensure HEDIS and CAHPS improvement. Directs all preparations for National Committee for Quality Assurance (NCQA), URAC or general accreditation and ensures that the plan maintains its NCQA “Excellent” or URAC equivalent status. Accountable for timely program revisions to meet NCQA, URAC or general accreditation, and other regulatory requirements. This position is responsible for overseeing the Quality Management and Improvement program and ensuring compliance with quality management requirements and quality improvement initiatives.

Essential Functions:

- Oversee the development, implementation and annual evaluation of the corporate quality improvement plan
- Monitor and ensure compliance with all State of Iowa regulatory requirements, including the State performance measures
- Serve as the organizational leader for Healthcare Effectiveness Data and Information Set (HEDIS) reporting and improvement initiatives, including the following:
 - Develop a comprehensive strategy for HEDIS improvement, including action plans for all key HEDIS measures
 - Coordinate and monitor HEDIS outreach efforts across all company departments
 - Analyze and review data to identify opportunities for HEDIS improvement
 - Oversee all vendor activities, including hybrid data collection/medical record review
- Serve as the organizational leader for CAHPS reporting and improvement initiatives, including the following:
 - Oversee the data collection and reporting activities of MHP’s CAHPS vendor
 - Provide analysis of the CAHPS survey and MHP’s internal member satisfaction survey and identify areas for improvement
 - Work collaboratively with other departments to develop and implement strategies to improve MHP’s CAHPS scores
- Lead and direct the organization’s accreditation survey preparation for managed care organizations, including the following:
 - Support all department directors and managers to ensure that the compliance requirements are met for each area
 - Ensure that all documentation is readily available for submission to NCQA, URAC or general accreditation committee
 - Coordinate all pre-survey, on-site, and post-survey activities with NCQA, URAC or general accreditation committee
- Oversee the development and implementation of Disease Management programs for chronic conditions identified as a priority within the MHP membership
- Ensure that appropriate policies and procedures are in place to support all quality improvement and disease management activities

Attachment 12 (Quality Management & Improvement Job Descriptions)

- Oversee the Quality Improvement Committee structure and participate in committee meetings as appropriate
- Develop and monitor the budget for quality improvement and disease management activities and ensure that sufficient resources are assigned to meet quality and performance goals
- Prepare monthly and quarterly management reports for submission to the MHP leadership team and the Board of Directors
- Coordinate activities with department directors to meet MHP's goals, and serve as the "quality champion" within the organization
- Serve as a liaison for the health plan concerning quality improvement activities, including participation in external meetings and coordination with external entities
- Maintain strict confidentiality of employee and organizational information in accordance with HIPAA and State privacy regulations
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree in nursing or related field is required.
- Current Iowa license as a registered nurse, physician or physician's assistant or a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (HCQM) by the American Board of Quality Assurance and Utilization Review Physicians.
- Master's degree in healthcare administration or related field is preferred.

Experience:

- At least five years of experience in health care quality improvement is required.
- Previous experience in managed health care and Medicaid programs is required.
- Prior successful completion of an NCQA, URAC or general accreditation survey for managed care is required.
- Previous management and supervisory experience is required.

Knowledge:

- Knowledge of the NCQA, URAC or general accreditation standards for managed care organizations
- Knowledge of HEDIS specifications and CAHPS survey requirements
- Knowledge of health care quality improvement processes and documentation
- Knowledge of medical records and claims data

Skills:

- Excellent written, verbal, presentation skills and inter-personal skills
- Strong computer skills, including Microsoft Office (Word, Excel, PowerPoint)
- Strong analytical and data interpretation skills

Abilities:

- Ability to work cooperatively with peers and subordinates
- Ability to oversee and comprehend department activities at a detailed level
- Ability to motivate others toward achievement of common goals
- Ability to think creatively to resolve common barriers and issues

Quality Coordinator

Reports To: Director of Quality Improvement/Quality Management Manager

Position Summary: This position assists in coordinating the development, implementation, documentation and evaluation of quality management initiatives for Meridian Health Plan. Assists and supports all quality management functions including QI projects, disease management programs, HEDIS, CAHPS and National Committee for Quality Assurance (NCQA), URAC or general accreditation efforts. This position supports the Meridian Health Plan women and children's services program by coordinating efforts pertaining to prenatal, postpartum and preventive care measures. This position implements multiple aspects of the women and children's services program including authorizations, scheduling appointments for members, reporting monthly data and assisting with HEDIS measures.

Essential Functions:

- Coordinate design and execution of activities necessary to identify trends and important aspects of care for the MHP enrolled population
- Identify opportunities for improvement in HEDIS and CAHPS scores based on results of data analysis and required state performance standards
- Serve as project manager or facilitator with regional teams and other departmental personnel to develop, implement and evaluate performance improvement initiatives
- Design and implement outreach strategies for providers and members to facilitate compliance and competency with established programs and guidelines
- Develop educational programs for providers and members as identified through evaluations, surveys and as directed by management
- Assist in the women's program for prenatal, postpartum and preventive measures including but not limited to:
 - Identifying pregnant members (through member services referrals, the pregnant enrollee database, and authorizations or claims as applicable) to authorize services and scheduling their visits, coordinating their care and assisting with emergent/urgent requests
 - Scheduling and authorizing postpartum visits
 - Assisting the scheduling and authorizing of preventive services for members
 - Participating in initiatives involved within the scope of work
 - Reporting monthly numbers of new pregnancies, physician access problems, completed pre and postpartum visits, and assistance efforts on preventive measures
 - Reporting monthly data on prenatal, postpartum and preventive measures
 - Monitoring the HEDIS databases for prenatal, postpartum and frequency of care
- Involvement in the Healthcare Effectiveness Data and Information Set (HEDIS) quality improvement efforts by assisting the coordination of internal activities in regards to:
 - Office scheduling
 - Chart requests
 - Faxing and mailing efforts
 - Audit preparations within the scope of work
- Assist with QI processes for fulfillment of National Committee for Quality Assurance (NCQA), URAC or general accreditation requirements including but not limited to the following:
 - Clinical Accessibility and Quality of Care audits
 - Assisting with initiatives and pilot studies
- Develop skills and proficiency with PC based Microsoft Office applications, Windows and other applications

Attachment 12 (Quality Management & Improvement Job Descriptions)

- Consistently demonstrate compliance with HIPAA regulations, professional conduct and ethical practice
- Support the Women & Children's Services and Member Services Department phone queues
- Support Disease Management initiatives
- Assist with the development of data collection tools and training materials for quality and disease management initiatives
- Document the results of quality improvement activities in a standardized NCQA, URAC or general accreditation approved format, and develop other reporting formats as needed to meet the requirements of the State, NCQA, URAC or other regulatory bodies
- Collaborate with other organizations, agencies, vendors and/or community groups in developing tools and evaluation methods as appropriate
- Consistently demonstrate compliance with HIPAA regulations, professional conduct and ethical practice
- Ability to travel, primarily within the State of Iowa
- Ability to train staff members on quality initiatives
- Responsible for the submission of grants and other RFP's as requested
- Coordination and organization of materials for the annual state site visits
- Assist with the MHP PAC committee by scheduling the meeting, preparing the materials and taking the minutes
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is required.

Experience:

- Six (6) months to one (1) year of experience in managed care is required.
- Experience with office functions (including: word processing, spreadsheets, mass mailings, etc) and telephone customer service is required.
- Prior experience with HEDIS and NCQA, URAC or general accreditation is a plus.

Knowledge:

- Knowledge of managed care
- Knowledge of Medicaid guidelines
- Medical/obstetrical terminology

Skills:

- Good organizational skills
- Excellent interpersonal communication skills
- Excellent writing skills

Abilities:

- Ability to develop written communication documents for different audiences and effectively present information in one-on-one and small group situations to customers, clients, and other employees of the organization
- The ability to apply common sense understanding in carrying out instructions furnished in written, oral, or diagram form. The ability to deal with problems involving several concrete variables in standardized situations.

Quality Analyst

Reports To: Director of Quality Improvement/Quality Management Manager

Position Summary: This position is responsible for providing data collection and analytical support for the quality improvement and disease management programs. This includes the development and maintenance of reporting tools, assistance with accreditation, and development of technical specifications to support system changes. In addition, this position will support team communication, and analysis/report generation. The position requires ability to perform as a self-starter with motivation to consistently produce high quality results.

Essential Functions:

- Develop and maintain reporting tools for weekly, monthly, quarterly, annual and ad hoc reporting requests to meet corporate, state and accreditation specifications for all areas of Quality Management.
- Coordinate design and execution of data collection activities necessary to identify trends and important aspects of care.
- Compile, analyze and interpret data collected from monitoring activities. Identify opportunities for improvement based on data analysis.
- Translate data into meaningful information. Track, trend and report findings to the QIC and its subcommittees, as well as administrative and executive leadership, as appropriate.
- Utilize drill down and root cause methodologies to review data statistics and identify opportunities for improvement for QIAs or other quality improvement efforts.
- Develop reporting systems for data presented to the State, National Committee for Quality Assurance (NCQA), URAC or general accreditation and other entities
- Assist with the development of data collection tools and training materials for quality and disease management initiatives.
- Identify potential data needs and coordinate with IT and Finance to develop specifications for reporting including changes to existing reports.
- Complete qualitative and quantitative data analysis to ensure departmental efficiencies.
- Participate in UAT testing, determine impact to department with MCS changes and create job aides for staff to aide in the training of staff on changes.
- Make recommendations to implement process improvement
- Consistently demonstrate compliance with HIPAA regulations, professional conduct and ethical practice.
- Perform other duties as assigned

Job Requirements:

Education:

- Associates degree in a health related field
- Bachelor's degree preferred. Degree in health care administration, business, health communication, public health, data analysis, nursing or related health care field is preferred.
- Must pass the MHP Analyst Assessment.

Experience:

- Experience in health care data analysis/quality management/managed care is required.
- Experience working on team projects.

Knowledge:

- Strong working knowledge of Microsoft Office tools (Word, Excel and Outlook)
- Demonstrable working knowledge of Healthcare Effectiveness Data and Information Set (HEDIS) reporting, NCQA, URAC or general accreditation requirements.
- Knowledge of research methods, including use of internet
- Knowledge of continuous quality improvement strategies and practical application methodologies

Attachment 12 (Quality Management & Improvement Job Descriptions)

Skills:

- Strong organizational skills
- Mathematical skills
- Excellent interpersonal and communication skills, both written and verbal

Abilities:

- Ability to integrate clinical knowledge and skills when analyzing complex tasks, systems and problems
- Able to analyze and present data in a meaningful way
- Identify data and system needs and develop corresponding analysis and process improvement

Medical Record Data Abstractor

Reports To: Manager of Performance Improvement

Position Summary: This position is responsible for ongoing medical chart data collection from provider offices and abstraction/data entry from medical records to support Healthcare Effectiveness Data and information set (HEDIS) Reporting and Quality Improvement.

Essential Functions:

- Follows established procedures for chart chases, scheduling and conducting chart abstractions.
- Coordinates audit schedule with Team Lead, as well as assigned Provider Network Development Representative and notifies management of any rescheduling needs.
- Timely notification to Team Lead and offices if appointments are cancelled or changed.
- Pulls charts to be audited as needed per Team Lead instructions.
- Extracts electronic medical record data on site using portals and off site at medical facilities.
- Enters pertinent data from paper and electronic medical records into MCS as required by established abstraction procedures.
- Scans documentation into a medical record system as required by abstraction procedures.
- Ensures that all information is collected in a safe, organized and confidential manner.
- Provides feedback to Team Lead regarding the abstraction process, resources required to complete abstractions accurately and other concerns related to chart abstraction.
- Communicates effectively and professionally with provider offices as they identify opportunities for improvement, as well as coordinating with local Provider Network Development Representatives as needed.
- Meets or exceeds interrater reliability audits
- Collects and records data for Quality Monitoring and Improvement.
- Maintains relationships with subject matter experts (SME's), clinic managers, and staff to facilitate medical record abstracting process including scheduling time to enter data at the health centers with flexibility around clinic schedules
- Conducts provider site visits to monitor compliance with facility standards.
- Perform other duties as assigned.

Job Requirements:

Education:

- High School Diploma is required.
- Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is preferred.

Experience:

- At least two years of relevant clinical experience involving medical record documentation or medical claims experience preferred.
- Prior HEDIS clinical field experience and HEDIS certified software experience preferred.
- Previous experience in managed health care and Medicaid programs is preferred.

Attachment 12 (Quality Management & Improvement Job Descriptions)

Knowledge:

- Detailed knowledge of computers/systems including word processing and Excel spreadsheets.
- Strong knowledge base of HEDIS Technical Standards
- Knowledge of claims and coding sets
- Knowledge of MS Project software
- Strong knowledge base of HEDIS Technical Standards and HEDIS Compliance Audit Standards preferred

Skills:

- Excellent written, verbal, presentation skills and inter-personal skills
- Strong computer skills, including Microsoft Office (Word, Excel, PowerPoint)
- Strong analytical and data interpretation skills
- Strong organizational skills
- Ability to exercise good judgment and maintain confidentiality
- Ability to coordinate multiple competing, complex tasks.

Abilities:

- Ability to work cooperatively with peers and leaders
- Ability to travel in multiple states

Outreach Specialist

Reports to: Director of Clinical Performance Improvement

Position Summary: This position works closely with the Director of Clinical Program Development to identify, design, and coordinate quality outreach efforts. The Coordinator will be responsible for ensuring multi-state outreach and program design for members and providers. This position will assist with tracking requirements associated with QI projects, disease management programs, HEDIS, CAHPS and National Committee for Quality Assurance (NCQA), URAC or general accreditation efforts.

Essential Functions:

- Develop, identify, and monitor performance and outcomes metrics associated with all outreach efforts
- Maintain performance work plans in alignment with state contractual and NCQA requirements for outreach activities
- Assist in the development of objectives and outcomes in alignment with the Quality Department strategic plan centered on outreach
- Perform activities necessary to identify trends and important aspects of care for the MHP enrolled population
- Identify opportunities for improvement in Healthcare Effectiveness Data and Information Set (HEDIS) and CAHPS scores based on results of data analysis and required state performance standards
- Assist with the design and implement outreach strategies for providers and members to facilitate compliance and competency with established programs and guidelines
- Assist with the development of data collection tools and training materials for quality and disease management initiatives
- Ensure that all disease management programs are compliant with the standards for Disease Management Accreditation from the National Committee for Quality Assurance (NCQA), URAC, or general accreditation and coordinate accreditation efforts, including but not limited to:
 - Use of evidence-based guidelines as a basis for the program
 - Obtaining patient and practitioner feedback regarding the program
 - Utilizing available data for identification and stratification of the population
 - Developing patient and practitioner oriented educational materials
 - Implementing interventions and providing feedback to patients and practitioners
- Collaborate with other organizations, agencies, vendors and/or community groups in developing tools and evaluation methods as appropriate
- Consistently demonstrate compliance with HIPAA regulations, professional conduct and ethical practice
- Ability to train staff members on outreach initiatives
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree required. Degree in health care administration, business, health communication, public health, data analysis, nursing or related health care field is preferred.
- Must pass the MHP Analyst Assessment.

Experience:

- Experience in data analytics, metric design
- Experience working with analytic software
- Experience in health care data analysis/quality management/managed care is required.
- Experience working on team projects.

Knowledge:

- Advanced knowledge of Excel
- Strong working knowledge of Microsoft Office tools (Word, Excel and Outlook)
- Demonstrable working knowledge of HEDIS reporting, NCQA, URAC or general accreditation requirements.
- Knowledge of research methods, including use of internet
- Knowledge of continuous quality improvement strategies and practical application methodologies

Skills:

- Strong organizational skills
- Mathematical skills
- Excellent interpersonal and communication skills, both written and verbal

Abilities:

- Ability to integrate clinical knowledge and skills when analyzing complex tasks, systems and problems
- Able to analyze and present data in a meaningful way
- Identify data and system needs and develop corresponding analysis and process improvement

Denials Nurse

Reports To: Manager of Utilization Management

Position Summary: This position is responsible for review and response of the adverse decisions for members of the health plan. Successfully maintains Federal and Local guidelines to meet general accreditation status with regard to denial letters. Responsible for the writing and editing of all letters sent out for denials.

Essential Functions:

- Responsible for reviewing all aspects of the denial processes within the department to promote consistency and accuracy within the processes and compliance with Medicare, NCQA, URAC or general accreditation, regulatory and HIPAA guidelines
- Meets all relevant regulatory requirements and comprehends and complies with best practices, professional standards, internal policies and procedures
- Analyzes the daily denial activities to ensure departmental goals are met with regards to timeliness, accuracy and consistency of medical decisions
- Recognizes opportunities to improve the quality of care/services and activities to continually strive to improve outcomes
- Responsible for providing expertise or general support to Denials Specialist staff in reviewing, researching, investigating, negotiating and resolving all types of denials
- Communicates with appropriate parties, issues, implications and decisions.
- Responsible for assisting in clinical coordination and presentation of information for administrative hearings and state external reviews
- Partnering with the Denials Team Lead to work with the IT department on MCS development issues as it pertains to denials
- Maintain strict confidentiality of employee and organizational information in accordance with MHP, HIPAA and State privacy regulations
- Perform other duties as assigned

Job Requirements:

Education:

- Current licensure to practice as a Registered Nurse or a Licensed Practical Nurse in the designated State, without restriction

Experience:

- Three to five years of experience, education and/or certifications in utilization management, case management or other appropriate health care specialty

Knowledge:

- Knowledge of MHP's mission and operational structure
- Knowledge of managed care, particularly utilization management processes
- Knowledge of Medicaid guidelines, medical necessity and benefit structure
- Knowledge of Medicare guidelines
- Knowledge of NCQA, URAC or general accreditation requirements and guidelines for utilization management and denials.

Attachment 13 (Utilization & Care Management Job Descriptions)

Skills:

- Demonstrated leadership skills
- Organizational skills
- Excellent written and verbal communication skills
- Demonstrated clinical knowledge and expertise

Abilities:

- Ability to prioritize work load
- Ability to work as part of a team while meeting individual goals and objectives
- Ability to identify, develop and implement process improvements

Denials Specialist

Reports To: Manager of Utilization Management

Position Summary: This position requires advanced knowledge of all lines of business for MHP including Medicare, Commercial and National Committee for Quality Assurance (NCQA), URAC or general accreditation requirements to collaboratively work with other MHP departments. This position will coordinate MHP's denial notification process and maintain accurate and timely tracking and reporting in accordance with federal and state laws and department policies.

Essential Functions:

- Coordinate and process all denial determinations
- Track all denial data components as required by MHP and regulatory and accrediting agencies
- Regularly provide written reports of compliance with denial notification standards
- Conduct monthly internal audits of denial process to assure compliance with staff time frame standards and report results to manager
- Draft denial letter templates
- Identify and implement process improvement opportunities
- Function as a liaison between the Utilization Management department and the Member Services Case Specialists
- Document user requirements for MCS systems development
- Analyze the data elements of denial reports
- Draft and update policies and procedures pertaining to the denial process
- Remain updated on all relevant policy changes made by MHP
- Remain updated on all relevant regulatory and accreditation reporting requirements and policy changes
- Perform other duties as assigned

Job Requirements:

Education:

- Associate's degree is required
- Bachelor's degree or Fellow designation from the Academy of Healthcare Management (AHM) is preferred.

Experience:

- A minimum of one to two years experience as a Utilization Management Specialist or one to two years of related health industry experience is required.

Knowledge:

- Knowledge of managed care and Iowa Medicaid guidelines
- Thorough knowledge of the authorization process
- Understanding of NCQA, URAC or general accreditation requirements for Utilization Management and appeals

Skills:

- Excellent verbal and written communication skills
- Basic computer skills
- Telephone service skills

Attachment 13 (Utilization & Care Management Job Descriptions)

Abilities:

- Ability to be patient and courteous to all members and providers in all situations
- Ability to work in teams

Testing Requirements:

- Successful completion of the Online Medicaid Managed Care Course

Denials Team Lead

Reports To: Manager of Utilization Management

Position Summary: This position is responsible for management of the Pre-Service Denials of the health plan. Successfully maintains National Committee for Quality Assurance (NCQA), URAC or general accreditation status with regard to denial letters. Responsible for the writing and final editing of all letters sent out for denials. Ensures that all staff who have a part in the denial process meet their timeline with a 100% accuracy rate.

Essential Functions:

- Responsible for managing all aspects of the appeal processes within the department to promote consistency and accuracy within the processes and compliance with NCQA, URAC or general accreditation, regulatory and HIPAA guidelines
- Ensures staff meets all relevant regulatory requirements and comprehends and complies with best practices, professional standards, internal policies and procedures
- Supervises, analyzes and coordinates the daily denial activities to ensure departmental goals are met with regards to timeliness, accuracy and consistency of medical decisions
- Recognizes opportunities to improve the quality of care/services and activities to continually strive to improve outcomes
- Responsible for providing expertise or general support in reviewing, researching, investigating, negotiating and resolving all types of denials
- Communicates with appropriate parties, issues, implications and decisions. Analyzes and identifies trends for denials
- Responsible for assisting in clinical coordination and presentation of information for administrative hearings and state external reviews
- Daily prioritization of staffing assignments for optimizing impact on department production
- Works with the IT department on MCS development issues as it pertains to denials
- Assists the Member Service department and State Director of Operations with the member complaints. Investigate relevant complaints; researches and provides written summary to support the health plan's decision
- Updates Pharmacy and Behavioral Health departments of relevant changes to the denial letters and all related policies and procedures
- Provide ongoing training and education to the staff through one-on-one and classroom settings regarding InterQual, medical policies, NCQA, URAC, or general accreditation, regulatory requirements and other necessary job-related skills
- Utilize professional knowledge, MHP knowledge and pertinent resources or use the appropriate reporting structure to solve problems and issues as identified
- Maintain strict confidentiality of employee and organizational information in accordance with MHP, HIPAA and State privacy regulations
- Perform other duties as assigned

Job Requirements:

Education:

- Current licensure to practice as a Registered Nurse or a Licensed Practical Nurse in the designated State, without restriction

Experience:

Attachment 13 (Utilization & Care Management Job Descriptions)

- Three to five years of experience, education and/or certifications in utilization management, case management or other appropriate health care specialty

Knowledge:

- Knowledge of MHP's mission and operational structure
- Knowledge of managed care, particularly utilization management processes
- Knowledge of Medicaid guidelines, medical necessity and benefit structure
- Knowledge of NCQA, URAC or general accreditation requirements and guidelines for utilization management, denials and appeals

Skills:

- Demonstrated leadership skills
- Organizational skills
- Excellent written and verbal communication skills
- Demonstrated clinical knowledge and expertise

Abilities:

- Ability to prioritize work load
- Ability to work as part of a team while meeting individual goals and objectives
- Ability to identify, develop and implement process improvements

Director of Utilization Management

Reports to: Medical Director

Position Summary: This position is responsible for developing and implementing a utilization management program that is consistent with the philosophy of Meridian Health Plan (MHP). This includes oversight of the utilization management and case management programs. This position is also responsible for ensuring that MHP's programs are compliant with National Committee for Quality Assurance (NCQA), URAC or general accreditation standards as well as State and federal regulatory requirements. This position manages all elements of the utilization management program and staff under the supervision of the Medical Director. This includes, but is not limited to functions related to prior authorization, medical necessity determinations, concurrent and retrospective reviews and other clinical and medical management programs.

Essential Functions:

- Design, develop and implement a comprehensive utilization management strategy for the organization that includes the following:
 - Use of Regional Teams to respond to member and provider concerns
 - Case Management programs for high cost or complex members
 - Support corporate Healthcare Effectiveness Data Information Set (HEDIS) improvement goals through utilization management
 - Use of a centralized tracking system (MCS) to ensure documentation of all contacts with members and providers related to utilization management
- Oversee the development, implementation and annual evaluation of the corporate utilization management program, including the following:
 - Develop systems and processes for prospective, concurrent and retrospective utilization review, including maintenance of the prior authorization list
 - Ensure that all utilization review decisions are based upon medical necessity guidelines, clinical protocols and recognized standards of care
 - Collect, analyze and maintain data regarding utilization of medical services
 - Identify, investigate and educate providers who are outliers in terms of medical practice
- Oversee the identification, tracking, resolution and response to all denials and appeals in compliance with NCQA, URAC or general accreditation standards
- Promote a provider-friendly, customer service oriented philosophy within the Utilization Management department
- Represent MHP at external meetings with provider groups to address issues, improve communication and educate providers regarding MHP's utilization management process
- Ensure that there are appropriate policies and procedures in place to support all utilization management and case management activities
- Ensure that all department activities are in compliance with the NCQA, URAC or general accreditation standards, as well as State and federal regulatory requirements
- Identify and implement opportunities to enhance efficiency through the use of the MCS system as well as departmental process improvements
- Coordinate activities with other department directors to meet MHP's goals

Attachment 13 (Utilization & Care Management Job Descriptions)

- Provide leadership for the Utilization Management Committee and participate on other committees as appropriate.
- Develop and monitor the budget for utilization management activities and ensure that sufficient resources are assigned to meet department goals.
- Prepare monthly and quarterly utilization management reports for submission to the MHP leadership team and the Board of Directors
- Serve as a liaison for the health plan concerning utilization management activities, including participation in external meetings and coordination with external entities
- Maintain strict confidentiality of employee and organizational information in accordance with HIPAA and State privacy regulations
- Perform other duties as assigned

Job Requirements:

Education:

- Current license (without restriction) to practice as an Iowa licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations
- License with appropriate training, as approved by DCH is required.
- Master's degree in nursing, health care administration, or related field is preferred.

Experience:

- Three to five years of experience in utilization management, with additional case management experience is preferred.
- Previous experience in managed care and Medicaid programs is required.
- Previous management and supervisory experience is required.

Knowledge:

- Knowledge of the NCQA, URAC or general accreditation standards for managed care organizations
- Knowledge of health care utilization management processes and documentation
- Knowledge of authorizations and claims data

Skills:

- Excellent written, verbal and presentation skills
- Excellent inter-personal skills
- Strong computer skills, including Microsoft Office (Word, Excel, PowerPoint)
- Strong analytical and data interpretation skills

Abilities:

- Ability to work cooperatively with peers and subordinates
- Ability to motivate others toward achievement of common goals
- Ability to think creatively to resolve common barriers and issues

Utilization Management Inpatient Review Nurse

Reports To: Manager of Utilization Management

Position Summary: This position ensures that authorization requests and provider inquiries are handled appropriately within established timeframes, and established guidelines and protocol are utilized for clinical decision-making. Functions collaboratively with the members of the Utilization Management team, and specifically with the review nurses, case managers and Medical Directors to ensure for timely disposition of inpatient authorization requests and discharge planning activities.

Essential Functions:

- Oversee the queue workload needs on a concurrent basis including the inpatient authorization queues and the inpatient fax queues in the UM department to concurrently prioritize self-assignment for greatest impact on department function
- Support orientation program for UM staff by acting as primary mentor for review nurses, UM specialists and physician reviewers
- In conjunction with medical leadership, act as resource for criteria and benefit interpretation including the correct and consistent application of the InterQual criteria on the appropriate topics, consistent application of procedural practices established by MHP
- Supply ongoing training and education to the staff through one-on-one and classroom settings regarding InterQual, National Committee for Quality Assurance (NCQA), URAC or general accreditation, MDCH and other necessary job-related skills
- Collaborate with the Disease Management, Quality Improvement, and Utilization Management departments in the development of protocols and guidelines designed to standardize care practice and care delivery. Seek out opportunities to improve HEDIS, NCQA, URAC or general accreditation and QIA activities.
- Receive and review all emergent inpatient admission and observation notifications
- Review clinical data against established protocols/guidelines and within established timeframes to determine disposition of admission authorization requests
- Complete authorization process in MCS system for approved authorizations and contact hospital reviewers with decision, days authorized and corporate authorization number
- Contact hospital reviewers where additional information is necessary to make a decision
- Consult with Medical Director as appropriate for all requests that do not meet criteria for admission and inform hospital reviewers of the Medical Director's decisions
- Create and fax/mail denial letters to hospitals as required and within established timeframes
- Receive and process clinical updates for continued stay
- Initiate and follow through on all aspects of discharge planning, including, but not limited to, identification of needs, coordination of care and transitioning to alternate levels of care
- Collaborate with inpatient reviewers and other MHP staff for discharge planning needs or transfer to alternative level of care
- Performs post discharge calls to members post inpatient, SNF and acute rehabilitation services in accordance with department guidelines. Assists to coordinate follow-up appointments, home health care services, pharmacy services, and refer to MHP care coordination or complex case management and/or community resources as indicated
- Monitor documentation, follow up calls to members are made in a timely manner according to follow date set and acuity level.
- Coordinates activities with other medical management departments as needed, including making referrals to Case Management and Behavioral Health.

Attachment 13 (Utilization & Care Management Job Descriptions)

- Communicate with providers and members on an ongoing basis to facilitate compliance and competency with established programs and guidelines to assist with decrease ER visits.
- Perform other duties as assigned

Job Requirements:

Education:

- Current license (without restriction) to practice as a Licensed Practical Nurse or Registered Nurse in the designated State is required.

Experience:

- At least two years experience in UM/UR and managed care experience is preferred.
- Three years of acute patient care with clinical background is required.

Knowledge:

- Knowledge of medical terminology, authorization processes, Medicaid, and Managed Care

Skills:

- Excellent customer service and interpersonal communication skills
- Excellent computer/data entry skills

Utilization Management Inpatient Review Nurse Team Lead

Reports To: Manager of Utilization Management

Position Summary: This position is responsible for specific functions within the Utilization Management Department including, orientation and training of new utilization management staff, monitor and report progress of new member training, provide staff training for new and updated policies and procedures, perform user testing for new MCS applications/functionality, monitor and optimize staff case loads, oversee small projects and manage half the case load as expected of a full time case manager. This position also provides first line clinical direction to the utilization management staff and refers to Manager of Utilization Management when necessary.

Essential Functions:

- Develop 60 day orientation/training schedule for new clinical utilization management staff. Monitor staff progress weekly and update training orientation outline accordingly.
- Provide at least weekly written progress reports to manager and updated training outline. Discuss issues or potential opportunities for staff improvement with manager.
- Identifies expected outcomes of the nurse reviewer orientation program and ongoing education programs
- Ensure training manual is updated regularly as revisions are made to processes, job aides, policies, procedures, etc.
- Implement new/revised processes among clinical utilization management staff. Provide written materials as needed for training purposes.
- Oversee workloads by monitoring the work queues of each staff member to ensure timeliness in decision making, and discharge planning activities are performed in accordance with MHP policies and procedures. Discuss variances that may be identified in team member case load/performance with manager; such as: untimely decision, insufficient documentation, lack of discharge planning, no evidence of appropriate referrals
- In conjunction with manager, act as resource for criteria and benefit interpretation including the correct and consistent application criteria on the appropriate topics, consistent application of procedural practices established by MHP and accurate and consistent utilization of medical director services.
- Monitor denial correspondence for consistency and accuracy with decisions, member language (when appropriate), and pertinent information. Monitor all correspondence for compliance. Inform manager of variances with URAC, MDCH and HIPAA guidelines.
- Supply ongoing training and education to the staff through one-on-one and classroom settings regarding InterQual, URAC, MDCH and other necessary job-related skills
- Oversee the Discharge Planning activities of clinical staff and timely referral of appropriate referrals to the case management staff; including but not limited to, the collection of key member demographic information, identification of member baseline condition, activities of daily living, and physician discharge plan. Develop a plan of action, obtaining the necessary equipment and supplies, negotiating prices, developing case contract, obtaining timely clinical updates, and monitoring the length of stay.
- Oversee activities conducted by clinical nurse reviewers and their timely, accurate application of decision criteria.
- Provide front line direction to clinical utilization management staff and consult with manager as appropriate for input.
- Ensure team members accurately record pertinent information for weekly prolonged length of stay report.

Attachment 13 (Utilization & Care Management Job Descriptions)

- Work in collaboration with Manager and administrative assistant to plan orientation schedule for new staff members.
- Once new staff member is assigned clinical cases, team leader will review cases weekly and provide immediate feedback to new staff member
- Provide for ongoing clinical training and education of all staff based on needs assessments done with each staff member to determine areas where more training is required.
- Provide for training for any MCS updates that would affect the case management staff.
- Work in collaboration with Manager to develop job aides for the clinical utilization management staff.
- Acts as a liaison with other MHP departments in relation to case management issues.
- Works collaboratively with Manager to perform monthly quality audits on clinical utilization management staff members.
- Assists Manager in the creation of the agenda for the weekly clinical utilization team meetings. Conducts weekly team meetings in the absence of the Manager.
- Consistently demonstrates compliance with HIPPA regulations, professional conduct and ethical practice.
- Assists with special projects or departmental process improvement efforts, as needed.
- Manage half the case load as a full time nurse reviewer.
- Performs post inpatient calls to members.
- Identifies members for disease and case management.
- Perform other duties as assigned.

Job Requirements

Education:

- Current license without restriction to practice as a Licensed Practical Nurse or Registered Nurse in the state is required.

Experience:

- A minimum of 1 year case management experience.
- Three years of acute patient care with clinical background is required.

Knowledge:

- Knowledge of managed care
- Knowledge of case management processes including tools and techniques for identification, stratification and management of high-risk members.
- Must possess working knowledge of MDCH regulations

Skills:

- Excellent organizational and critical thinking skills
- Excellent people skills
- Skilled in conducting telephone based nursing assessments
- Excellent written and verbal communication skills

Abilities:

- Must possess the ability to make independent decisions when circumstances warrant such action.
- Ability to prioritize and coordinate member care needs
- Ability to manage multiple tasks simultaneously

Attachment 13 (Utilization & Care Management Job Descriptions)

- Ability to work collaboratively and effectively with diverse groups
- Ability to function as part of an interdisciplinary team

Manager of Utilization Management

Reports To: Director of Utilization Management / Utilization Management Manager

Position Summary: This position is responsible for the daily operational management and supervision of the utilization review functions within the Utilization Management Department. This position includes the responsibility for providing overall direction, education, orientation, coordination and evaluation of the Nurse Reviewers, Pre-Service Review Nurses, Transitional Case Managers, Nurse Reviewer Team Lead, Pre-Service Nurse Reviewer Team Lead, Utilization Management Operational Team Leads, , Denials Team Lead, Denials Specialist, Transitional Care Coordinators, Transplant Care Coordinators, and Utilization Management Care Coordinators to optimize workload and outcomes, monitor the denial processes, maintain all regulatory and accreditation requirements and function cross-departmentally in the coordination of member care.

Essential Functions:

- Directly manage Nurse Reviewers, Pre-Service Review Nurses, Transitional Case Managers, Nurse Reviewer Team Lead, Pre-Service Nurse Reviewer Team Lead, Utilization Management Operational Team Leads , Denials Team Lead, Denials Specialist, Transitional Care Coordinators, Transplant Care Coordinators, and Utilization Management Care Coordinators including, but not limited to, hiring, training, scheduling, monitoring workload, conflict resolution, conducting performance evaluations and implementing performance improvement and disciplinary actions, when necessary.
- Provides oversight in the development and implementation of orientation and training activities for Nurse Reviewers, Pre-Services Nurse Reviewers, Transitional Case Managers, and Denials staff, and Utilization Management Care Coordinator staff.
- Oversee workload needs on a concurrent basis including monitoring phone coverage and clinical work queues in the department and weekly production reports. Daily prioritization of staffing assignments for optimizing impact on department production.
- Responsible for managing all aspects of the denial and appeal processes within the department to promote consistency and accuracy within the processes and compliance with HIPPA, and regulatory and accreditation guidelines
- Responsible for clinical coordination and presentation of information for administrative hearings and OFIR reviews
- Conducts inter-rater reliability tests and audits among Nurse Reviewers, Pre-Service Nurse Reviewers, Transitional Case Managers and Utilization Management Care Coordinators. Evaluates the consistency of utilization management decision making based on MHP, InterQual Medicare and state specific Medicaid criteria and acts on opportunities to improve consistency when applicable.
- Provide primary support to Medical Directors in the utilization review process.
- Act as the primary resource in cooperation with the Medical Director and Director of Utilization Management for criteria and benefit interpretation including the correct and consistent application of InterQual criteria and the consistent application of procedural practices established by MHP, Medicare, and state specific Medicaid guidelines
- Provides for ongoing training and education to the staff through one-on-one, classroom settings and web based programs in regards to InterQual, regulatory and accreditation requirements, and other necessary job-related skills.
- Identify, Implement and Evaluate process improvement activities.
- Provide on-going coaching and counseling of all staff.
- Promote the professional development of all staff.

Attachment 13 (Utilization & Care Management Job Descriptions)

- Oversee the discharge planning activities of the nurse reviewers, Pre-Service Nurse Reviewers, and Transitional Case Managers including but not limited to developing a plan of action, obtaining the necessary equipment and supplies, addressing discharge medication needs, referrals to disease and case management, negotiating prices, developing case contract, obtaining clinical updates, monitoring the number of days towards disenrollment and discharge planning from the SNF as well as post discharge calls to members.
- Oversee the collection of Healthcare Effectiveness Data Information Set (HEDIS) information as is applicable to the differing job functions.
- Oversee Long Term Care disenrollments, including gathering the clinical information and preparing a clinical summary and completing the required forms for submission to MDCH. Acts as the primary contact with MDCH in relation to long term care disenrollments.
- Actively participates in the Hospital Care Coordination weekly meetings by providing education and direction to the staff.
- Oversee the coordination of care of potential transplant members including obtaining all necessary clinical information to determine appropriateness and medical necessity of transplant, presentation of case to medical director for approval, coordination of care for member across the continuum by appropriate case management referrals, obtaining clinical updates and reviews as needed, and submitting the appropriate information to finance, claims and the re-insurer. Work with Provider Services for contract negotiation when necessary.
- Solve utilization issues that occur by acting as the primary resolution point of contact. Utilize professional knowledge, MHP knowledge and pertinent resources or use the appropriate reporting structure to solve problems and issues as identified.
- Maintain strict confidentiality of employee and organizational information in accordance with MHP, HIPAA and State privacy regulations.
- Performs other job functions as requested by the Deputy Director or Director of Utilization Management.

Job Requirements:

Education:

- Current licensure to practice as in the designated State, without restriction, is required.

Experience:

- Three to five years of experience, education and/or certifications in utilization management, case management or other appropriate health care specialty is required.
- A minimum of one year supervisory experience is required.

Knowledge:

- Knowledge of MHP's mission and operational structure
- Knowledge of managed care, particularly utilization management processes
- Knowledge of Medicaid guidelines, medical necessity and benefit structure
- Knowledge of National Committee for Quality Assurance (NCQA), URAC or general accreditation requirements and guidelines for utilization management, denials and appeals

Skills:

- Demonstrated leadership skills
- Organizational skills
- Excellent written and verbal communication skills
- Demonstrated clinical knowledge and expertise

Attachment 13 (Utilization & Care Management Job Descriptions)

Abilities:

- Ability to prioritize work load
- Ability to work as part of a team while meeting individual goals and objectives
- Ability to identify, develop and implement process improvements

Nurse Educator

Reports To: Manager of Utilization Management

Position Summary: This position is responsible for developing, implementing and overseeing training for the newly hired UM nursing staff and current Utilization Management nursing staff. This includes the development and maintenance of departmental training material, conducting training sessions and assessing staff training needs. This position also provides first line clinical direction to the utilization management staff and other supporting departments including Care Coordination, Behavioral Health, Medical Management, Meridian Rx and LTSS.

Essential Functions:

Training and Development of New Nursing Staff

- With assistance of the Training and Development department, develop a nurse preceptor program
- Assess learning needs of new staff and develop and implement a learning plan
- Provide training on MCS, UM processes and policies and procedures
- Evaluate employee competence
- Document employee learning and clinical progress
- Provides new employee performance data in relation to established internal and external benchmarks to the leadership team
- In collaboration with the leadership team, determines areas for improvement and develops improvement plans

Continuing Education and Professional Development of all Utilization Management Nursing Staff

- Develops, conducts, and participates in providing competency skills fairs, preceptor program, and in-service programs
- Conducts learning needs assessments for individuals/groups of staff
- Monitors ongoing competency through monthly quality audits
- Provide cross-training for staff members who are provide coverage in other areas
- Provides continuing education to nursing staff
- Acts as nurse leader and provides education for staff on nursing and UM standards
- Plans, implements, evaluates, and revises training for staff in accordance with accrediting and regulatory standards
- Demonstrates knowledge base of current trends and developments in managed care
- Performs inter-rater reliability assessments bi annually
- When applicable, provides training to other departments within MHP as it relates to UM policies and procedures
- Provides new employee performance data in relation to established internal and external benchmarks to the leadership team
- In collaboration with the leadership team, determines areas for improvement and develops improvement plans

Educational and Research Responsibilities

- Participates in the development of utilization and medical policies and provides training to staff
- Remains current with accrediting and regulatory standards by reviewing CMS and state publications on new policies, bulletins, new technology and disseminates findings to UM Director or UM Medical Director as appropriate

Attachment 13 (Utilization & Care Management Job Descriptions)

- Plans and implements educational programs for new/changing technology
- Maintains UM process competency by working in the queue a minimum of 0.5 days per week
- Maintains professional nursing competency through continuing education
- Contributes to the nursing profession through participation in professional activities at a local and/or national level

Job Requirements:

Education:

- Current license (without restriction) to practice as a Licensed Practical Nurse or Registered Nurse in the designated State is required.

Experience:

- Minimum of 1 year previous training experience required
- Minimum of 3 years' experience in Utilization Review is preferred

Knowledge:

- Working knowledge of Microsoft Office tools (Word, Excel and Outlook)
- Knowledge of managed care
- Must possess working knowledge of MDCH regulations
- Previous knowledge of InterQual criteria preferred
- Knowledge of utilization management processes

Skills:

- Strong organizational skills
- Excellent communication skills, both written and verbal

Abilities:

- Lead group and individual training sessions with ease
- Able to prioritize workload and balance multiple projects simultaneously
- Identify training needs and develop corresponding training materials

Utilization Management Pre-Service Review Nurse

Reports To: Manager of Utilization Management

Position Summary: This position ensures that authorization requests, provider inquiries and member inquiries are handled appropriately within established timeframes, and established guidelines and protocol are utilized for clinical decision-making. Functions collaboratively with the members of the Utilization Management team, and specifically with the inpatient review nurses, Case Managers, Utilization Management Specialists and Medical Directors to ensure for timely disposition of outpatient authorization requests.

Essential Functions:

- Perform review of requests for services/procedures including, but not limited to, elective surgery (inpatient and outpatient), Durable Medical Equipment, home care, therapy services, and IV infusions that require medical necessity review and/or benefit interpretation
- Use established medical criteria to approve services based on information obtained from attending physician and/or other providers
- Ensure timely disposition of requests according to established timeframes
- Consult with Medical Director as appropriate for all requests that do not meet criteria and inform providers of the Medical Director's decisions
- Ensure full collection of clinical information prior to rendering a decision
- Act as a member/family advocate in coordinating and accessing medical necessity health care services within the benefit plan
- Respond to member questions regarding the disposition of a request and/or the decision
- Manage workload needs on a concurrent basis, including authorization queues and fax queues in the UM department to concurrently prioritize self-assignment for greatest impact on department function
- Support orientation program for UM staff by acting as primary mentor for review nurses, UM specialists and physician reviewers
- In conjunction with medical leadership, act as resource for criteria and benefit interpretation including the correct and consistent application of the InterQual criteria on the appropriate topics, consistent application of procedural practices established by MHP
- Supply ongoing training and education to the staff through one-on-one and classroom settings regarding InterQual, National Committee for Quality Assurance (NCQA), URAC or general accreditation, MDCH and other necessary job-related skills
- Collaborates with the Disease Management, Quality Management, and Utilization Management departments in the development of protocols and guidelines designed to standardize care practice and care delivery. Seeks out opportunities to improve HEDIS, NCQA, URAC or general accreditation and QIA activities
- Complete authorization process in MCS system for approved authorizations and contact providers with decision and corporate authorization number
- Contact providers where additional information is necessary to make a decision
- Create and fax/mail denial letters to members/providers as required and within established timeframes
- Receive and process clinical updates for continuation of services
- Collaborate with inpatient reviewers, case managers and other MHP staff for care coordination
- Perform other duties as assigned

Job Requirements:

Education:

Attachment 13 (Utilization & Care Management Job Descriptions)

- Current license (without restriction) to practice as a Licensed Practical Nurse or Registered Nurse in the designated State is required.

Experience:

- At least one year experience in UM/UR and managed care experience is preferred.

Knowledge:

- Knowledge of medical terminology, authorization processes, Medicaid and Managed Care

Skills:

- Excellent customer service and interpersonal communication skills
- Excellent computer/data entry skills

Transitional Care Coordinator

Reports To: Manager of Utilization Management

Position Summary: This position works collaboratively with other members of the Utilization Management team to ensure that authorization requests, provider and member inquiries are handled appropriately, within established timeframes and utilizing established guidelines. This position will coordinate member care services as directed by the clinical staff and maintain accurate and timely tracking and reporting of activities performed.

Essential Functions:

- Perform member assessments for potential care coordination services
- Conduct post-discharge calls
- Perform member engagement activities, i.e., locating valid member contact information
- Conduct tasks as assigned by UM nurses, i.e., follow-up calls to members and providers for coordination of services
- Assist in the collection of Healthcare Effectiveness Data Information Set (HEDIS) data
- Serve as back up for processing referrals
- Record and report daily post-discharge call data
- Record and report daily member calls and outcomes
- Mailing of member and provider correspondence
- Remain updated on all relevant policy changes made by MHP or MDCH
- Understand principles of HIPAA and maintain confidentiality
- Manage telephone inquiries by logging into appropriate phone queue and handling or forwarding calls as needed
- Receive and organize authorization requests and clinical information via fax or telephone for all lines of business as needed
- Enter demographic data into MCS making certain that all data fields are correct and all necessary CPT, ICD-9 and diagnostic codes are entered. Utilize appropriate resources or contact provider offices to clarify information as needed.
- Enter a system approval for all PCP authorizable services
- Forward corporate authorization requests and accompanying clinical information to licensed reviewers
- Fax processed requests back to appropriate provider offices
- Manage telephone inquiries by logging onto appropriate phone queue and handling or forwarding calls as appropriate
- Provide support for processing denial and appeal letters as needed
- Make outgoing calls to members to conduct outreach related to MHP clinical priorities
- Process authorization requests for deliveries and observation stays
- Assist with special projects or department process improvement efforts, as needed
- Perform other duties as assigned

Job Requirements:

Education:

- High school diploma is required. Associate's degree is required. Bachelor's degree or Fellow designation from the Academy for Healthcare Management is preferred.

Experience:

Attachment 13 (Utilization & Care Management Job Descriptions)

- Three to five years of related experience and/or training is required.

Knowledge:

- Advanced knowledge of medical terminology
- Advanced knowledge of managed care and authorization processes
- Knowledge and/or experience in work teams

Skills:

- Excellent customer service and interpersonal communication skills
- Computer/data entry skills
- Telephone service skills

Abilities:

- Ability and desire to work in a team atmosphere
- Ability to prioritize work and function under time constraints

Transitional Case Manager

Reports To: Manager of Utilization Management

Position Summary: This position is responsible for the safe and effective transition of care for members from an acute care setting to another as the member's health status changes. Responsibilities include but are not limited to ensuring that authorization requests for skilled nursing facility placement and inpatient acute rehabilitation placements and provider inquiries are handled appropriately within established timeframes, and utilizing established guidelines, criteria and processes for clinical decision-making. In addition, this position is responsible for telephonic follow-up with a select population of members post discharge from the inpatient acute, SNF and inpatient acute Rehabilitation settings. Functions collaboratively with the members of the Utilization Management staff, and specifically with the inpatient review nurses, pre-service review nurses, case managers, pharmacists and Medical Directors to ensure for timely disposition of authorization requests and discharge planning activities.

Essential Functions:

- Performs skilled nursing facility and acute inpatient rehabilitation placements by review of clinical data and utilizing established clinical criteria for first level review.
- Applies clinical criteria appropriately and in a consistent manner.
- Conducts utilization review and meets decision timeframes consistent with URAC, NCQA, MDCH and HIPPA guidelines.
- Contacts hospital/Facility reviewers where additional information is necessary to make a decision within established timeframes.
- Coordinates discharge planning activities including SNF, Acute inpatient rehab, home health care, home infusion, DME and pre-authorization of discharge medications with multidisciplinary health providers for members referred by inpatient nurse reviewers, pre-service review nurses and case managers, consistent with MHP policies and procedures.
- Complete authorization process in MCS system for approved authorizations according to department processes and procedures and contacts facility reviewers with decision, days authorized and corporate authorization number.
- Documents discharge planning activities in the inpatient authorization on the same day that discussions with discharge planner occurred.
- Documents in the SNF/Acute Inpatient Rehabilitation authorization brief summary of reason member in acute inpatient, functioning prior to admission, social supports, plan of care needs, short and long term goals, current functioning with therapy, severity of illness and tentative discharge plan.
- Consults with Medical Director as appropriate for all requests that do not meet criteria for admission and inform hospital/facility reviewers of the Medical Director's decisions
- Provides verbal determination decisions and creates denial letters to hospitals/Facilities as required and within established timeframes
- Receives and processes clinical updates for continued stay review meeting all timeframes for decision making.
- Performs post discharge calls to members post inpatient, SNF and acute rehabilitation services in accordance with department guidelines. Assists to coordinate follow-up appointments, home health care services, pharmacy services, and refer to MHP case management and/or community resources as indicated.
- Processes SNF disenrollments in a timely manner and according to department policies and procedures.
- Perform other duties as assigned

Job Requirements

Education:

- Current license (without restriction) to practice as a Licensed Practical Nurse or Registered Nurse in the designated State is required.

Experience:

- At least two years' experience in UM/UR/CM and managed care experience is preferred.

Knowledge:

- Knowledge of medical terminology, authorization processes, Medicaid and Managed Care

Skills:

- Excellent customer service and interpersonal communication skills
- Excellent computer/data entry skills
- Demonstrated clinical knowledge and expertise
- Excellent written and verbal communication skills
- Excellent organizational skills

Abilities:

- Ability to prioritize work load
- Ability to work independently
- Ability to work as part of a team while meeting individual goals and objectives
- Ability to consistently apply clinical criteria

Transplant Care Coordinator

Reports To: Manager of Utilization Management

Position Summary: This position works collaboratively with other members of the Utilization Management team and multidisciplinary care teams that may include: the member's PCP, specialists, social worker/behavioral health specialist and community resource contacts to ensure that all services related to transplants including authorization requests, provider and member inquiries are handled appropriately, within established timeframes and utilizing established guidelines. This position performs telephonic member engagement activities related to pre- and post-transplant care, coordinates member care services as directed by the clinical staff, and maintains accurate and timely tracking and reporting of activities performed.

Essential Functions:

- Receive and organize transplant authorization requests and clinical information via fax or telephone for all lines of business as needed
- Enter demographic data into MCS making certain that all data fields are correct and all necessary CPT, ICD-9 and diagnostic codes are entered. Utilize appropriate resources or contact provider offices to clarify information as needed.
- Forward corporate authorization requests and accompanying clinical information to licensed reviewers
- Fax processed requests back to appropriate provider offices
- Manage telephone inquiries by logging onto appropriate phone queue and handling or forwarding calls as appropriate
- Conduct post inpatient calls
- Provide support for processing denial and appeal letters as needed
- Make outgoing calls to members to conduct outreach related to MHP clinical priorities
- Establishes and maintains effective partnerships between MHP and MHP contracted transplant Centers of Excellence with the goal of providing total quality and case management for MHP members receiving transplant services
- Assists in development and maintenance of educational materials for the MHP transplant program, including but not limited to, information for members, families, physicians, and Centers of Excellence
- Maintain complete and accurate transplant records and reports
- Perform member assessments for potential case management services
- Perform member engagement activities, i.e., locating valid member contact information
- Conduct tasks as assigned by nurse reviewers, case managers, i.e., follow-up calls to members and providers for coordination of services
- Assist in the collection of Healthcare Effectiveness Data Information Set (HEDIS) data
- Record and report daily member calls and outcomes
- Mailing of member and provider correspondence
- Remain updated on all relevant policy changes made by MHP
- Understand principles of HIPAA and maintain confidentiality
- Perform other administrative duties as assigned by leadership

Job Requirements

Education:

- Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is required.

Attachment 13 (Utilization & Care Management Job Descriptions)

- Successful completion of the Online Medicaid Managed Care course is preferred.

Experience:

- A minimum of one year customer service experience is required.
- A minimum of one year experience as a Utilization Management Specialist or two years of related health industry experience is required.

Knowledge:

- Knowledge of managed care and Iowa Medicaid guidelines
- Thorough knowledge of the authorization process
- Understanding of NCQA, URAC or general accreditation requirements for Utilization Management and Appeals

Skills:

- Excellent verbal and written communication skills
- Basic computer skills

Utilization Management Care Coordinator

Reports To: Manager of Utilization Management

Position Summary: This position works collaboratively with other members of the Utilization Management team to ensure that authorization requests, provider and member inquiries are handled appropriately, within established timeframes and utilizing established guidelines.

Essential Functions:

- Receive and organize authorization requests and clinical information via fax or telephone
- Enter demographic data into MCS making certain that all data fields are correct and all necessary CPT, ICD-9 and diagnostic codes are entered. Utilize appropriate resources or contact provider offices to clarify information as needed.
- Enter a system approval for all PCP authorizable services
- Forward corporate authorization requests and accompanying clinical information to licensed reviewers
- Fax processed requests back to appropriate provider offices
- Manage telephone inquiries by logging onto appropriate phone queue and handling or forwarding calls as appropriate
- Make outgoing calls to members to conduct outreach related to MHP clinical priorities
- Perform other duties as assigned such as faxing, filing and mailing

Job Requirements:

Education:

- High school diploma is required.
- Associate's degree is required. Pursuit of a Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is preferred.

Experience:

- At least 6 months related experience and/or training is preferred.

Knowledge:

- Basic knowledge of medical terminology
- Basic knowledge of managed care and authorization processes
- Knowledge and/or experience in work teams

Skills:

- Excellent customer service and interpersonal communication skills
- Computer/data entry skills
- Telephone service skills

Abilities:

- Ability and desire to work in a team atmosphere
- Ability to prioritize work and function under time constraints

Utilization Management Operational Lead

Reports To: Manager of Utilization Management

Position Summary: This position provides operational oversight of the Utilization Management department and is responsible for ensuring production and quality expectations are consistently met. The Operational Lead works in conjunction with the department managers to provide leadership and direction to the assigned teams.

Essential Functions:

- Oversees workload needs on a concurrent basis including monitoring phone coverage and authorization queues in the Utilization Management department to prioritize staffing assignments (including self-assignment) for greatest impact on department function
- Responsible for reviewing daily turnaround time reports and follow up cases that require decisions
- Responsible for reviewing individual, team and department production and phone queue reports to ensure expectations
- Develops and conducts monthly production and phone audits and acts on opportunities to improve efficiencies
- Responsible for oversight of the department phone queues to ensure all phone calls are answered within 30 seconds with a service rate of 98%
- Responsible for scheduling of the UM Care Coordinators work hours as well as coordination of their PTO requests
- Holds regular staff meetings with the Utilization Management teams
- Responsible for the training of all new Utilization Management staff as well as the ongoing training of existing staff
- Responsible for management of task timer and task timer edits
- Provide weekly reports on performance metrics to manager and director for assigned teams
- Identify barriers to meeting individual and department goals and work with manager and/or director to develop and implement opportunities for improvement
- Provide front line operational direction to department staff and consult with manager and/or director as appropriate for input
- Work in collaboration with Leadership and Training to develop job aides for the Utilization Management staff, identify learning opportunities and conduct targeted training and/or retraining
- Communicates any staff issues to the department manager and/or director
- Act as a liaison with other Meridian departments in relation to departmental issues
- Consistently demonstrate compliance with regulatory and accreditation standards
- Assist with special projects or departmental process improvement efforts as needed
- Maintain HIPAA standards and confidentiality of protected health information; and consistently demonstrate compliance with HIPAA regulations, professional conduct and ethical practice
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is preferred

Attachment 13 (Utilization & Care Management Job Descriptions)

Experience:

- At least one to three years in a Utilization Management position exceeding production and quality expectations or relevant experience within Meridian Health Plan or a healthcare setting

Knowledge:

- Must demonstrate customer focused interpersonal skills to interact in an effective manner with practitioners, the interdisciplinary health care team, community agencies, members, and families with diverse opinions, values and religious and cultural ideals
- Must also demonstrate the ability to work autonomously, follow through with delegated tasks and be directly accountable for deliverables
- Advanced knowledge of medical terminology
- Advanced knowledge of managed care and authorization processes
- Advanced knowledge of utilization management policies and procedures
- Knowledge and/or experience in work teams

Skills:

- Demonstrated leadership skills are required
- Excellent organizational and critical thinking skills
- Skilled in conducting telephone outreach and education
- Must have leadership qualities including:
 - Time management
 - Verbal and written communication skills
 - Problem solving and decision making skills
 - Priority setting
 - Work delegation and work organization as well as strong customer service focus, teamwork orientation, and resourcefulness in problem solving

Abilities:

- Must possess the ability to make independent decisions when circumstances warrant such action
- Must possess the ability to affect change, work as a productive and effective team member and adapt to changing needs/priorities
- Ability to prioritize and coordinate member care needs
- Ability to manage multiple tasks simultaneously
- Ability to work collaboratively and effectively with diverse groups
- Ability to function as part of an interdisciplinary team

Utilization Management Trainer

Reports To: Manager of Utilization Management

Position Summary: This position is responsible for developing, implementing and overseeing training for the Utilization Management (UM) department. This includes the development and maintenance of departmental training material, conducting training sessions and assessing staff training needs. This position also provides first line operational direction to the UM staff and other supporting departments including Care Coordination, Behavioral Health, Medical Management, MeridianRx and LTSS.

Essential Functions:

Training and Development of New Utilization Management Staff

- Develop, implement and continuously improve the new hire UM curriculum and training checklist for use by all new Utilization Management
- Assess learning needs of new staff and develop and implement a learning plan
- Provide training on MCS , UM processes and policies and procedures
- Evaluate employee competence
- Document employee learning and clinical progress
- Provides new employee performance data in relation to established internal and external benchmarks to the leadership team
- In collaboration with the leadership team, determines areas for improvement and develops improvement plans

Continuing Education and Professional Development of all Utilization Management Staff

- Develops, conducts, and participates in providing competency skills fairs, preceptor program, and in-service programs
- Conducts learning needs assessments for individuals/groups of staff
- Monitors ongoing competency through monthly quality audits
- Provide cross-training for staff members who are provide coverage in other areas
- Provides continuing education for all Utilization Management staff
- Plans, implements, evaluates, and revises training for staff in accordance with accrediting and regulatory standards
- Demonstrates knowledge base of current trends and developments in managed care
- Performs inter-rater reliability assessments bi annually
- When applicable, provides training to other departments within MHP as it relates to UM policies and procedures
- Provides new employee performance data in relation to established internal and external benchmarks to the leadership team
- In collaboration with the leadership team, determines areas for improvement and develops improvement plans
- Collaborates with trainers from the Training & Development, Care Coordination, Claims and Behavioral health departments to ensure comprehension of the UM department across the enterprise

Educational and Research Responsibilities

- Participates in the development of utilization and medical policies and provides training to staff regarding these policies

Attachment 13 (Utilization & Care Management Job Descriptions)

- Remains current with accrediting and regulatory standards by reviewing CMS and state publications on new policies, bulletins, new technology and disseminates findings to UM Director or UM Medical Director as appropriate
- Plans and implements educational programs for new/changing technology
- Maintains UM process competency by working in the queue a minimum of 0.5 days per week
- Maintains professional competency through continuing education

Job Requirements:

Education:

- Bachelor's degree with a concentration in healthcare related studies or Fellow, Academy for Healthcare Management (AHM) Designation is required

Knowledge:

- Must demonstrate knowledge of managed care and utilization management
- Must also demonstrate the ability to work autonomously, follow through with delegated tasks and be directly accountable for deliverables.
- Must have leadership qualities including time management, verbal and written communication skills, listening skills, problem solving and decision-making, priority setting, work delegation and work organization, as well as strong customer service focus, teamwork orientation and resourcefulness in problem solving.

Experience:

- At least three or more years of related healthcare or training experience required

Skills:

- Demonstrates excellent communication – both verbal and written
- Excellent interpersonal and facilitation skills

Abilities:

- Must have the ability to affect change, work as a productive and effective team member and adapt to changing needs/priorities

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Contract Administrator/CEO/COO

Reports To: Board of Directors

Position Summary: This position is responsible for developing and overseeing the implementation of the strategic business plan for Meridian Health Plan. The Contract Administrator/CEO/COO ensures that company operations support the strategic plan, performance objectives, policies and procedures. When the CEO is an MD he/she may participate in the review of appeals in accordance with National Committee for Quality Assurance (NCQA), URAC or general accreditation guidelines.

Essential Functions:

- Sets the strategic business direction for Meridian Health Plan
- Develops and oversees the implementation of the organization's strategic business plan
- Oversees plan operations and manages financial and physical resources
- Advises the Board of Directors on key issues
- Ensures financial performance and quality of care and service through well-defined policies and processes
- Formulates and executes major policies, programs and objectives to promote and ensure the continued success and growth of the plan
- Supervises and supports designated subordinates in achieving corporate goals and objectives
- Oversees budget development and manages organizational resources to support corporate objectives within budgetary guidelines
- Promotes policies and procedures that promote a work environment that facilitates optimum employee performance
- Oversees the development and implementation of policies and procedures necessary to assure compliance with all legal and regulatory guidelines impacting the plan and maintenance of responsibilities to members, providers, and employees
- Creates and provides necessary resources for committee activities designed to address the plan's legal requirements and regulatory requirements, as well as specific problems and opportunities which may affect plan performance
- Assures that the image of the plan and its programs and services is consistently presented in a strong and positive manner
- Establishes and maintains strong relationships with key stakeholders and other entities necessary to ensure the plan's continued growth
- May review appeals when able to meet NCQA, URAC or general accreditation qualifications for performing this function
- Perform other duties as assigned

Job Requirements:

Education:

- MD/MBA/MHA/MPA or equivalent is required.

Experience:

- Minimum of 7-10 years of progressive management position and experience in senior management positions in health care, managed care, or medical administration is required.

Knowledge:

- Knowledge of federal and state HMO regulations

Attachment 14 (Key Personnel Job Descriptions)

- Knowledge of federal and state Medicaid regulations
- Knowledge of the designated State managed care market

Skills:

- Demonstrated leadership skills
- Strong business development and strategic planning skills
- Demonstrated marketing skills
- Strong written and oral communication skills and the capability to articulate the plan's strategic vision and translate that into sound operational business plans.
- Proven entrepreneurial skills

Abilities:

- Proven ability to achieve goals and objectives
- Ability to develop and communicate a strategic vision for the plan to senior management and employees.
- Ability to relate to people on multiple levels
- Ability to prioritize based on corporate and budgetary limitations

Medical Director

Reports To: Contract Administrator/CEO/COO

Position Summary: This position provides oversight of the utilization management process and assumes responsibilities within the quality improvement program.

Essential Functions:

- Provide clinical leadership for the utilization management process, including authorizations, denials and appeals. Offer clinical guidance to the Utilization Management nurses and other staff.
- Provide oversight of all clinical functions including, but not limited to, disease and care management programs, the development of clinical care guidelines and utilization management
- Respond to provider inquiries regarding utilization management decisions, complaints and appeals. Promote positive provider relationships.
- Offer clinical insight for the development or adoption of utilization management, pharmacy and quality management programs, as well as medical necessity definition and criteria
- Review post-service appeals and make appropriate determinations regarding the medical necessity and appropriateness of services
- Review practice patterns of physicians and work with the Compliance Officer to identify potential for Fraud Waste and Abuse (FWA) and to report these findings to the Corporate FWA committee
- Investigate complaints from membership in regards to the quality of care they are receiving and to report these findings to the credentials committee
- Monitor compliance with physician credentialing and re-credentialing policies and procedures. Review “clean” files and prepare exception report prior to Credentialing Committee meeting.
- May serve as the chairperson for the Credentialing Committee and other QI Committees, as delegated by the Contract Administrator/CEO/COO
- Responsible for the coordination and implementation of the Quality Management and Improvement Program
- Attend and actively participate in any scheduled quality committee meetings as directed by DHS
- Directs Meridian’s internal utilization management committee
- Coordinate with the Contract Administrator/CEO/COO, the Pharmacy Director/Coordinator and Meridian’s pharmacy benefit manager to ensure appropriate administration of the pharmacy benefit
- Oversee staff training and education in matters relating to the delivery of medical care, the assurance of quality, and effective control of utilization
- Work with the Contract Administrator/CEO/COO to assure quality of care in all aspects of medical utilization and to assure that health care utilization is appropriate to meet the needs of the members and falls within the recognized standards of efficiency
- Collaborate with MHP Directors to assure MHP compliance with all regulatory programs including National Committee for Quality Assurance (NCQA), URAC or general accreditation and State Medicaid guidelines
- Represent the health plan in the medical community, upon request
- Act as a liaison between organization and community providers to promote, support and educate regarding managed care, Meridian and the Care Coordination Model.
- Perform other duties as assigned

Job Requirements:

Education:

- Current unrestricted license as Doctor of Medicine or Osteopathy for Iowa is required.
- Current board certification in his or her designated specialty is preferred.

Experience:

- 3 - 5 years experience in managed care and medical management of health plans or in medical programs administration is required.
- 5 years Post Graduate experience in direct patient care is required.
- Strong experience in developing and/or implementing practice guidelines is required.
- Experience in providing care to a Medicaid population is preferred.

Knowledge:

- Strong knowledge of utilization management and quality improvement
- Working knowledge of the accreditation standards of URAC and the National Committee for Quality Assurance (NCQA) and the Healthcare Effectiveness Data and Information Set (HEDIS)

Skills:

- Strong team-building skills; able to build consensus and to affiliate with and collaborate toward organizational objectives; able to foster effective interactions across organizational and departmental boundaries
- Strong, professional presentation skills; able to present organizational objectives, ideas, and/or concepts in a convincing and credible manner
- Strong interpersonal skills and the ability to promote the development of physician leaders

Abilities:

- Ability to comply with health plan attestation for credentialing requirements
- Ability to work independently as a key member of a management team and to prioritize workload
- Ability to work with colleagues and other health care professionals to resolve utilization and quality management issues as required
- Demonstrated commitment to ensure that clinical programs are culturally sensitive and linguistically competent
- Ability to communicate effectively with health professionals and administrators, both orally and in writing

Chief Financial Officer

Reports To: Contract Administrator/CEO/COO

Position Summary: This position is responsible for overseeing Meridian's financial and accounting operations, including financial management information systems, payroll, accounts payable, enrollment, and underwriting, as well as accounting, fiscal reporting, and budget preparation. Coordinates the overall financial management of the health plan.

Essential Functions:

Responsible for all financial activities of the corporation including:

- General Accounting
 - Oversight and maintenance of all financial records of the organization
 - Monthly close of financial records
 - Preparation of interim financial statements; presentation to Board and Contract Administrator/CEO/COO
 - Preparation and submission of state required reports
 - Annual Budget Preparation
 - Annual Audit coordination
 - Periodic State Examinations coordination
 - Coordination of External actuary activities
 - Oversight of Accounts Payable process
 - Oversight of Payroll preparation process
 - Reconciliation of revenue amounts to contract
 - Perform other duties as assigned
- Other Financial Operations
 - Oversight of cash management and treasury investment program
 - Development, implementation and maintenance of Internal Audit program
 - Audit of work performed by staff accountants
 - Financial analysis as required
 - Oversight of Capitated Provider Payments
 - Oversight of employee compensation system
 - Oversight and administration of employee benefit system
 - Development of financial policies and procedures and monitoring compliance with those policies and procedures, including Fraud, Waste and Abuse
 - Oversight of stop loss recovery processing
 - Oversight of corporate insurance policy renewals
 - Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree in Accounting is required.
- CPA or MBA is preferred.

Experience:

- Minimum of five years experience in the health care industry is required.
- At least two years experience in a managed care setting is required.

Attachment 14 (Key Personnel Job Descriptions)

Knowledge:

- Knowledge of GAAP required
- Knowledge of SAP required
- Familiarity with State reporting requirements strongly preferred

Skills:

- Excellent interpersonal skills
- Excellent written and oral communication skills
- Excellent negotiation skills

Abilities:

- Highly organized
- Ability to deal with multiple internal and external resources and customers
- Ability to work under tight timeframes and stressful conditions
- Ability to interpret financial regulations as they apply to the Medicaid program

Compliance Officer

Reports To: Chief Administrative Officer

Position Summary: This position establishes, implements, and ensures the maintenance of an effective corporate compliance program to prevent illegal, unethical or improper conduct. The compliance officer is also responsible for assuring that Meridian meets all contractual responsibilities with the Department of Community Health. The Compliance Officer monitors and reports results of compliance and ethics efforts of the company to senior management and the Board of Directors and provides guidance on matters related to compliance. The Compliance Officer, together with the compliance committee is authorized to implement all necessary actions to ensure achievement of the objectives of an effective government relations and compliance program.

Essential Functions:

- Develops, initiates, maintains and revises policies and procedures necessary for the operation of the Meridian compliance program and related activities
- Manages the day-to-day operations of the Meridian compliance program and takes appropriate steps to improve its effectiveness
- Develops and annually reviews and updates as necessary the Meridian Code of Conduct to ensure that Meridian employees receive current and relevant guidance with respect to corporate compliance expectations. Ensures that each employee annually signs a Code of Conduct certification
- Develops and monitors methodologies and systems to build compliance awareness into daily business processes
- Consults with Meridian Legal Counsel as necessary to resolve legal compliance issues
- Responds to alleged violations of rules, regulations, policies, procedures or standards of conduct by evaluating or recommending the initiation of investigative procedures and oversees the uniform handling of violations including any sanctions for plan employees
- Responsible for complying with all HIPAA and privacy regulations as well as coordinate reporting to the State and to review the timeliness, accuracy and completeness of reports and data submissions to the State
- Ensures proper reporting of fraud and abuse violations or suspected violations to the appropriate enforcement agencies including DCH
- Primary liaison with the State (or its designees) to facilitate communications between DHS, the State's contractors and Meridian's executive leadership and staff
- Chairs the Meridian Corporate Fraud and Abuse Committee and works with the committee to:
 - Identify potential areas of compliance vulnerability and risk
 - Develop and implement corrective action plans to resolve problematic issues
 - Provide general guidance on how to avoid or deal with similar situations in the future
- Coordinates internal compliance review and monitoring activities including periodic reviews of departments.
- Responsible for ensuring all Meridian functions are in compliance with the terms of the Contract, in close coordination with other Key Personnel
- Oversees the development of training materials and programs for members, providers and plan employees and ensures that all employees receive training on corporate compliance. Maintains attendance rosters and training documentation
- Ensures that all employees are aware of both corporate and confidential mechanisms for reporting suspected fraud, waste and abuse

Attachment 14 (Key Personnel Job Descriptions)

- Develop and implement methods and programs that encourage managers and employees to report non-compliance and potential FWA without fear of retaliation
- Responds to reports of potential FWA, including the coordination of internal investigations and the development of appropriate corrective and disciplinary actions
- Presents a summary of fraud, waste and abuse reporting activities at each Fraud, Waste and Abuse Compliance Committee meeting
- Prepares an annual report to the Quality Management Committee and the Meridian Board of Directors that summarizes Meridian's Fraud, Waste and Abuse monitoring and detection activities and any policy or process changes made to enhance compliance
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree in health care or related field is required.

Experience:

- A minimum of five years experience in a Medicaid Managed Care Program or five years experience in public sector services such as Medicare, Medicaid, Community Health, Public Health or Social Services is preferred.

Knowledge:

- Must maintain a current knowledge of federal and state legislation, legislative initiatives and regulations that may impact the program
- Working knowledge of the National Committee for Quality Assurance (NCQA), URAC or general accreditation policies and procedures
- Working knowledge of Health Employer Data Information Set (HEDIS) requirements
- Working knowledge of the Privacy and Security Health Insurance Portability and Accountability Act (HIPAA) regulations
- Knowledge of coding and reimbursement systems, risk management and performance improvement is helpful.

Skills:

- Strong computer/data entry and Internet research skills including Microsoft Office programs
- Excellent oral and written communication skills
- Demonstrated leadership capabilities
- Demonstrated team building skills

Abilities:

- Sound decision making abilities
- Ability to gather information from multiple sources to understand problems
- Ability to recognize symptoms that indicate problems
- Ability to communicate effectively to large and small groups
- Ability to communicate effectively with health professionals and administrators both orally and in writing.
- Ability to be flexible in a rapidly changing job and regulatory environment
- Ability to work independently and to set priorities
- Ability to build consensus and to collaborate with internal and external entities to achieve organizational objectives
- Ability to bridge departmental and organizational boundaries

Pharmacy Director/Coordinator

Reports To: Chief Executive Officer - Corporate

Position Summary: This position is responsible for oversight and coordination of all Pharmacy Benefit Manager (PBM) requirements including drug rebate. This includes development of clinical programs to support effective utilization of covered pharmacy services.

Essential Functions:

- Oversees the activities of the PBM, including monitoring of performance metrics, utilization and reporting data
- Works cooperatively with Finance and other departments to analyze and review pharmacy cost and utilization data and takes appropriate action to address areas of concern
- Makes recommendations for new clinical program development to support utilization and quality goals for the PBM
- Develops processes to incorporate pharmacy data and clinical information obtained in the pharmacy authorization process as delegated by the PBM's clients.
- Responds to provider and member questions regarding the pharmacy benefits program
- Assists with the preparation and distribution of communication materials between the plan and participating providers
- Formulates and recommends operational policies and procedures for MeridianRx
- Keeps informed of federal and state regulations as they relate to the operations of the PBM
- Must attend DHS Pharmaceutical & Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Commission meetings
- Serves as the administrative liaison for the Pharmacy and Therapeutics Committee of MeridianRx. Duties include record keeping, meeting notification, and utilization reports.
- Prepares state-required reports for review and submission at the Pharmacy and Therapeutics Committee meetings
- Performs other duties as assigned

Job Requirements:

License:

- R.Ph. or PharmD is required.
- Current unrestricted license in the state of Iowa as a Pharmacist and Controlled Substance licenses in good standing are required.

Experience:

- At least five years of experience in managed health care or pharmacy programs is required.
- Previous management and supervisory experience is required.
- Previous experience in patient care is required.
- Previous experience as a Medicaid Pharmacy Director or equivalent Medicaid pharmacy experience, inclusive of drug rebate is required

Knowledge:

- Knowledge of the National Committee for Quality Assurance (NCQA), URAC or general accreditation standards for managed care organizations as they relate to pharmacy programs and delegation
- Knowledge of pharmacy utilization management processes and documentation
- Knowledge of pharmacy claims/encounter data

Attachment 14 (Key Personnel Job Descriptions)

Skills:

- Excellent written, verbal and presentation skills
- Excellent inter-personal and team building skills
- Strong computer skills, including Microsoft Office (Word, Excel, PowerPoint)
- Strong analytical and data interpretation skills

Abilities:

- Ability to work cooperatively with peers and subordinates
- Ability to motivate others toward achievement of common goals
- Ability to think creatively to resolve common barriers and issues

Grievance & Appeals Manager

Reports To: Senior Vice President of Corporate Operations

Position Summary: This position manages Meridian's grievance and appeals process, ensuring compliance with processing timelines and policy and procedure adherence. This position is responsible for management of the Pre-Service Denial and Appeal division of the health plan. Successfully maintains National Committee for Quality Assurance (NCQA), URAC or general accreditation status with regard to denial letters. Responsible for the writing and final editing of all letters sent out for denials and appeals. Ensures that each employee that is part of the denial process is meets their timeline with a 100% accuracy rate as well as resolution of member grievances. Direct the Medicare Appeals and Grievance Department to ensure the timely and appropriate research, investigation and resolution of all Part C Appeals and Grievances received by the plan. For those cases being addressed by the QIO, the IRE, ALJ or the MAC, oversee the preparation of all documentation necessary to process the cases. Prepare and review all reports of Appeals and Grievances as directed in Chapter 13 of the Medicare Managed Care Manual, the IRE and QIO Manuals.

Essential Functions:

- Responsible for managing all aspects of the denial and appeal processes within the department to promote consistency and accuracy within the processes and compliance with NCQA, URAC or general accreditation, MDCH and HIPAA guidelines
- Assume primary responsibility for the resolution of member inquiries related to formal grievances
- Daily prioritization of staffing assignments for optimizing impact on department production
- Responsible for each IRO supporting the health plan's decisions and ensures that they meet the critical time lines
- Attends weekly post service appeals committee; understands each case and is prepared with review for each case
- Works with the Fraud, Waste and Abuse unit verifying claims issues on take backs
- Works with the IS department on MCS development issues as it pertains to appeals and denials
- Prepares, with the department assistant, each second level Pre-Service appeal for review by the appeals committee. Materials are prepared when the call to the member is placed.
- Educates the department assistant on all phone calls between the health plan and members.
- Reviews and participates in all appeals that go to the tribunal hearings. Assists with the preparation and ground work for each hearing maintaining a better than 99% reached verdict in favor of the health plan
- Assists the Member Service department with the member complaints
- Assists the Pharmacy department in their denial process
- Responsible for clinical coordination and presentation of information for administrative hearings and OFIR reviews
- Oversees the OFIR complaints; researches and writes the letters to support the health plans decisions
- Provide ongoing training and education to the staff through one-on-one and classroom settings regarding InterQual, NCQA, URAC or general accreditation, MDCH and other necessary job-related skills.
- Utilize professional knowledge, MHP knowledge and pertinent resources or use the appropriate reporting structure to solve problems and issues as identified
- Maintain strict confidentiality of employee and organizational information in accordance with MHP, HIPAA and State privacy regulations

Attachment 14 (Key Personnel Job Descriptions)

- Manage the staff that will receive and track all cases from any source
- Ensure that Non-Contracted Providers receive Waivers of Liability when appropriate
- Ensure that representatives receive an Appointment of Representative Form when necessary
- Oversee that all cases are properly documented and tracked
- Ensure that clinical staff making the organization determination in not the same medical professional making the reconsideration or redetermination.
- Work with the Medicare Medical Director to ensure proper medical review 24/7 for cases involving medical necessity and clinical decision making.
- Evaluate staff performance
- Provide feedback to Utilization Management staff on the issuance and content of Notices of Denial of Medicare Coverage, Notices of Medical Non-Coverage and Detailed Explanations of Non-Coverage for the QIO
- Identify issues and root causes of grievances and appeals for plan management and compliance
- Provide support for the investigation, analysis and resolution of CTM cases.
- Provide support and direction for the clinical pharmacist and medical staff on Part D cases.
- Provide interdepartmental coordination to ensure that all appeals decisions are effectuated and documented in a timely manner
- Ensure that all cases files are complete and current.
- Perform other duties as assigned

Job Requirements:

Education:

- Current licensure to practice as a Registered Nurse or a Licensed Practical Nurse in the designated State, without restriction or Bachelor's degree in a healthcare related field is required.

Experience:

- Three to five years of experience, education and/or certifications in utilization management, case management or other appropriate health care specialty is required
- 2 - 5 years experience with Medicare Appeals and grievances is required
- Experience working with physicians and clinicians in the appeals and grievance is required

Knowledge:

- Knowledge of MHP's mission and operational structure.
- Knowledge of managed care, particularly utilization management processes.
- Knowledge of Medicaid guidelines, medical necessity and benefit structure.
- Knowledge of NCQA, URAC or general accreditation requirements and guidelines for utilization management, denials and appeals.

Skills:

- Demonstrated leadership skills
- Organizational skills
- Excellent written and verbal communication skills
- Demonstrated clinical knowledge and expertise

Abilities:

- Ability to prioritize work load
- Ability to work as part of a team while meeting individual goals and objectives
- Ability to identify, develop and implement process improvements

Director of Quality Improvement/Quality Management Manager

Reports to: Contract Administrator/Chief Executive Officer/Chief Operations Officer

Position Summary: This position is responsible for achieving and maintaining the quality and performance goals of Meridian Health Plan. Leads, coordinates, and ensures documentation of quality improvement, accreditation, and regulatory activities for the health plan. Develops and implements a comprehensive corporate strategy to ensure HEDIS and CAHPS improvement. Directs all preparations for National Committee for Quality Assurance (NCQA), URAC or general accreditation and ensures that the plan maintains its NCQA “Excellent” or URAC equivalent status. Accountable for timely program revisions to meet NCQA, URAC or general accreditation, and other regulatory requirements. This position is responsible for overseeing the Quality Management and Improvement program and ensuring compliance with quality management requirements and quality improvement initiatives.

Essential Functions:

- Oversee the development, implementation and annual evaluation of the corporate quality improvement plan
- Monitor and ensure compliance with all State of Iowa regulatory requirements, including the State performance measures
- Serve as the organizational leader for Healthcare Effectiveness Data and Information Set (HEDIS) reporting and improvement initiatives, including the following:
 - Develop a comprehensive strategy for HEDIS improvement, including action plans for all key HEDIS measures
 - Coordinate and monitor HEDIS outreach efforts across all company departments
 - Analyze and review data to identify opportunities for HEDIS improvement
 - Oversee all vendor activities, including hybrid data collection/medical record review
- Serve as the organizational leader for CAHPS reporting and improvement initiatives, including the following:
 - Oversee the data collection and reporting activities of MHP’s CAHPS vendor
 - Provide analysis of the CAHPS survey and MHP’s internal member satisfaction survey and identify areas for improvement
 - Work collaboratively with other departments to develop and implement strategies to improve MHP’s CAHPS scores
- Lead and direct the organization’s accreditation survey preparation for managed care organizations, including the following:
 - Support all department directors and managers to ensure that the compliance requirements are met for each area
 - Ensure that all documentation is readily available for submission to NCQA, URAC or general accreditation committee
 - Coordinate all pre-survey, on-site, and post-survey activities with NCQA, URAC or general accreditation committee
- Oversee the development and implementation of Disease Management programs for chronic conditions identified as a priority within the MHP membership
- Ensure that appropriate policies and procedures are in place to support all quality improvement and disease management activities
- Oversee the Quality Improvement Committee structure and participate in committee meetings as appropriate

Attachment 14 (Key Personnel Job Descriptions)

- Develop and monitor the budget for quality improvement and disease management activities and ensure that sufficient resources are assigned to meet quality and performance goals
- Prepare monthly and quarterly management reports for submission to the MHP leadership team and the Board of Directors
- Coordinate activities with department directors to meet MHP's goals, and serve as the "quality champion" within the organization
- Serve as a liaison for the health plan concerning quality improvement activities, including participation in external meetings and coordination with external entities
- Maintain strict confidentiality of employee and organizational information in accordance with HIPAA and State privacy regulations
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree in nursing or related field is required.
- Current Iowa license as a registered nurse, physician or physician's assistant or a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (HCQM) by the American Board of Quality Assurance and Utilization Review Physicians.
- Master's degree in healthcare administration or related field is preferred.

Experience:

- At least five years of experience in health care quality improvement is required.
- Previous experience in managed health care and Medicaid programs is required.
- Prior successful completion of an NCQA, URAC or general accreditation survey for managed care is required.
- Previous management and supervisory experience is required.

Knowledge:

- Knowledge of the NCQA, URAC or general accreditation standards for managed care organizations
- Knowledge of HEDIS specifications and CAHPS survey requirements
- Knowledge of health care quality improvement processes and documentation
- Knowledge of medical records and claims data

Skills:

- Excellent written, verbal, presentation skills and inter-personal skills
- Strong computer skills, including Microsoft Office (Word, Excel, PowerPoint)
- Strong analytical and data interpretation skills

Abilities:

- Ability to work cooperatively with peers and subordinates
- Ability to oversee and comprehend department activities at a detailed level
- Ability to motivate others toward achievement of common goals
- Ability to think creatively to resolve common barriers and issues

Utilization Management Manager

Reports To: Vice President of Utilization Management and Medical Director

Position Summary: This position manages all elements of Meridian's utilization management program and staff under the supervision of the Medical Director. This includes, but is not limited to functions related to prior authorization, medical necessity determinations, concurrent and retrospective reviews, and other clinical and medical management programs.

Essential Functions:

- Directly manage Nurse Reviewers, Pre-Service Review Nurses, Transitional Case Managers, Nurse Reviewer Team Lead, Pre-Service Nurse Reviewer Team Lead, Utilization Management Operational Team Leads, Denials Team Lead, Denials Specialist, Transitional Care Coordinators, Transplant Care Coordinators, and Utilization Management Care Coordinators including, but not limited to, hiring, training, scheduling, monitoring workload, conflict resolution, conducting performance evaluations and implementing performance improvement and disciplinary actions, when necessary.
- Provides oversight in the development and implementation of orientation and training activities for Nurse Reviewers, Pre-Service Nurse Reviewers, Transitional Case Managers, and Denials staff, and Utilization Management Care Coordinator staff.
- Oversee workload needs on a concurrent basis including monitoring phone coverage and clinical work queues in the department and weekly production reports. Daily prioritization of staffing assignments for optimizing impact on department production.
- Responsible for managing all aspects of the denial and appeal processes within the department to promote consistency and accuracy within the processes and compliance with HIPPA, and regulatory and accreditation guidelines
- Responsible for clinical coordination and presentation of information for administrative hearings and OFIR reviews
- Conducts inter-rater reliability tests and audits among Nurse Reviewers, Pre-Service Nurse Reviewers, Transitional Case Managers and Utilization Management Care Coordinators. Evaluates the consistency of utilization management decision making based on Meridian, InterQual Medicare and state specific Medicaid criteria and acts on opportunities to improve consistency when applicable.
- Provide primary support to Medical Directors in the utilization review process.
- Act as the primary resource in cooperation with the Medical Director and Director of Utilization Management for criteria and benefit interpretation including the correct and consistent application of InterQual criteria and the consistent application of procedural practices established by Meridian, Medicare, and state specific Medicaid guidelines
- Provides for ongoing training and education to the staff through one-on-one, classroom settings and web based programs in regards to InterQual, regulatory and accreditation requirements, and other necessary job-related skills.
- Identify, Implement and Evaluate process improvement activities.
- Provide on-going coaching and counseling of all staff.
- Promote the professional development of all staff.
- Oversee the discharge planning activities of the nurse reviewers, Pre-Service Nurse Reviewers, and Transitional Case Managers including but not limited to developing a plan of action, obtaining the necessary equipment and supplies, addressing discharge medication needs, referrals to disease and case management, negotiating prices, developing case contract, obtaining clinical

Attachment 14 (Key Personnel Job Descriptions)

updates, monitoring the number of days towards disenrollment and discharge planning from the SNF as well as post discharge calls to members.

- Oversee the collection of Healthcare Effectiveness Data Information Set (HEDIS) information as is applicable to the differing job functions.
- Oversee Long Term Care disenrollments, including gathering the clinical information and preparing a clinical summary and completing the required forms for submission to MDCH. Acts as the primary contact with DCH in relation to long term care disenrollments.
- Actively participates in the Hospital Care Coordination weekly meetings by providing education and direction to the staff.
- Oversee the coordination of care of potential transplant members including obtaining all necessary clinical information to determine appropriateness and medical necessity of transplant, presentation of case to medical director for approval, coordination of care for member across the continuum by appropriate case management referrals, obtaining clinical updates and reviews as needed, and submitting the appropriate information to finance, claims and the re-insurer. Work with Provider Services for contract negotiation when necessary.
- Solve utilization issues that occur by acting as the primary resolution point of contact. Utilize professional knowledge, Meridian knowledge and pertinent resources or use the appropriate reporting structure to solve problems and issues as identified.
- Maintain strict confidentiality of employee and organizational information in accordance with Meridian, HIPAA and State privacy regulations.
- Performs other job functions as requested by the Medical Director

Job Requirements:

Education:

- Current licensure to practice as in the designated State, without restriction, as a licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations is required

Experience:

- 3-5 years of experience, education and/or certifications in utilization management, case management or other appropriate health care specialty is required.
- A minimum of one year supervisory experience is required.

Knowledge:

- Knowledge of Meridian's mission and operational structure
- Knowledge of managed care, particularly utilization management processes
- Knowledge of Medicaid guidelines, medical necessity and benefit structure
- Knowledge of National Committee for Quality Assurance (NCQA), URAC or general accreditation requirements and guidelines for utilization management, denials and appeals

Skills:

- Demonstrated leadership skills
- Organizational skills
- Excellent written and verbal communication skills
- Demonstrated clinical knowledge and expertise

Abilities:

- Ability to prioritize work load
- Ability to work as part of a team while meeting individual goals and objectives
- Ability to identify, develop and implement process improvements

Behavioral Health Manager

Reports To: Chief Operating Officer - Corporate

Position Summary: This position is responsible for the operational leadership and integration of the Behavioral Health programs at Meridian, including development of operational policy and procedures, setting and implementing department production goals, monitoring and measuring success of implemented strategies and the supervision, training, compliance and auditing oversight of all Behavioral Health programs. The Manager will also interface with all other operational units in regards to Operations, new program implementation, utilization management, customer service, Information systems, and program reporting. This position is responsible for ensuring that Meridian's programs are compliant with internal standards, all contracts, National Committee for Quality Assurance (NCQA), URAC or general accreditation standards as well as State and federal regulatory requirements.

Essential Functions:

- Collaborates with the Behavioral Health Medical Director in the operational design, development, implementation and outcomes monitoring of a comprehensive and integrated Behavioral Health program at Meridian, for both existing and emerging programs and lines of business
- Leads operations, process improvement and outcomes monitoring design and implementation initiatives for the Department
- Collaborates with the Director of Corporate Operations in development and maintenance of an operationally aligned and integrated Behavioral Health department within the Corporate Meridian organizational structure, while identifying and articulating any unique operational needs for appropriate procedural development and support
- Oversees the development, implementation and annual evaluation of corporate Behavioral Health operations, including the following:
 - Systems, processes, and training plans for prospective, concurrent and retrospective utilization review across all lines of BH business
 - Profiling and monitoring of Behavioral Health populations served
 - Member Services, Care Coordination and Communications policy compliance, plans and program or project implementation as required for operations
 - Oversight of written, electronic and portal communications development, member and provider education and correspondence policy, procedure, program design and implementation for all Behavioral Health lines of business, in compliance with Communications and Compliance policy and procedure
 - Reporting calendar and submission compliance coordination and oversight for the BH Department
 - Operational oversight of personnel performance in Care Coordination, Case Management, Tobacco Cessation, and Nutrition, including development of Departmental telephonic and documentation auditing plan and schedule
- Oversee the identification, tracking, resolution and response to all denials and appeals in compliance with NCQA, URAC or general accreditation standards
- In collaboration with the Medical Director, develop and oversee operational plans to assure integrated, timely and appropriate behavioral health services with the physical healthcare that members receive, including complex care, special needs and developmentally disabled populations
- Develops and oversees operational implementation of integrated pharmacy reporting and intervention initiatives in collaboration with the Meridian Medical Director and Meridian Rx Vice President of Operations to meet HEDIS objectives and to comply with state reporting or accreditation requirements

Attachment 14 (Key Personnel Job Descriptions)

- Represents Meridian at external meetings with provider groups to address issues, improve communication and educate providers regarding MHP's utilization management, communications or operational processes
- Ensures that all department activities are in compliance with the NCQA, URAC or general accreditation standards, as well as State and federal regulatory requirements
- Provides Behavioral Health leadership representation to the Utilization Management Committee, Corporate and state-specific Operations Committees and participate on other committees as appropriate
- Develops/maintains relationships with State Medicaid and Medicare Directors and other managed care Behavioral Health directors
- Develop and monitor the budget for utilization management behavioral health activities and ensure that sufficient resources are assigned to meet department goals
- Coordinate with all functional areas, including quality management, provider relations, member outreach and education, member services, contract compliance and reporting
- Prepares weekly, monthly and quarterly utilization management behavioral health reports for submission to the Medical Director of Behavioral Health, the leadership team and the Board of Directors
- Serves as a liaison for the health plan concerning Behavioral Health Departmental activities, including participation in external meetings, work groups of Committees, and coordination with external entities
- Serves as oversight and monitors any subcontractor Behavioral Health Organization, ensuring compliance to the contract
- Maintains strict confidentiality of employee and organizational information in accordance with HIPAA and State privacy regulations
- Performs other duties as assigned

Job Requirements:

Education:

- Current, unrestricted licensure in the state of Iowa as a behavioral health professional, such as a psychologist, psychiatrist, social worker, psychiatric nurse, marriage and family therapist or mental health counselor, is required
- Bachelor's degree in a health care related field with strong related experience or additional Fellow designation from the Academy of Healthcare Management (AHM) with is required

Experience:

- A minimum of five years professional operations management experience is required
- Experience in operational program design, implementation and process improvement is required
- Experience in data management, interpretation and presentation design in required
- Five (5) years managed care management experience is required
- Public sector managed care or services management experience is preferred
- Previous personnel management and supervisory experience is required

Knowledge:

- Knowledge of the NCQA, URAC or general accreditation standards for managed care organizations
- Knowledge of health care utilization management processes and documentation
- Knowledge of authorizations and claims data
- Knowledge of Call Center and Customer Services principles, policies, procedure and operations

Attachment 14 (Key Personnel Job Descriptions)

Skills:

- Excellent written, verbal and presentation skills for business communications
- Excellent inter-personal skills
- Strong computer skills, including Microsoft Office (Word, Excel, PowerPoint)
- Strong analytical, data interpretation and report design skills

Abilities:

- Ability to work cooperatively with peers and subordinates
- Ability to motivate others toward achievement of common goals
- Ability to think creatively to resolve common barriers and issues

Member Services Manager

Reports to: Senior Vice President of Corporate Operations

Position Summary: This position is responsible for oversight of the member services functions including, but not limited to, member helpline telephone performance, member e-mail communications, member education, the member website, member outreach programs, development, approval and distribution of member materials. This position also oversees the interface with the State or its subcontractors regarding such issues as member enrollment and disenrollment.

Essential Functions:

Member Services:

- Supervise and schedule departmental activities to ensure expected productivity levels are maintained and all calls are answered within 30 seconds with a service rate of 98%
- Establish staffing schedules to ensure that inbound and outbound call center activities are designed to meet company and member service goals relating to Healthcare Effectiveness Data Information Set (HEDIS) measures
- Perform quality monitoring on inbound and outbound calls and follow up with staff who are not meeting MHP's expectations
- Assist the department Director and Deputy Director with:
 - Weekly reports for inbound and outbound call productivity based on the bonus and incentive program
 - Implementation and documentation of disciplinary actions according to company policies and procedures
 - Performance reviews
- Complete bi-weekly payroll to include bonus payouts
- Educate members and providers on member benefits and member rights and responsibilities
- Educate staff, members, and providers on fraud, waste and abuse and HIPAA policies and procedures and processes
- Coordinate the tracking of guardianships and HIPAA privacy forms with the Privacy Officer
- Educate members and providers on Meridian policies and procedures regarding access to care, the grievance and appeals process and eligibility guidelines
- Annually assist Director and Deputy Director with review of department policies and procedures; Make updates as necessary.
- Ensure that all Job Aids, Policies and Procedures and any resource material used by staff are the appropriate version and available to staff at all times
- Acts as a liaison between providers and members on all issues
- Work with the department Director and Deputy Director to ensure member satisfaction and timely resolution of grievances and appeals
- Understand the system used to track and trend all provider and member inquiries, concerns, and complaints and appeals
- Update and educate staff on all member, provider and administrative policy changes made by Meridian or the State
- Address department related issues submitted by other Meridian departments
- Conduct Weekly Audit meeting with Team Leads. Review any failed audits with Team Lead and staff member.
- Review Bi-Weekly Team Meeting agendas and Meeting Minutes
- Attend meetings as requested by the Department Director and Deputy Director
- Perform other duties as assigned

Attachment 14 (Key Personnel Job Descriptions)

Job Requirements:

Education:

- Bachelor's degree or Fellow designation from the Academy for Healthcare Management (AHM) is required.

Experience:

- Minimum of 5 years of customer service experience is preferred.
- Experience in a call center setting for inbound and outbound calls is required.
- One year supervisory experience in a call center operation is strongly preferred.
- Background and experience in a managed care setting is strongly preferred.
- Project management experience is required.
- Experience and comfort with public speaking are required.

Knowledge:

- Working knowledge in Microsoft Office applications (Outlook, Word, Excel, etc.)
- Knowledge of call center operations
- Managed Care and Iowa Medicaid knowledge is an asset
- Knowledge of continuous quality improvement strategies and practical application methodologies

Skills:

- Strong leadership skills
- Demonstrated customer service skills
- Excellent interpersonal communication skills
- Excellent verbal and written communication skills
- Strong team building skills

Abilities:

- Ability to manage multiple priorities in an effective manner
- Ability to motivate and supervise member service staff to meet company and departmental goals
- Ability to develop presentations

Provider Services Manager

Reports To: Contract Administrator/Chief Executive Officer/Chief Operations Officer

Position Summary: This position is responsible for the oversight of all provider services functions and day to day operations. This position also oversees the Corporate Provider Services Representatives staff to maintain a complete and comprehensive provider network in all Meridian Health Plan (MHP) service areas. General responsibilities of this position include, but are not limited to, oversight of the provider services helpline, provider recruitment, contracting and credentialing, facilitating the claims dispute process, and developing provider outreach programs.

Essential Functions:

- Coordinate all incoming provider communications, phone, claims questions, mail, online chat and provider portal, including the education of providers on MHP's provider policies and procedures
- Assist with planning and development activities of the Corporate Provider Services department
- Provide training and mentoring of the Data Management staff
- Assist the Director of Corporate Provider Services and Credentialing with planning and implementing special projects to support corporate operations
- Provide subject matter expertise within the department for assigned topics or projects
- Oversight of new provider data entry in the Managed Care System
- Oversee the maintenance of provider files including applications, contracts and facility site reviews in electronic and hard copy form, provider changes and system updates, as well as the exporting of provider data and coordinating with the Credentialing and Finance departments
- Oversee the collection of all practitioner and ancillary signed contracts, applications and necessary credentialing information.
- Oversees the development and distribution of the provider manual and education materials
- Ensuring MHP's credentialing standards are maintained as well as maintaining accurate provider data through update forms and claim information
- Work collectively with the Manager of Provider Data Analytics to ensure accurate reporting of contracted providers through spreadsheets, provider directories and weekly production reporting for the Corporate Provider Services Representatives.
- Performing and preparing analysis of provider data for committees and meetings
- Occasional special projects related to provider services, quality improvement coordination and data management
- Assure compliance with requirements of all national and State regulatory agencies, including NCQA, URAC, CMS, or general accreditation
- Maintain strict confidentiality of employee and organizational information in accordance with HIPAA and State privacy regulations
- Initiate workgroups and meetings to develop productive communication and customer service pathways.
- Maintain and develop, where necessary, the MHP training manuals, policy, procedures and job aids
- Coordinates with Key Personnel to ensure that all Provider Services operations are and remain in compliance
- Oversee the Corporate Provider Services phone queue

Attachment 14 (Key Personnel Job Descriptions)

- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree in business administration, healthcare administration, communications, marketing or other related field is required.

Experience:

- 3-5 years previous experience in a provider services role is required.
- Prior experience in a managed care setting is strongly preferred.
- Prior call center experience is preferred

Knowledge:

- Advanced knowledge of MHP's philosophy and organizational structure
- Thorough knowledge of MHP's provider policies and procedures as described in the Provider Manual
- Thorough knowledge of geographic areas in which MHP is licensed to operate, including, types of providers in area, relationships between providers (PO, PHO, independent) and key providers/decision makers
- Understanding of Healthcare Effectiveness Data Information Set (HEDIS) reporting and HIPAA regulations
- Thorough knowledge of MHP's contracts including Practitioner, Ancillary, Hospital and Delegated Agreements
- Knowledge of basic reimbursement methods and rates
- Knowledge of managed care, guidelines, reimbursement and competitors

Skills:

- Strong organizational and project management skills
- Strong customer service skills, including follow-up and follow through skills
- Computer skills including working knowledge of software products: Word, Excel, Oracle, Publisher

Abilities:

- Ability to communicate clearly and concisely both orally and via written documents
- Ability to work as part of a team while meeting and maintaining individual goals and objectives
- Ability to organize and manage the activities of other personnel
- Ability to prioritize workload and respond to multiple competing deadlines

Director of EDI/Information Systems Manager

Reports to: Vice President of Information Technologies

Position Summary: This position manages a team of IT Analysts, Developers, and Quality Assurance Analysts implementing and maintaining EDI data exchanges with external trading partners, development of mapping and requirements, analysis, configuration and testing of internal and external EDI transaction intake and output systems and data exchanges. Provides leadership, coordination, and planning for the team ensuring it appropriately supports both IT's and Meridian's overall direction and goals, ensuring adherence to mandated EDI/HIPAA transaction standards. Collaborates with peers to optimize EDI Operational processes and application delivery. This position is responsible for ensuring all information system security and controls, program data transactions, data exchanges and other information system requirements are compliant.

Essential Functions:

- Work with management team to determine EDI Exchange implementation and adoption strategy in order to meet project and operational goals.
- Ensures data exchanges with EDI trading partners adhere to Federal and State HIPAA transaction compliance standards and best practices
- Ensures inquiries regarding EDI issues with enrollment, claims, payments, encounters, and/or clearinghouse activities are effectively addressed.
- Oversees the planning, coordination and execution of EDI testing and trading partner implementation initiatives.
- Ensures operational stability and oversees the prompt resolution of production issues and defects.
- Provide vendor management to outside organizations delivering services for EDI data exchanges.
- Continually assess work processes and recommend changes which facilitate operational excellence. Partnering with IT leadership, develop short-term team goals which support long-term goals. Participate in annual planning.
- Understand the needs of the business in a service delivery model. Ensure work product and data provided for reporting or to other teams is accurate. In collaboration with senior management, set service level agreements to deliver on commitments to customer's satisfaction.
- Champion innovative thinking and bring forth new ideas and alternative solutions which align with department and company goals to senior management. Embrace and champion change relevant to the organization's direction and mission.
- Manage the day-to-day operations of the IT EDI team. Foster teamwork and remove obstacles to achieving goals. Develop a game plan for associates and recommend training and development plans. Responsible for providing consistent performance feedback to associates.
- Ensure adequate resources are maintained to achieve operational excellence. Collaborate with management to re-allocate resources to support business operations. Assist with budget planning and make recommendations on expenses.
- Anticipate, identify, and manage potential risk/issues within area of responsibility. Determine when escalation of issues is appropriate and seek advice and recommend potential solutions.

Job Requirements:

Education:

- Bachelor's Degree in Computer Science or a related field or an equivalent combination of education, training and experience is required.

Experience:

- Five (5) years' experience managing people or leading project teams, including proven experience providing effective coaching and feedback to team members
- Three (3) years' proven track record of technical expertise in IT, including EDI Operations, application management experience or production system responsibilities
- Proven track record of delivering high quality products and services resulting in highly satisfied customers. Experience working with vendors to deliver on business needs

Knowledge:

- Knowledgeable in application system design, development or testing in client server computing environments
- Knowledge of Healthcare ANSI X12 HIPAA Transactions (270/271, 276/277, 278, 834, 835, 837, etc.), HL7, and EDI technologies

Abilities:

- Ability to be on-call for after-hours work commitments in support of production requirements
- Ability to collaborate cross-functionally to understand shared goals and objectives. Ability to set short and long-term team goals that align with overall IT organizational direction
- Ability to effectively deal with rapid change in a positive manner and to lead staff through changing priorities
- Proven ability to build successful work teams and manage and retain high performing talent. Ability to mentor and foster a positive environment. Models leadership values.
- Demonstrated ability to plan work for teams, manage workload balance and have proven track record of delivering results
- Proven ability to develop effective relationships and to work at all levels of the company including senior and executive management. Experience working effectively across divisional lines in a complex, multi-site organization

Claims Administrator

Reports To: Senior Vice President of Corporate Operations

Position Summary: This position is responsible for ensuring prompt and accurate provider claims processing. Coordinate and direct all activities within the Claims Department. Interface with other departments to ensure that department and company goals are met. Ensure that claims are processed accurately and timely in compliance with policy and procedure guidelines. Resolve customer inquiries promptly and courteously. Explore and develop process improvements to more effectively manage operational costs.

Essential Functions:

- Direct overall activities of claims examiners and maintain appropriate staffing levels. Ensure that the staff maintains adequate expertise in claims, eligibility, and policy interpretation, while meeting or exceeding production and accuracy standards.
- Review and advise on those claims with the highest complexity and sensitivity, and those that exceed claims examiners payment authorizations
- Develop performance expectations and standards for claims examiners, revise as situations dictate, and identify requirements for future training needs
- Interface with diverse levels of internal and external personnel to develop and maintain effective rapport and to resolve issues and inquiries
- Handle Third Party Liability investigations and complete necessary reporting to the State
- Prepare status reports that provide clear and concise information regarding claims status
- Complete claim payment cycle including posting claim payments, printing remittance vouchers and forwarding necessary information to the finance area for check processing
- Administer and adhere to company and department policies and procedures
- Recommend and assist in acquisition of technology and other tools or equipment and resources to optimize departmental performance and output
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's Degree or Fellow designation from the Academy for Healthcare Management (AHM) is required.

Experience:

- 3-5 years of previous claims management experience is required.
- Previous experience in a leadership role is required.

Knowledge:

- Excellent knowledge of all aspects of claims processing
- Excellent knowledge of CPT and ICD-9 coding
- Excellent knowledge of claims policies and procedures
- Thorough knowledge of MHP's systems
- Thorough knowledge of MHP's contracts
- Knowledge of reimbursement methods and rates
- Working knowledge of PC applications.

Attachment 14 (Key Personnel Job Descriptions)

Skills:

- Strong organizational, planning, analytical and communication skills
- Excellent analytical and problem solving skills
- Excellent interpersonal skills necessary to interact with all levels of personnel

Abilities:

- Ability to problem solve
- Ability to develop a team based attitude toward accomplishing goals within the department

Compliance Officer/Program Integrity Manager

Reports To: Chief Administrative Officer

Position Summary: This position establishes, implements, and ensures the maintenance of an effective corporate compliance program to prevent illegal, unethical or improper conduct. The compliance officer is also responsible for assuring that Meridian meets all contractual responsibilities with the Department of Community Health. The Compliance Officer/Program Integrity Manager monitors and reports results of compliance and ethics efforts of the company to senior management and the Board of Directors and provides guidance on matters related to compliance. The Compliance Officer/Program Integrity Manager, together with the compliance committee is authorized to implement all necessary actions to ensure achievement of the objectives of an effective government relations and compliance program.

Essential Functions:

- Develops, initiates, maintains and revises policies and procedures necessary for the operation of the Meridian compliance program and related activities
- Manages the day-to-day operations of the Meridian compliance program and takes appropriate steps to improve its effectiveness
- Develops and annually reviews and updates as necessary the Meridian Code of Conduct to ensure that Meridian employees receive current and relevant guidance with respect to corporate compliance expectations. Ensures that each employee annually signs a Code of Conduct certification
- Develops and monitors methodologies and systems to build compliance awareness into daily business processes
- Consults with Meridian Legal Counsel as necessary to resolve legal compliance issues
- Responds to alleged violations of rules, regulations, policies, procedures or standards of conduct by evaluating or recommending the initiation of investigative procedures and oversees the uniform handling of violations including any sanctions for plan employees
- Responsible for complying with all HIPAA and privacy regulations as well as coordinate reporting to the State and to review the timeliness, accuracy and completeness of reports and data submissions to the State
- Ensures proper reporting of fraud and abuse violations or suspected violations to the appropriate enforcement agencies including DCH
- Primary liaison with the State (or its designees) to facilitate communications between DHS, the State's contractors and Meridian's executive leadership and staff
- Chairs the Meridian Corporate Fraud and Abuse Committee and works with the committee to:
 - Identify potential areas of compliance vulnerability and risk
 - Develop and implement corrective action plans to resolve problematic issues
 - Provide general guidance on how to avoid or deal with similar situations in the future
- Coordinates internal compliance review and monitoring activities including periodic reviews of departments.
- Responsible for ensuring all Meridian functions are in compliance with the terms of the Contract, in close coordination with other Key Personnel
- Oversees the development of training materials and programs for members, providers and plan employees and ensures that all employees receive training on corporate compliance. Maintains attendance rosters and training documentation
- Responsible for oversight of the special investigations unit (SIU) activity.
- Serve as the liaison between the state agencies, law enforcement, and federal agencies.

Attachment 14 (Key Personnel Job Descriptions)

- Responsible for staying informed of current trends in fraud, waste, and abuse as well as mechanisms to detect such activity
- Ensures that all employees are aware of both corporate and confidential mechanisms for reporting suspected fraud, waste and abuse
- Develop and implement methods and programs that encourage managers and employees to report non-compliance and potential FWA without fear of retaliation
- Responds to reports of potential FWA, including the coordination of internal investigations and the development of appropriate corrective and disciplinary actions
- Presents a summary of fraud, waste and abuse reporting activities at each Fraud, Waste and Abuse Compliance Committee meeting
- Prepares an annual report to the Quality Management Committee and the Meridian Board of Directors that summarizes Meridian's Fraud, Waste and Abuse monitoring and detection activities and any policy or process changes made to enhance compliance
- Perform other duties as assigned

Job Requirements:

Education:

- Bachelor's degree in health care or related field is required.

Experience:

- A minimum of five years' experience in a Medicaid Managed Care Program or five years' experience in public sector services such as Medicare, Medicaid, Community Health, Public Health or Social Services is preferred.

Knowledge:

- Must maintain a current knowledge of federal and state legislation, legislative initiatives and regulations that may impact the program
- Working knowledge of the National Committee for Quality Assurance (NCQA), URAC or general accreditation policies and procedures
- Working knowledge of Health Employer Data Information Set (HEDIS) requirements
- Working knowledge of the Privacy and Security Health Insurance Portability and Accountability Act (HIPAA) regulations
- Knowledge of coding and reimbursement systems, risk management and performance improvement is helpful.

Skills:

- Strong computer/data entry and Internet research skills including Microsoft Office programs
- Excellent oral and written communication skills
- Demonstrated leadership capabilities
- Demonstrated team building skills

Abilities:

- Sound decision making abilities
- Ability to gather information from multiple sources to understand problems
- Ability to recognize symptoms that indicate problems
- Ability to communicate effectively to large and small groups
- Ability to communicate effectively with health professionals and administrators both orally and in writing.
- Ability to be flexible in a rapidly changing job and regulatory environment
- Ability to work independently and to set priorities

Attachment 14 (Key Personnel Job Descriptions)

- Ability to build consensus and to collaborate with internal and external entities to achieve organizational objectives
- Ability to bridge departmental and organizational boundaries

Long Term Care Manager

Reports To: Vice President of Care Coordination

Position Summary: This position is responsible for the oversight and implantation of Meridian Health Plan's state community based and facility based programs. This position also is responsible for the oversight of the community care coordination program, supervising the services provided by plan community-based care coordinators and community health outreach workers. The care coordinators and community health outreach workers are responsible for assessing the member's needs; and facilitating, promoting and advocating for the member's ongoing self-sufficiency and independence. Additionally, the community care coordinator and community health outreach workers are responsible for sustaining the natural supports of the member, offers person-centered care planning, service coordination and support services for members receiving long-term care (LTC) and home and community (HCBS) services. This includes but is not limited to assessing the availability of natural supports, representative or family members to ensure the ongoing and physical and behavioral health of those natural supports.

Essential Functions:

- In collaboration with the leadership, assist in the development and implementation of community relations strategic plan. Build positive relationships with community and regulatory stakeholders.
- Directly manage all community outreach staff including, but not limited to, hiring, training, scheduling, monitoring workload, conflict resolution, conducting performance evaluations, and implementing performance improvement and disciplinary actions, when necessary
- Track and trend under and over-utilization of services to identify opportunities for improvement, followed by implementation of policies and procedures to initiate and monitor the community care coordination activities
- Oversee workload needs on a concurrent basis including monitoring staff production metrics, auditing assessments and member plans of care according to respective policies and procedures. Daily prioritization of staffing assignments for optimizing impact on department production
- Monitor the performance of the care coordination team leaders and provide constructive feedback and opportunities for improvement.
- Conduct regular evaluation of the care coordination program, including, but not limited to; timely review of the member's plan of care with the interdisciplinary team, collaborative review and reassessment of the member's plan of care as defined and coordination of the member services.
- Responsible for coordination and presentation of information for reviews, such as long-term care provider reviews, utilization reviews, member satisfaction surveys, and member health and welfare
- Conducts inter-rater reliability tests and audits among clinical staff. Evaluates the consistency of utilization management decision making based on MPM developed criteria and InterQual and acts on opportunities to improve consistency, when applicable
- Responsible for developing a strong working relationship with the Care Coordination staff and with all of MHP's corporate care coordination staff and other internal teams to encourage a cooperative sharing of ideas and support
- Facilitate, promote, and coordinate post-acute care within the most appropriate care setting through on site care management activities in post-acute care facilities
- Develop and implement guidelines of community care coordination for admission and discharge criteria, as well as care plan documentation guidelines
- Identify and track care coordination and Healthcare Effectiveness Data Information set (HEDIS) and performance outcomes
- Provide on-going coaching and counseling to all staff

Attachment 14 (Key Personnel Job Descriptions)

- Create culturally appropriate health education, information, and outreach in community-based settings
- Develop and maintain all community activities that are included in the QIP, Work Plan, QIC meetings, and policies and procedures
- Conduct quality audits of Care Coordination staff activities in accordance with respective policies and procedures
- Manages the NCQA, URAC, or general accreditation and all initiatives, activities, and efforts for reporting and maintaining performance rates
- Monitor and track compliance with HIPAA regulations, professional conduct, and ethical practice
- Assist in the development of multidisciplinary community training and education programs for internal and external customers
- Analyze outcomes on community-related measures to identify potential barriers, interventions, and opportunities for improvement

Job Requirements:

Education:

- Bachelor's degree in a healthcare related discipline such as Nursing, Social Work, Healthcare Administration, Counseling, Special Education, Sociology, Psychology, or Gerontology; or
- Fellow, Academy for Healthcare Management (AHM) Designation is required

Experience:

- 3 - 5 years experience in management of community-based program/agency, project management, health promotion, and community assessments, or program development
- A minimum of at least 5 years of experience in long term care policy
- Must have a comprehensive understanding of CMS rules and regulations
- Experience in working with the Medicaid and/or Medicare populations
- Experience in a managed care setting and/or direct experience in the delivery of community services and/or care coordination, discharge planning, or behavioral health or long term care services.
- At least 1 year of leadership/management experience is preferred
- Experience with billing codes including CPT and/or ICD-9

Knowledge:

- Knowledge of Home and Community Based Services.
- Working knowledge of accreditation standards of NCQA, URAC, or general accreditation and the Healthcare Effectiveness Data Information Set (HEDIS)

Skills:

- Excellent customer service and interpersonal communication skills
- Excellent written and verbal communication skills
- Telephone service skills

Abilities:

- Ability to work independently and collaboratively with a team
- Ability to prioritize work and function under time constraints

Director of Operations

Reports to: Contract Administrator/Chief Executive Officer/Chief Operations Officer

Position Summary: This position is responsible for representing Meridian Health Plan of Iowa in operational matters. The Director of Operations assists the Contract Administrator/Chief Executive Officer/Chief Operations Officer in providing overall direction and guidance to Iowa specific departments as designated by the Contract Administrator/Chief Executive Officer/Chief Operations Officer, including Network Development and Quality Improvement. Additionally, the Director of Operations assists the Contract Administrator/Chief Executive Officer/Chief Operations Officer in interfacing with designated corporate departments, including but not limited to Administration, Member Services, Finance, Claims, Care Coordination, Human Resources, Provider Services & Analytics, the Project Management Office, Legal & Compliance, Training & Development, Communications, Information Services and Utilization Management (Medical & Behavioral Health). The Director of Operations is designated as the primary point of contact with the Agency for delivery system reform activities, including managing a specific project plan and reporting on activity and progress towards identified goals.

Essential Functions:

- Work with the Contract Administrator/Chief Executive Officer/Chief Operations Officer to work with each reporting department director to develop and implement specific strategic goals and business-related plans to facilitate efficiencies and minimize duplication across the organization
- In conjunction with the Contract Administrator/Chief Executive Officer/Chief Operations Officer, track and ensure that health plan compliance with all State contractual obligations
- Participate in or liaison with relevant plan committees
- Collaborate with the Director of Network Development and Director of QI in managing staff and setting their staffing plans
- Help set Quality standards for Meridian Health Plan of Iowa
- Convey the health plan's mission, values, objectives, and policies to the staff
- Work with the Contract Administrator/Chief Executive Officer/Chief Operations Officer to develop the annual budget
- Ensure organizational compliance and adherence to the customer service guidelines and support ongoing customer service quality improvement initiatives
- Serve as a point of contact for to the Ruan building manager
- Communicate with the Contract Administrator/Chief Executive Officer/Chief Operations Officer, IS, Compliance Office and/or Human Resources on necessary items
- Assist with development of Medicaid Expansion and ACO implementation for the State of Iowa
- Assist with the negotiation of contracting with hospitals and health systems in the State of Iowa
- Coordinate the activities of external vendors supporting various office operations
- Serve as the primary liaison for Meridian Health Plan customers who contact the office by phone or in person. Follow up and respond to customer requests in a timely manner with the assistance of the corporate compliance office
- Coordinate with the corporate compliance office to obtain any necessary information to respond to inquiries and requests from members, providers and the State
- Provide oversight on mailings to members and providers with other departments, the mailing vendor and the corporate office
- Provide assistance in the preparation of materials and documentation pertaining to all reporting to the State of Iowa for compliance with contract and regulatory requirements
- Ensure official documents, contracts and records are established and maintained
- Conduct research, assessment and analysis for projects or reports, as needed

Attachment 14 (Key Personnel Job Descriptions)

- Supervise and train subordinate administrative employees
- Assist in the development of the policies and procedures for the office
- Maintain strict confidentiality of employee and organizational information
- Coordinate with the Human Resources Director and Contract Administrator/Chief Executive Officer/Chief Operations Officer on employee related matters
- Perform other duties as assigned

Job Requirements:

Education: Bachelor's degree is required.

Experience:

- At least five years of progressive management experience is required.
- Three to five years of experience in a Medicaid Managed Care Program or in public sector services such as Medicare, Medicaid, Community Health, Public Health or Social Services is preferred.

Knowledge:

- Strong managed health care knowledge
- Knowledge of Medicaid Managed Care guidelines
- A thorough understanding of the role and objectives of all MHP Departments
- Knowledge of plan policies and procedures
- Familiarity with healthcare laws, regulations and standards
- Working knowledge of the National Committee for Quality Assurance (NCQA), URAC or general accreditation policies and procedures
- Working knowledge of Healthcare Effectiveness Data and Information Set (HEDIS) requirements
- Working knowledge of the Privacy and Security Health Insurance Portability and Accountability Act (HIPAA) regulations
- Knowledge of coding and reimbursement systems, risk management and performance improvement is helpful.

Skills:

- Strong computer skills/data entry: Internet, Windows, Microsoft Word, Excel
- Excellent verbal and written communication skills
- Change management skills
- Demonstrated leadership capabilities
- Demonstrated team building skills

Abilities:

- The ability to be flexible in a rapidly changing job environment
- The ability to speak effectively to and with small or large groups
- The ability to monitor, interpret and implement federal and state Medicaid regulations to ensure continued plan adherence
- Sound decision making abilities
- Ability to gather information from multiple sources to understand problems
- Ability to recognize symptoms that indicate problems
- Ability to communicate effectively with health professionals and administrators both orally and in writing
- Ability to work independently and to set priorities
- Ability to build consensus and to collaborate with internal and external entities to achieve organizational objectives
- Ability to bridge departmental and organizational boundaries
- Creative, conceptual thinking with excellent oral, written, and interpersonal skills, and the ability to motivate and lead staff

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SECTION C. COGNITION

1. **COGNITIVE SKILLS FOR DAILY DECISION MAKING**
Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do
 0. **Independent**—Decisions consistent, reasonable, and safe
 1. **Modified independence**—Some difficulty in new situations only
 2. **Minimally impaired**—In specific recurring situations, decisions become poor or unsafe; cues/supervision necessary at those times
 3. **Moderately impaired**—Decisions consistently poor or unsafe; cues / supervision required at all times
 4. **Severely impaired**—Never or rarely makes decisions
 5. **No discernable consciousness, coma [Skip to Section G]**
2. **MEMORY/RECALL ABILITY**
Code for recall of what was learned or known
 0. Yes, memory OK
 1. Memory problem
 - a. **Short-term memory OK**—Seems / appears to recall after 5 minutes
 - b. **Long-term memory OK**—Seems / appears able to recall distant past
 - c. **Procedural memory OK**—Can perform all or almost all steps in a multitask sequence without cues
 - d. **Situational memory OK**—Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room)
3. **PERIODIC DISORDERED THINKING OR AWARENESS**
[Note: Accurate assessment requires conversations with staff, family or others who have direct knowledge of the person's behavior over this time]
 0. Behavior not present
 1. Behavior present, consistent with usual functioning
 2. Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)
 - a. **Easily distracted**—e.g., episodes of difficulty paying attention; gets sidetracked
 - b. **Episodes of disorganized speech**—e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought
 - c. **Mental function varies over the course of the day**—e.g., sometimes better, sometimes worse
4. **ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING**—e.g., restlessness, lethargy, difficult to arouse, altered environmental perception
 0. No
 1. Yes
5. **CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)**
 0. Improved
 1. No change
 2. Declined
 3. Uncertain

SECTION D. COMMUNICATION AND VISION

1. **MAKING SELF UNDERSTOOD (Expression)**
Expressing information content—both verbal and non-verbal
 0. **Understood**—Expresses ideas without difficulty
 1. **Usually understood**—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
 2. **Often understood**—Difficulty finding words or finishing thoughts AND prompting usually required
 3. **Sometimes understood**—Ability is limited to making concrete requests
 4. **Rarely or never understood**
2. **ABILITY TO UNDERSTAND OTHERS (Comprehension)**
Understanding verbal information content (however able; with hearing appliance normally used)
 0. **Understands**—Clear comprehension
 1. **Usually understands**—Misses some part / intent of message BUT comprehends most conversation
 2. **Often understands**—Misses some part / intent of message BUT with repetition or explanation can often comprehend conversation
 3. **Sometimes understands**—Responds adequately to simple, direct communication only
 4. **Rarely or never understands**
3. **HEARING**
 - a. **Ability to hear** (with hearing appliance normally used)
 0. **Adequate**—No difficulty in normal conversation, social interaction, listening to TV
 1. **Minimal difficulty**—Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet [2 meters] away)

2. **Moderate difficulty**—Problem hearing normal conversation, requires quiet setting to hear well
 3. **Severe difficulty**—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
 4. **No hearing**
- b. **Hearing aid used**
 0. No
 1. Yes
4. **VISION**
 - a. **Ability to see in adequate light** (with glasses or with other visual appliance normally used)
 0. **Adequate**—Sees fine detail, including regular print in newspapers/books
 1. **Minimal difficulty**—Sees large print, but not regular print in newspapers/books
 2. **Moderate difficulty**—Limited vision; not able to see newspaper headlines, but can identify objects
 3. **Severe difficulty**—Object identification in question, but eyes appear to follow objects; sees only light, colors, shapes
 4. **No vision**
 - b. **Visual appliance used**
 0. No
 1. Yes

SECTION E. MOOD AND BEHAVIOR

1. **INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD**
Code for indicators observed in last 3 days, irrespective of the assumed cause [Note: Whenever possible, ask person]
 0. Not present
 1. Present but not exhibited in last 3 days
 2. Exhibited on 1-2 of last 3 days
 3. Exhibited daily in last 3 days
 - a. **Made negative statements**—e.g., "Nothing matters; Would rather be dead; What's the use; Regret having lived so long; Let me die"
 - b. **Persistent anger with self or others**—e.g., easily annoyed, anger at care received
 - c. **Expressions, including non-verbal, of what appear to be unrealistic fears**—e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations
 - d. **Repetitive health complaints**—e.g., persistently seeks medical attention, incessant concern with body functions
 - e. **Repetitive anxious complaints / concerns (non-health related)**—e.g., persistently seeks attention / reassurance regarding schedules, meals, laundry, clothing, relationships
 - f. **Sad, pained, or worried facial expressions**—e.g., furrowed brow, constant frowning
 - g. **Crying, tearfulness**
 - h. **Recurrent statements that something terrible is about to happen**—e.g., believes he or she is about to die, have a heart attack
 - i. **Withdrawal from activities of interest**—e.g., long-standing activities, being with family / friends
 - j. **Reduced social interactions**
 - k. **Expressions, including non-verbal, of a lack of pleasure in life (anhedonia)**—e.g., "I don't enjoy anything anymore"
2. **SELF-REPORTED MOOD**
 0. Not in last 3 days
 1. Not in last 3 days, but often feels that way
 2. In 1-2 of last 3 days
 3. Daily in the last 3 days
 8. Person could not (would not) respond

Ask: "In the last 3 days, how often have you felt..."

 - a. **Little interest or pleasure in things you normally enjoy?**
 - b. **Anxious, restless, or uneasy?**
 - c. **Sad, depressed, or hopeless?**
3. **BEHAVIOR SYMPTOMS**
Code for indicators observed, irrespective of the assumed cause
 0. Not present
 1. Present but not exhibited in last 3 days
 2. Exhibited on 1-2 of last 3 days
 3. Exhibited daily in last 3 days
 - a. **Wandering**—Moved with no rational purpose, seemingly oblivious to needs or safety
 - b. **Verbal abuse**—e.g., others were threatened, screamed at, cursed at
 - c. **Physical abuse**—e.g., others were hit, shoved, scratched, sexually abused

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- d. **Socially inappropriate or disruptive behavior**—e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through other's belongings
- e. **Inappropriate public sexual behavior or public disrobing**
- f. **Resists care**—e.g., taking medications / injections, ADL assistance, eating

SECTION F. PSYCHOSOCIAL WELL-BEING

1. SOCIAL RELATIONSHIPS

[Note: Ask person, direct care staff, and family, if available]

- 0. Never
- 1. More than 30 days ago
- 2. 8 to 30 days ago
- 3. 4 to 7 days ago
- 4. In last 3 days
- 8. Unable to determine

- a. **Participation in social activities of long-standing interest**
- b. **Visit with a long-standing social relation or family member**
- c. **Other interaction with long-standing social relation or family member**—e.g., telephone, e-mail

2. SENSE OF INVOLVEMENT

- 0. Not present
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1-2 of last 3 days
- 3. Exhibited daily in last 3 days

- a. **At ease interacting with others**
- b. **At ease doing planned or structured activities**
- c. **Accepts invitations into most group activities**
- d. **Pursues involvement in life of facility**—e.g., makes or keeps friends; involved in group activities; responds positively to new activities; assists at religious services
- e. **Initiates interaction(s) with others**
- f. **Reacts positively to interactions initiated by others**
- g. **Adjusts easily to change in routine**

3. UNSETTLED RELATIONSHIPS

- 0. No
- 1. Yes

- a. **Conflict with or repeated criticism of other care recipients**
- b. **Conflict with or repeated criticism of staff**
- c. **Staff report persistent frustration in dealing with person**
- d. **Family or close friends report feeling overwhelmed by person's illness**
- e. **Says or indicates that he/she feels lonely**

4. MAJOR LIFE STRESSORS IN LAST 90 DAYS—

e.g., episode of severe personal illness; death or severe illness of close family member / friend; loss of home; major loss of income/assets; victim of a crime such as robbery or assault; loss of driving license/car

- 0. No
- 1. Yes

5. STRENGTHS

- 0. No
- 1. Yes

- a. **Consistent positive outlook**
- b. **Finds meaning in day-to-day life**
- c. **Strong and supportive relationship with family**

SECTION G. FUNCTIONAL STATUS

1. ADL SELF-PERFORMANCE

Consider all episodes over 3-day period.

If all episodes are performed at the same level, score ADL at that level. If any episodes at level 6, and others less dependent, score ADL as a 5.

Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2-5.

- 0. **Independent**—No physical assistance, setup, or supervision in any episode
- 1. **Independent, setup help only**—Article or device provided or placed within reach, no physical assistance or supervision in any episode
- 2. **Supervision**—Oversight / cuing
- 3. **Limited assistance**—Guided maneuvering of limbs, physical guidance without taking weight

- 4. **Extensive assistance**—Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
- 5. **Maximal assistance**—Weight-bearing support (including lifting limbs) by 2+ helpers —OR— Weight-bearing support for more than 50% of subtasks
- 6. **Total dependence**—Full performance by others during all episodes
- 8. **Activity did not occur during entire period**

- a. **Bathing**—How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR
- b. **Personal hygiene**—How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS
- c. **Dressing upper body**—How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.
- d. **Dressing lower body**—How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.
- e. **Walking**—How walks between locations on same floor indoors
- f. **Locomotion**—How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair
- g. **Transfer toilet**—How moves on and off toilet or commode
- h. **Toilet use**—How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET
- i. **Bed mobility**—How moves to and from lying position, turns from side to side, and positions body while in bed
- j. **Eating**—How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)

2. LOCOMOTION / WALKING

- a. **Primary mode of locomotion**
 - 0. Walking, no assistive device
 - 1. Walking, uses assistive device—e.g., cane, walker, crutch, pushing wheelchair
 - 2. Wheelchair, scooter
 - 3. Bedbound
- b. **Timed 4-meter (13 foot) walk**
 [Lay out a straight unobstructed course. Have person stand in still position, feet just touching start line]
Then say: "When I tell you begin to walk at a normal pace (with cane/walker if used). This is not a test of how fast you can walk. Stop when I tell you to stop. Is this clear?" Assessor may demonstrate test.
Then say: "Begin to walk now" Start stopwatch (or can count seconds) when first foot falls. End count when foot falls beyond 4-meter mark.
Then say: "You may stop now"
 Enter time in seconds, up to 30 seconds.
 - 30. 30 or more seconds to walk 4-meters
 - 77. Stopped before test complete
 - 88. Refused to do the test
 - 99. Not tested—e.g., does not walk on own

- c. **Distance walked**—Farthest distance walked at one time without sitting down in the LAST 3 DAYS (with support as needed)
 - 0. Did not walk
 - 1. Less than 15 feet (under 5 meters)
 - 2. 15-149 feet (5-49 meters)
 - 3. 150-299 feet (50-99 meters)
 - 4. 300+ feet (100+ meters)
 - 5. 1/2 mile or more (1+ kilometers)
- d. **Distance wheeled self**—Farthest distance wheeled self at one time in the LAST 3 DAYS (includes independent use of motorized wheelchair)
 - 0. Wheeled by others
 - 1. Used motorized wheelchair / scooter
 - 2. Wheeled self less than 15 feet (under 5 meters)
 - 3. Wheeled self 15-149 feet (5-49 meters)
 - 4. Wheeled self 150-299 feet (50-99 meters)
 - 5. Wheeled self 300+ feet (100+ meters)
 - 8. Did not use wheelchair

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3. ACTIVITY LEVEL

a. Total hours of exercise or physical activity in LAST 3 DAYS—e.g., walking

- 0. None
- 1. Less than 1 hour
- 2. 1-2 hours
- 3. 3-4 hours
- 4. More than 4 hours

b. In the LAST 3 DAYS, number of days went out of the house or building in which he / she resides (no matter how short the period)

- 0. No days out
- 1. Did not go out in last 3 days, but usually goes out over a 3-day period
- 2. 1-2 days
- 3. 3 days

4. PHYSICAL FUNCTION IMPROVEMENT POTENTIAL

0. No 1. Yes

- a. Person believes he / she is capable of improved performance in physical function
- b. Care professional believes person is capable of improved performance in physical function

5. CHANGE IN ADL STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO

0. Improved 2. Declined
1. No change 8. Uncertain

SECTION H. CONTINENCE

1. BLADDER CONTINENCE

- 0. **Continent**—Complete control; DOES NOT USE any type of catheter or other urinary collection device
- 1. **Control with any catheter or ostomy over last 3 days**
- 2. **Infrequently incontinent**—Not incontinent over last 3 days, but does have incontinent episodes
- 3. **Occasionally incontinent**—Less than daily
- 4. **Frequently incontinent**—Daily, but some control present
- 5. **Incontinent**—No control present
- 8. **Did not occur**—No urine output from bladder in last 3 days

2. URINARY COLLECTION DEVICE (Exclude pads / briefs)

- 0. None
- 1. Condom catheter
- 2. Indwelling catheter
- 3. Cystostomy, nephrostomy, ureterostomy

3. BOWEL CONTINENCE

- 0. **Continent**—Complete control; DOES NOT USE any type of ostomy device
- 1. **Control with ostomy**—Control with ostomy device over last 3 days
- 2. **Infrequently incontinent**—Not incontinent over last 3 days, but does have incontinent episodes
- 3. **Occasionally incontinent**—Less than daily
- 4. **Frequently incontinent**—Daily, but some control present
- 5. **Incontinent**—No control present
- 8. **Did not occur**—No bowel movement in the last 3 days

4. OSTOMY

0. No 1. Yes

SECTION I. DISEASE DIAGNOSES

Disease Code

- 0. Not present
- 1. Primary diagnosis / diagnoses for current stay
- 2. Diagnosis present, receiving active treatment
- 3. Diagnosis present, monitored but no active treatment

1. DISEASE DIAGNOSES

MUSCULOSKELETAL

- a. Hip fracture during LAST 30 DAYS (or since last assessment if less than 30 DAYS)
- b. Other fracture during LAST 30 DAYS (or since last assessment if less than 30 DAYS)

NEUROLOGICAL

- c. Alzheimers disease
- d. Dementia other than Alzheimers disease
- e. Hemiplegia
- f. Multiple sclerosis
- g. Paraplegia

h. Parkinson's disease

i. Quadriplegia

j. Stroke / CVA

CARDIAC OR PULMONARY

k. Coronary heart disease

l. Chronic obstructive pulmonary disease

m. Congestive heart failure

PSYCHIATRIC

n. Anxiety

o. Bipolar disorder

p. Depression

q. Schizophrenia

INFECTIONS

r. Pneumonia

s. Urinary tract infection in LAST 30 DAYS

OTHER

t. Cancer

u. Diabetes mellitus

2. OTHER DISEASE DIAGNOSES

| Diagnosis | Disease Code | ICD code |
|-----------|--------------|----------|
| a. | | |
| b. | | |
| c. | | |
| d. | | |
| e. | | |
| f. | | |

[Note: Add additional lines as necessary for other disease diagnoses]

SECTION J. HEALTH CONDITIONS

1. FALLS

- 0. No fall in last 90 days
- 1. No fall in last 30 days, but fell 31-90 days ago
- 2. One fall in last 30 days
- 3. Two or more falls in last 30 days

2. RECENT FALLS

[Skip if last assessed more than 30 days ago or if this is first assessment]

- 0. No
- 1. Yes
- [blank] Not applicable (first assessment, or more than 30 days since last assessment)

3. PROBLEM FREQUENCY

Code for presence in last 3 days

- 0. Not present
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1 of last 3 days
- 3. Exhibited on 2 of last 3 days
- 4. Exhibited daily in last 3 days

BALANCE

a. Difficult or unable to move self to standing position unassisted

b. Difficult or unable to turn self around and face the opposite direction when standing

c. Dizziness

d. Unsteady gait

CARDIAC OR PULMONARY

e. Chest pain

f. Difficulty clearing airway secretions

PSYCHIATRIC

g. Abnormal thought process—e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality

h. Delusions—Fixed false beliefs

i. Hallucinations—False sensory perceptions

NEUROLOGICAL

j. Aphasia

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GI STATUS

- k. **Acid reflux**—Regurgitation of acid from stomach to throat
- l. **Constipation**—No bowel movement in 3 days or difficult passage of hard stool
- m. **Diarrhea**
- n. **Vomiting**

SLEEP PROBLEMS

- o. **Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep**
- p. **Too much sleep**—Excessive amount of sleep that interferes with person's normal functioning

OTHER

- q. **Aspiration**
- r. **Fever**
- s. **GI or GU bleeding**
- t. **Peripheral edema**

4. DYSPNEA (Shortness of breath)

- 0. Absence of symptom
- 1. Absent at rest, but present when performed moderate activities
- 2. Absent at rest, but present when performed normal day-to-day activities
- 3. Present at rest

5. FATIGUE

Inability to complete normal daily activities—e.g., ADLs, IADLs

- 0. **None**
- 1. **Minimal**—Diminished energy but completes normal day-to-day activities
- 2. **Moderate**—Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
- 3. **Severe**—Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
- 4. **Unable to commence any normal day-to-day activities**—Due to diminished energy

6. PAIN SYMPTOMS

[Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]

- a. **Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other non-verbal signs suggesting pain)**
 - 0. No pain
 - 1. Present but not exhibited in last 3 days
 - 2. Exhibited on 1-2 of last 3 days
 - 3. Exhibited daily in last 3 days
- b. **Intensity of highest level of pain present**
 - 0. No pain
 - 1. Mild
 - 2. Moderate
 - 3. Severe
 - 4. Times when pain is horrible or excruciating
- c. **Consistency of pain**
 - 0. No pain
 - 1. Single episode during last 3 days
 - 2. Intermittent
 - 3. Constant
- d. **Breakthrough pain**—Times in last 3 days when person experienced sudden, acute flare-ups of pain
 - 0. No
 - 1. Yes
- e. **Pain control**—Adequacy of current therapeutic regimen to control pain (from person's point of view)
 - 0. No issue of pain
 - 1. Pain intensity acceptable to person; no treatment regimen or change in regimen required
 - 2. Controlled adequately by therapeutic regimen
 - 3. Controlled when therapeutic regimen followed, but not always followed as ordered
 - 4. Therapeutic regimen followed, but pain control not adequate
 - 5. No therapeutic regimen being followed for pain; pain not adequately controlled

7. INSTABILITY OF CONDITIONS

- 0. No
- 1. Yes
- a. **Conditions / diseases make cognitive, ADL, mood or behavior patterns unstable** (fluctuating, precarious, or deteriorating)
- b. **Experiencing an acute episode, or a flare-up of a recurrent or chronic problem**
- c. **End-stage disease, 6 or fewer months to live**

8. SELF-REPORTED HEALTH

Ask: "In general, how would you rate your health?"

- 0. Excellent
- 1. Good
- 2. Fair
- 3. Poor
- 8. Could not (would not) respond

9. TOBACCO AND ALCOHOL

- a. **Smokes tobacco daily**
 - 0. No
 - 1. Not in last 3 days, but is usually a daily smoker
 - 2. Yes
- b. **Alcohol**—Highest number of drinks in any "single sitting" in LAST 14 DAYS
 - 0. None
 - 1. 1
 - 2. 2-4
 - 3. 5 or more

SECTION K. ORAL AND NUTRITIONAL STATUS

1. HEIGHT AND WEIGHT [INCHES AND POUNDS—COUNTRY SPECIFIC]

Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in LAST 30 DAYS.

- a. HT (in.)
- b. WT (lb.)

2. NUTRITIONAL ISSUES

- 0. No
- 1. Yes
- a. **Weight loss of 5% or more in last 30 days, or 10% or more in last 180 days**
- b. **Dehydrated, or BUN/Cre ratio >25** [Ratio, country specific]
- c. **Fluid intake less than 1,000cc per day (less than four 8 oz cups/day)**
- d. **Fluid output exceeds input**

3. MODE OF NUTRITIONAL INTAKE

- 0. **Normal**—Swallows all types of foods
- 1. **Modified independent**—e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
- 2. **Requires diet modification to swallow solid food**—e.g., mechanical diet (puree, minced, etc.) or only able to ingest specific foods
- 3. **Requires modification to swallow liquids**—e.g., thickened liquids
- 4. **Can swallow only pureed solids —AND— thickened liquids**
- 5. **Combined oral and parenteral or tube feeding**
- 6. **Nasogastric tube feeding only**
- 7. **Abdominal feeding tube**—e.g., PEG tube
- 8. **Parenteral feeding only**—includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
- 9. **Activity did not occur**—During entire period

4. PARENTERAL OR ENTERAL INTAKE

The proportion of TOTAL CALORIES received through parenteral or tube feedings in the LAST 3 DAYS

- 0. No parenteral / enteral tube
- 1. Parenteral / enteral tube, but no caloric intake
- 2. 1% to 25% of total calories through device
- 3. 26% or more of total calories through device

5. DENTAL OR ORAL

- 0. No
- 1. Yes
- a. **Wears a denture (removable prosthesis)**
- b. **Has broken, fragmented, loose, or otherwise non-intact natural teeth**
- c. **Reports mouth or facial pain / discomfort**
- d. **Reports having dry mouth**
- e. **Reports difficulty chewing**
- f. **Presents with gum (soft tissue) inflammation or bleeding adjacent to natural teeth or tooth fragments**

SECTION L. SKIN CONDITION

1. MOST SEVERE PRESSURE ULCER

- 0. No pressure ulcer
- 1. Any area of persistent skin redness
- 2. Partial loss of skin layers
- 3. Deep craters in the skin
- 4. Breaks in skin exposing muscle or bone
- 5. Not codeable, e.g., necrotic eschar predominant

- 2. PRIOR PRESSURE ULCER**
 0. No 1. Yes
- 3. PRESENCE OF SKIN ULCER OTHER THAN PRESSURE ULCER**—e.g., venous ulcer, arterial ulcer, mixed venous-arterial ulcer, diabetic foot ulcer
 0. No 1. Yes
- 4. MAJOR SKIN PROBLEMS**—e.g., lesions, 2nd or 3rd degree burns, healing surgical wounds
 0. No 1. Yes
- 5. SKIN TEARS OR CUTS**—Other than surgery
 0. No 1. Yes
- 6. OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION**—e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema
 0. No 1. Yes
- 7. FOOT PROBLEMS**—e.g., bunions, hammer toes, overlapping toes, structural problems, infections, ulcers
 0. No foot problems
 1. Foot problems, no limitation in walking
 2. Foot problems limit walking
 3. Foot problems prevent walking
 4. Foot problems, does not walk for other reasons

SECTION M. ACTIVITY PURSUIT

- 1. AVERAGE TIME INVOLVED IN ACTIVITIES**—e.g., alone, in social group
 [Note: When awake and not receiving treatments or ADL care]
 0. Most—more than 2/3 of time
 1. Some—from 1/3 to 2/3 of time
 2. Little—less than 1/3 of time
 3. None
- 2. ACTIVITY PREFERENCES AND INVOLVEMENT (adapted to current abilities)**
 0. No preference, not involved in last 3 days
 1. No preference, involved in last 3 days
 2. Preferred, not involved
 3. Preferred, regularly involved but not in last 3 days
 4. Preferred, involved in last 3 days
- a. Cards, games, or puzzles
 b. Computer activity
 c. Conversing or talking on the phone
 d. Crafts or arts
 e. Dancing
 f. Discussing/remiscing about life
 g. Exercise or sports
 h. Gardening or plants
 i. Helping others
 j. Music or singing
 k. Pets
 l. Reading, writing, or crossword puzzles
 m. Spiritual or religious activities
 n. Trips or shopping
 o. Walking or wheeling outdoors
 p. Watching TV or listening to radio
- 3. TIME ASLEEP DURING DAY**
 0. Awake all or most of time (no more than one nap in the morning or afternoon)
 1. Had multiple naps
 2. Asleep most of the time, but some periods awake and alert (e.g., at meals)
 3. Largely asleep or unresponsive

SECTION N. MEDICATIONS

- 1. LIST OF ALL MEDICATIONS**
 List all active prescriptions, and any non-prescribed (over the counter) medications taken in the LAST 3 DAYS
 [Note: Use computerized records if possible, hand enter only when absolutely necessary]
 For each drug record:
- a. Name
 b. Dose—A number such as 0.5, 5, 150, 300. [NOTE: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg).]

- c. **Unit**—Code using the following list:
 gtts (Drops) mEq (Milli-equivalent) Puffs
 gm (Gram) mg (Milligram) % (Percent)
 L (Liters) ml (Milliliter) Units
 mcg (Microgram) oz (Ounce) OTH (Other)
- d. **Route of administration**—Code using the following list:
 PO (By mouth/oral) REC (Rectal) ET (Enteral Tube)
 SL (Sublingual) TOP (Topical) TD (Transdermal)
 IM (Intramuscular) IH (Inhalation) EYE (Eye)
 IV (Intravenous) NAS (Nasal) OTH (Other)
 Sub-Q (Subcutaneous)
- e. **Freq**—Code the number of times per day, week, or month the medication is administered using the following list:
 Q1H (Every hour) 5D (5 times daily)
 Q2H (Every 2 hours) Q2D (Every other day)
 Q3H (Every 3 hours) Q3D (Every 3 days)
 Q4H (Every 4 hours) Weekly
 Q6H (Every 6 hours) 2W (2 times weekly)
 Q8H (Every 8 hours) 3W (3 times weekly)
 Daily 4W (4 times weekly)
 BED (At bedtime) 5W (5 times weekly)
 BID (2 times daily) 6W (6 times weekly)
 (includes every 12 hrs) 1M (Monthly)
 TID (3 times daily) 2M (Twice every month)
 QID (4 times daily) OTH (Other)
- f. PRN
 0. No 1. Yes

g. **Computer-entered drug code** g. ATC or NDC code

| a. Name | b. Dose | c. Unit | d. Route | e. Freq. | f. PRN | g. ATC or NDC code |
|---------|---------|---------|----------|----------|--------|--------------------|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |

[Note: Add additional lines, as necessary, for other drugs taken]
 [Abbreviations are Country Specific for Unit, Route, Frequency]

- 2. ALLERGY TO ANY DRUG**
 0. No known drug allergies 1. Yes

SECTION O. TREATMENTS AND PROCEDURES

- 1. PREVENTION**
 0. No 1. Yes
- a. Blood pressure measured in LAST YEAR
 b. Colonoscopy test in LAST 5 YEARS
 c. Dental exam in LAST YEAR
 d. Eye exam in LAST YEAR
 e. Hearing exam in LAST 2 YEARS
 f. Influenza vaccine in LAST YEAR
 g. Mammogram or breast exam in LAST 2 YEARS (for women)
 h. Pneumovax vaccine in LAST 5 YEARS or after age 65
- 2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 3 DAYS)**
 0. Not ordered AND did not occur
 1. Ordered, not implemented
 2. 1-2 of last 3 days
 3. Daily in last 3 days

- TREATMENTS**
- a. Chemotherapy
 b. Dialysis
 c. Infection control—e.g., isolation, quarantine
 d. IV medication
 e. Oxygen therapy
 f. Radiation
 g. Suctioning
- h. Tracheostomy care
 i. Transfusion
 j. Ventilator or respirator
 k. Wound care
- PROGRAMS**
- l. Scheduled toileting program
 m. Palliative care program
 n. Turning / repositioning program

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3. THERAPY/NURSING SERVICES IN LAST 7 DAYS— e.g.,

therapist or therapy assistant under direction of therapist
 [Note: count only post admission therapies]

- A. # of days treatment scheduled in the LAST 7 DAYS
- B. # of days administered for 15 minutes or more
- C. Total # of minutes provided in LAST 7 DAYS
 (or ordered if days administered = 0 and days scheduled > 0)

| | Days | | Total |
|---|------------|---------------|-------|
| | Sched-uled | Admin-istered | |
| | A | B | C |
| a. Physical therapy | | | |
| b. Occupational therapy | | | |
| c. Speech-language pathology and audiology services | | | |
| d. Respiratory therapy | | | |
| e. Functional rehabilitation or walking program by licensed nurse | | | |
| f. Psychological therapy (by any licensed mental health professional) | | | |

- a. Physical therapy
- b. Occupational therapy
- c. Speech-language pathology and audiology services
- d. Respiratory therapy
- e. Functional rehabilitation or walking program by licensed nurse
- f. Psychological therapy (by any licensed mental health professional)

4. HOSPITAL AND EMERGENCY ROOM USE

Code for number of times in LAST 90 DAYS (or since last assessment if LESS THAN 90 DAYS)

- a. Inpatient acute care hospital with overnight stay
- b. Emergency room visit (not counting overnight stay)

5. PHYSICIAN VISITS

Number of days in LAST 14 DAYS (or since admission if less than 14 days in facility) physician examined person. Include authorized assistant or practitioner. Enter 0 if None

6. PHYSICIAN ORDERS

Number of days in LAST 14 DAYS (or since admission if less than 14 days in facility) physician changed person's orders. Include authorized assistant or practitioner. Do not include order renewals without changes. Enter 0 if None

7. RESTRICTIVE DEVICES

- 0. Not used
- 1. Used less than daily
- 2. Used daily—Nights only
- 3. Used daily—Days only
- 4. Used night and days, but not constant
- 5. Constant use for full 24 hours (may include periodic releases)

- a. Full bed rails on all open sides of bed
- b. Trunk restraint
- c. Chair prevents rising

SECTION P. RESPONSIBILITY AND DIRECTIVES

1. RESPONSIBILITY / LEGAL GUARDIAN [EXAMPLE—USA]

0. No 1. Yes

- a. Legal guardian
- b. Other legal oversight
- c. Durable power of attorney / health care
- d. Durable power attorney / financial
- e. Family member responsible

2. ADVANCE DIRECTIVES [EXAMPLE - USA]

0. Not in place 1. In place

- a. Advance directives for not resuscitating
- b. Advance directives for not intubating
- c. Advance directives for not hospitalizing
- d. Advance directives for not tube feeding
- e. Advance directives for medication restriction

SECTION Q. DISCHARGE POTENTIAL

1. DISCHARGE POTENTIAL

0. No 1. Yes

- a. Expresses / indicates preference to return to or remain in the community
- b. Has a support person who is positive towards discharge or maintaining residence in community
- c. Has housing available in community

2. How long person is expected to stay in the current setting or under the care of this service prior to discharge to community (count from assessment reference date, including that day)

- 0. 1-7 days
- 1. 8-14 days
- 2. 15-30 days
- 3. 31-90 days
- 4. 91 or more days
- 5. Discharge to community not expected

SECTION R. DISCHARGE

[Note: Complete Section R at Discharge only]

1. LAST DAY OF STAY

2 0 — —
 Year Month Day

2. DISCHARGED TO

- 1. Private home / apartment / rented room
- 2. Board and care
- 3. Assisted living or semi-independent living
- 4. Mental health residence—e.g., psychiatric group home
- 5. Group home for persons with physical disability
- 6. Setting for persons with intellectual disability
- 7. Psychiatric hospital or unit
- 8. Homeless (with or without shelter)
- 9. Long-term care facility (nursing home)
- 10. Rehabilitation hospital / unit
- 11. Hospice facility / Palliative care unit
- 12. Acute care hospital
- 13. Correctional facility
- 14. Other
- 15. Deceased

3. SCHEDULED TO RECEIVE HOME CARE SERVICES AT DISCHARGE

0. No 1. Yes

SECTION S. ASSESSMENT INFORMATION

SIGNATURE OF PERSON COORDINATING / COMPLETING THE ASSESSMENT

1. Signature (sign on above line)

2. Date assessment signed as complete

2 0 — —
 Year Month Day

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SECTION C. COGNITION

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING

Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do

- 0. **Independent**—Decisions consistent, reasonable, and safe
- 1. **Modified independence**—Some difficulty in new situations only
- 2. **Minimally impaired**—In specific recurring situations, decisions become poor or unsafe; cues / supervision necessary at those times
- 3. **Moderately impaired**—Decisions consistently poor or unsafe; cues / supervision required at all times
- 4. **Severely impaired**—Never or rarely makes decisions
- 5. **No discernable consciousness, coma** [Skip to Section G]

2. MEMORY / RECALL ABILITY

Code for recall of what was learned or known

- 0. Yes, memory OK
- 1. Memory problem

- a. **Short-term memory OK**—Seems / appears to recall after 5 minutes
- b. **Procedural memory OK**—Can perform all or almost all steps in a multitask sequence without cues
- c. **Situational memory OK**—Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room)

3. PERIODIC DISORDERED THINKING OR AWARENESS

[Note: Accurate assessment requires conversations with staff, family or others who have direct knowledge of the person's behavior over this time]

- 0. Behavior not present
- 1. Behavior present, consistent with usual functioning
- 2. Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)
- a. **Easily distracted**—e.g., episodes of difficulty paying attention; gets sidetracked
- b. **Episodes of disorganized speech**—e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought
- c. **Mental function varies over the course of the day**—e.g., sometimes better, sometimes worse

4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING—e.g., restlessness, lethargy, difficult to arouse, altered environmental perception

- 0. No
- 1. Yes

5. CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)

- 0. Improved
- 1. No change
- 2. Declined
- 8. Uncertain

SECTION D. COMMUNICATION AND VISION

1. MAKING SELF UNDERSTOOD (Expression)

Expressing information content—both verbal and non-verbal

- 0. **Understood**—Expresses ideas without difficulty
- 1. **Usually understood**—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
- 2. **Often understood**—Difficulty finding words or finishing thoughts AND prompting usually required
- 3. **Sometimes understood**—Ability is limited to making concrete requests
- 4. **Rarely or never understood**

2. ABILITY TO UNDERSTAND OTHERS (Comprehension)

Understanding verbal information content (however able; with hearing appliance normally used)

- 0. **Understands**—Clear comprehension
- 1. **Usually understands**—Misses some part / intent of message BUT comprehends most conversation
- 2. **Often understands**—Misses some part / intent of message BUT with repetition or explanation can often comprehend conversation
- 3. **Sometimes understands**—Responds adequately to simple, direct communication only
- 4. **Rarely or never understands**

3. HEARING

Ability to hear (with hearing appliance normally used)

- 0. **Adequate**—No difficulty in normal conversation, social interaction, listening to TV
- 1. **Minimal difficulty**—Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet [2 meters] away)

- 2. **Moderate difficulty**—Problem hearing normal conversation, requires quiet setting to hear well
- 3. **Severe difficulty**—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
- 4. **No hearing**

4. VISION

Ability to see in adequate light (with glasses or with other visual appliance normally used)

- 0. **Adequate**—Sees fine detail, including regular print in newspapers / books
- 1. **Minimal difficulty**—Sees large print, but not regular print in newspapers / books
- 2. **Moderate difficulty**—Limited vision; not able to see newspaper headlines, but can identify objects
- 3. **Severe difficulty**—Object identification in question, but eyes appear to follow objects; sees only light, colors, shapes
- 4. **No vision**

SECTION E. MOOD AND BEHAVIOR

1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD

Code for indicators observed in last 3 days, irrespective of the assumed cause [Note: Whenever possible, ask person]

- 0. Not present
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1-2 of last 3 days
- 3. Exhibited daily in last 3 days

- a. **Made negative statements**—e.g., "Nothing matters; Would rather be dead; What's the use; Regret having lived so long; Let me die"
- b. **Persistent anger with self or others**—e.g., easily annoyed, anger at care received
- c. **Expressions, including non-verbal, of what appear to be unrealistic fears**—e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations
- d. **Repetitive health complaints**—e.g., persistently seeks medical attention, incessant concern with body functions
- e. **Repetitive anxious complaints / concerns (non-health related)**—e.g., persistently seeks attention / reassurance regarding schedules, meals, laundry, clothing, relationships
- f. **Sad, pained, or worried facial expressions**—e.g., furrowed brow, constant frowning
- g. **Crying, tearfulness**
- h. **Recurrent statements that something terrible is about to happen**—e.g., believes he or she is about to die, have a heart attack
- i. **Withdrawal from activities of interest**—e.g., long-standing activities, being with family / friends
- j. **Reduced social interactions**
- k. **Expressions, including non-verbal, of a lack of pleasure in life (anhedonia)**—e.g., "I don't enjoy anything anymore"

2. SELF-REPORTED MOOD

- 0. Not in last 3 days
- 1. Not in last 3 days, but often feels that way
- 2. In 1-2 of last 3 days
- 3. Daily in the last 3 days
- 8. Person could not (would not) respond

Ask: "In the last 3 days, how often have you felt..."

- a. **Little interest or pleasure in things you normally enjoy?**
- b. **Anxious, restless, or uneasy?**
- c. **Sad, depressed, or hopeless?**

3. BEHAVIOR SYMPTOMS

Code for indicators observed, irrespective of the assumed cause

- 0. Not Present
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1-2 of last 3 days
- 3. Exhibited daily in last 3 days

- a. **Wandering**—Moved with no rational purpose, seemingly oblivious to needs or safety
- b. **Verbal abuse**—e.g., others were threatened, screamed at, cursed at
- c. **Physical abuse**—e.g., others were hit, shoved, scratched, sexually abused
- d. **Socially inappropriate or disruptive behavior**—e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through other's belongings
- e. **Inappropriate public sexual behavior or public disrobing**
- f. **Resists care**—e.g., taking medications / injections, ADL assistance, eating

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SECTION F. PSYCHOSOCIAL WELL-BEING

1. SOCIAL RELATIONSHIPS

[Note: Whenever possible, ask person]

- 0. Never
- 1. More than 30 days ago
- 2. 8 to 30 days ago
- 3. 4 to 7 days ago
- 4. In last 3 days
- 8. Unable to determine

- a. **Participation in social activities of long-standing interest**
- b. **Visit with a long-standing social relation or family member**
- c. **Other interaction with long-standing social relation or family member**—e.g., telephone, e-mail
- d. **Conflict or anger with family or friends**
- e. **Fearful of a family member or close acquaintance**
- f. **Neglected, abused, or mistreated**

2. LONELY

Says or indicates that he / she feels lonely

- 0. No
- 1. Yes

3. CHANGE IN SOCIAL ACTIVITIES IN LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO)

Decline in level of participation in social, religious, occupational or other preferred activities

IF THERE WAS A DECLINE, person distressed by this fact

- 0. No decline
- 1. Decline, not distressed
- 2. Decline, distressed

4. LENGTH OF TIME ALONE DURING THE DAY (MORNING AND AFTERNOON)

- 0. Less than 1 hour
- 1. 1-2 hours
- 2. More than 2 hours but less than 8 hours
- 3. 8 hours or more

5. MAJOR LIFE STRESSORS IN LAST 90 DAYS—e.g., episode of severe personal illness; death or severe illness of close family member / friend; loss of home; major loss of income / assets; victim of a crime such as robbery or assault; loss of driving license/car

- 0. No
- 1. Yes

SECTION G. FUNCTIONAL STATUS

1. IADL SELF PERFORMANCE AND CAPACITY

Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

- 0. **Independent**—No help, setup, or supervision
- 1. **Setup help only**
- 2. **Supervision**—Oversight / cuing
- 3. **Limited assistance**—Help on some occasions
- 4. **Extensive assistance**—Help throughout task, but performs 50% or more of task on own
- 5. **Maximal assistance**—Help throughout task, but performs less than 50% of task on own
- 6. **Total dependence**—Full performance by others during entire period
- 8. **Activity did not occur**—During entire period [DO NOT USE THIS CODE IN SCORING CAPACITY]

| | |
|-------------|--|
| PERFORMANCE | |
| | |
| CAPACITY | |
| | |

- a. **Meal preparation**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)
- b. **Ordinary housework**—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)
- c. **Managing finances**—How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored
- d. **Managing medications**—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)
- e. **Phone use**—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)
- f. **Stairs**—How full flight of stairs is managed (12-14 stairs)
- g. **Shopping**—How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION

- h. **Transportation**—How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)

2. ADL SELF-PERFORMANCE

Consider all episodes over 3-day period.

If all episodes are performed at the same level, score ADL at that level. If any episodes at level 6, and others less dependent, score ADL as a 5.

Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2-5.

- 0. **Independent**—No physical assistance, setup, or supervision in any episode
- 1. **Independent, setup help only**—Article or device provided or placed within reach, no physical assistance or supervision in any episode
- 2. **Supervision**—Oversight / cuing
- 3. **Limited assistance**—Guided maneuvering of limbs, physical guidance without taking weight
- 4. **Extensive assistance**—Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
- 5. **Maximal assistance**—Weight-bearing support (including lifting limbs) by 2+ helpers —OR— Weight-bearing support for more than 50% of subtasks
- 6. **Total dependence**—Full performance by others during all episodes
- 8. **Activity did not occur during entire period**

- a. **Bathing**—How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR

- b. **Personal hygiene**—How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS

- c. **Dressing upper body**—How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.

- d. **Dressing lower body**—How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.

- e. **Walking**—How walks between locations on same floor indoors

- f. **Locomotion**—How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair

- g. **Transfer toilet**—How moves on and off toilet or commode

- h. **Toilet use**—How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET

- i. **Bed mobility**—How moves to and from lying position, turns from side to side, and positions body while in bed

- j. **Eating**—How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)

3. LOCOMOTION / WALKING

a. Primary mode of locomotion

- 0. Walking, no assistive device
- 1. Walking, uses assistive device—e.g., cane, walker, crutch, pushing wheelchair
- 2. Wheelchair, scooter
- 3. Bedbound

b. Timed 4-meter (13 foot) walk

[Lay out a straight unobstructed course. Have person stand in still position, feet just touching start line]

Then say: "When I tell you begin to walk at a normal pace (with cane/walker if used). This is not a test of how fast you can walk. Stop when I tell you to stop. Is this clear?" Assessor may demonstrate test.

Then say: "Begin to walk now" Start stopwatch (or can count seconds) when first foot falls. End count when foot falls beyond 4-meter mark.

Then say: "You may stop now"

Enter time in seconds, up to 30 seconds.

30. 30 or more seconds to walk 4-meters

77. Stopped before test complete

88. Refused to do the test

99. Not tested—e.g., does not walk on own

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BALANCE

- a. **Difficult or unable to move self to standing position unassisted**
- b. **Difficult or unable to turn self around and face the opposite direction when standing**
- c. **Dizziness**
- d. **Unsteady gait**

CARDIAC OR PULMONARY

- e. **Chest pain**
- f. **Difficulty clearing airway secretions**

PSYCHIATRIC

- g. **Abnormal thought process**—e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality
- h. **Delusions**—Fixed false beliefs
- i. **Hallucinations**—False sensory perceptions

NEUROLOGICAL

- j. **Aphasia**

GI STATUS

- k. **Acid reflux**—Regurgitation of acid from stomach to throat
- l. **Constipation**—No bowel movement in 3 days or difficult passage of hard stool
- m. **Diarrhea**
- n. **Vomiting**

SLEEP PROBLEMS

- o. **Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep**
- p. **Too much sleep**—Excessive amount of sleep that interferes with person's normal functioning

OTHER

- q. **Aspiration**
- r. **Fever**
- s. **GI or GU bleeding**
- t. **Hygiene**—Unusually poor hygiene, unkempt, disheveled
- u. **Peripheral edema**

4. DYSPNEA (Shortness of breath)

- 0. Absence of symptom
- 1. Absent at rest, but present when performed moderate activities
- 2. Absent at rest, but present when performed normal day-to-day activities
- 3. Present at rest

5. FATIGUE

Inability to complete normal daily activities—e.g., ADLs, IADLs

- 0. **None**
- 1. **Minimal**—Diminished energy but completes normal day-to-day activities
- 2. **Moderate**—Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
- 3. **Severe**—Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
- 4. **Unable to commence any normal day-to-day activities**—Due to diminished energy

6. PAIN SYMPTOMS

[Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]

- a. **Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other non-verbal signs suggesting pain)**
 - 0. No pain
 - 1. Present but not exhibited in last 3 days
 - 2. Exhibited on 1-2 of last 3 days
 - 3. Exhibited daily in last 3 days
- b. **Intensity of highest level of pain present**
 - 0. No pain
 - 1. Mild
 - 2. Moderate
 - 3. Severe
 - 4. Times when pain is horrible or excruciating

c. Consistency of pain

- 0. No pain
- 1. Single episode during last 3 days
- 2. Intermittent
- 3. Constant

d. Breakthrough pain—Times in LAST 3 DAYS when person experienced sudden, acute flare-ups of pain

- 0. No
- 1. Yes

e. Pain control—Adequacy of current therapeutic regimen to control pain (from person's point of view)

- 0. No issue of pain
- 1. Pain intensity acceptable to person; no treatment regimen or change in regimen required
- 2. Controlled adequately by therapeutic regimen
- 3. Controlled when therapeutic regimen followed, but not always followed as ordered
- 4. Therapeutic regimen followed, but pain control not adequate
- 5. No therapeutic regimen being followed for pain; pain not adequately controlled

7. INSTABILITY OF CONDITIONS

- 0. No
- 1. Yes

a. Conditions / diseases make cognitive, ADL, mood or behavior patterns unstable (fluctuating, precarious, or deteriorating)

b. Experiencing an acute episode, or a flare-up of a recurrent or chronic problem

c. End-stage disease, 6 or fewer months to live

8. SELF-REPORTED HEALTH

Ask: "In general, how would you rate your health?"

- 0. Excellent
- 1. Good
- 2. Fair
- 3. Poor
- 8. Could not (would not) respond

9. TOBACCO AND ALCOHOL

a. Smokes tobacco daily

- 0. No
- 1. Not in last 3 days, but is usually a daily smoker
- 2. Yes

b. Alcohol—Highest number of drinks in any "single sitting" in LAST 14 DAYS

- 0. None
- 1. 1
- 2. 2-4
- 3. 5 or more

SECTION K. ORAL AND NUTRITIONAL STATUS

1. HEIGHT AND WEIGHT [INCHES AND POUNDS— COUNTRY SPECIFIC]

Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in LAST 30 DAYS.

- a. HT (in.) b. WT (lb.)

2. NUTRITIONAL ISSUES

- 0. No
- 1. Yes
- a. **Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS**
- b. **Dehydrated or BUN / Cre ratio > 25** [Ratio, country specific]
- c. **Fluid intake less than 1,000 cc per day (less than four 8 oz cups/day)**
- d. **Fluid output exceeds input**

3. MODE OF NUTRITIONAL INTAKE

- 0. **Normal**—Swallows all types of foods
- 1. **Modified independent**—e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
- 2. **Requires diet modification to swallow solid food**—e.g., mechanical diet (e.g., puree, minced, etc.) or only able to ingest specific foods
- 3. **Requires modification to swallow liquids**—e.g., thickened liquids
- 4. **Can swallow only pureed solids —AND— thickened liquids**
- 5. **Combined oral and parenteral or tube feeding**
- 6. **Nasogastric tube feeding only**
- 7. **Abdominal feeding tube**—e.g., PEG tube
- 8. **Parenteral feeding only**—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
- 9. **Activity did not occur**—During entire period

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- 4. DENTAL OR ORAL**
 0. No 1. Yes
- a. **Wears a denture (removable prosthesis)**
 - b. **Has broken, fragmented, loose, or otherwise non-intact natural teeth**
 - c. **Reports having dry mouth**
 - d. **Reports difficulty chewing**

SECTION L. SKIN CONDITION

- 1. MOST SEVERE PRESSURE ULCER**
 0. No pressure ulcer
 1. Any area of persistent skin redness
 2. Partial loss of skin layers
 3. Deep craters in the skin
 4. Breaks in skin exposing muscle or bone
 5. Not codeable, e.g., necrotic eschar predominant
- 2. PRIOR PRESSURE ULCER**
 0. No 1. Yes
- 3. PRESENCE OF SKIN ULCER OTHER THAN PRESSURE ULCER**—e.g., venous ulcer, arterial ulcer, mixed venous-arterial ulcer, diabetic foot ulcer
 0. No 1. Yes
- 4. MAJOR SKIN PROBLEMS**—e.g., lesions, 2nd or 3rd degree burns, healing surgical wounds
 0. No 1. Yes
- 5. SKIN TEARS OR CUTS**—Other than surgery
 0. No 1. Yes
- 6. OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION**—e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema
 0. No 1. Yes
- 7. FOOT PROBLEMS**—e.g., bunions, hammer toes, overlapping toes, structural problems, infections, ulcers
 0. No foot problems
 1. Foot problems, no limitation in walking
 2. Foot problems limit walking
 3. Foot problems prevent walking
 4. Foot problems, does not walk for other reasons

SECTION M. MEDICATIONS

- 1. LIST OF ALL MEDICATIONS**
 List all active prescriptions, and any non-prescribed (over the counter) medications taken in the LAST 3 DAYS
 [Note: Use computerized records if possible; hand enter only when absolutely necessary]
- For each drug record:**
- a. **Name**
 - b. **Dose**—A positive number such as 0.5, 5, 150, 300.
 [Note: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg)]
 - c. **Unit**—Code using the following list:

| | | |
|-----------------|------------------------|-------------|
| gtts (Drops) | mEq (Milli-equivalent) | Puffs |
| gm (Gram) | mg (Milligram) | % (Percent) |
| L (Liters) | ml (Milliliter) | Units |
| mcg (Microgram) | oz (Ounce) | OTH (Other) |
 - d. **Route of administration**—Code using the following list:

| | | |
|----------------------|-----------------|-------------------|
| PO (By mouth/oral) | REC (Rectal) | EI (Enteral Tube) |
| SL (Sublingual) | TOP (Topical) | TD (Transdermal) |
| IM (Intramuscular) | IH (Inhalation) | EYE (Eye) |
| IV (Intravenous) | NAS (Nasal) | OTH (Other) |
| Sub-Q (Subcutaneous) | | |
 - e. **Freq**—Code the number of times per day, week, or month the medication is administered using the following list:

| | |
|-------------------------|------------------------|
| Q1H (Every hour) | 5D (5 times daily) |
| Q2H (Every 2 hours) | Q2D (Every other day) |
| Q3H (Every 3 hours) | Q3D (Every 3 days) |
| Q4H (Every 4 hours) | Weekly |
| Q6H (Every 6 hours) | 2W (2 times weekly) |
| Q8H (Every 8 hours) | 3W (3 times weekly) |
| Daily | 4W (4 times weekly) |
| BED (At bedtime) | 5W (5 times weekly) |
| BID (2 times daily) | 6W (6 times weekly) |
| (includes every 12 hrs) | 1M (Monthly) |
| TID (3 times daily) | 2M (Twice every month) |
| QID (4 times daily) | OTH (Other) |
 - f. **PRN**
 0. No 1. Yes

| | g. Computer-entered drug code | | | | | | 9. ATC or NDC code |
|----|-------------------------------|---------|---------|----------|----------|--------|--------------------|
| | a. Name | b. Dose | c. Unit | d. Route | e. Freq. | f. PRN | |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |

[NOTE: Add additional lines, as necessary, for other drugs taken]
 [Abbreviations are Country Specific for Unit, Route, Frequency]

- 2. ALLERGY TO ANY DRUG**
 0. No known drug allergies 1. Yes
- 3. ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN**
 0. Always adherent
 1. Adherent 80% of time or more
 2. Adherent less than 80% of time, including failure to purchase prescribed medications
 8. No medications prescribed

SECTION N. TREATMENT AND PROCEDURES

- 1. PREVENTION**
 0. No 1. Yes
- a. Blood pressure measured in LAST YEAR
 - b. Colonoscopy test in LAST 5 YEARS
 - c. Dental exam in LAST YEAR
 - d. Eye exam in LAST YEAR
 - e. Hearing exam in LAST 2 YEARS
 - f. Influenza vaccine in LAST YEAR
 - g. Mammogram or breast exam in LAST 2 YEARS (for women)
 - h. Pneumovax vaccine in LAST 5 YEARS or after age 65

- 2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 3 DAYS)**
 0. Not ordered AND did not occur
 1. Ordered, not implemented
 2. 1-2 of last 3 days
 3. Daily in last 3 days

- TREATMENTS**
- a. Chemotherapy
 - b. Dialysis
 - c. Infection control—e.g., isolation, quarantine
 - d. IV medication
 - e. Oxygen therapy
 - f. Radiation
 - g. Suctioning
 - h. Tracheostomy care
 - i. Transfusion
 - j. Ventilator or respirator
 - k. Wound care
- PROGRAMS**
- l. Scheduled toileting program
 - m. Palliative care program
 - n. Turning / repositioning program

3. FORMAL CARE
 Days (A) and Total minutes (B) of care in last 7 days
 Extent of care/treatment in LAST 7 DAYS (or since last assessment or admission, if less than 7 days) involving:

| | (A) # of Days | (B) Total Minutes in last week |
|---|---------------|--------------------------------|
| a. Home health aides | | |
| b. Home nurse | | |
| c. Homemaking services | | |
| d. Meals | | |
| e. Physical therapy | | |
| f. Occupational therapy | | |
| g. Speech-language pathology and audiology services | | |
| h. Psychological therapy (by any licensed mental health professional) | | |



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Community Transition Plan Checklist Tool ICF/ID Members

| | | |
|--------------------------|---------------------------------|--|
| <input type="checkbox"/> | Desire to Transition | Member identified or requesting transition to the community as documented in the Plan of Care |
| <input type="checkbox"/> | Medical Records | Community Care Coordinator ensures medical records are requested |
| <input type="checkbox"/> | Signed consent forms | Community Care Coordinator ensures consent forms are completed |
| <input type="checkbox"/> | Member's Needs | Community Care Coordinator identifies the member's needs, risks, and current functions as determined by the initial InterRAI comprehensive assessment and documented in the Plan of Care |
| <input type="checkbox"/> | Member's Transition Team | Community Care Coordinator identifies all entities (family, friends, and providers) involved in transition by documenting in Plan of Care and Care Team |
| <input type="checkbox"/> | Choosing Qualified Residences | Community Care Coordinator documents Member's desired residence in Plan of Care |
| <input type="checkbox"/> | Member's Services and Equipment | Community Care Coordinator documents Member's needed services and equipment in Plan of Care |
| <input type="checkbox"/> | Post- transition monitoring | Community Care Coordinator documents Member's condition and satisfaction, and coordinates other needed services in the Plan of Care |

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Attachment 18 (Sample Self-Assessment Tool)

Is Self-Directed Care Right for Me?

The checklist below is used to determine if Customer-Directed Care is the right fit for you:

- Do you need assistance living independently at home? Yes No
- Do you know what your needs are? Yes No
- Do you know how to manage the assistance you will receive? Yes No
- Do you know what supplies you need to meet your healthcare needs? Yes No
- Do you know where to get these supplies and who to call if they run out? Yes No
- Are you comfortable being an employer? Yes No
- Do you prefer family to help you? Yes No
- Are you able to take charge of your healthcare needs? Yes No
- Are you able to describe your healthcare needs? Yes No
- Do you think it is ok for your provider to be late? Yes No
- Are you able to train your provider to meet your needs? Yes No
- Are you able to speak for yourself? Yes No
- Will you cooperate with your provider and the payment process? Yes No

What would you do if your worker put hours on their timesheet when they were not actually at work?

What would you do if you are unhappy with the services being provided?

What are do I need help with?

Rank the following items based on how much assistance you need with them. 3 meaning you need a lot of help and 1 meaning you need only a review

- Understanding the payment process
- Finding a responsible person to provide care

Attachment 18 (Sample Self-Assessment Tool)

- Writing a job description for your provider
- Screening and interviewing potential providers
- Reading and understanding a criminal background check
- Setting and enforcing rules for your provider
- Training your employee
- Reviewing and approving your employees time sheets
- Deciding on how much to pay your worker
- Dealing with poor worker performance
- Developing a Care Plan
- Identifying your needs
- Knowing what extra assistance is available in your community
- Knowing who to call in case of emergency
- Understating your diagnoses
- Knowing who your primary care and specialists are
- Knowing and understanding the medications you take

Making a Personal Care Task List

Identify the amount of assistance you need with the items below

| | Independent | Limited | Extensive | Dependent |
|------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Bathing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Outside the Home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dressing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mobility | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Personal hygiene | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Toilet use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Transferring | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Attachment 18 (Sample Self-Assessment Tool)

| | | | | |
|------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Meal preparation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Housework | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Managing Money | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Shopping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Transportation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

What time of day do you need these services?

| Day | Start Time | End Time |
|-----------|------------|----------|
| Sunday | | |
| Monday | | |
| Tuesday | | |
| Wednesday | | |
| Thursday | | |
| Friday | | |
| Saturday | | |

Finding the right Support Network

Check the response that most closely describes how important the following things are when choosing a provider

| | Very Important | Somewhat Important | Not Important |
|---|--------------------------|--------------------------|--------------------------|
| The worker arrives on time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My worker stays the entire time scheduled | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The worker is a family member or friend | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My worker follows my instructions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The worker is already trained | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My worker knows what supplies I need and where to get those supplies from | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Attachment 18 (Sample Self-Assessment Tool)

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Iowa Department of Human Services
**Home- and Community-Based Services
Consumer Choices Option
Informed Consent and Risk Agreement**

I, _____, choose to participate in the Consumer Choices Option.
Consumer

I understand that my participation in the Consumer Choices Option is completely voluntary. If I decide that the Consumer Choices Option is not right for me, I understand that I may withdraw from the Consumer Choices Option and receive the services for which I am eligible for under the traditional home- and community-based waiver services. I will not be penalized in any way. I will not lose any benefits to which I am entitled and I will not have to be placed on a waiting list.

(Initial to show you have read and understood the above information.)

I will receive a monthly budget in the amount \$_____ to buy services and make other purchases related to my long-term care needs. I understand that I will choose personal care services, community and employment supports and services, and other goods and services that will best meet my needs and are cost effective. I understand that there is an approved list of services and supports that I may purchase from and if I choose a service or support not on the approved list, I will have to seek approval from the Iowa Medicaid Enterprise before purchasing. I understand that I will choose who provides my services, they do not need to be a Medicaid provider, and I will be the employer of record for employees I hire. I understand that by hiring my own employees I accept the risk associated with being an employer. I understand that I will be required to work with an independent support broker of my choosing. I will develop an individual budget with my independent support broker.

I understand that I will also be required to work with a Financial Management Services provider that will be responsible for issuing payment to my employees and for my purchases from my individual budget funds. I understand that if I overspend my budget and no longer have funds in my Individual budget, I am personally responsible to pay my employees and to pay for my purchases. I understand that I am legally required to pay employer-related taxes for the employees I hire. My individual budget must be used to pay for the employer-related taxes. My individual budget must be used to pay for the Financial Management Services fees and the independent support broker's fees. The Financial Management Services will pay for the employer-related taxes, the Financial Management Service fees and independent support broker fees from my individual budget on my behalf.

I will get help from my independent support broker in making sure the budget is being used correctly. I understand that if I misuse my individual budget, I may be transferred back to the traditional home-

Attachment 19 (Informed Consent and Risk Agreement)

and community-based Medicaid services for which I am eligible. I understand that I cannot purchase room and board, childcare, and personal entertainment items with my budget.

(Initial to show you have read and understood the above information.)

I understand that I will be responsible for signing all my employees' time cards and by doing so I am verifying that my employees did work the hours claimed on the time card to provide services for me. I understand that signing an employee time card which contains false information about hours worked, may make me a party to Medicaid fraud and legal action could occur.

(Initial to show you have read and understood the above information.)

I have read and understood this consent form. I understand that I get to keep a copy of this consent form.

Consumer's Signature

Date Signed

If applicable, Guardian's Signature

Date Signed

Meridian Health Plan - Provider Portal

Overview

Meridian Health Plan's Managed Care System (MCS) Provider Portal is a secure, proprietary software program that offers unmatched flexibility and efficiency for our network providers. The MCS Provider Portal is free of charge to all participating Meridian Health Plan providers.

Features

The Meridian Provider Portal is available for contracted providers

- > Verify eligibility for ANY Medicaid member
- > Claims status and submission/correction
- > Meridian member information and reports
- > HEDIS self-reporting
- > Authorizations
- > Enrollment lists
- > HEDIS bonus information
- > Plus much more...

How to Register

A Meridian-supplied user name is required for access.

1. Go to www.mhplan.com

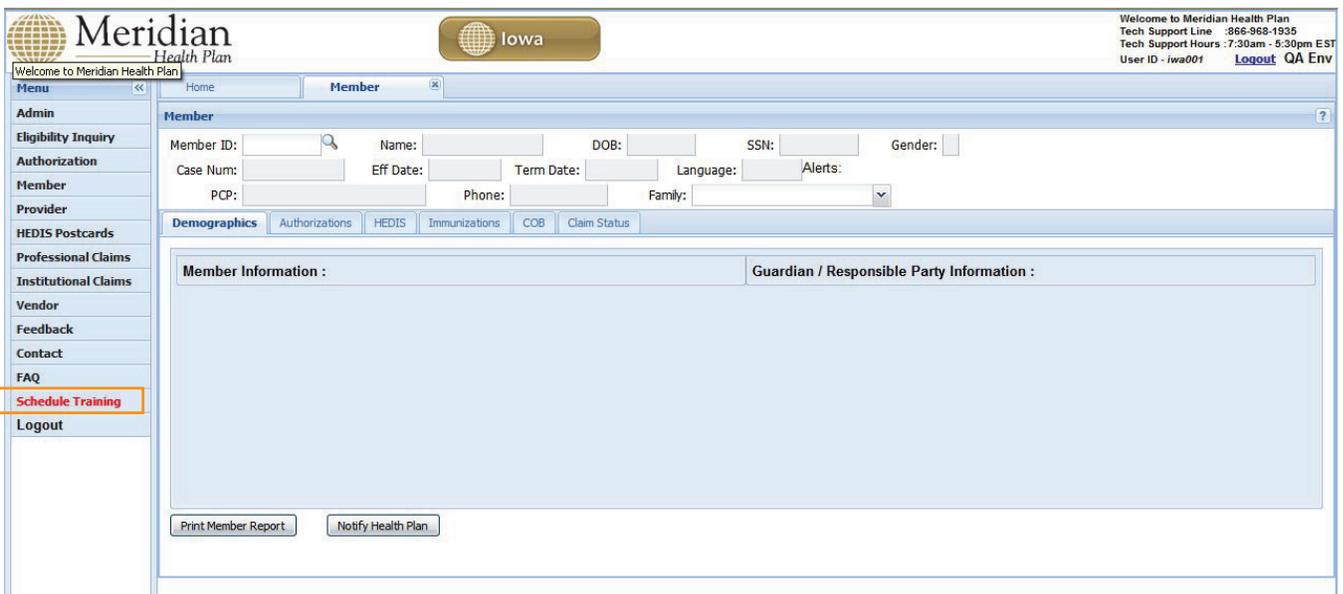
2. Click 

3. Click  **PROVIDER**
Portal Login

4. Click  [New Provider? Register Here](#)

Schedule Training

You can schedule training at any time using the Provider Portal.



**Training is also available through your local Provider Network Development Representative.

For more information, please contact your local Provider Network Development Representative or the Provider Services department at 877-204-8977.

System Requirements

One of the following web browsers: Internet Explorer v. 7 or higher or Firefox 2.0 or higher, 1024 x 768 screen resolution or higher, allow pop-up's (disable pop-up blocker) and Adobe Reader

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Appropriate Treatment for Children with Upper Respiratory Infection

Antibiotic resistance can be reduced through proper prescribing practices

Sneezing, scratchy throat and runny nose are symptoms of the common cold or upper respiratory infection (URI). Typical URIs are usually viral, and consequently, do not benefit from antibiotics.

As a key quality measure, Meridian Health Plan monitors the percentage of children (3 months - 18 years) who were diagnosed as having a URI who were NOT prescribed an antibiotic.

Coding Tips:

If your diagnosis is URI or Nasopharyngitis, then these are viral entities and antibiotics should generally NOT be prescribed.

Coding of URI

| | |
|-----------------|-----|
| Nasopharyngitis | 460 |
| URI | 465 |

These do NOT warrant antibiotics.

Instead, please prescribe over the counter medicines that can help relieve cold symptoms.

If there is a secondary diagnosis such as a bacterial infection of the upper respiratory tract [e.g., Sinusitis (acute or chronic), Strep tonsillitis (with confirmatory Strep test), etc.], then antibiotics are appropriate and the second diagnosis should be billed for.

| Diagnoses Indicative of a Bacterial Infection of the Upper Respiratory Tract | Diagnosis Codes |
|--|--|
| Bacterial infection unspecified | 041.9 |
| Acute sinusitis | 461 |
| Acute pharyngitis (confirmed with strep test) | 034.0, 462 |
| Chronic sinusitis | 473 |
| Infections of pharynx, larynx, tonsils, adenoids | 464.1 - 464.3, 474, 478.21 - 478.24, 478.29, 478.71, 478.79, 478.9 |

These MAY warrant antibiotics.

When parents ask for antibiotics to treat viral infections:

- **Explain that unnecessary antibiotics can be harmful.** Tell parents that based on the latest evidence, unnecessary antibiotics CAN be harmful by promoting resistant organisms in their child and the community.
- **Share the fact.** Explain that bacterial infections can be cured by antibiotics, but viral infections cannot.
- **Build cooperation and trust.** Convey a sense of partnership and do not dismiss the illness as “only a viral infection.”
- **Encourage active management of the illness.** Plan the treatment of symptoms with parents. Describe the expected normal time course of the illness and tell parents to come back if symptoms persist or worsen.
- **Be confident with the recommendation to use alternative treatment.** Provide analgesics, if appropriate. Emphasize the importance of adequate nutrition and hydration and consider providing “care packages” with non-antibiotic therapies.

Create an office environment to promote the reduction in antibiotic use!

- **Start the educational process in the waiting room.** Videotapes, posters and other materials are available at www.cdc.gov/getsmart/antibiotic-use/
- **Involve office personnel in the education process**
- **Use the CDC/AAP pamphlets and principles to support your treatment decisions**

Appropriate Testing for Children with Pharyngitis

Pharyngitis diagnosis should be based on results of a streptococcus (strep) test.

The main symptom of Pharyngitis is a sore throat. Other symptoms include fever, headache, joint pain and muscle aches, skin rashes and swollen lymph nodes in the neck. Antibiotics do not help viral sore throats. Using these medicines to treat viral infections helps strengthen bacteria and make them resistant to antibiotics. Clinical guidelines recommend a strep test in cases where the only diagnosis is Pharyngitis.

As a key quality measure, Meridian Health Plan monitors the percentage of children (2 years – 18 years) who were diagnosed with Pharyngitis, dispensed an antibiotic **and** received a group A strep test for the episode.

| Diagnosis | CDC/AAP Principles of Appropriate Use |
|-------------|---|
| Pharyngitis | <ol style="list-style-type: none"> 1. Diagnose as Group A streptococcal pharyngitis using a laboratory test in conjunction with clinical and epidemiological findings 2. Antibiotics should not be given to a child with pharyngitis in the absence of diagnosed Group A streptococcal infection 3. A penicillin remains the drug of choice for treating Group A streptococcal pharyngitis |

Codes to Identify Pharyngitis

| Description | ICD-9-CM Diagnosis |
|---------------------------|--------------------|
| Acute pharyngitis | 462 |
| Acute tonsillitis | 463 |
| Streptococcal sore throat | 034.0 |

Codes to Identify Group A Streptococcus Tests

| CPT | LOINC |
|---|---|
| 87070, 87071, 87081, 87430, 87650-87652, 87880 | 626-2, 5036-9, 6556-5, 6557-3, 6558-1, 6559-9, 11268-0, 17656-0, 18481-2, 31971-5, 49610-9, 60489-2, 68954-7 |



Remember to visit Meridian's online Provider Portal to enter relevant HEDIS® information:
www.mhplan.com/ia/mcs



Medical records may be faxed to:
515.802.3563



If you have any questions, please call Meridian's Quality Improvement department at:
515.802.3500

IOWA
**MEMBER
HANDBOOK**

MEMBER SERVICES:
877-204-9132

TTY/TDD:
800-735-2942



www.mhplan.com

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WELCOME LETTER

Dear Meridian Member,

Thank you for choosing Meridian Health Plan! We are here to provide quality health care to you and your family.

Meridian covers a wide range of care. This handbook helps you know your benefits. It helps you get the care you need.

We want you to be happy with your health care. Please call Member Services toll-free at 877-204-9132 if you have any questions.

You can also visit our website for more information (www.mhplan.com). Please call Member Services at 877-204-9132 if you need a printed copy of any website information.

The Member Handbook is reviewed once a year. We will notify you through newsletters and other mailings if there are changes to the handbook.

Thank you again for joining the Meridian family.

Wishing you good health,

A handwritten signature in black ink that reads "David B. Cotton M.D." in a cursive style.

David B. Cotton, MD
President/CEO
Meridian Health Plan

TABLE OF CONTENTS

WELCOME LETTER.....3
MEMBER SERVICES6
 Your Member ID Card.....6
 Important ID Notes.....7
 Interpreter Services.....7
 Hearing and Vision Impairment.....7
 Routine Transportation.....8
BENEFITS.....8
 Care Covered by Meridian.....8
 Care Covered by Iowa Medicaid Enterprise..... 13
 Care Not Covered By Meridian or Iowa Medicaid Enterprise..... 14
 Emergency Care..... 15
 Prior Authorization..... 15
 Pharmacy and Prescription Drug Coverage..... 16
 Away from Home..... 16
PRIMARY CARE PROVIDER..... 16
 Choosing Your PCP..... 16
 Changing Your PCP..... 18
 Getting Care from Your PCP..... 18
 Urgent Care and Routine Care..... 19
DO I NEED A SPECIALIST? 19
HOSPITAL CARE.....20
SPECIAL HEALTHCARE PROGRAMS..... 20
 Care Coordination..... 20
 Maternity Care Coordination..... 21
 Weight Management Care Coordination 23
 Complex Case Management 23
 Disease Management (DM)..... 23
 Text Messaging Program..... 24
PREVENTIVE HEALTH..... 24
 Children’s Health 24
 Women’s Health..... 25
 Pregnant Women..... 26
 Family Planning..... 26
 Men’s Health..... 26

| | |
|---|----|
| COMMUNITY HEALTHCARE RESOURCES | 27 |
| Women, Infants and Children (WIC) | 27 |
| Maternal and Child Health Program..... | 27 |
| Early ACCESS | 28 |
| Family Investment Program (FIP) | 28 |
| GRIEVANCES..... | 28 |
| External Review of Grievances..... | 29 |
| APPEALS..... | 30 |
| Urgent Appeal | 32 |
| Fair Hearing by the State of Iowa..... | 32 |
| RIGHTS AND RESPONSIBILITIES..... | 32 |
| SUMMARY OF PRIVACY PRACTICES..... | 34 |
| FRAUD, WASTE AND ABUSE | 36 |
| Reporting FWA | 37 |
| OTHER IMPORTANT INFO | 38 |
| How Meridian Makes Healthcare Decisions..... | 38 |
| New Technology..... | 38 |
| Quality Improvement Program | 38 |
| Advance Health Directives..... | 38 |
| Health Insurance Premium Payment (HIPPP) Program..... | 39 |
| If You Get a Bill or Statement | 40 |
| Changing Your Managed Care Coverage | 40 |
| SERVICE AREA | 41 |
| IMPORTANT NUMBERS..... | 42 |

MEMBER SERVICES

Welcome to Meridian Health Plan!

Our Member Services department is ready to help you get the most from Meridian. You can call Member Services toll-free at 877-204-9132. We are here to help Monday – Friday from 8 a.m. – 8 p.m.

Member Services can help you if you need:

- More info about your benefits
- Help finding a Primary Care Provider (PCP)
- To change your PCP
- A new Meridian ID card or handbook
- To change your address or phone number
- To get basic plan info

Be sure to have your Medicaid ID number ready when you call.

You can also reach Member Services with Live Chat. Visit www.mhplan.com to chat with a Representative. Live Chat is ready to help you Monday – Friday from 8 a.m. – 8 p.m.

Your Member ID Card

You have two ID cards. Keep both cards with you at all times.



Your **Iowa medical assistance** card lists this info:

- Your name
- Date of birth
- Medicaid ID number
- Member Services phone number
- How to check eligibility and plan enrollment

Your **Meridian ID** card lists this info:

- Your name
- Medicaid ID number
- Member Services phone number
- Other special instructions

Important ID Notes

- Bring both ID cards with you when you go to the doctor or pharmacy
- Do not let anyone else use your cards
- You may also need to show a picture ID. This is to make sure the right person is using the card
- Call your caseworker as soon as you can when you have a baby. Your caseworker will add your baby to your case. This starts the process of signing your baby up for Meridian
- Your baby is covered by Meridian at the time of birth. You need to call Member Services and tell us:
 - The day you gave birth
 - Your baby's name
 - Your baby's Medicaid ID number that you get from your caseworker
- Your baby will get an ID card and info within 30 days
- Call Member Services at 877-204-9132 if you need help choosing a doctor for your baby
- Call your caseworker to change your records if your name changes

Call Meridian Member Services at 877-204-9132 if you do not have your Member ID card. Call Iowa Medicaid Enterprise at 800-338-8366 if you do not have your Iowa Medicaid card.

Interpreter Services

Meridian can arrange for an interpreter to help you speak with us or your doctor in any language. Interpreter services are free for Meridian members. Call Member Services for help.

¿Habla español? Por favor contacte a Meridian al 877-204-9132.

Hearing and Vision Impairment

We offer TTY/TDD services free of charge if you have hearing problems. The TTY/TDD line is open 24/7 at 800-735-2942. We also have a Live Chat online help program. You can instant message with a Representative through Live Chat. Visit www.mhplan.com to use Live Chat. We are here to chat Monday – Friday from 8 a.m. – 8 p.m.

We offer the Member Handbook and other materials in Braille if you have vision problems. Our website also has buttons to make the print bigger and simpler to read.

Routine Transportation

You have options for transportation to and from visits to the doctor, behavioral health visits and pharmacies. You can also get paid back for gas to and from office visits. You need to call 866-572-7662 at least three days before your appointment to talk about your options.

Have this info ready when you call:

- Your name, Medicaid ID number and date of birth
- The address and phone number where you will be picked up
- The address and phone number where you are going
- Your appointment date and time
- The name of your provider

Call 866-572-7662 to learn more about your transportation options or to schedule or cancel your ride. You should call as soon as you can if you need to cancel your ride.

BENEFITS

Care Covered by Meridian

This is a list of care you can get with Meridian. Your Certificate of Coverage (COC) has the complete list of covered care. Call Member Services at 877-204-9132 if you would like a printed copy of the COC or have questions about your benefits.

NOTE: You DO NOT have co-pays for covered care. See the section after the charts for prior authorization info.

| Children’s Care | |
|----------------------------------|--|
| Newborn Care | Newborn screenings are covered. Circumcisions performed on male newborns before leaving the hospital are covered. |
| Immunizations & Vaccines (shots) | You can get these at the doctor’s office or the local health department. Immunizations and vaccines are covered according to the Centers for Disease Control and Prevention (CDC) and American Academy of Pediatrics vaccination schedule. |

| Children's Care | |
|---|---|
| Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (under 21 years old) | Covered services include: <ul style="list-style-type: none"> • Well-child visits • Developmental screening • Vision testing • Behavioral screening • Immunizations • Hearing testing |
| Lead Screening | Lead screenings can be done at the doctor's office or local health department. Your child needs six blood lead tests. The first test should be before your child is one year old. A blood lead test should be done once a year until your child is six years old. |
| Office Visits | Well-child visits, routine visits and sick visits are covered. Certified pediatric and family nurse practitioner care is included. |
| Women's Care | |
| Family Planning | Family planning offers counseling, supplies, routine care and treatment for sexually transmitted infections (STIs). This care is private. Your doctor or Obstetrician/Gynecologist (OB/GYN) can give this care. |
| Obstetric & Maternity Care | <p>Each pregnant member has a Maternity Care Coordinator who helps find and set up all needed care.</p> <p>You are covered for:</p> <ul style="list-style-type: none"> • Doctor and hospital care before your baby is born (prenatal care) • Delivery • Care after birth (postpartum care) • Certified midwife care • Birthing and parenting classes <p>You may choose an Obstetrician (OB) or OB/GYN for prenatal care and postpartum care without a referral.</p> <p>You can stay in the hospital up to 2 days after a normal vaginal delivery and up to 4 days after a Cesarean delivery.</p> |
| Well-Care for Women | You may see an OB or OB/GYN for routine office visits, mammograms, Pap tests and family planning. No referral is needed. |
| Sterilization | Sterilization requires prior authorization. |
| Abortions | Covered if medically necessary as defined by Iowa state law. |

| Emergency and Urgent/Hospital Care | |
|---|--|
| Emergency Room Care, Ambulance & Other Emergency Transportation | <p>Emergency care is for a medical issue that is a threat to your life or that can badly harm your health if you do not get care right away. Here are some examples of emergencies:</p> <ul style="list-style-type: none"> • Convulsions • Uncontrollable bleeding • Chest pain • High fever • Serious breathing problems • Knife or gunshot wounds • Broken bones • Loss of consciousness (fainting or blackout) <p>Emergency care does not need prior authorization and you can get it out-of-network, including post-stabilization care. Post-stabilization care includes the care you get after an emergency to make you stable or to maintain, improve or resolve your health condition.</p> <p>Ambulance services for emergency transportation are covered.</p> |
| Medical Inpatient Care | Hospital inpatient care is covered when medically necessary. |
| Urgent Care Visits | <p>Urgent care is for problems that need prompt medical attention but are not life threatening. Here are some examples of urgent care:</p> <ul style="list-style-type: none"> • Sore throat or cough • Back pain • Tension headache • Earache • Flu or cold symptoms • Frequent urination • Minor sickness • Minor injury <p>Visits to an urgent care center are covered.</p> |
| Outpatient Care | |
| Cardiac & Pulmonary Rehab | Covered when medically necessary with prior authorization. |
| Home Health Care | Skilled nursing care and other skilled nursing services, like physical therapy, are covered in the home when medically necessary. Prior authorization is needed. |
| Rehabilitative Therapy | <p>This type of care is given after serious illness or injury to restore function:</p> <ul style="list-style-type: none"> • Physical therapy • Occupational therapy • Speech therapy <p>These are covered when medically necessary with prior authorization.</p> |

| Outpatient Care | |
|--|---|
| Specialty Care (Office Visits & Clinics) | You do not need prior authorization to see a specialist. Talk to your doctor to see if you need specialty care. Your doctor will refer you to a specialist if needed. |
| Diagnostic Testing | <p>These lab tests are covered:</p> <ul style="list-style-type: none"> • Blood tests • Anemia testing • Urinalysis and urine cultures • Pregnancy testing • Radiology services (x-rays) <p>Other tests are covered. Audiology services need prior authorization.</p> |
| Surgery | |
| Organ Transplants, Inpatient, Ambulatory, Outpatient, Emergency & Reconstructive Surgeries | <p>Outpatient/ambulatory surgeries may be performed in a hospital or in a freestanding surgical care center.</p> <p>Surgery for medical emergencies is covered.</p> <p>Plastic surgery is only covered when it is medically necessary to treat illness or injury. Oral surgery is covered only for diseases of the mouth and jaw and injury that was not planned. Breast reconstruction surgery is covered after a mastectomy (breast removal). Breast reduction surgery is covered when medically necessary.</p> <p>Surgeries are covered when asked for by a Meridian doctor. All surgeries and some services need prior authorization.</p> |
| Hospice | |
| Hospice Care | Hospice care is for people with an illness causing limited life expectancy as decided by your doctor. It is most often given in the home. Your doctor will help you arrange the care you need. Hospice care needs prior authorization. |
| Other Covered Care & Programs | |
| Asthma Care | <p>Covered equipment, supplies and services include:</p> <ul style="list-style-type: none"> • Peak flow meters • Spacers • Nebulizers & masks • Regular doctor visits • Specialist visits • Other supplies needed to manage asthma |
| Care Coordination | Care Coordination is a program that links you to services and resources. This helps improve your health while coordinating care with your care team and doctors. See page 21 for more info. |

| Other Covered Care & Programs | |
|--|---|
| Disease Management (DM) | DM helps you stay on track managing your disease. See page 24 for more info. |
| Durable Medical Equipment (DME) | DME items have a medical purpose. They would not be used if a person did not have an illness. Wheelchairs and hospital beds are types of DME. Meridian covers most DME. You need a prescription from your doctor and you should use a Meridian DME provider. Some DME may also require medical need determination and/or prior authorization. |
| Eye Care & Eyeglasses | You can get one routine eye exam in a 12-month period. There is no limit to the number of repairs and replacement frames and lenses if you are 20 years old and younger. If you are 21 years old and older, you can get new frames when they are lost or broken or there is a prescribed lens change and the lenses cannot fit into the existing frame. Exceptions need prior authorization. |
| Hearing Aids | Call your doctor. A referral, prior authorization and clinical info may be needed to get these. |
| Nutritional Classes/Counseling | Nutritional services/counseling must be given by a licensed dietician. It is covered if you have certain medical conditions. You must be referred by a Meridian doctor. |
| Podiatry (Foot) Care | Routine foot care is covered. |
| Prosthetics & Orthotics | These items need prior authorization. |
| Weight Management (WM) | WM programs are covered when medically necessary. Prior authorization is needed. |
| Federally Qualified Health Center (FQHC) | A FQHC offers primary care and preventive health care. A FQHC may also give oral, mental health or substance abuse care. You can go to any FQHC. You do not need a referral from your doctor. |
| Rural Health Clinics (RHC) | RHCs give health care in rural areas with few doctors. You do not need a referral from your doctor. |

There is not a yearly or lifetime maximum covered benefit as long as you are enrolled with Meridian. Meridian does not deny any service based solely on grounds of moral or religious objection. Meridian is only responsible for services authorized by Meridian or required to be covered through the contract with Iowa Medicaid Enterprise.

Care Covered by Iowa Medicaid Enterprise

This is a list of medical care covered by Iowa Medicaid Enterprise (IME). You must use your Iowa Medical Assistance Eligibility Card to get this care. This is not a full list.

| Behavioral Health | |
|--|--|
| Outpatient Behavioral Health (BH) | <p>BH is a type of care that offers emotional support, guidance and counseling options. You can get BH care from Magellan Health Services of Iowa.</p> <p>Call 800-317-3738 for help getting care or for 24 hour crisis support. Magellan can help you find a doctor and make an appointment.</p> |
| Psychiatric Services | <p>Psychiatric services are for those with serious mental illness or severe emotional disturbances. It includes:</p> <ul style="list-style-type: none"> • Inpatient hospitalization • Counseling • Outpatient partial hospitalization • Screening & assessment <p>Call Magellan Health Services of Iowa at 800-317-3738 for help getting this care.</p> |
| Substance Abuse Services | <p>This includes:</p> <ul style="list-style-type: none"> • Screening & assessment • Detox • Intensive outpatient counseling • Other outpatient care <p>Call Magellan Health Services of Iowa at 800-317-3738 for help getting this care.</p> |
| Other Covered Care & Programs | |
| Dental Care | <p>IME covers dental care. Call 800-338-8366 for help or to find an in-network dentist.</p> |
| Home & Community Based Services (HCBS) | <p>Iowa HCBS Waivers are Medicaid programs from the federal government, which have rules set aside or “waived.” This gives you more choice of how and where you get care. It is for people with disabilities and older people who need care. Iowa has seven Medicaid HCBS waivers at this time:</p> <ul style="list-style-type: none"> • AIDS/HIV • Brain Injury (BI) • Elderly • Health and Disability • Intellectual Disability • Physical Disability (PD) • Children’s Mental Health (CMH) <p>Call IME at 800-338-8366 to see if you or your family member can get a HCBS Waiver.</p> |

| Other Covered Care & Programs | |
|---|--|
| Prescription & Over-the-Counter (OTC) Drugs | Call IME at 800-338-8366 to find out what drugs are covered and to find an in-network pharmacy. |
| Services by Area Educational Agencies | An Area Educational Agency is a regional service center for children needing special education. Call IME at 800-338-8366 for more info. |
| Skilled Nursing Facility | IME covers skilled nursing facility care. Call IME at 800-338-8366 for more info. |
| Smoking Cessation (Quit Smoking) | Smoking cessation medicines and counseling are covered by IME. <ul style="list-style-type: none"> • For medicine info call 800-338-8366 • For counseling info call 800-638-8820 <p>For a personal quit coach call the Iowa Tobacco Quit line at 800-QUIT-NOW (800-784-8669).</p> |
| Transportation (Non-Emergency) | You can get non-emergency transportation for medically necessary care. Call 866-572-7662 to talk about your options. You can also get gas money back for your own travel. You must call before your appointment to ask for this. |

Care Not Covered By Meridian or Iowa Medicaid Enterprise

This is not a full list:

- Any care not approved by your doctor, except emergency care, well-woman care, maternity care, behavioral health care, care at local health departments, immunizations, family planning, pediatrician visits or as required by IME or otherwise stated in this handbook
- Elective cosmetic surgery
- Experimental and/or investigational drugs, procedures or equipment
- Infertility care and medicine for erectile dysfunction
- Any service that is not medically necessary
 - “Medically necessary” means services will be covered to prevent, diagnose, correct, improve or cure conditions that endanger life, cause pain, result in illness or could cause or worsen a handicap or physical defect
 - “Medically necessary” care must be appropriate for the specific health issue or when no other equally effective care is an option

Emergency Care

Emergency care is for a medical situation that is a threat to your life or that can badly harm your health if you do not get care right away.

Here are some examples of emergencies:

- Convulsions • Uncontrollable bleeding • Chest pain
- High fever • Serious breathing problems • Knife or gunshot wounds
- Broken bones • Loss of consciousness (fainting or blackout)

Do not drive yourself to the hospital if you think you need emergency care. Call 911 if there is no one to drive you. Call the nearest ambulance service if there is no 911 service in your area.

Meridian covers emergency care given in any in-network or out-of-network facility. You do not need prior authorization to get emergency care and post-stabilization care. Post-stabilization care includes care related to a medical emergency that is given after you are stabilized. Post-stabilization care gives you the chance to keep the stabilized condition or to improve or resolve the condition.

You should call your doctor within 24 hours after you go to the emergency room. Your doctor will make sure you get the follow-up care you need.

Not sure? Call your doctor. Call our after-hours line at 877-204-9132 if your doctor does not call you back.

Prior Authorization

What is a Prior Authorization (PA)?

Meridian covers many services without a referral or medical review. However, some care, like surgery, needs a prior authorization. Your doctor has a list of services that need PA. Your doctor needs to fill out a Prior Authorization Request Form and send it to Meridian if you need care that needs PA.

Note: We must approve the PA request before you can get the care.

How will I know if the PA is approved?

We tell your doctor when the PA is approved. Call your doctor first to check the status. Call Member Services if your doctor does not know the status.

Will my PA still apply if I leave Meridian?

Your PA may or may not be accepted if you leave our plan. You need to ask your new insurance if they accept our PAs.

Pharmacy and Prescription Drug Coverage

The State of Iowa covers your medicines. You should use your Iowa Medicaid card to get your prescription medicine. There may be co-pays for your prescriptions. Call Iowa Medicaid Enterprise at 800-338-8366 or 515-256-4600 in the Des Moines area for more info on prescriptions.

Away from Home

Take these steps if you are away from home and need medical care:

- Call your doctor to talk about your illness or concern if it is not an emergency
- Go to the nearest emergency room or call 911 if it is an emergency

Moving?

Don't forget to call your local Iowa Medicaid Enterprise office and Meridian Member Services with your new address.

- To find your local Iowa Medicaid Enterprise office, go to:
http://www.dhs.iowa.gov/Consumers/Find_Help/MapLocations.html
- Meridian Member Services: 877-204-9132

PRIMARY CARE PROVIDER

Your Primary Care Provider (PCP) gives you most of your care. Your PCP works with you to keep you healthy. Your PCP will send you to other doctors if you need special care.



What is a PCP?

- A person who practices medicine
 - A doctor, a nurse practitioner, a physician assistant or anyone listed in "Choosing Your PCP"
-

Choosing Your PCP

You can choose your own PCP with Meridian. You can have one PCP for your whole family or you can choose PCPs for each family member. You can choose one of these providers as your PCP:

- General doctor
- Family doctor
- Nurse practitioner (nurse with special training)
- Physician assistant (supervised by a doctor)
- Internist (doctor for adults)
- Pediatrician (doctor for kids/teens)
- OB/GYN (doctor for women)

KEYS TO CARE

Your PCP's office is your medical home. They arrange all your health care and make sure you get the care you need.

Call Member Services right away to choose your PCP. Member Services can help you find a PCP in your area. Meridian will choose a PCP for you if you did not choose one when you filled out your enrollment paperwork.

You can also find a PCP in the Provider Directory on our website:

www.mhplan.com/ia/providerdirectory

The Provider Directory lists PCPs and their addresses, office hours and languages spoken. You can also use the Directory to find specialists, hospitals, pharmacies and other healthcare support. Call Member Services if you want a printed copy of the Provider Directory.

The Provider Directory also gives info about doctor specialties and qualifications, like:

- Medical school
- Residency
- Board certification

You can also visit these websites for more info on doctors:

- American Board of Medical Specialties: <http://www.abms.org>
- American Medical Association: <https://apps.ama-assn.org/doctorfinder>
- American Osteopathic Association: <http://www.osteopathic.org>

Changing Your PCP

Meridian wants you to be happy with your PCP. Call Member Services if you want to change your PCP. You can tell them which new PCP you want. You can also ask to change your PCP through My MHP. My MHP is the secure, member-only online portal. Visit www.mhplan.com/ia/MyMHP to learn more.

We will send you a letter if your PCP leaves the Meridian Provider Network. We will give you another PCP within 30 minutes or 30 miles from your home. You can also choose a PCP from the Provider Directory. Meridian will work with you to make sure your healthcare needs are met.

Meridian tracks the number of times you change your PCP. We have the right to review your PCP change if it could impact your care coordination.

Getting Care from Your PCP

Your PCP gets to know you and is there when you need medical help.

Your PCP's office is your medical home. The office arranges all your health care and makes sure you get the care you need. Your medical records are kept there. You get better care because your PCP knows all of your needs. You can call your PCP's office 24/7 if you have questions about your health or medical care.

KEYS TO CARE

Health tips are not clear at times. The Ask Me 3™ program run by the National Patient Safety Foundation can help. The program gives you three questions to ask your doctor during a visit:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Asking questions helps you know how to stay well or get better!

For more information on Ask Me 3™, please visit www.npsf.org. Ask Me 3™ is a registered trademark of the National Patient Safety Foundation (NPSF). Meridian Health Plan is not affiliated with nor endorsed by NPSF.

Call your PCP's office when you need care. Member Services can help you set up an office visit.

Your appointment is important. Please take it seriously and get to the office on time. Call the office as soon as you can if you cannot keep your appointment. You can make a new appointment when you call to cancel. Some offices will not see you again if you do not call to cancel.



What should you bring to your PCP visit?

- Your Meridian member ID card
 - Your Iowa Medicaid ID card
 - A picture ID
 - All of your medicines, vitamins & over-the-counter drugs
 - A list of questions you want to ask
-

You will wait a few minutes after you check-in at the office. You will then wait a few more minutes in the exam room. **A normal wait time is 30 minutes.** Some wait times may be longer if the doctor has an emergency. Wait times are also longer at walk-in clinics.

Urgent Care and Routine Care

Urgent care is for things like:

- Sore throat or cough
- Back pain
- Tension headache
- Earache
- Flu or cold symptoms
- Frequent urination
- Minor sickness
- Minor injury

These need to be looked at soon, but are not life-threatening. Your PCP should give you an appointment within one or two days for urgent care.

Routine care is for things like:

- Yearly wellness exams
- School physicals
- Health screenings
- Vision exams
- Lab tests
- X-rays

Your PCP should give you an appointment within 30-45 days for routine adult care. You should have an appointment within two weeks for children under 18 months old. You should have an appointment within four weeks for children over 18 months old.

Call Member Services if you have questions about wait times to see your PCP.

DO I NEED A SPECIALIST?

Your PCP is trained to give you most of the care you need. Sometimes you need care from a different type of doctor. Your PCP works with you to choose a specialist if you need one. Your PCP arranges your specialist care.



What is a specialist?

A doctor for certain types of health care like cardiology (heart health), orthopedics (bones and joints) or gynecology (women's health).

You can use the Provider Directory to find a list of specialists in your area. You can also call Member Services at 877-204-9132 for more info. You should be able to find doctors in our network to give you care. We will help you find an out-of-network doctor if you cannot find one in our network to give you medically necessary care. We will work with the out-of-network doctor for payment so there is no cost to you.

You can ask for a second opinion about your care at no cost to you. The second opinion can be from a Meridian doctor or an out-of-network doctor. Call Member Services if you need help getting a second opinion.

HOSPITAL CARE

Your PCP makes the arrangements if you need hospital care. Some other doctor at the hospital may fill in for your PCP to make sure you get the care you need if an emergency happens.

Hospital care is for care like delivering a baby or taking care of a bad sickness. It also covers care you would get in the hospital, like lab tests or x-rays.

Call your PCP as soon as you are admitted (checked in) to the hospital if it was not arranged by your PCP. Ask a family member or friend to call for you if you cannot. It is important to call your PCP right away and make an office visit within seven days of being sent home. You can talk about and arrange your care after you leave the hospital during this follow-up office visit.

SPECIAL HEALTHCARE PROGRAMS

Care Coordination

Do you have a chronic health problem or disability? Do you see more than one doctor or need special care? Do you need help with your diet or day-to-day life changes? Do you have a child with special needs and/or disabilities?

It's easy to feel overwhelmed with being in charge of your care if you have many health issues and see many doctors. It can add more stress to your daily life. Meridian is here to help you!

Our goal is to offer personal care for you and to help make your quality of life better. We have nurses, Care Coordinators, social workers and other health experts to help you and your care team.

What is Care Coordination?

Care Coordination is a program that links you to services and resources in your community to help improve your health. It also arranges care with your care team and doctors. This program is focused on you and your needs. There are many types of Care Coordination. The goals of Care Coordination are to:

- Focus on your personal needs
- Help you access community resources and services
- Work with your PCP to arrange care and make sure you are taking care of your health as planned

How can Care Coordination help you?

Your personal Care Coordinator will help you:

- Make a plan of care to meet your health goals
- Connect with resources in your community
- Control your health issues
- Know your benefits through Meridian
- Talk about any questions or concerns you have

Call Member Services at 877-204-9132 for more info about any of these services.

Maternity Care Coordination

Meridian pairs each pregnant member with a Maternity Care Coordinator who finds and arranges all needed care.

All pregnant members need to start care within the first 12 weeks of their pregnancy. You may see any Meridian OB or OB/GYN without a referral from your PCP. Call your Maternity Care Coordinator if the OB or OB/GYN you want to see is not in our network. They will work with your doctor to make sure that you can continue care.

Maternity Care Coordinators help you have a healthy pregnancy by:

- Helping you find an OB or OB/GYN
- Reminding you about prenatal visits
- Completing a prenatal screening. Your Care Coordinator will send you to a Case Manager and help you find a high-risk doctor if needed
- Running depression screening. This is good to do after your baby is born. Your Care Coordinator will refer you for behavioral health care if needed
- Making appointments for you. Your appointments should be at these stages:

| Stage of Your Pregnancy | When to See Your Doctor |
|---|---|
| Less than 13 weeks (or as soon as you think you are pregnant) | Get your first prenatal visit as soon as you can |
| 14 – 28 weeks | Every 4 weeks |
| 29 – 36 weeks | Every 2 weeks |
| 37 – 40 weeks | Every week |
| After you give birth | Get your postpartum checkup 3-6 weeks after birth |

- Following up with you after birth to make sure you and your baby are doing well. Your Care Coordinator can help you plan your postpartum visit and your baby's first check-up

KEYS TO CARE

Make your postpartum (after birth) office visit and your baby's first check-up exam while in the hospital.

You will need postpartum care after your baby is born. You should see your doctor 3-6 weeks after your baby is born. At this visit, your doctor will:

- Choose the best birth control for you. See the Family Planning section on page 27 for more info
- Help you find the Women, Infants and Children (WIC) program in your area. You may be able to get free formula, milk and food from WIC. Talk to your doctor or local health department about these services

Your baby should see the doctor one to two weeks after birth or sooner. Your Care Coordinator can help you make this appointment.

Weight Management Care Coordination

The Weight Management Care Coordination program is here to help if you are ready to lose weight. You are given a Nutrition Care Coordinator. Nutrition Care Coordinators help you lose weight with support, education and communication. They help you stay on track to reach your weight loss goals. Members who qualify are enrolled in Weight Watchers®. Call 877-204-9132 for more info or to see if you qualify for the Weight Management program.

Complex Case Management

You are given a Nurse Case Manager if you have many and/or complex health issues. The Nurse Case Manager works with you to find goals to optimize health, improve self-management and support plans of care.

Here is what Complex Case Management can do for you:

- Give you personal attention and arrange your care
- Teach you and your care team about your benefits
- Educate you about your health issue(s), treatment and medicines
- Give you ways to self-manage your health issue(s)
- Help you tell your care team about your needs and ask questions
- Help you get care near you, including care offered by mental health providers and/or schools
- Work with you and your doctor(s) to arrange the best possible care
- Make sure you get all of the services you need

Complex Case Managers help you to:

- Know your situation and take care of your health
- Learn more about the medicines prescribed by your doctor(s)
- Make and fulfill your own plan of care

Disease Management (DM)

DM helps you stay on track managing your disease. Our DM programs are for people with:

- Asthma
- Diabetes
- Heart Disease
- COPD

You get this info when you are a part of DM:

- A welcome packet
- Educational info about your health issue
- DM newsletters mailed two times a year

- Reminders of preventive care you need to stay healthy
- Referral to a Care Coordinator if you need more help



How do I become part of a Special Healthcare Program?

- Your PCP can refer you to a program
- Refer yourself by calling 877-204-9132
- Sign up using My MHP. My MHP is our secure, member-only online portal. Visit www.mhplan.com/ia/MyMHP to learn more
- You may be signed up automatically when we pay a bill related to your lab test, medicine or office visit

Call 877-204-9132 if you want to be taken out of a Special Healthcare Program. We'll be happy to help you.

Text Messaging Program

You may get text messages from us on your cell phone. These messages remind you of doctor visits and needed preventive care. You are signed-up for this program when you join Meridian. You may opt-out at any time by texting "STOP" to 647526 or by calling us at 877-204-9132. For full terms and conditions of the texting program, visit our website at <http://www.mhplan.com/ia/members> and click "Privacy Practices" on the left side. Standard message and data rates may apply.

PREVENTIVE HEALTH

Preventive health is about good health habits and making the right choices. Your PCP is the key to keeping you and your family healthy. We have programs to help you stay on track with preventive health.

Children's Health

Your children change a lot as they grow. They should see their PCP at least once a year to check their growth even if they are healthy. This is known as a well-child visit. Well-child visits are a good time to ask questions about your child's health and how it can be better.

Each well-child visit should have:

- Health history
- Physical exam
- Shots (if needed)
- Height & weight
- Developmental assessment
- Health info to keep your child healthy



What is a Developmental Assessment?

- Helps measure your child's growth to make sure they are on track
- Checks your child's physical, language, mental and feeling/social skills
- Hearing and eyesight may also be tested
- Be ready to answer questions about:
 - Your family health history
 - Your child's health history, including:
 - Sleep patterns • Feeding and eating habits • Fears • Play
 - Social, coping, language and communication skills

Babies from birth through 15 months need at least six well-child visits. These visits often are at these ages:

- 1-14 days
- 2 months
- 4 months
- 9 months
- 12 months
- 15 months

KEYS TO CARE

Set up your child's next visit when you check out after a visit.
Ask for a reminder card or phone call so you will remember the visit date.
Always reschedule cancelled visits the same day you call to cancel.

Your child also needs six blood lead tests. Your child should have a blood lead test before they are one year old. Then they should have a blood lead test once each year until they are six years old. These blood lead tests are important even if you do not live in an older home. Lead is also found in playgrounds and other toys.

Meridian offers reminder calls, postcards and incentives to make sure your child gets important health care.

Women's Health

Women may see any Meridian OB/GYN for yearly care. You do not need a referral from your PCP. Your PCP may be able to give this care. Ask your PCP if this can be done in the office.

Meridian covers these important women's health screenings:

- **Mammograms** (breast cancer screening): One mammogram every one to two years is covered for women 40 years old and older
- **Pap Test** (cervical cancer testing): One test is covered each year for women 21 years old and older

- **Chlamydia Test** (STI testing): Covered for women ages 16-24 who are sexually active
- **Annual Well Exam:** Includes counseling on family planning and inter-conception care (how to get your body ready if you are thinking of getting pregnant and how to space out your pregnancies)
- **Flu Shots and Immunizations**, if needed

Pregnant Women

It is very important to start care within the first 12 weeks of your pregnancy. You may see any Meridian OB/GYN without a referral from your PCP. Please call your Maternity Care Coordinator if the OB/GYN you want to see is not a Meridian doctor. They will work with your doctor to make sure that you can get care.

You need postpartum care after your baby is born. You should see your doctor 3-6 weeks after your baby is born. At this visit, your doctor will:

- Choose the best birth control for you. See the Family Planning section below for more info
- Help you find the Women, Infants and Children (WIC) program in your area. You may be able to get free formula, milk and food from the WIC program. Talk to your doctor or local health department about these services. See page 28 for more info on WIC

Your baby should see the doctor one to two weeks after birth or sooner.

Family Planning

You can get family planning info from your PCP, OB/GYN or a Family Planning Center.

Family planning includes counseling, supplies and birth control. The State covers birth control. It is important to get a Pap test and Chlamydia test before getting birth control. You do not need a referral from your PCP for this care.

Men's Health

Meridian wants to help male members stay healthy. We cover and encourage male members to:

- Go for wellness exams each year
- Have screening tests on time to find health problems early. You have more care choices when problems are found early. Be sure to have these tests:
 - Blood pressure
 - Cholesterol
 - Diabetes
 - Depression
 - Colorectal cancer
- Quit smoking
- Get needed immunizations. You need a flu shot each year. Your doctor may also suggest the pneumonia shot

COMMUNITY HEALTHCARE RESOURCES

Women, Infants and Children (WIC)

WIC is a program that helps moms and their children get food coupons, health education and nutrition support. You must meet certain conditions to get WIC goods. Call WIC at 515-281-6650 if you live in the 515 area code for more info. Call 800-532-1579 for more info if you do NOT live in the 515 area code. Call your caseworker if you have questions.

Maternal and Child Health Program

The Iowa Department of Public Health sponsors this program for pregnant women and children.

The Maternal Health program contracts with 24 local community-based offices. These offices focus on assuring prenatal and postpartum care for pregnant women. They may also involve oral care by a hygienist and referrals to dental homes.

The Child Health program is contracted with 22 local community-based agencies to make sure children get well-child exams. The Child Health program also includes oral care and referrals to a dental home (I-Smile Program). Call the Iowa Department of Public Health toll-free at 866-227-9878 for more info on this program. You can also call 515-281-7689 in the Des Moines area.

Early ACCESS

Early ACCESS is Iowa's system of early intervention services for infants and toddlers with or at risk for developmental delays. With a devoted, caring staff, Early ACCESS unites people to local children's providers within the Early ACCESS system. Call Early ACCESS toll-free at 888-IA-KIDS1 (888-425-4371) for more info. You can also email the program at earlyaccessia@vnsdm.org.

Family Investment Program (FIP)

FIP is Iowa's Temporary Assistance to Needy Families (TANF) program. FIP gives cash assistance to needy families as they become self-supporting so that children may be cared for in their own homes or in the homes of family members. Call your caseworker in your local Human Services office if you have questions. You may also call Iowa Legal Aid for help at 800-532-1275.

GRIEVANCES

We hope that you are always happy with Meridian and our providers. There may be times when you are not.

Member Services can help resolve problems. Please call us first. You can call us at 877-204-9132, Monday – Friday from 8 a.m. – 8 p.m. We have an after-hours service so someone will answer your call 24/7. This helps if you need an expedited (fast) decision. All calls you make are toll-free.

You can file a grievance if Member Services cannot resolve your problem. Meridian will not treat you any differently if you choose to use your right to file a grievance.

A grievance is a complaint about anything other than a denied, reduced or terminated (ended) medical service.

Examples of a grievance:

- My provider's office was dirty
- I could not get an appointment in a timely manner
- I was denied my rights as a Meridian member

You may file a grievance by calling Member Services toll-free at 877-204-9132.

You can file a formal grievance if you are not happy about the decision made over the phone. You can also file a formal grievance in writing. Your doctor or a designated representative may file a grievance for you in writing. Please include a phone number where we can reach you with your written grievance. Mail your written grievance to:

Meridian Health Plan
Grievance Coordinator
666 Grand Avenue, 14th Floor
Des Moines, IA 50309

Meridian will acknowledge your grievance by sending you or your representative a letter. The letter will be sent within five business days of getting your grievance. This Level One Grievance will be resolved within 15 calendar days. We will call you with the decision. We will also send a written response.

You may file a Level Two Grievance with us if you are not happy with your Level One Grievance results. You must submit a Level Two Grievance within five business days of getting your Level One Grievance decision.

Level Two Grievances will be reviewed by the Meridian Grievance Committee. This Committee is formed by our Board of Directors. You or your representative can appear in person or by phone before the Grievance Committee. You can also send written info for the Grievance Committee to review. You or your representative will be notified within three business days of the Grievance Committee's decision. We will call you with the decision. We will also send you a written response. The combined time frame for the Level One and Level Two Grievance process will not be more than 30 calendar days.

External Review of Grievances

You may ask for a review by the Iowa Insurance Division if you are not happy with the decision of the Level Two Grievance. Send your request to:

Iowa Insurance Division
601 Locust Street, 4th Floor
Des Moines, IA 50309

You have the right to ask for a Fair Hearing from the State of Iowa within 90 days of the date of the Level Two Grievance decision letter. Your Fair Hearing request must be in writing. Send your request to:

Department of Human Services
Appeals Section
1305 E Walnut Street, 5th Floor
Des Moines, IA 50319
Phone: 515-281-3094

APPEALS

You may file an appeal with us if you are not happy with a decision made by Meridian. An appeal is a formal way of asking us to review and change a coverage decision we made. An appeal is about a denied, reduced or terminated (ended) medical service.

Reasons for appeals:

- Medical care that you used to get has been reduced, suspended or ended
- Denied payment for an authorized and covered service
- Denied request for care or medical supplies

You can file an appeal 20 to 90 days after you get notice of a denial from us. You can ask another person, such as your PCP, a family member or a friend, to file an appeal for you. You must put in writing that you want the person to appeal for you. You must also give this person access to your health info. Your doctor will not be punished for supporting your appeal or for asking for an urgent (faster) decision. You have the right to ask for 14 more days if you need time to get more info for your appeal.

Meridian may ask for 14 more days. This happens if we need more info and it is in your best interest. We will send you written notice of the reason for the delay if this happens.

If we are going to reduce or stop a service we already approved, you can keep getting benefits during the appeals and fair hearing process. You must meet these criteria to do so:

- The appeal is filed within 10 days of the date the denial letter was mailed
- You ask to keep the service

The service will stop if:

- You withdraw your appeal
- You do not ask for a State Fair Hearing within 10 days from when Meridian mails the denial letter
- A State Fair Hearing decision is made against you
- The authorization ends or authorization service limits are met

You may have to pay for care you received during the appeals process if:

- The final decision is the same as Meridian's initial decision
- The services were only given as part of this appeal process

You can appeal by calling Member Services toll-free at 877-204-9132. You can also appeal in writing or use the Internal Appeal form that is sent with the first denial letter. Please include a phone number where we can reach you if you write to us. Meridian can help you file your appeal with interpretation and teletypewriter services. We will let you know when we get your appeal.

Mail your written appeal to:

Meridian Health Plan Appeals Coordinator
666 Grand Avenue, 14th Floor
Des Moines, IA 50309

Meridian will let you know if more info is needed to process your appeal within three days of getting your appeal. We will give you the decision of your appeal within 30 days of getting all needed info. We will let you, your doctor and any other doctor involved in the appeal know the decision within five days of a decision. We will tell you the decision on the phone. We will also send you a letter with the decision.

A doctor with the same or like specialty as your treating doctor will review your appeal. It will not be the same doctor as the doctor who made the original decision to deny, reduce or stop the medical service.

Urgent Appeal

Sometimes you may need a decision made about your care very quickly. You can call Meridian Member Services at 877-204-9132 to ask for an urgent appeal. Your doctor must agree to the urgent appeal.

Meridian will tell you of all the needed info to process your appeal within 24 hours of getting it. We will decide on your appeal within three days of getting all needed info. We will let you, your doctor and any other doctor involved in the appeal know the decision by phone. We will also send you a letter with the decision.

Fair Hearing by the State of Iowa

You have the right to request a Fair Hearing from the State of Iowa if you are not happy with Meridian's decision. You can ask for a Fair Hearing by writing to:

Department of Human Services
Appeals Section
1305 E Walnut Street, 5th Floor
Des Moines, IA 50319
Phone: 515-281-3094

Please call Member Services at 877-204-9132 if you have any questions about the appeals process. You can also call if you need help asking for an appeal or a State Fair Hearing.

RIGHTS AND RESPONSIBILITIES

You have rights and responsibilities as a Meridian member. Meridian staff will respect your rights. Meridian will not discriminate against you for using your rights.

You have the right to:

- Get healthcare services that comply with Meridian's contract with the state and all state and federal laws
- Ask for and be sent info about:
 - Meridian
 - Its services
 - Its providers

- Member rights and responsibilities
- Meridian structure and operation
- Our provider incentive programs. (Meridian may give providers incentives to help make sure you get the care you need when you need it)
- Your medical records
- Changing or correcting your medical records
- Be treated with respect
- Have your dignity and right to privacy recognized
- Have your personal and medical info kept private
- Work with doctors to make decisions about your health care. This includes the right to refuse care and state your preferences about care
- Talk about appropriate or medically necessary care options, regardless of cost or coverage
- File complaints or appeals about Meridian or care it provides
- Be free:
 - From any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
 - From other discrimination prohibited by state and federal regulation, including race, color, religion, sex, national origin, ancestry, age and physical or mental disability
 - To use all of these rights without adversely affecting the way Meridian, providers or the state treats you
- Suggest changes to these rights and responsibilities

You have the responsibility to:

- Learn about these rights and responsibilities
- Give Meridian and your doctors as much info about your health as possible
- Learn about your health status
- Work with your doctor to set and follow care plans and goals
- Live a healthy lifestyle
- Make responsible care decisions
- Tell us if your contact info (like your address or phone number) changes

Questions? Call Member Services at 877-204-9132.

SUMMARY OF PRIVACY PRACTICES

This summary tells you how personal and medical info about you may be used, disclosed and how you can access it.

Please visit www.mhplan.com/ia for the full Notice of Privacy Practices (NPP). You can also call us at 877-204-9132 to ask for a printed copy.

INFORMATION WE HAVE

We have enrollment info about you. This includes your date of birth, sex, ID number and other personal info. We also get bills, doctor reports and other info about your care.

OUR PRIVACY POLICY

We care about your privacy. We guard your info carefully in oral, written and electronic form. We are required to keep your info private by law. We must also give you this NPP. We will not sell any info about you. Only people who have both the need and the legal right may see your info. Unless you give us written authorization, we will only give out your info for:

- **TREATMENT**
We may give out your medical info to help coordinate your care. For example, we may notify your doctor about care you get in an emergency room.
- **PAYMENT**
We may use and give out your info so that your doctors can bill and get paid for your care. For example, we may ask an emergency room for details about your care before we pay the bill.
- **BUSINESS OPERATIONS**
We may use and give out your medical info for our business operations. For example, we may use your medical info to check the quality of your care.
- **AS REQUIRED BY LAW**
We will give out your info when the law requires it. For example, we may give your info out for court orders or to prevent health emergencies.

- **AUTHORIZATIONS**

We may use and give out your personal info if you give us written permission. You have the right to change your mind and take back that permission.

COPIES OF THIS NOTICE

You have the right to get a copy of this NPP at any time. You are entitled to a paper copy of this NPP even if you agreed to get it electronically. Please call or write to us to get a copy.

CHANGES TO THIS NOTICE

We have the right to change this NPP. A revised NPP will be effective for medical info we already have about you and for any future info we may get. We are required by law to comply with the most current notice. Any changes to our notice will be printed in our Member Newsletter.

YOUR RIGHT TO INSPECT AND COPY

You have the right to inspect the info we have about you and to get copies of it. You must ask for it in writing. We can deny your request for some reasons, but we must give you a written reason for our denial. We may charge a fee for copying your records.

YOUR RIGHT TO AMEND

You can ask us in writing to change your info if you think it is incomplete or wrong. We can deny your request for some reasons, but we must give you a written reason for our denial.

YOUR RIGHT TO A LIST OF DISCLOSURES

You have a right to get a list of our disclosures of your info, except when you authorized those disclosures or if the disclosures are made for care, payment or healthcare operations. You must ask us in writing. We are not required to give you a list of disclosures made before April 14, 2003.

YOUR RIGHT TO REQUEST RESTRICTIONS ON OUR USE OR DISCLOSURE OF INFORMATION

You have the right to ask for restrictions on the info we may use or give out about you. You must ask us in writing. We are not required to agree to such requests.

YOUR RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to ask that we tell you about medical matters in a certain way or at a certain location. You must ask us in writing. For example, you can ask that we only contact you at home or only at a certain address or only by mail.

HOW TO USE YOUR RIGHTS UNDER THIS NOTICE

Your request to use your rights under this notice must be in writing. You can call us for help writing your request, if needed.

COMPLAINTS TO THE FEDERAL GOVERNMENT

If you believe your privacy rights have been violated, you have the right to file a complaint with the federal government. You may write to:

Office for Civil Rights
U.S. Department of Health & Human Services
601 East 12th Street – Room 353
Kansas City, MO 64106

You can also visit their website at <http://www.hhs.gov/ocr>. You will not be penalized for filing a complaint with the federal government.

COMPLAINTS AND COMMUNICATIONS TO US

To use your rights under this NPP, talk with us about privacy or file a privacy-related complaint, write to:

Meridian Health Plan
Chief Privacy Officer
666 Grand Avenue, 14th Floor
Des Moines, IA 50309

You can also call us at 877-204-9132. You will not be penalized for filing a complaint.

FRAUD, WASTE AND ABUSE

Healthcare fraud, waste and abuse (FWA) costs millions of dollars each year. This money should be spent on health care for people who need it. FWA violates state and federal law.

Here are some examples of fraud:

- Using a member ID card that belongs to someone else
- Changing a prescription written by a doctor
- Billing for services that were not provided
- Billing for the same service more than once

Here are some examples of abuse:

- Using the emergency room for non-emergency health care
- Going to more than one doctor to get the same prescription
- Threatening or offensive behavior at a provider's office, hospital or pharmacy

Waste goes beyond fraud and abuse. Waste usually means poor management, inappropriate actions or inadequate oversight. It is not a violation of the law, but it takes money away from health care for people who need it.

Reporting FWA

You must report any members, providers or pharmacies who commit fraud, waste or abuse. You do not have to give your name to report fraud, waste or abuse.

You can report fraud, waste or abuse to us at:

Meridian Health Plan
Compliance Officer
666 Grand Avenue, 14th Floor
Des Moines, IA 50309
Phone: 877-204-9086
Email: fwa.ia@mhplan.com

You can also report fraud, waste or abuse to the state at:

Medicaid Fraud Control Unit of Iowa
Department of Inspections and Appeals
3rd Floor, Lucas State Office Building
Des Moines, IA 50319
Phone: 515-281-0506
Fax: 515-725-1245

OTHER IMPORTANT INFO

How Meridian Makes Healthcare Decisions

Meridian providers and healthcare staff make decisions based on the care that is right for you and what is covered by your Medicaid benefits. This is called Utilization Management (UM).

Meridian does not reward providers for denying your care. Meridian employees who make UM decisions are not rewarded for limiting your care. You can call us at 877-204-9132 if you have a question about your benefits, providers or any service you have asked for or received. We are open Monday – Friday from 8 a.m. – 8 p.m. When a Meridian representative answers the phone, they will greet you by telling you their name, title and company. Meridian has 24/7 phone coverage. All calls you make are toll-free.

New Technology

Meridian wants to make sure you have access to new health technologies and procedures. You can recommend that we cover new technology. Meridian providers and clinical staff research the new technology before it is approved. Any updates that affect you will be noted in the member newsletter.

This info comes from medical professional groups, Medicaid, other government groups and scientific groups.

Quality Improvement Program

The Quality Improvement (QI) Program is designed to give you quality health care and great customer service. Meridian's QI Program sets quality goals each year. The QI Program also measures how well we meet those goals. Each year we send members a survey to learn how satisfied they are with us and our providers. It also helps us find out how we can improve care and customer service.

Call Member Services at 877-204-9132 if you would like more information on Meridian's QI Program.

Advance Health Directives

Advance directives are legal documents. They are used when you are very sick and cannot explain the kind of care you want. They let your family, friends and doctors know about your end-of-life decisions ahead of time.

There are two kinds of advance directives:

Living Will – A living will tells how you feel about care that continues your life. This kind of care includes:

- The use of dialysis and breathing machines
- Tube feeding
- Organ or tissue donation
- If you want to be saved when your breathing or heartbeat stops

You can accept or refuse any of this care. Your living will becomes active **ONLY** when you are not able to make decisions on your own.

Durable Power of Attorney for Health Care – A durable power of attorney for health care lets you choose a healthcare agent. A healthcare agent is someone who can make decisions about your care when you are not able to.

You may not be able to make your own healthcare decisions if you are seriously injured or sick. Your healthcare agent can make decisions about your care in these cases.

With a durable power of attorney, your agent can:

- See your medical and other personal information
- Choose and dismiss your doctors
- Say yes or no to medical care
- Sign waivers and other documents to allow or stop your medical care

Your agent should be someone you trust, like a family member or a friend. Talk with your agent about your values and wishes. The more your agent knows about you, the better decisions he or she can make.

Call Member Services at 877-204-9132 if you have questions about advance directives. Advance directive forms are available on our website. You can also get advance directive forms at your doctor's office or local hospital.

Health Insurance Premium Payment (HIPP) Program

The HIPP program is a service that you may be able to get. The HIPP program can help you get insurance or keep insurance you already have by reimbursing the cost of the premiums. You can apply for the HIPP program through your

caseworker. Call 888-346-9562 for more information or email hipp@dhs.state.ia.us.

If You Get a Bill or Statement

Meridian does not charge you co-pays. This means that you should never get any bills for your Meridian-covered care, pre-authorized services or medical supplies. If you get a bill by mistake, send it to:

Meridian Health Plan
Attention: Claims Department
1001 Woodward Avenue, Suite 530
Detroit, MI 48226

Call Member Services at 877-204-9132 for help if you have any other problems with medical bills for Meridian-covered care.

Sometimes you may get a bill for care you had before you joined Meridian. Call your provider's office for help for this type of bill.

Changing Your Managed Care Coverage

You can change your Managed Health Care (MHC) provider within the first 90 days of enrolling with Meridian. You must stay with Meridian for six months if you do not change your MHC provider within your first 90 days.

The Iowa Medicaid Enterprise (IME) will send you a letter 60 days before the end of your first six months of enrollment with Meridian. This letter will say you can stay enrolled with Meridian or change your MHC provider. You can call IME Member Services at 800-338-8366 if you want to change at this time.

You can disenroll (leave) Meridian at any time if you establish "good cause."

Examples of good cause include:

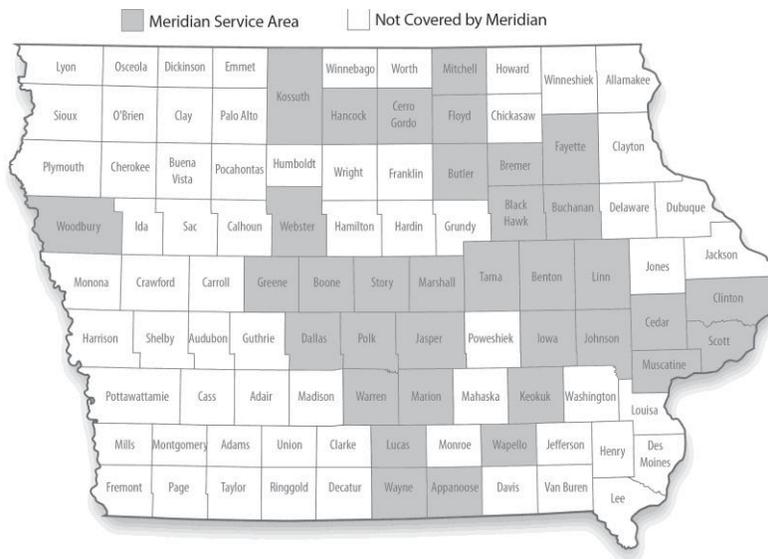
- Medical care is not accessible to you
- Your doctor or your doctor's staff behaves inappropriately towards you
- You do not get enough quality of care from your PCP
- You do not get medically necessary care in a timely manner

Call Member Services at 877-204-9132 if you want to disenroll. We can refer you to the IME. You can also call IME directly at 800-338-8366.

SERVICE AREA

Meridian is approved to serve these counties:

- Appanoose • Boone • Benton • Black Hawk • Bremer • Buchanan • Butler
- Cedar • Cerro Gordo • Clinton • Dallas • Fayette • Floyd • Greene
- Hancock • Iowa • Johnson • Keokuk • Kossuth • Linn • Lucas • Marion • Marshall
- Mitchell • Muscatine • Polk • Scott • Story • Tama • Wapello • Warren • Wayne
- Webster • Woodbury



This map may change as we work to grow our service area to improve your care. Please call Member Services at 877-204-9132 if you have questions.

IMPORTANT NUMBERS

| In an emergency | 911 |
|--|--------------|
| Meridian Member Services | 877-204-9132 |
| TTY/TDD | 800-735-2942 |
| Transportation (non-emergency) | 866-572-7662 |
| Magellan Behavioral Health | 800-317-3738 |
| Magellan Behavioral Health 24-Hour Crisis Line | 800-317-3738 |
| Iowa Medicaid Enterprise Member Services | 800-338-8366 |
| Women, Infants and Children (WIC) | |
| Within the 515 Area Code | 515-281-6650 |
| Outside the 515 Area Code | 800-532-1579 |

My PCP's Phone Number:

My Pharmacy's Phone Number:

Phone Number of Closest Urgent Care:

Other Phone Numbers:



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NEED HELP? We're Here for You!

CALL US!

Member Services: 877-204-9132 | TTY/TDD: 800-735-2942

Hours: Monday – Friday from 8 a.m. to 8 p.m.



www.mhplan.com. Visit us today for:

- Preventive & chronic health tips
- Special Healthcare program info
- Member newsletters
- Privacy info
- Online Provider Directory
- Useful links
- And more



Live Chat is our instant message system to talk with a live Representative. Go to www.mhplan.com/ia and click the Live Help button to start a chat. Live Chat is open Monday – Friday from 8 a.m. – 8 p.m.



My MHP (Member Portal)

My MHP is our member-only online portal. It is an easy and secure way to handle your health info. You can use My MHP to:

- Ask to change your Primary Care Provider (PCP)
- Get a replacement ID card
- Fill out your Health Risk Assessment (HRA)
- Change your address or phone number
- Order a Member Handbook
- Find PCP, specialist and vision providers in your area

You can sign up for My MHP online at www.mhplan.com/ia/MyMHP. You can also call Member Services at 877-204-9132 for help. You will need your Medicaid ID number to sign up.



@MeridianHP



www.facebook.com/MeridianHealthPlan

Revised: 10-17-2014
State Approved: 10-20-2014

Attachment 23 (Sample ID Card Letter)

<Date>

<Member Name>

<Member Address>

<City, State, Zip Code>

Welcome to Meridian Health Plan!

Enclosed is your Member ID card. Only the person named on the card can use the card. **Carry this card with you for all medical care and emergency care.** Your Meridian Health Plan ID card has this information:

- Member Name
- Member ID number given to you by the State of Iowa for medical services
- Toll-free phone number for Meridian Health Plan Member Services department

It is important that you choose a Primary Care Provider (PCP). Your PCP's office is your medical home. The office will coordinate your healthcare and make sure you get the services you need. Our records show that your PCP is:

| <u>Recipient Name</u> | <u>PCP Name</u> | <u>PCP Phone</u> |
|-----------------------|-----------------|------------------|
| <insert> | <insert> | <insert> |
| <insert> | <insert> | <insert> |

If you would like to change your PCP, call Member Services. We can be reached at 877-204-9132, Monday – Friday, 8 a.m. to 8 p.m. or visit My MHP, the Meridian Member Portal, online at www.mhplan.com/ia.

Your PCP will refer you to other providers you may need to see. Children, 18 years old and under, may see an in-network pediatrician for routine office visits without a PCP referral.

It is very important for you to get a physical, or well-visit, every year. Infants need at least six well-child visits before they are 15 months old. Children also need a lead screening before their 2nd birthday. Please make an appointment with your doctor as soon as possible.

You can get a list of Meridian providers by visiting www.mhplan.com/ia. If you would like a paper copy of this Provider Directory, please call Member Services.

We want to know how best to contact you as well as meet your health needs. **Please complete the attached health risk assessment (HRA) form.** You can return it in the postage-paid envelope provided with this mailing. **Please call us at 877-204-9132** so that we can help your family members complete their HRAs.

Thank you for choosing Meridian Health Plan.

Sincerely,

Member Services
Meridian Health Plan



Member Name:
Member ID:

MHP Member Services: 877-204-9132
◆ General Information ◆ Benefits ◆ Provider Network ◆
(Available 24 hours a day, 7 days a week)



Member Name:
Member ID:

MHP Member Services: 877-204-9132
◆ General Information ◆ Benefits ◆ Provider Network ◆
(Available 24 hours a day, 7 days a week)

Attachment 23 (Sample ID Card Letter)

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STAY HEALTHY

With an Annual Exam

Make sure you and your family have a fun summer and that your children are ready for school in the fall. Schedule annual check-ups for your entire family.

Have you scheduled your annual exam?

Children and adults need annual exams. At this appointment, your Primary Care Provider (PCP) can get to know you better. This way your PCP is more prepared to help you when you have a medical problem. You do not need to feel sick to visit your PCP for your annual exam.

When you schedule your annual exam, ask your PCP about these preventive services:

- Blood pressure screening
- Cholesterol level screening: adults should have this test at least every 5 years
- Chlamydia screening: all teenage girls should be tested every year
- Pap tests: women 21 years old and older should have this every year
- Immunizations: make sure your children are up-to-date on their shots
- Mammograms: women should get one annually starting at 40 years old
- Quitting smoking

Make an appointment with your PCP for your annual exam!

To schedule an appointment for your annual exam, call your PCP's office. Meridian's Member Services can help you find a PCP. We can also help you make an appointment. Call Member Services at 877-204-9132.

Have an appointment, but no ride to your PCP's office? We can help!

Non-emergency transportation for medically necessary services is covered. After you schedule your annual exam with your PCP, call 866-572-7662 to set up your ride.



My MHP RAFFLE

Open only to our members, My MHP is an easy, secure way to handle your health information. You can use My MHP to:

- Ask to change your PCP
- Get a replacement ID card
- Complete your Health Survey
- Change your address or phone number
- Order a Member Handbook
- Find PCP, specialist and vision providers in your area

Sign up for My MHP at www.mhplan.com/ia/MyMHP and be entered to win a \$50 gift card! You will need your Medicaid ID number to sign up.



You can also call Member Services at 877-204-9132 for help.

Complete your Health Survey. >> Enter a Raffle. >> Win a Prize.

Meridian wants to make sure you get the right care at the right time. That is why all members must complete a Health Survey with us. The Health Survey asks questions about your health so we can help you get the care you need. When you finish your Health Survey within 30 days of joining the plan, you will be entered into a raffle to win an iPad! Call us at 877-204-9132 to complete your Health Survey today!

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Important Numbers

| | |
|---|--------------|
| In an Emergency | 911 |
| Meridian Health Plan Member Services | 866-606-3700 |
| TTY for the Hearing Impaired | 711 |
| Transportation (non-emergency) | 866-796-1165 |
| Behavioral Health Services | 866-796-1167 |
| MeridianRx (pharmacy) | 855-580-1688 |
| Illinois Client Enrollment Broker (ICEB) | 877-912-8880 |
| Women, Infants and Children (WIC) | 217-782-2166 |

¿Habla español?
Por favor contacte a Meridian al 866-606-3700.

Interpreter Services and Alternative Formats

Meridian can arrange for an interpreter to help you speak with us or your healthcare provider in any language. Interpreter services and alternative formats are provided to Meridian members free of charge.

Alternative formats help members with different reading skills, backgrounds or disabilities understand Meridian materials. If you need the Member Handbook or other Meridian materials in alternative formats, please call Member Services for help.

¿Habla español?
Por favor contacte a Meridian al 866-606-3700.

Hearing and Vision Impairment

For our members with hearing problems, we offer TTY service free of charge. The TTY line is open 24 hours a day, 7 days a week at 711. We also have a Live Chat online help program where you can instant message with a Member Services Representative. You can use Live Chat Monday – Friday, from 8 a.m. – 8 p.m. at www.mhplan.com.

For our members with vision problems, we offer the Meridian Member Handbook and other materials in Braille. Our website also has buttons to make the print bigger and simpler to read. You can also call Member Services at 866-606-3700 for help.

Reporting Abuse, Neglect, Exploitation, or Unusual Incidents

The Health Care Worker Background Check Act applies to all unlicensed individuals employed or retained by a health care employer as home health care aides, nurse aides, personal care assistants, private duty nurse aides, day training personnel, or an individual working in any similar health-related occupation where he or she provides direct care. You can contact the Department of Public Health online or by phone at 217-785-5133 to verify status prior to employment, or the Department of Financial and Professional Regulation for information on any Licensed Practical Nurse (LPN) or Registered Nurse (RN) (nurses) that you want to employ to see if they have allegations of abuse, neglect or theft.

If you are the victim of abuse, neglect or exploitation, you should report this to your Meridian Case Manager right away. You should also report the issue to one of the following agencies based on your age or placement. All reports to these agencies are kept confidential and anonymous reports are accepted.

- **Nursing Home Hotline 1-800-252-4343**

Illinois Department of Public Health Nursing Home Hotline is for reporting complaints regarding hospitals, nursing facilities, and home health agencies and the care or lack of care of the patients.

- **Supportive Living Program Complaint Hotline 1-800-226-0768**

- **Adult Protective Services 1-866-800-1409 (TTY – 1-888-206-1327)**

The Illinois Department on Aging Adult Protective Services Hotline is to report allegations of abuse, neglect, or exploitation for all adults 18 years old and over. Your Meridian Case Manager will provide you with 2 brochures on reporting Abuse, Neglect and Exploitation. You can request new copies of these brochures at any time.

Illinois law defines abuse, neglect, and exploitation as:

- **Physical abuse** — Inflicting physical pain or injury upon a senior or person with disabilities.
- **Sexual abuse** — Touching, fondling, intercourse, or any other sexual activity with a senior or person with disabilities, when the person is unable to understand, unwilling to consent, threatened or physically forced.
- **Emotional abuse** — Verbal assaults, threats of abuse, harassment, or intimidation.
- **Confinement** — Restraining or isolating the person, other than for medical reasons.
- **Passive neglect** — The caregiver's failure to provide a senior or person with disabilities with life's necessities, including, but not limited to, food, clothing, shelter or medical care.
- **Willful deprivation** — Willfully denying a senior or person with disabilities medication, medical care, shelter, food, a therapeutic device or other physical assistance, and thereby exposing that adult to the risk of physical, mental, or emotional harm — except when the person has expressed intent to forego such care.
- **Financial exploitation** — The misuse or withholding of a senior or person with disabilities' resources to the disadvantage of the person or the profit or advantage of someone else.

Self-Directed Care

What is Self-Directed Care?

Self-directed care gives members greater power and control over their personal assistant (PA) services. In self-directed care, the member manages the PA while Illinois Department of Healthcare and Family Services (HFS) pays the PA.

How Does Self-Directed Care Work?

Self-directed care is given by a PA who works for the member. The member finds, manages and determines the job duties of the PA. The member can hire and fire the PA at any time.

I Found a PA. How Do I Know If This Person Can Work In Self-Directed Care?

The PA must meet employment and training criteria set by HFS. The following PA candidates are NOT eligible to participate:

- The member's legally responsible family members
- The member's minor child (under age 18)
- The member's foster parents if under age 18
- The member's stepparents, if the member is under age 18

How Do I Decide Self-Directed Care is Right for Me?

The member works with his/her Meridian Care Coordinator to discuss, assess and decide if self-directed care is right for them. If a member is not ready to self-direct his/her care, they can work on goals to develop the skills they need to self-direct in the future.

How Do I Know if I am Eligible for Self-Directed Care?

Members enrolled in certain Home and Community Based Waiver Programs are eligible for self-directed care.

For more information about Self-Directed Care, please call your Care Coordinator at 866-606-3700.



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Meridian

Health Plan

<Print Date>

<membName1>
 <membName2>
 <membAddress1>
 <membAddress2>
 <membCity>, <membState> <membZip>

Meridian Health Plan (MHP) is committed to preventing health care fraud. The following explanation of benefits is being provided to ensure that you received the services that were billed to MHP.

This is not a bill. You are not financially responsible for any of these services.

Patient Information:

Recipient ID: <RecipientID>
 Patient Name: <PatientName>
 Date of Birth: <PatientDOB>

Service Information:

Claim #: <ClaimNum>
 Date of Service: <ServiceDates>
 Type of Service: <ClaimType>
 Date Claim Received: <DateRecd>

Primary Diagnosis:

| Code | Description |
|------------|-------------------|
| <DiagCode> | <DiagDescription> |

Procedure(s):

| Code | Qty | Description |
|-------------|------------|-------------|
| <ProcCode1> | <ProcQty1> | <ProcDesc1> |
| <ProcCode2> | <ProcQty2> | <ProcDesc2> |
| <ProcCode3> | <ProcQty3> | <ProcDesc3> |
| <ProcCode4> | <ProcQty4> | <ProcDesc4> |
| <ProcCode5> | <ProcQty5> | <ProcDesc5> |

Service Provider: <ProvName>
 <ProvAddress1>
 <ProvAddress2>
 <ProvCity>, <ProvState> <ProvZip>

Please review this statement carefully. If you did not receive the services listed above or if you have any questions, please contact MHP Member Services immediately at 877-204-9132.

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AN OVERALL HEALTH ASSESSMENT DESIGNED ESPECIALLY FOR YOU

What does good health mean to you? Each of us has a unique idea of what good health means because health is a very personal matter. In many ways our health can and does shape who we are now and who we will be in the future. No one wants poor health. But many of us do things that can make us unhealthy, sometimes unknowingly.

It is human nature for us to want to understand ourselves better. At one time or another, nearly everyone has asked.

- "HOW HEALTHY AM I?"
- "AM I AT RISK?"
- "COULD I BE HEALTHIER?"
- "HOW CAN I REDUCE MY RISK?"

HealthMedia Succeed® will help you understand what steps you can take to improve or maintain your health by creating a personal healthy lifestyle plan just for you. Your personal plan is based on the answers you provide in this questionnaire. The better we understand you, the better we can create a plan to meet your needs. So, it is important to answer all of the questions that apply to you, but if there are any questions you don't want to answer, feel free to skip them.

It's easy to participate in HealthMedia Succeed®. Start by completing this questionnaire, which takes most people about 20 minutes. You'll receive your own personal healthy lifestyle plan about two weeks after you mail in your completed questionnaire.

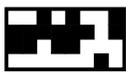
Complete the HealthMedia Succeed® questionnaire today to find out how you can live a healthier lifestyle.

Let's get started!

Getting Started

- 1.** Answer all questions as honestly as possible.
- 2.** Do not skip questions unless you are instructed to do so or are unable or unwilling to answer.
- 3.** Use a black pen to complete your responses.
 - Shade circles or boxes completely 
 - Fill all boxes and print clearly 
- 4.** Return the questionnaire in the enclosed reply envelope.

Note: It is very important, but not required, that you complete the entire questionnaire (except for optional questions); otherwise we may not be able to produce a personal plan for you. By submitting this questionnaire to Wellness & Prevention, Inc. you are agreeing to the terms in the Privacy Statement. **See back cover for more information.**



64984

Fill ALL boxes
and print clearly

5 ft 0 0 in

Shade response
completely

Use a black pen to complete your responses.

About You

RESPONSE REQUIRED

1. Date of Birth *Example: 01/31/1970*

| | | | | | | | | | |
|--|--|---|--|--|---|--|--|--|--|
| | | / | | | / | | | | |
|--|--|---|--|--|---|--|--|--|--|

2. Are you:

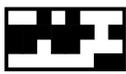
- Male
 Female

3. What's your ethnicity? *Choose one.*

- White, Non-Hispanic
 Black or African-American
 Hispanic
 Asian
 Pacific Islander
 Native American Indian or Native Alaskan
 Native Hawaiian
 Multiracial
 Other

4. Have you ever been diagnosed with any of the following? *Choose all that apply.*

- Angina
 Asthma
 Back pain
 Breast cancer
 Cervical cancer
 Chronic kidney disease
 Chronic obstructive pulmonary disease (COPD, including chronic bronchitis and emphysema)
 Chronic pain (e.g., arthritis, migraine, fibromyalgia, neuropathy)
 Colorectal cancer
 Coronary heart disease
 Depression
 Diabetes
 Heart attack
 Heart failure
 Hepatitis B
 High blood pressure
 High cholesterol
 Insomnia
 Metabolic syndrome
 Obesity
 Osteoporosis
 Other heart disease
 Peripheral vascular disease (PVD)
 Prediabetes
 Prostate cancer
 Sexually transmitted disease (STD)
 Skin cancer
 Stroke or transient ischemic attack (TIA)
 None of the above



64984

Fill ALL boxes
and print clearly

5 ft 0 0 in

Shade response
completely

Use a black pen to complete your responses.

About You (continued)

5. Who lives with you? *Choose all that apply.*

- Child(ren) under 2 years old
- Child(ren) between 2 and 12 years old
- Teen(s) between 13 and 18 years old
- Other adult(s)
- I live alone.

6. How would you describe your relationship status?

- Married
- Divorced
- Widowed
- Separated
- Never married
- Unmarried couple living together

7. What's the highest grade or year of school you completed?

- Never attended school
- Elementary
- Some high school
- High school grad/GED
- Some college or tech school
- College grad or higher

Quality of Life & Health

1. Would you say that in general your quality of life is:

- Excellent
- Very good
- Good
- Fair
- Poor

2. Would you say that in general your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

3. Compared to others like you, how would you rate your own health?

- Much better
- Better
- Average
- Worse
- Much worse



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 Fill ALL boxes
and print clearly

5 ft 0 0 in

 Shade response
completely

Use a black pen to complete your responses.

Pain

1. Have you been experiencing any significant pain for more than 3 months?

Yes

No  SKIP to next section

2. How motivated are you to manage your pain?

Not At All
Motivated

Extremely
Motivated

0 1 2 3 4 5 6 7 8 9 10

3. How confident are you that you can manage your pain?

Not At All
Confident

Extremely
Confident

0 1 2 3 4 5 6 7 8 9 10

Weight Management

1. How tall are you (to the nearest inch)?

feet inches

2. How much do you weigh (to the nearest pound)?

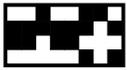
pounds

3. What's your waist measurement (to the nearest inch, measured between the lowest ribs and the top of the hips, not your belt size)?

inches

4. Have you been actively trying to manage your weight?

- No, and I don't plan to start trying in the next 6 months.
- No, but I plan to start trying in the next 6 months.
- Yes, I've recently (within 30 days) begun trying to manage my weight, but inconsistently.
- Yes, I've been trying to manage my weight for less than 6 months.
- I've managed my weight for 6 months or more.



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 Fill ALL boxes
and print clearly

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 Shade response
completely

Use a black pen to complete your responses.

Weight Management (continued)

5. How motivated are you to make improvements in your weight management?

| | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| Not At All Motivated | | | | | | | | | | | Extremely Motivated |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

6. How confident are you that you can improve your weight management?

| | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| Not At All Confident | | | | | | | | | | | Extremely Confident |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

7. How confident are you that you can manage your weight when:

| | Not Confident | Somewhat Confident | Confident | Very Confident | Extremely Confident |
|---|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| | 1 | 2 | 3 | 4 | 5 |
| a. you're upset or angry? | <input type="radio"/> |
| b. it's the holiday season or you're on vacation? | <input type="radio"/> |
| c. you eat out a lot? | <input type="radio"/> |
| d. you're tired or stressed? | <input type="radio"/> |
| e. you don't exercise regularly? | <input type="radio"/> |
| f. you're lonely or bored? | <input type="radio"/> |



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 Fill ALL boxes
and print clearly

5 ft 00 in

 Shade response
completely

Use a black pen to complete your responses.

Physical Activity

1. Have you been told by a doctor or other health care professional that you shouldn't do physical activity?

- Yes  SKIP to next section
 No

2. Are any of the following statements true for you?

- Your doctor has said that you have a heart condition, and you should only do physical activity recommended by a doctor.
 - You feel pain in your chest when you do physical activity.
 - In the past month, you had chest pain when you weren't doing physical activity.
 - You get dizzy and lose your balance, or lose consciousness.
 - You have a bone or joint problem (back, knee, or hip, for example) that could be made worse by a change in your physical activity.
 - Your doctor is currently prescribing drugs (for example, water pills) for your blood pressure or heart condition.
 - There is any other reason why you should not do physical activity.
- Yes
 No

3. In a typical week, what is the average amount of time you spend doing moderate-intensity physical activity?

days per week minutes per day
 that you exercised

Moderate-intensity physical activity:

You should be able to have a conversation during these activities, but will have an increase in breathing, increase in heart rate, and light sweating.

Examples:

- brisk walking
- casual swimming
- mowing with a power motor

4. In a typical week, what is the average amount of time you spend doing vigorous-intensity physical activity?

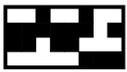
days per week minutes per day
 that you exercised

Vigorous-intensity physical activity:

You should be too out of breath to hold a conversation when doing these activities. There will also be a large increase in heart rate and breathing.

Examples:

- running (11-12 min/mile)
- bicycling (>10 mph)
- swimming laps
- weight circuit training



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 Fill ALL boxes
and print clearly

5 ft 00 in

 Shade response
completely

Use a black pen to complete your responses.

Physical Activity (continued)

5. How about strength-training exercises, such as using free weights, weight machines, or resistance bands? How often do you do those?

- Rarely or never
 Once a week
 Twice a week
 3 times a week
 4-5 times a week
 6-7 times a week

6. How often do you stretch or perform range-of-motion exercises, like stretching, yoga, or Tai chi?

- Rarely or never
 1 or 2 times a week
 3-5 times a week
 6-7 times a week

7. Regular exercise is at least 30 minutes of moderate activity at least 5 days a week or at least 25 minutes of vigorous activity at least 3 days a week. Based on this definition, do you get regular exercise?

- No, and I don't plan to start trying in the next 6 months.
 No, but I'm thinking about starting to exercise in the next 6 months.
 I've recently (within the last 30 days) begun to exercise, but inconsistently.
 Yes, I've begun to exercise regularly in the past 6 months.
 Yes, I exercise regularly and have for 6 months or more.

8. How motivated are you to increase your physical activity?

- | | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| Not At All Motivated | | | | | | | | | | | Extremely Motivated |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

9. How confident are you that you can increase your physical activity?

- | | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| Not At All Confident | | | | | | | | | | | Extremely Confident |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

10. How confident are you that you can be physically active when:

- | | | | | |
|------------------|-----------------------|-----------|-------------------|------------------------|
| Not Confident | Somewhat Confident | Confident | Very Confident | Extremely Confident |
| 1 | 2 | 3 | 4 | 5 |

a. you don't have someone to exercise with?

- 1 2 3 4 5

b. you feel tired?

- 1 2 3 4 5

c. you haven't been exercising regularly?

- 1 2 3 4 5

d. you can't find an activity you enjoy?

- 1 2 3 4 5

e. the weather is poor?

- 1 2 3 4 5

f. your schedule is inconsistent?

- 1 2 3 4 5



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 Fill ALL boxes
and print clearly

5 ft 0 0 in

 Shade response
completely

Use a black pen to complete your responses.

Nutrition

1. Is there anything you don't eat? *Choose all that apply.*

- Beef
- Dairy
- Eggs
- Fish
- Gluten
- Grains
- Lamb
- Nuts
- Pork or ham
- Poultry
- Shellfish
- None of the above

2. On most days, how many servings of grain products do you eat, such as bread, rice, or pasta? (1 serving = 1 ounce)

What counts as 1 ounce?

1/2 cup cooked rice
1/2 cup cooked pasta
1 slice of bread
1 pancake
1 packet of cooked cereal
1 small flour tortilla
1 mini bagel

- None
- 1-2 servings
- 3-4 servings
- 5 servings
- 6 servings
- 7 servings
- 8 servings
- 9 servings
- 10 servings
- More than 10 servings

3. On most days, how many of those servings are whole grains?

Whole Grain Examples:

Cereals: bran, shredded types, fruit with fiber types, oat bran, oatmeal

Breads: whole wheat, rye, and pumpernickel
Brown rice or other whole grains

- None
- Fewer than half
- Half
- More than half
- All

4. On most days, how many servings of meat, poultry, fish, beans, eggs, and/or nuts do you eat? (1 serving = 1 ounce)

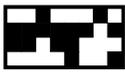
Examples of common meat, poultry, and/or fish portions are often more than 1 ounce:

1 small steak = 3 1/2-4 ounces
1/2 chicken breast = 3 ounces
1 can of tuna, drained = 3-4 ounces

Others:

1 egg
1/4 cup dry beans or dry peas

- None
- 1-2 servings
- 3-4 servings
- 5 servings
- 5 1/2 servings
- 6 servings
- 6 1/2 servings
- 7 servings
- More than 7 servings



64984

 Fill ALL boxes
and print clearly

5 ft 0 0 in

 Shade response
completely

Use a black pen to complete your responses.

Nutrition (continued)

5. On most days, how many cups of vegetables do you eat?

What counts as 1 cup of vegetables?

12 baby carrots
3 spears of broccoli, 5" long, raw or cooked
2 cups raw leafy greens
1 medium baked potato
1 large ear of corn (8"-9" long)

- None
 1 cup
 1 1/2 cups
 2 cups
 2 1/2 cups
 3 cups
 3 1/2 cups
 4 cups
 More than 4 cups

6. On most days, how many cups of fruit do you eat?

What counts as 1 cup of fruit?

8 large strawberries
32 seedless grapes
1 small apple
1 large orange
1 large banana (8"-9" long)

- None
 1 cup
 1 1/2 cups
 2 cups
 2 1/2 cups
 More than 2 1/2 cups

7. On most days, how many cups of calcium-rich foods (such as milk, cheese, or fortified soy beverages) do you eat?

What counts as 1 cup of calcium-rich foods?

8 ounces of milk or fortified soy beverage
1 8-ounce container of yogurt
2 slices of hard cheese
2 cups of cottage cheese

- None
 1 cup
 2 cups
 3 cups
 More than 3 cups

8. In general, how much salt or sodium do you eat?

- I rarely add salt to my food, and I don't eat many processed foods or salted snacks (lunchmeat, canned vegetables, chips, or pretzels).
 I taste food before salting it, add salt sparingly, and eat processed foods or salty snacks sparingly (3 times a week or less).
 I use salt liberally, and I eat processed foods or salted snacks almost daily.



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 Fill ALL boxes
and print clearly

5 ft 0 0 in

 Shade response
completely

Use a black pen to complete your responses.

Nutrition (continued)

9. On most days, how many total servings of soft margarine, mayonnaise, oil, or salad dressing do you eat? (1 serving = 1 teaspoon)

Common portions of foods containing more than 1 teaspoon of oil:

1 tbl of soft margarine = 2 1/2 tsp of oil
 1 tbl of mayonnaise = 2 1/2 tsp of oil
 1 tbl of vegetable oil = 3 tsp of oil
 2 tbl of salad dressing = 2 tsp of oil

- Less than 5 servings
- 5 servings
- 6 servings
- 7 servings
- 8 servings
- 9 servings
- 10 servings
- 11 servings
- More than 11 servings

10. On most days, how many servings of foods high in saturated or trans fats do you eat (including foods made with butter, lard, shortening, or solid margarine)?

Examples:

| | |
|-------------------------|-------------|
| baked goods or desserts | ice cream |
| regular cheeses | bacon |
| whole milk or cream | fried foods |

- None
- 1 serving
- 2 servings
- 3 servings
- 4 or more servings

11. The daily recommendation for a healthy diet is:

5-10 ounces of bread, cereal, pasta, or rice
 2-4 cups of vegetables
 1 1/2 - 2 1/2 cups of fruit
 3 cups of milk, yogurt, cheese, or fortified soy beverages
 5-7 ounces of meat, poultry, fish, dry beans, eggs or nuts
 5-11 teaspoons of oils (unsaturated fats)
 limited amounts of saturated and trans fats

Does what you eat match this recommendation?

- No, and I don't intend to follow it in the next 6 months.
- No, but I'm thinking about following it in the next 6 months.
- I've recently (within the past 30 days) started to meet this, but inconsistently.
- Yes, I meet this recommendation and have for less than 6 months.
- Yes, I meet this recommendation and have done so for 6 months or more.



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 Fill ALL boxes
and print clearly

5 ft 00 in

 Shade response
completely

Use a black pen to complete your responses.

Nutrition (continued)

12. How motivated are you to improve your eating habits?

| Not At All Motivated | | | | | | | | | | Extremely Motivated |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="radio"/> |

13. How confident are you that you can improve your eating habits?

| Not At All Confident | | | | | | | | | | Extremely Confident |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="radio"/> |

14. How confident are you that you can follow a healthy diet when:

| Not Confident | Somewhat Confident | Confident | Very Confident | Extremely Confident |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| 1 | 2 | 3 | 4 | 5 |
| a. you're around others who don't follow healthful diets? | | | | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. you're tired and don't feel like preparing a healthy meal? | | | | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. you eat out frequently? | | | | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. you feel the need to reward yourself with food? | | | | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. you're around tempting desserts or fast foods? | | | | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. you haven't had time to shop for groceries? | | | | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



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Fill ALL boxes
and print clearly

5 ft 00 in

Shade response
completely

Use a black pen to complete your responses.

Tobacco

1. Do you currently use any of the following tobacco products? *Choose all that apply.*

- Cigars
- Pipe
- Chewing tobacco
- Snuff
- No, I do not currently use any of these items.

2. Do you smoke cigarettes?

- No, I've never smoked cigarettes. SKIP to next section
- Yes, and I don't plan to quit in the next 6 months.
- Yes, but I'm thinking of quitting in the next 6 months.
- Yes, but I intend to quit within the next 30 days and have quit for at least 24 hours in the past year.
- No, I've quit smoking cigarettes within the last 6 months. SKIP to next section
- No, I've quit smoking cigarettes for more than 6 months. SKIP to next section

3. How many cigarettes do you typically smoke in a day? (e.g. 20 cigarettes)

| | |
|--|--|
| | |
|--|--|

4. How long have you been smoking? Round up or down to the nearest whole number.

| | |
|--|--|
| | |
|--|--|

 years

5. How soon do you smoke your first cigarette after you wake up?

- Within 5 minutes
- Within 6-30 minutes
- Within 31-60 minutes
- After 60 minutes

6. What's the longest you were able to stay quit?

- I've never tried to quit
- At least a day but less than 2 weeks
- At least 2 weeks but less than 3 months
- At least 3 months but less than a year
- At least a year

7. How motivated are you to quit smoking?

- | | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| Not At All Motivated | | | | | | | | | | | Extremely Motivated |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

8. How confident are you that you can quit smoking?

- | | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| Not At All Confident | | | | | | | | | | | Extremely Confident |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

9. How confident are you that you can keep from smoking cigarettes when:

- | | | | | |
|------------------|-----------------------|-----------|-------------------|------------------------|
| Not Confident | Somewhat Confident | Confident | Very Confident | Extremely Confident |
| 1 | 2 | 3 | 4 | 5 |

a. you feel you need a lift?

- 1 2 3 4 5

b. you feel stressed?

- 1 2 3 4 5

c. you feel angry?

- 1 2 3 4 5

d. you feel bored?

- 1 2 3 4 5

e. you have a physical craving for a cigarette?

- 1 2 3 4 5

f. you feel you need to control your weight?

- 1 2 3 4 5



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Fill ALL boxes
and print clearly

5 ft 0 0 in

Shade response
completely

Use a black pen to complete your responses.

Stress & Well-being

1. In the past month, how often have you felt nervous and stressed?

- Never
- Rarely
- Sometimes
- Fairly often
- Always

2. In the last month, how often have you been angered because of things that happened that were outside of your control?

- Never
- Almost never
- Sometimes
- Fairly often
- Very often

3. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

- Never
- Almost never
- Sometimes
- Fairly often
- Very often

4. In the last month, how often have you felt confident about your ability to handle your personal problems?

- Never
- Almost never
- Sometimes
- Fairly often
- Very often

5. In the last month, how often have you felt that you were on top of things?

- Never
- Almost never
- Sometimes
- Fairly often
- Very often

6. Examples of stress management techniques include:

| | |
|------------------------------|------------------------|
| relaxation | time management |
| meditation | deep breathing |
| yoga | learning coping skills |
| exercise (physical activity) | tai chi |

Which statement best describes your current stress management status?

- I don't currently try to manage stress and don't plan to do so in the next 6 months.
- I don't currently try to manage my stress, but I plan to start in the next 6 months.
- I've recently (within the last 30 days) tried to manage stress, but inconsistently.
- I consistently try to manage stress but have done so for less than 6 months.
- I consistently try to manage stress and have done so for 6 months or more.

7. Are you being treated for depression or bipolar disorder by a psychiatrist, psychologist, or other health professional?

- Yes
- No
- Prefer not to answer



64984

 Fill ALL boxes
and print clearly

5 ft 0 0 in

 Shade response
completely

Use a black pen to complete your responses.

Stress & Well-being (continued)

8. During the past week...

- a. I felt depressed.
 Yes No
- b. I felt that people disliked me.
 Yes No
- c. I was happy.
 Yes No
- d. I felt that everything I did was an effort.
 Yes No
- e. My sleep was restless.
 Yes No
- f. I felt lonely.
 Yes No
- g. People were unfriendly.
 Yes No
- h. I enjoyed life.
 Yes No
- i. I felt sad.
 Yes No
- j. I could not get going.
 Yes No

9. How motivated are you to manage your stress?

- | | | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|--|
| Not At All Motivated | | | | | | | | | | | Extremely Motivated | |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| | <input type="radio"/> | |

10. How confident are you that you can manage your stress?

- | | | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|--|
| Not At All Confident | | | | | | | | | | | Extremely Confident | |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| | <input type="radio"/> | |

11. How confident are you that you can:

| | | | | |
|------------------|-----------------------|-----------|-------------------|------------------------|
| Not Confident | Somewhat Confident | Confident | Very Confident | Extremely Confident |
|------------------|-----------------------|-----------|-------------------|------------------------|

| | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|

- a. reduce the stress in your life?
 1 2 3 4 5
- b. practice stress management techniques consistently?
 1 2 3 4 5
- c. practice stress management techniques even when demands on your time increase?
 1 2 3 4 5
- d. find support for the changes you're making?
 1 2 3 4 5
- e. set reasonable limits despite other people's demands?
 1 2 3 4 5
- f. remove yourself from stressful situations?
 1 2 3 4 5

12. If you were to experience depressive symptoms, how confident are you that:

| | | | | |
|------------------|-----------------------|-----------|-------------------|------------------------|
| Not Confident | Somewhat Confident | Confident | Very Confident | Extremely Confident |
|------------------|-----------------------|-----------|-------------------|------------------------|

| | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|

- a. you'd know where/how to get help?
 1 2 3 4 5
- b. you could find a caring professional to talk with?
 1 2 3 4 5
- c. your concerns would be kept confidential?
 1 2 3 4 5
- d. you could follow through with the treatment being offered?
 1 2 3 4 5
- e. you could benefit from the professional treatment that you receive?
 1 2 3 4 5
- f. you have a good support system to help you with this process (friends, family, clergy, doctor, therapist, etc.)?
 1 2 3 4 5



64984

Fill ALL boxes
and print clearly

5 ft 00 in

Shade response
completely

Use a black pen to complete your responses.

Sleep

1. Over the past week, how much sleep did you generally get in each 24-hour period?

Please round to the nearest half hour.

Hours

| | |
|--|--|
| | |
|--|--|

1/2 hour

2. How restful is your sleep?

Very poor

0 1 2 3 4 5 6 7 8 9 10

Very restful

3. What problems do you have sleeping? *Choose all that apply.*

- I have a hard time falling asleep.
- I have a hard time staying asleep.
- I wake too early.
- I still feel tired even if I get 6 or more hours of sleep.
- I don't have any problems sleeping.

4. How motivated are you to improve your sleep?

Not At All
Motivated

0 1 2 3 4 5 6 7 8 9 10

Extremely
Motivated

5. How confident are you that you can improve your sleep?

Not At All
Confident

0 1 2 3 4 5 6 7 8 9 10

Extremely
Confident

Anxiety

1. Do you have sudden intense and overwhelming fears that seem to come on for no apparent reason?

Yes

No  SKIP to question 3

2. With these fears, do you have symptoms like racing heart, chest pain, difficulty breathing, choking sensation, lightheadedness, tingling, or numbness?

Yes

No

3. Is it hard for you to control your worry about certain events or activities (such as work or school performance)?

Yes

No

4. Do you have any of the following symptoms? *Choose all that apply.*

- Feeling restless or on edge
- Easily worn out or fatigued
- Difficulty concentrating
- Feeling irritable
- Muscle tension
- Difficulty falling or staying asleep, or restless sleep

5. Have you ever had or seen a frightening, traumatic event that harmed or threatened to harm you or another person?

Yes

No  SKIP to question 7

6. Do you continue to have upsetting memories or dreams of the event or do you feel anxious when you're reminded of the event?

Yes

No



64984

 Fill ALL boxes
and print clearly

5 ft 0 0 in

 Shade response
completely

Use a black pen to complete your responses.

Anxiety (continued)

7. Do you have any of the following symptoms?
Choose all that apply.
- Difficulty falling or staying asleep
 - Irritability or angry outbursts
 - Difficulty concentrating
 - Feeling "on guard"
 - Being easily startled
8. Do you have recurring thoughts or images (other than the worries of everyday life) that you can't get out of your head and make you anxious?
- Yes
 - No
9. Do you engage in any repetitive behaviors (like hand washing, ordering, or checking) or mental acts (like praying, counting, or repeating words silently) to end these intrusive thoughts or images?
- Yes
 - No
10. Are you afraid of any of the following social or performance situations? *Choose all that apply.*
- Speaking up
 - Taking a test
 - Eating, writing, or working in public
 - Being the center of attention
 - Asking someone for a date
11. Do you get anxious and worried in those situations or do you avoid them when possible?
- Yes
 - No
12. Are you afraid of one specific object or situation, such as heights, storms, water, animals, elevators, closed-in spaces, receiving an injection, seeing blood, or flying?
- Yes
 - No

Eating Habits

1. Do you ever eat what other people would consider an unusually large amount of food?
- Yes
 - No  SKIP to question 3
2. In the past month, how many times have you eaten what other people would consider an unusually large amount of food?
- | | |
|--|--|
| | |
|--|--|
3. In the past month, did you ever feel like you lost control of your eating?
- Yes
 - No  SKIP to next section
4. In the past month, how many times did you feel you lost control of your eating?
- | | |
|--|--|
| | |
|--|--|



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Fill ALL boxes
and print clearly

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Shade response
completely

Use a black pen to complete your responses.

Alcohol

These questions are about drinking alcoholic beverages. Included are beer, wine, and liquor.

If you are pregnant, please answer the following questions about alcohol with your CURRENT use in mind.

One drink equals :

- one 12 oz. beer
- one 5 oz. glass of wine
- one shot (1.5 oz.) of liquor

1. On average, how often do you have a drink containing alcohol?

- Never. I do not drink  SKIP to next section
- Less than once a month
- Once a month
- 2-3 days a month
- 1-2 days a week
- 3-4 days a week
- Nearly every day

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

| | |
|--|--|
| | |
|--|--|

For the question that follows, please use this information:

- For women of all ages and men age 65 and over, binge drinking is defined as 4 or more drinks in about 2 hours or less.
- For men under age 65, binge drinking is defined as 5 or more drinks in about 2 hours or less.

3. How often do you binge drink?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

4. The National Institutes of Health recommends:

consuming no more than 1 drink a day for women of all ages, 1 drink a day for men age 65 and over, and 2 drinks a day for men under age 65. Pregnant women should not drink any alcohol.

Which of the following best describes your alcohol use?

- I drink more than what's recommended and don't plan to drink less in the next 6 months.
- I drink more than what's recommended but plan to drink less in the next 6 months.
- In the last 30 days I've begun to drink less, but I'm doing so inconsistently.
- I drink within the recommended amount but have done so for less than 6 months.
- I drink within the recommended amount and have done so for 6 months or more.



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 Fill ALL boxes
and print clearly

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 Shade response
completely

Use a black pen to complete your responses.

Alcohol (continued)

5. How motivated are you to reduce your alcohol consumption?

| Not At All Motivated | | | | | | | | | | Extremely Motivated |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

6. How confident are you that you can reduce your alcohol consumption?

| Not At All Confident | | | | | | | | | | Extremely Confident |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

7. How confident are you that you can limit how much you drink when:

| Not Confident | Somewhat Confident | Confident | Very Confident | Extremely Confident |
|---|-----------------------|-----------------------|-----------------------|------------------------|
| 1 | 2 | 3 | 4 | 5 |
| a. you're feeling depressed or worried? | | | | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. you're on vacation and want to relax? | | | | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. you're angry or frustrated? | | | | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. you're socializing with friends or co-workers? | | | | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. you're at a bar or party? | | | | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. you're alone? | | | | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



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Fill ALL boxes
and print clearly

5 ft 00 in

Shade response
completely

Use a black pen to complete your responses.

Drug Use

1. Have you ever done any of the following? *Choose all that apply.*

- Taken more of my prescription medication than was prescribed.
- Used recreational drugs (e.g., marijuana, hashish, cocaine, acid, ecstasy, heroin, hallucinogens, inhalants, methamphetamines).
- Neither of the above. SKIP to next section

2. Currently, do you do any of the following? *Choose all that apply.*

- Taken more of my prescription medication than was prescribed.
- Used recreational drugs (e.g., marijuana, hashish, cocaine, acid, ecstasy, heroin, hallucinogens, inhalants, methamphetamines).
- Neither of the above.

3. Have you ever experienced any of the following as a result of taking more of your prescription medication than is prescribed and/or as a result of using recreational drugs? *Choose all that apply.*

- End of marriage or break-up with partner
- End of other relationships (e.g., friends, children, or parents)
- Loss of custody of children
- Loss of job or job opportunities
- Trouble with the law or loss of driver's license
- Financial difficulties
- Poor health
- Other
- None of the above

4. Do you follow these recommendations?

1. Take all medications as prescribed.
2. Don't use recreational drugs (e.g., marijuana, hashish, cocaine, acid, ecstasy, heroin, hallucinogens, inhalants, methamphetamines).

- No, and I don't intend to follow them in the next 6 months.
- No, but I'm thinking of doing so in the next 6 months.
- Yes, in the past 30 days I've followed them, but inconsistently.
- Yes, I began following them in the past 6 months.
- Yes, I've been following them for more than 6 months.

5. Have you ever gotten professional help or treatment for taking more of your prescription medication than is prescribed?

- Yes
- No

6. Have you ever gotten professional help or treatment for recreational drug use?

- Yes
- No

7. How motivated are you to reduce your drug use?

- | | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| Not At All Motivated | | | | | | | | | | | Extremely Motivated |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

8. How confident are you that you can reduce your drug use?

- | | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| Not At All Confident | | | | | | | | | | | Extremely Confident |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |



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 Fill ALL boxes
and print clearly

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 Shade response
completely

Use a black pen to complete your responses.

Skin Protection

1. When you go outside on a very sunny day for more than 15 minutes, how often do you:

a. wear protective clothing such as wide-brimmed hats or long-sleeved shirts?

- Seldom or never
 Some of the time
 Most of the time
 Always

b. avoid the sun by staying in the shade?

- Seldom or never
 Some of the time
 Most of the time
 Always

c. use sunscreen of SPF 15 or higher?

- Seldom or never
 Some of the time
 Most of the time
 Always

2. After several months of not being in the sun, if you then went out in the sun without sunscreen or protective clothing for an hour, which of the following would happen to your skin? *Choose one answer.*

- Severe sunburn with blisters
 Severe sunburn for a few days with peeling
 Mild burn with some tanning
 Tan without sunburn
 Nothing would happen in an hour
 Other
 Don't know

3. If you were out in the sun for a long time repeatedly, what would happen to your skin? *Choose one answer.*

- Very dark and deeply tanned
 Moderately tanned
 Mildly tanned
 Only freckled
 No change
 Repeated sunburns
 Other
 Don't know

4. In your opinion, how sensitive is your skin to sunlight?

- Extremely sensitive
 Moderately sensitive
 Mildly sensitive
 Not sensitive at all
 Don't know

5. How motivated are you to improve your skin protection habits whenever you are outdoors?

- | | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| Not At All Motivated | | | | | | | | | | | Extremely Motivated |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

6. How confident are you that you can improve your skin protection habits whenever you are outdoors?

- | | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| Not At All Confident | | | | | | | | | | | Extremely Confident |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

7. How confident are you that you can:

- | | | | | |
|------------------|-----------------------|-----------|-------------------|------------------------|
| Not Confident | Somewhat Confident | Confident | Very Confident | Extremely Confident |
| 1 | 2 | 3 | 4 | 5 |

a. consistently use sunscreen of SPF of 15 or higher when exposed to the sun for more than 15 minutes?

- 1 2 3 4 5

b. protect your skin when outside?

- 1 2 3 4 5

c. stay in the shade when not wearing protective clothing or sunscreen?

- 1 2 3 4 5

d. avoid sun exposure between 10 a.m. and 4 p.m.?

- 1 2 3 4 5

e. check your skin monthly for changes?

- 1 2 3 4 5



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 Fill ALL boxes
and print clearly

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 Shade response
completely

Use a black pen to complete your responses.

Injury Prevention

1. Are ALL of the following statements TRUE for you?

- I don't drink and drive or ride with anyone who has been drinking.
- I always wear a seatbelt when I'm driving or riding in a car.
- I drive within 5 MPH of the speed limit (or, I don't drive at all).

 Yes SKIP to next section

 No

2. In the past 12 months, how many times have you ridden with a driver who might have had too much to drink?

| | | |
|--|--|--|
| | | |
|--|--|--|

3. During the past 12 months, how many times have you driven a car or other motor vehicle within 2 hours after drinking an alcoholic beverage?

| | | |
|--|--|--|
| | | |
|--|--|--|

4. How often do you use a seatbelt when you drive or ride in a car?

- Never
- Seldom
- Sometimes
- Nearly always
- Always
- I never drive or ride in a car.

5. On average, how close to the speed limit do you drive?

- Within 5 MPH of limit
- 6-10 MPH over limit
- 11-15 MPH over limit
- More than 15 MPH over limit
- I don't drive.

9. How motivated are you to reduce your risk of injury?

Not At All
MotivatedExtremely
Motivated

| | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="radio"/> |

10. How confident are you that you can reduce your risk of injury?

Not At All
ConfidentExtremely
Confident

| | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="radio"/> |

11. How confident are you that you can:

| | | | | |
|------------------|-----------------------|-----------|-------------------|------------------------|
| Not Confident | Somewhat Confident | Confident | Very Confident | Extremely Confident |
|------------------|-----------------------|-----------|-------------------|------------------------|

| | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|

a. wear your seatbelt every time you're in a car?

| | | | | |
|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |
|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|

b. not drive when drunk, even if there's no one else to drive you?

| | | | | |
|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |
|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|

c. drive within 5 mph of the posted speed limit?

| | | | | |
|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |
|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|

d. not ride with a driver who has been drinking?

| | | | | |
|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |
|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|



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Fill ALL boxes
and print clearly

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Shade response
completely

Use a black pen to complete your responses.

Sexual Behavior

1. Are any of the following true for you?

- I haven't had sex in the past 12 months.
- Neither I nor my partner have had sex outside our relationship in the past 12 months
- My partner and I don't have sex outside our relationship and have both tested negative for STDs, including HIV.

- Yes  SKIP to next section
- No

2. During the past 12 months, how many people have you had sex with?

| | | |
|--|--|--|
| | | |
|--|--|--|

3. During the past 12 months, who have you had sex with?

- Only males
- Only females
- Both males and females

4. In the past 12 months, have you been involved in an ongoing sexual relationship with someone?

- Yes
- No  SKIP to question 6

5. During the past 12 months, when you had sex with someone in an ongoing relationship, how often did you use a condom?

- Every single time
- Almost every single time
- At least half of the time
- At least once, but less than half the time
- Never

6. At any time in the past 12 months did you have sex with anyone you weren't in an ongoing relationship with?

- Yes
- No  SKIP to question 8

7. During the past 12 months, when you had sex with someone you weren't in an ongoing relationship with, how often did you use a condom?

- Every single time
- Almost every single time
- At least half of the time
- At least once, but less than half the time
- Never

8. Which of the following statements best describes your safer sex practices?

Practicing safer sex means doing things that reduce your risk of getting a sexually transmitted disease, such as abstaining from sex with others or using barrier protection (e.g., condoms) every time you have sex.

- I don't currently practice safer sex and don't plan to start in the next 6 months.
- I don't currently practice safer sex but plan to start doing so every time in the next 6 months.
- I've recently (within the past 30 days) started practicing safer sex, but inconsistently.
- I do practice safer sex every time I have sex, and I've been doing so for less than 6 months.
- I do practice safer sex every time I have sex, and I've been doing so for more than 6 months.



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 Fill ALL boxes
and print clearly

5 ft 0 0 in

 Shade response
completely

Use a black pen to complete your responses.

Sexual Behavior (continued)

9. How motivated are you to practice safer sex?

| | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| Not At All Motivated | | | | | | | | | | | Extremely Motivated |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

10. How confident are you that you can practice safer sex?

| | | | | | | | | | | | |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| Not At All Confident | | | | | | | | | | | Extremely Confident |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

11. How confident are you that you can practice safer sex when:

| | | | | |
|------------------|-----------------------|-----------|-------------------|------------------------|
| Not Confident | Somewhat Confident | Confident | Very Confident | Extremely Confident |
|------------------|-----------------------|-----------|-------------------|------------------------|

| | | | | |
|----------|----------|----------|----------|----------|
| 1 | 2 | 3 | 4 | 5 |
|----------|----------|----------|----------|----------|

a. you or your partner have been using drugs or alcohol?

1 2 3 4 5

b. you don't think you're at risk for disease?

1 2 3 4 5

c. you feel uncomfortable discussing condom use with your partner?

1 2 3 4 5

d. you already use other birth control?

1 2 3 4 5

e. you're sexually aroused?

1 2 3 4 5

f. you feel uncomfortable buying condoms?

1 2 3 4 5



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 Fill ALL boxes
and print clearly

5 ft 0 0 in

 Shade response
completely

Use a black pen to complete your responses.

Immunizations & Health Screenings

1. Have you ever had the following immunizations (shots)?

a. MMR (measles/mumps/rubella) vaccine

- Yes
 No
 Don't know

b. Hepatitis B vaccine (series of 3 shots)

- Yes
 No
 Don't know

c. Pneumonia vaccine

- Yes
 No
 Don't know

d. Tetanus vaccine within the last 10 years

- Yes
 No
 Don't know

e. Influenza (flu) vaccine within the last 12 months

- Yes
 No
 Don't know

f. Have you ever had chickenpox or had the vaccination?

- Yes
 No
 Don't know

If you are age 26 and under, please answer the following question.

g. Have you had the HPV (Human Papillomavirus) vaccine (series of three shots)? HPV is the virus that causes cervical cancer in women and genital warts in men and women?

- Yes No Don't know

Select the appropriate choice for each test or exam question.

2. Have you had a colonoscopy within the last 10 years? (This is when a tube is inserted in the rectum to check the large intestine.)

- Yes  SKIP to question 6
 No
 Don't know

3. Have you had a fecal occult blood test (FOBT) within the past 12 months? (This is when your stool is examined for blood.)

- Yes
 No
 Don't know

4. Have you had a sigmoidoscopy within the past 5 years? (This is when a tube is inserted in the rectum to check for lower intestinal problems.)

- Yes
 No
 Don't know

5. Have you had a double-contrast barium enema (X-ray of the large intestine) within the past 5 years to screen for cancer of the colon or rectum?

- Yes
 No
 Don't know

If you are age 60 or older, please answer the following question. Otherwise, SKIP to the next question.

6. Have you had the shingles vaccine?

- Yes
 No
 Don't know



64984

 Fill ALL boxes
and print clearly

5 ft 0 0 in

 Shade response
completely

Use a black pen to complete your responses.

Immunizations & Health Screenings (continued)

7. a. When was the last time you had your blood pressure checked?

- Less than 1 year ago
 1 to 2 years ago
 More than 2 years ago
 Don't know

b. Do you know your blood pressure?

(The first number will be between 50 and 300, and the second number will be between 30 and 180.)

Yes, it's

| | | | | | | |
|--|--|--|------|--|--|--|
| | | | over | | | |
|--|--|--|------|--|--|--|

- Not the exact numbers, but I've been told it's normal.
 Not the exact numbers, but I've been told it's high.
 No, I don't.

8. a. Have you had your cholesterol checked within the last 5 years?

- Yes No  SKIP to question 9 Don't know

b. What was your total cholesterol number?

(Please enter a number between 60 and 999.)

| | | |
|--|--|--|
| | | |
|--|--|--|

Don't know

c. What was your HDL cholesterol number?

(Please enter a number between 10 and 150.)

| | | |
|--|--|--|
| | | |
|--|--|--|

Don't know

d. What was your LDL cholesterol number?

(Please enter a number between 5 and 999.)

| | | |
|--|--|--|
| | | |
|--|--|--|

Don't know

e. What was your triglyceride number?

(Please enter a number between 5 and 9999.)

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

Don't know

9. a. Have you had your blood sugar checked in the past 3 years?

- Yes No  SKIP to next page Don't know  SKIP to next page

b. What was your blood sugar level?

(Please enter a number between 30 and 999.)

| | | |
|--|--|--|
| | | |
|--|--|--|

Fasting

| | | |
|--|--|--|
| | | |
|--|--|--|

Non-fasting

Don't know my blood sugar level



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Fill ALL boxes
and print clearly

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Shade response
completely

Use a black pen to complete your responses.

Women only:

1. Select the appropriate answer regarding pregnancy:

- I'm currently pregnant.
- I had a baby within the past 3 months. SKIP to question 3
- I'm planning on becoming pregnant in the next 6 months. SKIP to question 6
- I'm not currently pregnant and not planning on becoming pregnant in the next 6 months. SKIP to question 3

2. What is your estimated due date?

/ /

SKIP to question 6

3. Are you currently on estrogen or hormone therapy, or planning to start?

- Yes
- No
- A doctor has advised me not to do this.

4. Have you ever had a total hysterectomy (removal of both uterus and cervix)?

- Yes, because of a diagnosis of cancer of the cervix
- Yes, for a reason other than cancer of the cervix
- Yes, but am unsure of the reason
- No

If you are age 50 or older, please answer the following question.

5. Have you ever had a bone density scan?

- Yes No Don't know

6. When was your last Pap smear?

- Less than 1 year ago
- 1 to 3 years ago
- More than 3 years ago
- Don't know
- I've never had a Pap smear

7. Have you had a clinical breast exam by a health care provider in the past 12 months?

- Yes No Don't know

8. When was your last mammogram?

- Less than 1 year ago
- 1 to 2 years ago
- More than 2 years ago
- Don't know
- I've never had a mammogram

9. Are you currently breastfeeding?

- Yes
- No SKIP to next section

10. Baby's date of birth

/ /

11. How much breast milk and formula does your baby get?

- Breast milk only, no formula
- At least half breast milk, plus some formula
- Some breast milk, mostly formula

Men only:

1. Have you been screened for prostate cancer in the past 12 months?

- Yes No Don't know



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 Fill ALL boxes
and print clearly

5 ft 0 0 in

 Shade response
completely

Use a black pen to complete your responses.

A Little More About You

1. What's the main way you make a living?

- Executive, administrator, or senior manager (e.g., CEO, sales VP, plant manager)
- Professional (e.g., engineer, accountant, systems analyst)
- Technical support (e.g., lab technician, legal assistant, computer programmer)
- Sales (e.g., sales representative, stockbroker, retail sales)
- Clerical and administrative support (e.g., secretary, billing clerk, office supervisor)
- Service occupation (e.g., security officer, food service worker, janitor)
- Precision production and crafts worker (e.g., mechanic, carpenter, machinist)
- Operator or laborer (e.g., assembly line worker, truck driver, construction worker)
- Not currently working outside the home (e.g., retired, student, caregiver for children) 

SKIP to question 7

2. In the past 12 months, how many days of work have you missed due to illness?

| | | |
|--|--|--|
| | | |
|--|--|--|

 days

3. During the past 4 weeks, how many hours did you miss from work because of your health problems?

Include hours you missed on sick days, times you went in late, left early etc., because of your health problems. Do not include time you missed to participate in this program.

| | | |
|--|--|--|
| | | |
|--|--|--|

 hours

4. During the past 4 weeks, how many hours did you miss from work because of any other reason, such as vacation, or holidays?

| | | |
|--|--|--|
| | | |
|--|--|--|

 hours

5. During the past 4 weeks, how many hours did you actually work?

| | | |
|--|--|--|
| | | |
|--|--|--|

 hours

6. During the past 4 weeks, how much did your health problems affect your productivity while you were working?

Think about the days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. If health problems affected your work only a little, choose a low number. Choose a high number if health problems affected your activities a great deal.

 Health problems
had no effect on
my work

 Health problems
completely prevented
me from working

| | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="radio"/> |

7. During the past 4 weeks, how much did your health problems affect your ability to do your regular daily activities, (other than work at a job)?

By regular activities, we mean the usual activities you do, such as work around the house, shopping, child care, exercising, studying, etc. Think about times you were limited in the amount or kind of activities you could do and times you accomplish less than you would like. If health problems affected your activities only a little, choose a low number. Choose a high number if health problems affected your activities a great deal.

 Health problems
had no effect on
my daily activities

 Health problems completely
prevented me from doing
my daily activities

| | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="radio"/> |

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This Privacy Statement is designed to tell you about our practices regarding the collection, use, and disclosure of information about you throughout your participation in health and performance programs (the "Programs") provided to you by Wellness & Prevention, Inc. ("Wellness & Prevention", "We", or "Us"). Please be sure to read this entire Privacy Statement before participating in the Programs.

In particular, completion of this health risk assessment may allow you to use health and performance services made available to you by your sponsor (e.g., your employer, health plan, or healthcare provider) and provided to you by Wellness & Prevention. Your participation in the Programs is voluntary and based on your eligibility as determined by your sponsor.

By participating in the Programs, you agree to the terms of this Privacy Statement. Specifically, you authorize the collection, processing, retention, and disclosure of information about you by Wellness & Prevention and its business partners and service providers for the purposes described in this Privacy Statement.

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- To your sponsoring employer:
 - We may provide aggregate and statistical information and reporting (i.e., information that does not identify you).
 - To support an incentive management program related to the Programs, We may provide your sponsoring employer general information about your participation in the various components of the Programs; We would not, however, provide your sponsoring employer the names or identifiers of the specific components of the Programs in which you participated.
 - However, We may provide information about you and your participation in the Programs if you specifically authorize Us to do so.
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- To respond to law enforcement requests or where required by applicable laws, court orders, or government regulations, We may transfer information about you to other parties for legal purposes.

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We take reasonable steps to protect information about you in our possession and control, and to protect such information from loss, misuse, and unauthorized access, disclosure, alteration, or destruction.

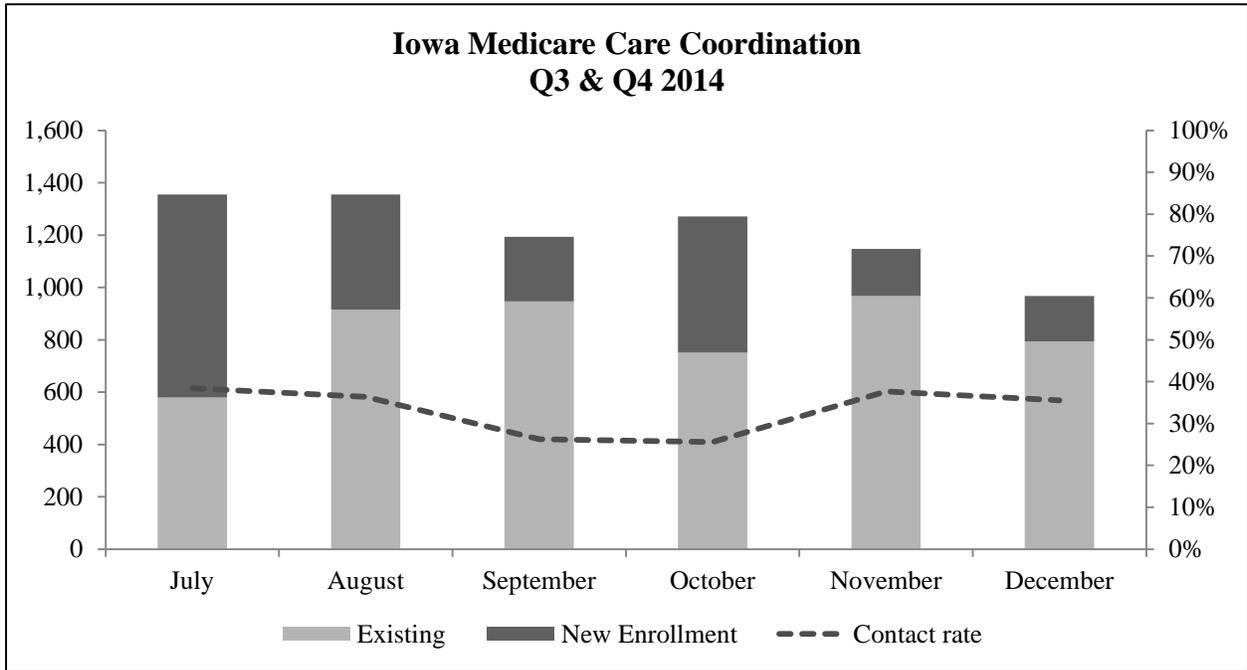
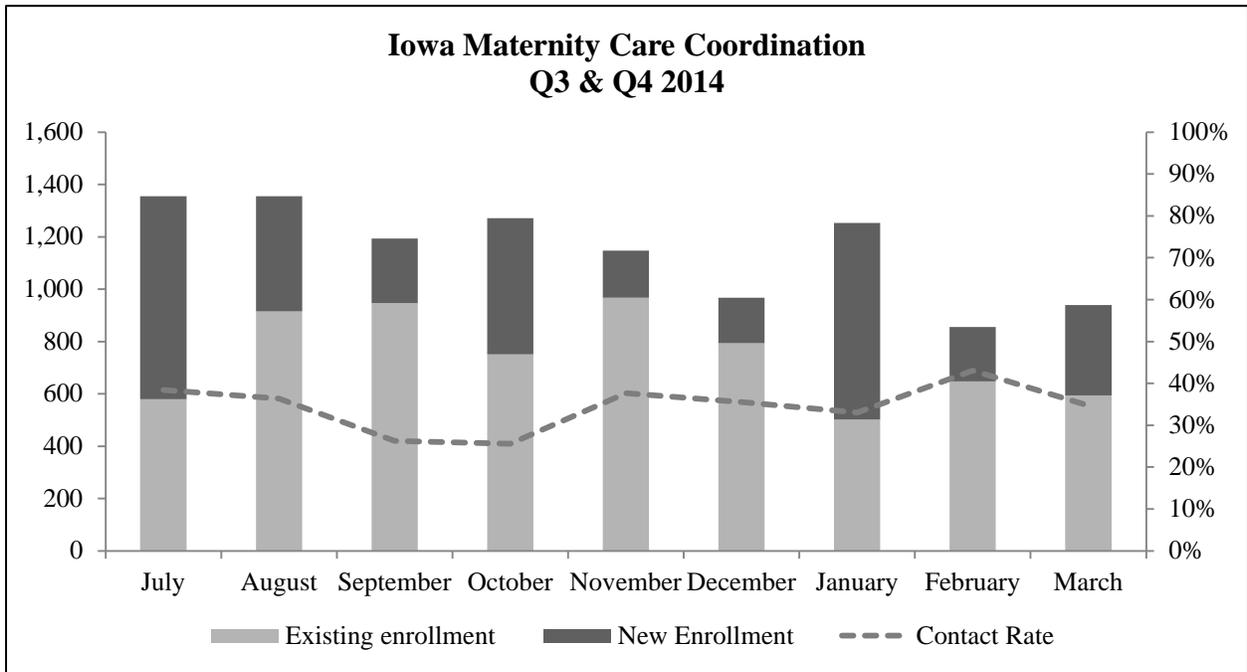
You may review and update certain self-reported, unverified information through the various Programs that you use by contacting Customer Care. You may cancel your participation in our Programs by contacting your sponsor or Customer Care.

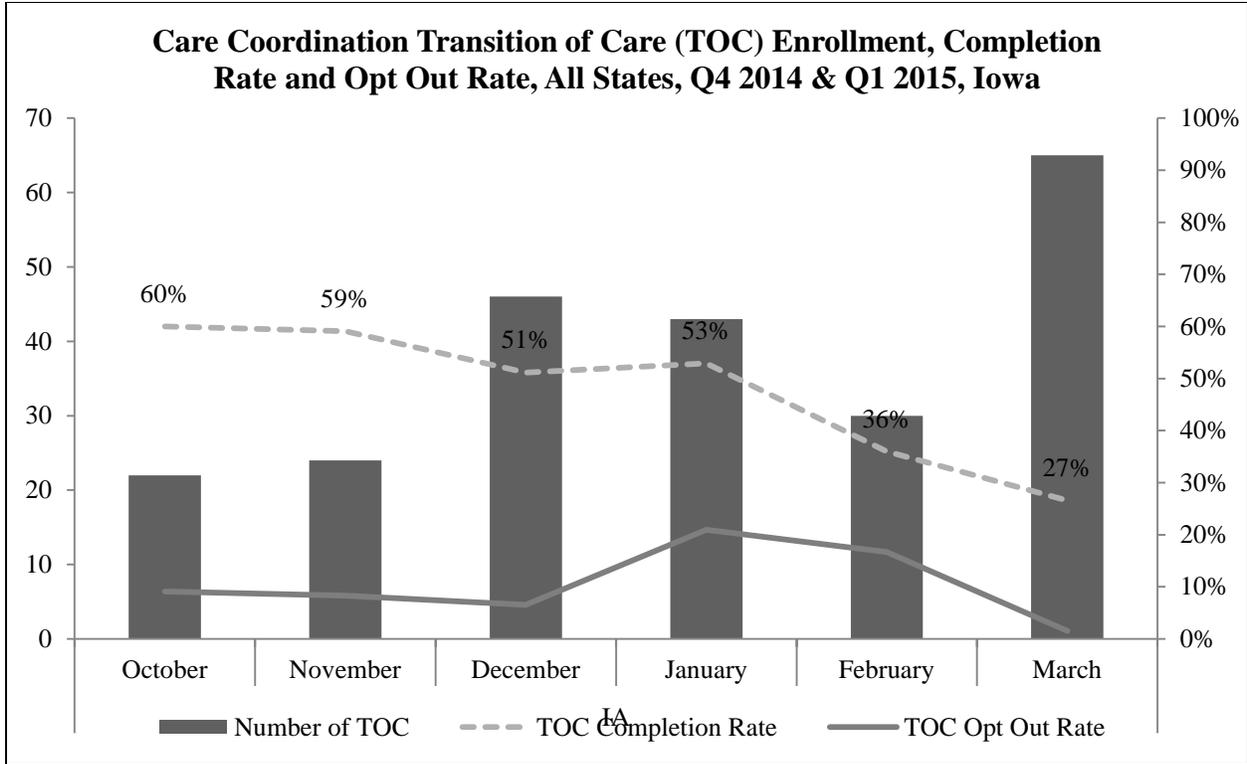
If you have any questions or concerns about this Privacy Statement you may contact:

Customer Care
Wellness & Prevention, Inc.
130 S. First Street
Ann Arbor, MI 48104 USA
+1-866-433-9284

Effective Date: March 2014

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*Meridian Health Plan of Iowa
2014 Provider satisfaction Analysis*

In 2014, Meridian Health Plan of Iowa conducted its first annual Provider Satisfaction survey.¹ The purpose of the Provider Satisfaction survey is to measure how well the health plan is meeting the expectations and needs of its providers. Meridian partnered with the NCQA certified vendor, The Myers Group (TMG), to produce a two-wave survey that utilized mail and Internet with a phone follow-up. The surveys were administered from July to September of 2014. In July, a sample of 1,250 providers was randomly selected to participate in the survey. Responses were received from 216 providers at a 20% response rate.

Response Rates

A response rate is calculated for providers who were eligible and able to respond. Meridian Health Plan of Iowa randomly selected 1,250 providers: half of the providers chosen were listed as Primary Care Practitioners (PCPs) and the other half were specialists. Questionnaires were mailed or available via the Internet on two separate occasions before a telephonic effort was made in order to complete the survey. TMG received 216 completed surveys, with the telephonic completion being the largest at 135 surveys. The survey received an overall response rate of 17%.

$$\frac{\text{Mail completes (63)} + \text{Internet completes (18)} + \text{Phone completes (135)}}{\text{Total Sample (1250)} - \text{Total Ineligible (187)}} = \frac{216}{1063}$$

= Response Rate = 20%

| Survey Year | Sample | Mail Completes | Phone Completes | Internet Completes | Total Responses | Response Rate |
|-------------|--------|----------------|-----------------|--------------------|-----------------|---------------|
| 2014 | 1,250 | 63 | 135 | 18 | 216 | 20% |

Key Measures

Iowa first participated in the Provider Satisfaction survey in 2014. There are six rankable measures. In the initial year, Iowa received two measures in the seventy-fifth and three measures at or exceeding the twenty-fifth percentile. The two measures obtaining a seventy-fifth percentile ranking were Overall Satisfaction and Provider Relations. The Provider Relations composite ranking addresses the quality of the provider orientation process, written communication, policy bulletins, and manuals. The ability for a provider representative to answer questions and resolve problems for the provider is also measured. The other areas in which Iowa demonstrated a high level of proficiency are listed in the table below.

¹ A Copy of the Provider Satisfaction Survey can be found in the Appendix

Attachment 30 (Provider Satisfaction Analysis)

| Composite Measure | Percentile Ranking |
|---------------------------------------|--------------------|
| Overall Satisfaction | 75 th |
| Provider Relations | 75 th |
| Finance Issues | 25 th |
| Utilization and Quality Management | 25 th |
| Health Plan Call Center Service Staff | 25 th |

In Iowa's initial year, the only measure that did not obtain a ranking to at the least the twenty-fifth percentile was Network/Coordination of Care. This composite measure addresses the number and quality of specialists, as well as the timeliness of feedback from specialists, in this health plan's provider network.

216 Total Respondents

| Composite/Attribute | 2014 Meridian Health Plan of Iowa Summary Rate Score ^a | Percentile Ranking | 2013 TMG B.o.B. Summary Rate ^{**} | 2013 TMG Medicaid B.o.B. Percentiles | | | |
|---|---|--------------------|--|--------------------------------------|-------|-------|-------|
| | | | | 25th | 50th | 75th | 90th |
| Overall Satisfaction | 76.5% | 78th | 65.9% | 56.0% | 69.3% | 74.6% | 80.8% |
| 7A. Would you recommend Meridian Health Plan of Iowa to other physicians' practices? | 87.4% | 74th | 80.5% | 73.1% | 81.7% | 87.5% | 91.5% |
| 7B. Please rate your overall satisfaction with Meridian Health Plan of Iowa. | 76.5% | 78th | 65.9% | 56.0% | 69.3% | 74.6% | 80.8% |
| All Other Plans (Comparative Rating) | | | | | | | |
| 1A. How would you rate Meridian Health Plan of Iowa compared to all other health plans you contract with? | 35.9% | 49th | 37.3% | 25.3% | 36.2% | 48.2% | 53.3% |
| Finance Issues | 30.7% | 38th | 34.6% | 26.9% | 33.1% | 38.0% | 43.8% |
| 2A. Consistency of reimbursement fees with your contract rates. | 23.4% | 30th | 30.1% | 21.9% | 29.3% | 34.2% | 39.1% |
| 2B. Accuracy of claims processing. | 34.8% | 46th | 37.9% | 28.4% | 36.2% | 42.9% | 47.7% |
| 2E. Timeliness of claims processing. | 36.6% | 51st | 37.7% | 31.7% | 36.2% | 40.2% | 47.1% |
| 2F. Resolution of claims payment problems or disputes. | 28.1% | 37th | 32.5% | 26.3% | 31.1% | 36.4% | 41.3% |
| Utilization and Quality Management | 33.0% | 47th | 37.1% | 28.8% | 33.7% | 41.4% | 51.8% |
| 3A. Access to knowledgeable UM staff. | 35.2% | 67th | 35.0% | 26.4% | 31.4% | 38.5% | 51.7% |
| 3B. Procedures for obtaining pre-certification/referral/authorization information. | 36.3% | 70th | 36.2% | 27.2% | 32.9% | 39.5% | 56.8% |
| 3C. Timeliness of obtaining pre-certification/referral/authorization information. | 25.9% | 24th | 37.5% | 26.0% | 36.6% | 38.9% | 55.1% |
| 3D. The health plan's facilitation/support of appropriate clinical care for patients. | 28.1% | 26th | 35.9% | 27.5% | 32.6% | 41.0% | 49.8% |
| 3E. Access to Case/Care Managers from this health plan. | 27.3% | 34th | 33.5% | 26.7% | 31.0% | 36.7% | 45.4% |
| 3F. Degree to which the plan covers and encourages preventive care and wellness. | 45.2% | 50th | 44.5% | 35.8% | 45.0% | 53.6% | 56.3% |
| Network/Coordination of Care | 25.6% | 13th | 32.6% | 27.0% | 29.3% | 38.4% | 44.8% |
| 4A. The number of specialists in this health plan's provider network. | 26.9% | 58th | 27.8% | 22.8% | 24.9% | 32.4% | 41.2% |
| 4B. The quality of specialists in this health plan's provider network. | 27.6% | <10th | 37.5% | 29.8% | 34.8% | 45.1% | 52.8% |
| 4C. The timeliness of feedback/reports from specialists in this health plan's provider network. | 22.2% | <10th | 32.5% | 26.6% | 30.4% | 36.1% | 44.4% |
| Health Plan Call Center Service Staff | 40.2% | 33rd | 44.1% | 34.9% | 41.3% | 42.8% | 58.4% |
| 5A. Ease of reaching health plan call center staff over the phone. | 44.2% | 80th | 41.8% | 33.0% | 38.7% | 39.9% | 57.5% |
| 5B. Process of obtaining member information (eligibility, benefit coverage, co-pay amounts). | 42.3% | 39th | 48.4% | 39.3% | 45.2% | 48.5% | 64.8% |
| 5C. Helpfulness of health plan call center staff in obtaining referrals for patients in your care. | 33.9% | 27th | 41.9% | 32.5% | 38.9% | 42.2% | 56.0% |
| 5D. Overall satisfaction with health plan's call center service. | 40.5% | 32nd | 44.4% | 35.0% | 42.3% | 43.4% | 57.8% |
| Provider Relations | 57.0% | 83rd | 45.1% | 38.4% | 42.4% | 50.6% | 61.4% |
| 6A. Do you have a Provider Relations representative from this health plan assigned to your practice? | 63.5% | 93rd | 52.1% | 46.7% | 49.3% | 55.7% | 60.1% |
| 6B. Provider Relations representative's ability to answer questions and resolve problems. | 79.6% | 99th | 57.9% | 52.7% | 53.5% | 65.4% | 68.9% |
| 6C. Quality of provider orientation process. | 43.2% | 75th | 36.5% | 29.0% | 31.7% | 42.5% | 52.3% |
| 6D. Quality of written communications, policy bulletins, and manuals. | 48.4% | 79th | 42.1% | 35.6% | 39.4% | 46.3% | 57.5% |

- At or above the 75th percentile.
- At or above the 50th percentile, but below the 75th percentile.
- At or above the 25th percentile, but below the 50th percentile; or no benchmark.
- Below the 25th percentile.

Provider Demographics

Demographic markers were evaluated in the Provider Satisfaction Survey via questions surrounding the respondent’s medical practice. The markers that indicated high levels of variance were Area of Medicine, Physicians in Practice, Years in Practice, and Survey Respondent. Area of medicine was divided into two types, Primary Care and Specialty. Primary Care physicians rated each composite measure higher than the specialty physicians. Primary Care practitioners rated the composite measure, Provider Relations, 17% higher than specialists. Similarly, Utilization and Quality Management was rated 14% higher by primary care practitioners over specialists. Medical practices that reported staffing six or more physicians indicated a higher level of satisfaction with provider relations and overall satisfaction with the health plan compared to medical practices staffed with one to five physicians. Medical practices reporting only one physician gave the lowest ratings for all composite measures.

The demographic marker “Years in Practice” provided the largest variance amongst group ratings. Medical practices that have been in practice less than five years indicated the highest level of overall satisfaction with the health plane, while medical practices in practice sixteen or more years indicated the highest level of satisfaction with provider relations. The Survey Respondent marker also indicated variance amongst respondents. The three types of respondents were physician, office manager, and nurse/other staff. Based on the data, office managers ranked all composite measures higher than physicians and nurse/other staff. Physicians of the medical practice indicated the lowest level of satisfaction for all composite measures.

Area of Medicine

| Composite Measure | Physicians | Specialists |
|---------------------------------------|------------|-------------|
| Overall Satisfaction | 78.9% | 72.7% |
| Finance Issues | 33.2% | 27.1% |
| Utilization and Quality Management | 38.6% | 24.9% |
| Network/Coordination of Care | 27.5% | 25.0% |
| Health Plan Call Center Service Staff | 42.2% | 38.2% |
| Provider Relations | 63.4% | 46.1% |

Physicians in Practice

| Composite Measure | Solo | 2-5 Physicians | More than 5 Physicians |
|---------------------------------------|-------|----------------|------------------------|
| Overall Satisfaction | 69.2% | 77.2% | 82.4% |
| Finance Issues | 24.9% | 40.0% | 15.3% |
| Utilization and Quality Management | 23.9% | 39.7% | 27.9% |
| Network/Coordination of Care | 10.9% | 34.4% | 22.2% |
| Health Plan Call Center Service Staff | 31.8% | 46.5% | 36.1% |
| Provider Relations | 49.2% | 57.0% | 62.6% |

Attachment 30 (Provider Satisfaction Analysis)

Years in Practice

| Composite Measure | Less than 5 years | 5-15 years | 16 years or more |
|---------------------------------------|--------------------------|-------------------|-------------------------|
| Overall Satisfaction | 83.9% | 79.0% | 72.6% |
| Finance Issues | 27.2% | 29.6% | 34.3% |
| Utilization and Quality Management | 28.9% | 34.6% | 34.0% |
| Network/Coordination of Care | 18.3% | 27.9% | 28.3% |
| Health Plan Call Center Service Staff | 38.2% | 41.9% | 41.7% |
| Provider Relations | 43.4% | 56.2% | 65.1% |

Survey Respondent

| Composite Measure | Physician | Office Manager | Nurse/Other staff |
|---------------------------------------|------------------|-----------------------|--------------------------|
| Overall Satisfaction | 52.9% | 81.0% | 76.1% |
| Finance Issues | 24.1% | 36.2% | 23.9% |
| Utilization and Quality Management | 13.3% | 36.2% | 23.9% |
| Network/Coordination of Care | 2.4% | 35.2% | 16.8% |
| Health Plan Call Center Service Staff | 27.4% | 48.4% | 33.2% |
| Provider Relations | 21.1% | 61.7% | 56.2% |

Key Drivers for Provider Satisfaction

TMG also conducted a regression analysis of the Provider Satisfaction Survey to identify key drivers or areas that correlate with key composites. The measure that was identified as positively affecting the overall satisfaction of a provider was Provider Relations. This composite was the only other composite that received a seventy-fifth percentile ranking, other than the Overall Satisfaction. Four measures were identified as areas of improvement and indicated a negative correlation with the overall satisfaction of the provider. TMG divided the areas of improvement into two categories: Top Priority and Medium Priority. The composite measure that received Top Priority was Finance Issues. This composite measure received a twenty-fifth percentile ranking. The three measures that obtained a Medium Priority were Network/Coordination of Care, Health Plan Call Center Service Staff and Utilization and Quality Management. Although Network/Coordination of Care ranked below the twenty-fifth percentile, it has a lesser impact on a provider’s indication of satisfaction.

| | | |
|--|---|---|
| Top Priority | | Strength |
| Finance Issues, 38 th , .494 | | |
| Network/Coordination of Care, 13 th , .402 | Utilization and Quality Management, 47 th , .477 | Provider Relations, 83 rd , .464 |
| Health Plan Call Center Service Staff, 33 rd , .431 | | |
| Medium Priority | | Monitor and Maintain |

Supplemental Questions

Meridian added additional questions to the 2014 Provider Satisfaction survey to obtain a better understanding of its provider network. The supplemental questions that were included are the following:

- What is your preferred method of receiving communications from this health plan?
- What can Meridian Health Plan of Iowa do to improve its service to your organization?²

Methods of Communication

Meridian Health Plan of Iowa asked providers to indicate their preferred method of communication. The preferred method of communication varied depending on the respondent. Physicians and nurse/other staff indicated that they prefer mail as the primary method of communication, whereas office managers indicated that they prefer e-mail as their primary method. The preferred method also differed depending on the years in practice. Medical practices who had been in operation less than five years and sixteen or more years indicated that they preferred standard mail as the primary method of communication. E-mail was indicated as the preferred method for offices in practice five to fifteen years.

² Verbatim responses can be found in the Appendix.

Attachment 30 (Provider Satisfaction Analysis)

The overall analysis indicated that e-mail is the preferred method of communication for participants in the Provider Satisfaction Survey.

| Method of Communication | PCP | Specialty | Physician | Office Mngr. | Nurse/ Other staff | <5 years | 5-15 years | 16 years+ |
|--------------------------|--------------|--------------|--------------|--------------|--------------------|--------------|--------------|--------------|
| Mail | 29.7% | 34.5% | 75.0% | 26.8% | 31.0% | 38.3% | 27.8% | 34.6% |
| Telephone | 2.3% | 2.3% | 5.0% | 1.0% | 2.4% | -- | 2.8% | 1.3% |
| Fax | 26.4% | 26.4% | 10.0% | 22.7% | 26.2% | 27.7% | 23.6% | 19.2% |
| Online Portal | 2.3% | 2.3% | -- | 4.1% | 1.2% | 2.1% | 1.4% | 3.8% |
| E-mail | 33.1% | 29.9% | 5.0% | 38.1% | 27.4% | 29.8% | 34.7% | 28.2% |
| From your representative | 11.9% | 2.3% | -- | 7.2% | 9.5% | 2.1% | 6.9% | 11.5% |

Customer Service

One of the supplemental questions asked providers to expand on what Meridian Health Plan of Iowa could do to improve its services to its provider network. Of the 216 providers that initially participated in the survey, 90 providers expanded upon their ranking of satisfaction. After analyzing the verbatim response, six areas of improvement were identified by the providers. The leading area of improvement was related to finance issues at 19% (Claims Payment and Billing).

Top Six Areas for Improvement

| What can Meridian Health Plan of Iowa do to improve its service to your organization? | |
|---|-----|
| Claims Payment | 13% |
| Authorization Process | 10% |
| Plan Coverage | 10% |
| Health Plan Call Center | 10% |
| Billing/Credentialing | 6% |
| Provider Representatives | 4% |

Recommendations

After reviewing the data, Iowa has identified areas of strength and areas of improvement based on provider responses. In Iowa's initial year of participating in the Provider Satisfaction Survey process, the health plan received a 20% response rate. Iowa will continue to work with its vendor, TMG, to increase the number of response received. It may be of interest for Iowa to perform a cost-effectiveness analysis of utilizing e-mail as a survey tool, since many providers indicated that their preferred method of communication is via e-mail.

Throughout the course of the data review, different areas of improvement were identified by the providers: Finance Issues, Network/Coordination of Care, Health Plan Call Center Staff, and Utilization and Quality Management. To address Finance Issues, Meridian Health Plan of Iowa is looking to restructure the claims department by having a more fluent auto-adjudication process in order to reduce the amount of manual processes. Meridian will also continue to work with its payout vendor to ensure that all provider addresses are accurate and that payments are made on time.

Attachment 30 (Provider Satisfaction Analysis)

The Care Management Transformation Team (CMTT) is currently addressing the issues of Network/Coordination of Care and Utilization and Quality Management through strategic plans that will initiate action. Meridian Health Plan is taking a holistic and long-term view of Care Management in order to distinguish the areas of the current program that are successful and determine how to overcome the areas that are not functioning as anticipated. One aspect that may improve provider response regarding Network/Coordination of Care and Utilization and Quality Management is having personnel in Iowa that work directly with Iowa providers versus utilizing corporate staff. Similar to Network/Coordination of Care and Utilization and Quality Management, it would be beneficial to have provider service call center staff in Iowa to help manage the amount of questions providers may have regarding the health plan structure.

Conclusion

Meridian Health Plan of Iowa values the input of its providers. In July of 2014 Meridian utilized the Provider Satisfaction Survey as an opportunity to identify strengths and areas of improvement with the health plan. This being the baseline year for the Provider Satisfaction Survey, Iowa will utilize the information obtained and incorporate the input of the provider into strategic and actions plans to continue to better the health plan for the upcoming year. Overall, providers seemed relatively satisfied with the health plan.

Appendix

Verbatim Responses

| Q8. What can Meridian Health Plan of Iowa do to improve its service to your organization? |
|---|
| Alert patients that billing is different and patients need to present their new insurance card even though the ID# is the same as Meridian coverage. Patients do not understand that coverage is changed on Meridian. |
| To allow physicians to bill office visit care in the same manner as others. |
| We have a very specific problem. Meridian requires to break payments down. It does not do global billing. It makes it very difficult and time consuming. I would not recommend Meridian Health of Iowa to any OB/GYN. |
| Let me know how to bill them and how to bill Title 19 and how to tell the difference on the card. |
| Provide a user friendly portal for credentialing. |
| Currently right now, nothing. |
| I cannot think of anything. |
| I do not have any opinion on that. |
| I do not know. |
| I do not know. |
| I do not know. There is not a lot of people on that health plan. |
| I don't have any suggestions. |
| I have no idea. |
| I honestly cannot think of anything. |
| I really do not have any comment as we only see a few Meridian patients. |
| I think we are doing okay with them. |
| It is fine. No complaints. |
| No comment at this time. |
| Not aware of any problems. |
| Nothing at this time. |
| Nothing at this time. |
| Nothing comes to mind. |
| Nothing right now. |
| Nothing that I can think of at the moment. |
| Nothing that I can think of right off the bat. |
| Nothing that I can think of. |
| Nothing that I know of. |
| Nothing. |
| Nothing. |
| Nothing. |
| Nothing. I think they are fine. |
| Nothing. It is good. |
| Nothing. It's working fine. |
| That would be a question for the billing department. I don't know too much about it. |
| There isn't anything I can think of at the moment. |

| Q8. What can Meridian Health Plan of Iowa do to improve its service to your organization? |
|---|
| We are pretty satisfied with everything. |
| We have not been with them that long so I have no comment. |
| We have only recently become associated with Meridian and have only had patients assigned to us for approximately one month. I don't feel we have had substantial enough time to make suggestions at this time. |
| Better communication with the patients. |
| Continue to contact patients on our behalf. |
| I always have trouble with the call center. I would say have nicer and more helpful staff. |
| Make it easier to contact them. |
| Maybe make it a little easier to find out which patient has a care manager. |
| The process of calling customer service. Getting claims appeals and denials approved is not done in a timely manner. You also do not have a good relationship with your patients as half of them do not know they are on Meridian or what their process is. |
| Try to get the representative to give the correct information on eligibility and services. We had our front desk call and she was told that a patient of twenty one years of age did not need a prior authorization. When I called they told me she did need a prior authorization. |
| When I call I wish it was quicker to get through to someone, but every healthcare organization has that problem. |
| When we are directed to call for the patient's member physician, this is not essential and a waste of staff time. |
| They can start following the rules that the state of Iowa follows and not making them up. |
| They need more care for pregnant patients or acute care. They need possible rehab paid for. |
| They need to cover more services, mainly exams. |
| Cover chiropractic exam codes. |
| Increase the number of chiropractic visits patients in Iowa are allowed. Not everything can be fixed in 12 visits. |
| Increase visit limits for patients to be similar to Medicaid based on coding. |
| It would be nice for patients if it covered EMS and US therapies, as well as office visits and x-rays. |
| Just cover medications. |
| Speed the process of coverage. |
| I think that Meridian Health Plan could provide booklets to us on the plans it provides and its procedures so that patients could be more knowledgeable. |
| Information on third party coverage is not accurate. |
| Just as you require me to provide intimate details about my patients and require me to provide you with evidence based rationale for my treatment decisions. It is fair and reasonable for you to provide to me basis in evidence based medicine for decisions you make. |
| Let us be able to tell if the patients are eligible for replacement glasses online. |

| Q8. What can Meridian Health Plan of Iowa do to improve its service to your organization? |
|---|
| Need more experience. |
| Perhaps a phone call from a representative. |
| Provide what we need when we ask. |
| Speed up the referral process. Open up the specialists in Iowa without asking the person to go out of state to Minnesota. They want to stay in Iowa. |
| This survey will be flawed in that you are asking questions that a provider does not typically have the primary role in these knowledge/experience areas. |
| Better reimbursements. |
| I think one of our biggest issues is claims processing, it seems to take a while. We just had issues with getting providers on the plan as well. |
| Improve reimbursement. |
| Increase allowed fees for chiropractic care. |
| Increase reimbursement for deliveries. |
| Increase reimbursements. |
| Increase the amount of payment. |
| Increase the speed of secondary claims processing. |
| Reimbursement. |
| The only issue is the fee schedule because it is low but we understand because it is according to state guidelines and the processing of certain claims. When it involves certain procedures they bundle them when they should not. |
| We had a few patients that claims did not come back for a while. |
| We would like them to provide HEDIS bonuses when Meridian is secondary. Provide further education for customer service. |
| Allow for care or allow members to see a podiatrist without having to have LOPS. For example, all foot ulcers should be allowed to be treated by the podiatrist that has completed wound care training. |
| I know that I hear the staff often complain on how difficult it is to get a pre-authorization for procedures and the length of time it takes. |
| Increase the ease of approving needed medical care so care to our sick patients is not continually delayed. |
| Make the authorization process easier. |
| Online prior authorization system. |
| Pre-certification requirements are unreasonable for oncology specialty. |
| Quicker turnaround times on prior authorizations. |
| Sending OB claims. |
| When we call to get authorizations, they limit us to one or two approvals. Sometimes the patients need more than that, and I feel badly. We feel that it should be on a case by case, not just a "this is what you get". |
| Being more clear about treatment guidelines for patients limited visits. |
| The field representative is too much. The constant harassment on the phone is too much. Calling to talk with patients on the phone and we don't have time for that! |

Q8. What can Meridian Health Plan of Iowa do to improve its service to your organization?

To continue to have a provider representative stop by the office at all locations. I have enjoyed working with the provider representatives. They have been very helpful.

When we first went to a meeting, it was stated that a representative would visit monthly. Disappointed that did not happen.

Provider Satisfaction Survey

 **PHYSICIAN SATISFACTION SURVEY**

Answer all the questions by shading the circle with blue or black ink. Use this ●
 With the exception of Question F, all responses to this survey are kept confidential and only The Myers Group has access to them. If you want to know more about this study, please call The Myers Group at 1-800-682-0041.

Please answer the following questions about you and your practice:

E. Demographics Please mark who is completing the survey. (Check only one)

A. Please indicate your area of medicine. (Mark all that apply)

- Behavioral Health Clinician
- Primary Care
- Nurse
- Behavioral Health Clinician
- Other staff

B. How many physicians are in your practice?

- 0-20
- 21-50
- More than 50

C. How many years have you been in this practice?

- Less than 5 years
- 6 to 10 years
- 11 years or more

D. What portion of your managed care volume is represented by HEALTH PLAN?

- None
- 1-10%
- 11-20%
- 21-30%
- 31-50%
- 51-75%
- 76-100%

F. What is your preferred method of receiving communications from the health plan?

- Mail
- Telephone
- Fax
- On-site
- E-mail (Please indicate your e-mail address):
- In person from your Provider Representative
- Other

G. Please indicate the number of insurance companies with which you or your practice participates.

- 3 or fewer
- 4 to 7
- 8 to 11
- 12 to 15
- More than 15

Comparative Rating

This first question asks you to think about HEALTH PLAN in comparison to all of the other health plans that you work with.

1A. How would you rate HEALTH PLAN compared to all other health plans you contract with?

Very poor
 Poor
 Average
 Good
 Excellent

Financial Issues

These questions ask about financial issues. Please rate HEALTH PLAN in the following service areas when compared to your experience with other health plans you work with.

2A. Consistency of reimbursement fees with your contract rates.

2B. Accuracy of claims processing.

2C. Timeliness of claims processing.

2D. Resolution of claims payment problems or disputes.

Thank You

Please return the completed survey in the postage-paid envelope to:

The Myers Group
 PO Box 1077
 Dulon, GA 30090-0825
 Toll-Free: 1-800-682-0041



For Internal Purposes Only: 3666

Page 4

Page 1

Please continue inside

Utilization and Quality Management
These questions ask about Utilization and Quality Management. Please rate HEALTH PLAN in the following service areas when compared to your experience with other health plans you work with.

7A. Do you have a Provider Relations representative from this health plan assigned to your practice?
 Yes go to question 7B
 No go to question 7C

7B. Provider Relations representative's ability to answer questions and resolve problems.
 Very little average
 Little average
 Average
 More than average
 Very little average

7C. Quality of provider orientation process.
 Very little average
 Little average
 Average
 More than average
 Very little average

7D. Quality of written communications, policy bulletins, and manuals.
 Very little average
 Little average
 Average
 More than average
 Very little average

Overall Satisfaction
These questions ask about your overall satisfaction with HEALTH PLAN. Additionally, please rate your satisfaction with the other plans listed and provide feedback on how HEALTH PLAN can improve.

8A. Would you recommend HEALTH PLAN to other physicians' practices?
 Yes
 No

Please rate your overall satisfaction with each of the following health plans:

8B. HEALTH PLAN
 Completely Satisfied
 Satisfied
 Somewhat Satisfied
 Somewhat Dissatisfied
 Dissatisfied
 Completely Dissatisfied

8C. COMPETITOR #1
 Completely Satisfied
 Satisfied
 Somewhat Satisfied
 Somewhat Dissatisfied
 Dissatisfied
 Completely Dissatisfied

8D. COMPETITOR #2
 Completely Satisfied
 Satisfied
 Somewhat Satisfied
 Somewhat Dissatisfied
 Dissatisfied
 Completely Dissatisfied

8E. COMPETITOR #3
 Completely Satisfied
 Satisfied
 Somewhat Satisfied
 Somewhat Dissatisfied
 Dissatisfied
 Completely Dissatisfied

8F. COMPETITOR #4
 Completely Satisfied
 Satisfied
 Somewhat Satisfied
 Somewhat Dissatisfied
 Dissatisfied
 Completely Dissatisfied

9. What can HEALTH PLAN do to improve its service to your organization?

Page 2 Please continue on back

Attachment 30 (Provider Satisfaction Analysis)

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Attachment 31 (Quality KPIs)

| Goal/Objective/KPI | 1/16 | 1/30 | 2/13 | 2/27 | 3/13 | 3/27 | 4/10 | 4/24 | 5/8 | 5/22 | 6/5 | 6/19 | 7/3 | 7/17 | 7/31 | 8/14 | 8/28 | 9/11 | 9/25 | 10/9 | 10/23 | 11/6 | 11/20 | 12/4 | 12/18 | Notes |
|--|------|------|------|------|------|------|------|------|-----|------|-----|------|-----|------|------|------|------|------|------|------|-------|------|-------|------|-------|-------|
| 1) Prioritize HEDIS, Star Ratings, and consumer and provider surveys to sustain and achieve excellence in all areas of quality. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>a. Reprioritize HEDIS measures to first account for financial impact, then accreditation status, and ratings at the start of 2015. Consider state-level impact potential in prioritization. Develop and implement operational reports reflective of the new prioritization and true work effort</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>b. Continue best practices for monitoring HEDIS. Set process and outcome metrics for outreach initiatives both existing and new.</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2) Collaborate with stakeholders and community partners to accomplish annual goals. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>a. Support inquiries into the characterization of Meridian membership. Consider academic partnerships to support sustain prospective population observation. Outreach to the University of Michigan and other potential state partners within the first quarter of 2015.</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3) Establish an integrated quality system leveraging state and corporate resources to maximize efficiency and effectiveness. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>a. As part of an effort to move toward EDI for all HEDIS data, set a prioritization list for electronic medical record access for each state. Outreach to health systems and clinics comprising 40% of each state's membership by end of year</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>b. Identify health information exchange (HIE) readiness by state. Determine structure of exchange, legislative parameters for third-party payer access, health plans with access, and level of health system participation by EOY.</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4) Set standards for operations including core functions, delineation of corporate and state responsibilities, and expectations for communication and state reporting. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>a. Develop standard document templates. Establish publication schedule for use in producing outcomes and state-required reports presented to the QIC by end of 1st Quarter.</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>b. Streamline use of position descriptions. Determine which positions are necessary to carry out core functions, responsibilities of corporate and state staff, and how the department interacts with other departments throughout the organization.</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5) Recognize the need for annual planning, strategic and budgetary, accounting for population change (including lines of business), shifts in contractual, NCQA or other requirements, and draft a continuous plan for reference for the department. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>a. Publish annual strategic plan and accompanying work plans- both corporate and state</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>b. Examine per member spend by state. Consider state requirements and limitations for incentives. Anticipate budget fluctuations based on new lines of business and changes to attribution</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6) Develop a uniform perception of need; consider whether business units are scalable and agile. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>a. Support corporate expansion efforts by providing quality outcomes data and other evidence as needed. Assess department needs required to adequately staff new lines of business.</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |

Attachment 31 (Quality KPIs)

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Meridian Health Plan: Iowa QI Work Plan 2014

| Standard | Activities | Associated Goals/Objective | Required Documents | Responsible Person | Target Date | State Deliverable | Frequency | Committee |
|---|---|--|---|--|---|-------------------|-----------|-----------|
| QI 3- Program Structure The organization clearly defines its quality improvement (QI) structures and processes and assigns responsibility to appropriate individuals SFY 2012: V 12.15.11 Pg 51-54; SFY 2012: V 12.15.11 Pg 57; Pg 102 | Annual review of QI Program | Evaluate QI program, identify changes and needed resources. | 2014 QI Program (QIP) Description, Evaluation | QI Coordinator | 4/15/2015 | 7/31/2015 | Annually | QIC |
| QI-1-Program Structure SFY 2012: V 12.15.11 Pg 51 | Annual Review and Updates of Quality Policies/Procedures/desk level aids | Ensure compliance with accreditation and state requirements. | QI Policies and Procedures | QI Director | 7/1/2015 | Yes | Annually | QIC |
| QI-1-Program Structure: SFY 2012: V 12.15.11 Pg 52-55; Pg 57, Pg 102 | Quarterly review of QI Work Plan | Timely completion of QI activities. | 2014 QI Work Plan | QI Coordinator | 1/2/2015 4/1/2015 7/1/2015 10/1/2015 | No | Quarterly | QIC |
| QI-1-Program Structure | Review/Revise QIC Roster | To ensure that the list of attendees/contacts is current for Quality Improvement Committee Activities. | QIC Roster | Corporate QI | 1/9/2015 | No | Annually | QIC |
| QI-1-Program Structure | Information in member handbook | To improve member health. | Member handbook | QI Director and Corporate QI, Director of Operations | N/A | No | Ongoing | N/A |
| QI-1-Program Structure | Information in member newsletter | To improve member health. | Member newsletter | QI Coordinator, Corporate QI | 10/1/2015 | No | Annually | N/A |
| QI-1-Program Structure | Information in member section of website | To improve member health. | MHP website | QI Coordinator, Corporate QI | 10/1/2015 | No | Ongoing | N/A |
| QI-1-Program Structure | Include safety assessment in HRAs | To improve member health. | Health risk assessment | Member Services/Utilization Mgmt. Outreach Staff | N/A | No | Ongoing | N/A |
| QI-1-Program Structure | Annual - HIPAA Compliance Training | Continued Awareness and Compliance | | Compliance | 6/1/2015 | No | Annually | |
| QI-1-Program Structure | Annual - Fraud, Waste and Abuse Annual Updated Training | Continued Awareness and Compliance | | Compliance | 12/31/2015 | No | Ongoing | |
| QI-1-Program Structure | Annual Review of the FWA/Compliance Policies/Procedures/Desk Level Aids | Obj. Continued Updates/Improvements for Compliance | | Compliance | 12/31/2015 | No | Ongoing | |
| QI 2- Program Operations | | | | | | | | |
| QI-2-Program Operations | Make information about QI Program available to providers | To ensure proper QI program oversight, input, and communication from MHP practitioners. | Provider manual, news letter, & link on website | QI Department | 6/30/2015 | No | Ongoing | N/A |
| QI-2-Program Operations | Report QI program information to Board of Directors | Report QI program information to BOD | QIC Summary for BOD | QI Coordinator | 2/6/2015 5/1/2015 8/3/2015 11/2/2015 | No | Quarterly | BOD |
| QI-2-Program Operations | Make information about QI Program available to members | To ensure that members are aware of MHP initiatives to improve preventive health and quality. | Member handbook, newsletter, & link on website | QI Department | 6/30/2015 | No | Ongoing | N/A |
| QI 4- Availability of Practitioners | | | | | | | | |
| QI-4- Availability of Practitioners | Assess the cultural, ethnic, racial and linguistic needs of members | To ensure that the organization's network meets the cultural, racial and linguistic needs of members. | CLAS Analysis | QI Coordinator | 3/1/2015 | No | Annually | QIC |
| QI 4- Availability of Practitioners | Analyze performance against standards for number and geographic distribution of each type of practitioner | Geographic Standards: PCP, SPC, and BH Practitioner within 30 minutes drive; Practitioner to member ratios: 1 : 750 members for PCP or 2 within each county; 1: 3,000 for SPC; 1: 3,000 or 2 within each county for BH | Network Availability Analysis (ratio and geo-access) | QI Coordinator/Provider Services | 6/30/2015 | No | Annually | QIC |
| QI 5- Accessibility of Services | | | | | | | | |
| QI 5- Accessibility of Services | Appointment Availability Audit and Analysis | Preventive adult: 30 days; child <18 mos: 2 weeks; child >18 mos: 30 days; Urgent: 24 hours; ER: Immediate. Wait time < 60 minutes. <6 apts/ hour/ provider; PN 1st and 2nd Tri 7 days, 3 and High Risk 3 days | Member Access Evaluation MCO Contract V 5.13(e)-(1), CFR 438.206 (b)(6), QIS: Element A | QI Coordinator | 6/24/2015 10/24/2015 - follow-up for failed providers | | Annually | QIC |

Meridian Health Plan: Iowa QI Work Plan 2014

| Standard | Activities | Associated Goals/Objective | Required Documents | Responsible Person | Target Date | State Deliverable | Frequency | Committee |
|--|---|--|--|--------------------------------|--|-------------------|-------------|-----------|
| QI 5-Accessibility of Services | After-Hours Access Audit and Analysis | Available 24 hours/day, 7 days/week. | Member Access Evaluation | QI Coordinator | 6/24/2015 10/24/2015 - follow-up for failed providers | No | Annually | QIC |
| QI 5-Accessibility of Services | CAP Monitoring and Reporting | To ensure access to primary care services and member services. | Corrective Action Plan Letters/Excel Tracker | QI Coordinator | 12/31/2015 | No | Ongoing | QIC |
| QI 5-Accessibility of Services | Monthly Credentialing Committee | Review providers up for re-credentialing | | Credentialing | 12/31/2015 | No | Monthly | |
| QI 6- Member Satisfaction/Quality of Service | Member Advisory Committee and Focus Group | 4 MAC meetings per year | MAC Summary report to QIC | QI Department | 1/2/2015-4/1/2015 7/1/2015 10/1/2015 | No | Quarterly | N/A |
| QI 6- Member Satisfaction/Quality of Service (This is RR standard) | Monitor web satisfaction survey | To monitor member satisfaction with its services and identify areas of potential improvement. | Web based provider directory usability testing study results | QI Department | 12/31/2015 | No | Ongoing | QIC |
| QI 6- Member Satisfaction/Quality of Service-CAHPS | Timeline received from Morpace (CAHPS Vendor) | Timely reporting of CAHPS to State and NCOA | CAHPS Timeline | Corporate QI | 11/1/2014 | No | Annually | N/A |
| QI 6- Member Satisfaction/Quality of Service-CAHPS | Touchstar CAHPS Campaign | Inform members of possible survey, encourage members to complete survey. | Touchstar CAHPS Script | Corporate QI | 2/1/2015 | No | Annually | N/A |
| QI 6- Member Satisfaction/Quality of Service-CAHPS | CAHPS Data to NCOA and State | Meet CAHPS reporting deadline to NCOA and State | IDSS | Corporate QI | 6/8/2015 | 6/8/2015 | Annually | N/A |
| QI 6- Member Satisfaction/Quality of Service-CAHPS | Final report received from Morpace (CAHPS Vendor) | NA | MHP Final CAHPS Report | Corporate QI | 6/1/2015 | No | Annually | N/A |
| QI 6- Member Satisfaction/Quality of Service-CAHPS | CAHPS Provider Education | Educate providers on CAHPS and customer service. | CAHPS Provider Education Piece. (HEDIS Work Plan) | Corporate QI | 12/31/2014 | No | Bi-annually | N/A |
| QI 6- Member Satisfaction/Quality of Service-CAHPS | CAHPS Employee Education | Educate employees on CAHPS and customer service. | CAHPS educational pieces | Corporate QI | 2/16/2015 | No | Annually | N/A |
| QI 6- Member Satisfaction/Quality of Service-CAHPS | CAHPS Annual Employee Training | Educate employees on CAHPS and customer service. | CAHPS Annual Employee Training Presentation & Materials | Corporate QI | 1/15/2015 | No | Annually | N/A |
| QI 6- Member Satisfaction/Quality of Service | Analysis of member satisfaction | < 0.20 complaints per 1,000 member months, appeals, CAHPS, and MAC/FGs | Member Satisfaction Performance Evaluation | QI Coordinator | 1/2/2015-4/1/2015 7/1/2015 10/1/2015 | No | Quarterly | QIC |
| QI 7- Complex Case Management | Annual review of CM Program | To evaluate the initiatives that MHP has coordinated for members with complex conditions to ensure that they have access to needed services. | | Utilization Management Analyst | 1/10/2015 | No | Annually | UMC |
| QI 7- Complex Case Management | Medicaid Annual Population Assessment | To evaluate the entire population and those in Complex Case Management to determine if there are any substantial changes in enrollment. | Annual Population Assessment Analysis | Corporate QI | 8/1/2015 | No | Annually | QIC |
| QI 8- Disease Management | Annual review of DM Program documents | To improve the health status of members with chronic conditions by evaluating initiatives and health outcomes. | Asthma Program Description, Diabetes Program Description, CVD Program Description, COPD Program Description, CHE Program Description | QI Coordinator; Corporate QI | 2/1/2015 | 7/1/2015 | Annually | QIC |
| QI 8- Disease Management | Annual review of stratification logic | To ensure that the members with varying levels of chronic conditions are treated appropriately. | Strat logic | Corporate QI, QI Director | 5/31/2015 | No | Annually | N/A |
| QI 8- Disease Management | Provide eligible members with info. about program | To improve the health status of members with chronic conditions by educating them about available resources. | DM information on Web site; DM program information in member newsletter. | QI Coordinator | N/A | No | Ongoing | N/A |
| QI 8- Disease Management | Inform Providers about DM Program | To improve the health status of members with chronic conditions by educating providers on the appropriate treatments and options available to MHP members. | Provider Bulletins | QI Coordinator | N/A | No | Ongoing | N/A |
| QI 8- Disease Management | Annual review of DM Program Evaluation | To improve the health status of members with chronic conditions by evaluating initiatives and health outcomes. | DM Program Evaluation | QI Coordinator | 7/1/2015 | No | Annually | QIC |

Meridian Health Plan: Iowa QI Work Plan 2014

| Standard | Activities | Associated Goals/Objective | Required Documents | Responsible Person | Target Date | State Deliverable | Frequency | Committee |
|--|--|--|--|---|------------------------|-------------------|-----------|-----------|
| QI 8- Disease Management | Assess member satisfaction of DM Programs | To monitor member satisfaction with Disease Management services and identify areas of potential improvement. | DM Program Surveys | QI Coordinator | 7/31/2015 | No | Annually | N/A |
| QI 8- Disease Management | New Member Mailings | To improve the health status of members with chronic conditions by educating them about available resources and appropriate steps to manage the condition(s). | New member mailings | QI Coordinator | N/A | No | Monthly | N/A |
| QI 8- Disease Management | Strat Mailings | To improve the health status of members with chronic conditions by educating them about available resources and appropriate steps to manage the condition(s). | Strat mailings | QI Coordinator | N/A | No | Quarterly | N/A |
| QI 8- Disease Management | Newsletter | To improve the health status of members with chronic conditions by educating them about available resources and appropriate steps to manage the condition(s). | DM Newsletters | QI Coordinator | 1/15/2015 6/15/2015 | No | 2/ year | N/A |
| QI 8- Disease Management | Telephonic Outreach | To improve the health status of members with chronic conditions by educating them about available resources and appropriate steps to manage the condition(s). | NA | QI Intern Team | N/A | No | Ongoing | N/A |
| QI 8- Disease Management | Health Risk Assessments | To identify member health status, health care needs, and educational needs in an attempt to improve their overall health status. | NA | Member Services/Utilization Mgmt./Care Coordination Staff | N/A | No | Ongoing | N/A |
| QI 8- Disease Management | Annual review of DM materials on website | To update all DM materials/information available to members and providers across all states and LOB | NA | QI Coordinator, Corporate QI | 2/15/2015 | No | Annually | N/A |
| QI 9- Clinical Practice Guidelines QI 9- Clinical Practice Guidelines SFY 2012: V 12.15.11 Pg 53 | Disseminate CPGs to providers, Quarterly review Clinical Practice Guidelines | The organization is accountable for adopting and disseminating clinical practice guidelines relevant to its members for the provision of nonpreventive acute and chronic medical services and for preventive and nonpreventive behavioral health services. | Provider education pieces: Well-Child, Tobacco Cessation, & Comprehensive Diabetes Care; Link to MQIC Guidelines on MHP website, MQIC CPGs | Corporate QI, QI Coordinator | N/A | No | Quarterly | QIC |
| QI 10- Continuity and Coordination of Medical Care | | | | | | | | |
| QI 10- Continuity and Coordination of Medical Care | Annual analysis of all medical care coordination activities | To improve continuity and coordination of care across the health care network. | Annual Continuity and Coordination of Medical Care Analysis | QI Coordinator | 9/30/2015 | No | Annually | QIC |
| QI 10- Continuity and Coordination of Medical Care | Allegiance-ER Case Management-Program-QIA | To improve continuity and coordination of care across the health care network. | Allegiance-ER Case Management-QIC | Utilization Management | N/A | No | Ongoing | N/A |
| QI 10- Continuity and Coordination of Medical Care | Provider Satisfaction Survey QIA | To improve continuity and coordination of care across the health care network. 80% Satisfaction | PCP Satisfaction Survey Results | Provider Services, QI Coordinator | 7/31/2015 | No | Annual | QIC |
| QI 10- Continuity and Coordination of Medical Care | Coordination of Medical Care-QIA | To improve continuity and coordination of care across the health care network. | Coordination of Medical Care-QIA | QI Coordinator | 9/30/2014 | No | Annual | QIC |
| QI 10- Continuity and Coordination of Medical Care | High Risk Assessments/Prenatal Surveys for Cultural Tracking and Trend - Care Coordination | To track and trend results from standard assessments | | Care Coordination | 7/1/2015 | 7/30/2015 | Ongoing | |
| QI 10- Continuity and Coordination of Medical Care | Annual Cultural-Linguistic Staff Training - Care Coordination | To provide awareness on cultural/linguistic variances | | Training | 7/1/2015 | 7/30/2015 | Annual | |

Meridian Health Plan: Iowa QI Work Plan 2014

| Standard | Activities | Associated Goals/Objective | Required Documents | Responsible Person | Target Date | State Deliverable | Frequency | Committee |
|--|---|--|---|--|---|------------------------|-----------------|------------|
| QI 10- Continuity and Coordination of Medical Care | Member transition to other care when benefits end | To improve continuity and coordination of care across the health care network. | Redetermination and Disenrollment campaigns; BH staff assisting members with CMH when they reach 20 outpatient visit benefit limit. | Member Services, Care Coordination | N/A | No | Ongoing | N/A |
| QI 11- Continuity and Coordination between Medical Care and Behavioral Healthcare | Postpartum depression screenings | 80% of women who delivery are screened for post partum depression | Postpartum depression screening QIA | Care Coordination, QI Coordinator | 6/30/2015 | No | Annually | QIC |
| QI 11- Continuity and Coordination between Medical Care and Behavioral Healthcare | Review BH referral process | To identify and appropriately refer members to Magellan | | QI Department | 6/30/2015 | No | Annually | N/A |
| Iowa Medicaid Contract Compliance | | | | | | | | |
| SFY 2012: V.12.15.11 Pg 37 | EPSDT Reporting, included in the Annual Report. | 80% of recipients under age 21 must receive EPSDT screenings | EPSDT Report and all supporting materials | QI Department, Director of Operations | 7/31/2015 | 7/31/2015 | Annually | QIC |
| SFY 2012: V.12.15.11 Pg 53 (Section 4.20.1) | QI Activities for review by the Department no later than 30 days following the Quarterly QIC meeting. | Provide to State | QIC Documents | QI Department | 2/24/2015 5/26/2015 8/25/2015 11/24/2015 | Yes | Annually | QIC |
| SFY 2012: V.12.15.11 Pg 38 | Immunizations, included in the Annual Report | 90% by age 2 95% by age 6 | Site Visit Tool | QI Department | 6/30/2015 | Yes | Annually | N/A |
| SFY 2012: V.12.15.11 Pg 52 | Member notification of cancer screenings | Notify members in writing of cancer screenings covered by MCO and provide the current US Task Force Cancer guidelines for all cancer screenings | | QI Department | 2/1/2015 | Yes | Annually | N/A |
| SFY 2012: V.12.15.11 Pg 52; Pg 82 | Enrollee Special Needs Care Coordination | Assess each member identified as having special health care needs, ensure course of treatment and care monitoring is maintained. | Final approved P&Ps for QI & UM | QI Department | 6/1/2015 | Yes | Annually | N/A |
| SFY 2012: V.12.15.11 Pg 30 | WIC Referrals and Education Care Coordination | Refer all pregnant women, infants and children up to the age 5 to the WIC program in the service area, and inform the Enrollee of eligibility for this program | HEDIS IDSS | Care Coordination, Member Services | 7/1/2015 | Yes | Annually | N/A |
| SFY 2012: V.12.15.11 Pg 97 | Summary of QI and Health Education and Prevention Program submitted to the State | Provide to State | Member newsletter, member handbook | QI Director, Director of Operations | 3/25/2015 | 4/1/2015 | Annually | N/A |
| SFY 2012: V.12.15.11 Pg 97 | Semi-annual Report of QI Activities to maintain accreditation | Provide to State | | QI Director | 1/23/2015 7/23/2015 | 1/30/2015 7/30/2015 | 2/year | |
| CR6- Practitioner Office Site Quality | Performance Improvement Projects and Performance Measures | Submission of PIP's and PMS to EQRO in preparation of Annual Site Visit | PIPS and PMS | QI Director | 4/29/2014 | 5/6/2014 | Annually | |
| CR 6 | Complaint monitoring | Monitor complaints against provider offices (D9 complaints) | Complaint Monitoring Report | QI Coordinator | Quarterly | No | Quarterly | QIC |
| CR 6 | Site Visits in Response to D9 complaints | To assess the quality, safety, and accessibility of office sites where care is delivered. | Corporate site Visit Survey Form | QI Coordinator | N/A | No | As Needed | QIC |
| RR4I- Usability Testing | | | | | | | | |
| RR 4 I | Web based Provider Directory - Usability Testing | To evaluate web-based physician and hospital directories for understandability and usefulness to members and prospective members, considering the following: *Font Size *Reading Level *Content Organization *Ease of Navigation *Languages (if applicable) | Documented Testing Process, Reports, and Results. | QI Department | 12/31/2015 | No | Annual | QIC |
| HEDIS Reporting | | | | | | | | |
| HEDIS Reporting | Data Collection | Support HEDIS Reporting | HEDIS MR training materials | Corporate QI | N/A | No | Ongoing | N/A |

Meridian Health Plan: Iowa QI Work Plan 2014

| Standard | Activities | Associated Goals/Objective | Required Documents | Responsible Person | Target Date | State Deliverable | Frequency | Committee |
|--|---|--|---|---|-------------|-----------------------|-----------|-----------|
| HEDIS Reporting | Provider HEDIS faxing | Support HEDIS Reporting | | QI Department | N/A | No | Ongoing | N/A |
| HEDIS Reporting | Supplemental data training, Supplemental data employee IRR, audit | Goal: 80% Accuracy for consistent data entering | Supplemental data training materials, IRR Results (to HEDIS auditor) | QI Department | N/A | No | Quarterly | N/A |
| HEDIS Reporting | Prepare and submit HEDIS Roadmap | Support HEDIS Reporting | HEDIS Roadmap | HEDIS Manager | 2/21/2015 | 2/28/2015 | Annually | N/A |
| HEDIS Reporting | Onsite HEDIS Audit | Support HEDIS Reporting | HEDIS Compliance Audit Report | Corporate QI | 2/7/2015 | 8/1/2015 | Annually | N/A |
| HEDIS Reporting | Complete & Submit HEDIS rates to HEDIS Auditor via IDSS- Plan Lock Date | Support HEDIS Reporting | IDSS | HEDIS Manager | 6/8/2015 | No | Annually | N/A |
| HEDIS Reporting | Complete & Submit Audited HEDIS to NCOA via IDSS | Support HEDIS Reporting | IDSS | HEDIS Manager | 6/15/2015 | No | Annually | N/A |
| HEDIS Reporting/Iowa Medicaid Contract 1.042A(4) | Send auditor locked IDSS to MDCH Contract Manager | Support HEDIS Reporting | CSV and XML auditor locked IDSS in CD format, along with a hard copy of the signed IDSS attestation. | HEDIS Manager | 6/30/2015 | 7/1/2015 | Annually | N/A |
| Clinical Quality Improvement/Outreach | | | | | | | | |
| Clinical Quality Improvement/Outreach | HEDIS Work Plan, Member mailings/Educational postcards | To maintain all member, provider, and employee HEDIS education, along with member mailings, state approvals, and due dates | 2014 HEDIS Work Plan | QI Department | N/A | No | Annually | HEDIS |
| Clinical Quality Improvement/Outreach | HEDIS Employee Education | To Promote Staff Knowledge of HEDIS | 2014 HEDIS Work Plan and HEDIS Employee Education Portal | HEDIS Coordinator | N/A | No | Weekly | HEDIS |
| Service Improvement | HEDIS Week | To Promote Staff Knowledge of HEDIS and CAHPS, with an emphasis on customer service. | HEDIS Week schedule and budget | Corporate QI | 7/11/2015 | No | Annually | HEDIS |
| Clinical Quality Improvement/Outreach | New Member Mailings | To educate members on Doctor appointments, healthy lifestyle before pregnancy, flu information | Preconception Brochure, flu flyer, What to Expect at a PCP Appt, Common Questions to Ask when at Your Dr. Appts | | N/A | No | Ongoing | |
| Clinical Quality Improvement/Outreach | Member Outreach campaigns | To engage and educate members in their health care: focus on preventive health. | | Corporate QI; QI Student Intern Team | N/A | No | Ongoing | QIC |
| Clinical Quality Improvement/Outreach | Weight Management program for members | To provide follow-up for all members enrolled in MHP's Weight Watchers® program to ensure compliance and overall weight loss | | Disease Management, Nutrition Coordinator | 12/31/2015 | No | Ongoing | |
| Clinical Quality Improvement/Outreach | Weight Management program for members | Educate members on nutrition and healthy food choices | Glaxo Smith Kline mailing pieces that educate healthy lifestyles/diet/nutrition | Quality Improvement Care Coordination | 12/31/2015 | No | Ongoing | |
| Clinical Quality Improvement/Outreach | Member Incentives | To engage and educate members in their health care: focus on preventive health. | H:\Marketing\Active Files\Meridian IOWA.zip\Meridian IOWA\BI-Folds; HEDIS Work Plan | QI Coordinator; QI Director | N/A | No | Ongoing | HEDIS |
| Clinical Quality Improvement/Outreach | Provider educational pieces | To promote practitioner adherence to evidence based clinical and preventive health guidelines. | HEDIS Work Plan- Provider Education | QI Coordinator | N/A | No | Monthly | HEDIS |
| Clinical Quality Improvement/Outreach | Provider incentive program | To promote practitioner adherence to evidence based clinical and preventive health guidelines. | Provider Bonus Summary (MHP Website) | Provider Services, QI Director | 1/1/2015 | No | Annually | HEDIS |
| Service Improvement | Administer MHP Participation in Community Events | To promote health education within the communities Meridian services; to build partnerships with community resources. | H:\Quality Management\Community Events and Partnerships\2012 | QI Coordinator | N/A | 3/1/14 (EPSDT report) | Ongoing | HEDIS |
| Service Improvement | Quality of Care Grievance Monitoring and Reporting | To ensure members receive quality services and take action against practitioners with quality of care issues. | Quality of Care Summary | Medical Management | N/A | No | Quarterly | QIC |
| Quality Improvement Activities | | | | | | | | |
| | | Refer to QI10 and QI11 Activities and Iowa Medicaid Contract Compliance | | | | | | |

Meridian Health Plan: Iowa QI Work Plan 2014

| Standard | Activities | Associated Goals/Objective | Required Documents | Responsible Person | Target Date | State Deliverable | Frequency | Committee |
|------------------------------|--|--|------------------------|--------------------|-------------|-------------------|-----------|-----------|
| Clinical Service Improvement | Comprehensive Diabetes Care | Improve Care for members ages 18-75 with Type 1 or Type 2 Diabetes. *BP Control <140/90- 50th Percentile *Eye Exams- 75th Percentile *HbA1c Testing-75th/90th Percentile *LDL Screening-75th/90th Percentile *Medical Attention for Nephropathy--75th/90th NCOA Medicaid 90th percentile | DM Program; HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Controlling High Blood Pressure | NCOA Medicaid 75th percentile | DM Program; HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Use of Appropriate Medication for People with Asthma | NCOA Medicaid 75th percentile | DM Program; HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Childhood Immunizations | Improve childhood immunizations among members turning 2 during the measurement year. Performance goal is NCOA Medicaid 75th/90th percentile | HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Breast Cancer Screening | Goal: To reach the 75th/90th percentile for BCS | HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Cervical Cancer Screening | Goal: To reach the 75th/90th percentile for CCS | HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Lead Screening | Goal: To reach the 75th/90th percentile for LSC | HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Chlamydia Screening in Women | Goal: To reach the 75th/90th percentile for CHL | HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Well Child Visits | Improve well child care among members age birth to 15 months, 3-6 years old, and 12-21 years old. Performance goal is NCOA Medicaid: *15 months-75th/90th percentile *3 6 years-75th/90th percentile *12-21 years--75th/90th percentile | HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Access to Care Child | Improve access to care among members age 12-24 months, 25 months--6 years, 7-11 years, and 12-19 years. Performance goal is NCOA Medicaid: *12-24 months- 75th/90th percentile *25 mons-6 years- 75th/90th percentile *7-11 years- 75th/90th percentile *12 19 years--75th-90th percentile | HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Access to Care Adult | Improve access to care among members age 20-44 years and 45-64 years. Performance goal is NCOA Medicaid: *20-44 years- 75th/90th percentile *45-64 years- 75th/90th percentile | HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Prenatal and Postpartum Care | Improve prenatal and postpartum care. Performance goal is NCOA Medicaid 75th/90th percentile | HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Immunizations for Adolescents | Improve immunizations for members turning 13 during the measurement year. *IMA-- 75th/90th percentile. *HPV-- 75th/90th percentile | HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Body Mass Index (BMI) Measurement | Ensure providers are calculating a BMI/BMI Percentile at each office visit and advising patients as needed. * Adult BMI- 75th/90th percentile (goal) *Child BMI- 75th/90th percentile (goal) | HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |
| Clinical Service Improvement | Appropriate Treatment for Children with URI | 50th percentile | HEDIS IDSS | QI Department | 6/8/2015 | No | Annual | QIC |

Meridian Health Plan: Iowa QI Work Plan 2014

| Standard | Activities | Associated Goals/Objective | Required Documents | Responsible Person | Target Date | State Deliverable | Frequency | Committee |
|---------------------------------------|--|--|--|--|---|-------------------|-----------|-----------|
| | Quarterly Physician Advisory Committee for updates, review and approval of the Medical Policies and Clinical Practice Guidelines | Continuously review for updates | | Care Coordination, Medical Director | 1/2/2015 4/1/2015 7/1/2015 10/1/2015 | No | Quarterly | PAC |
| Quality Improvement Operations | | | | | | | | |
| N/A | Member Handbook Auditing | Audit Member handbook on a monthly basis to ensure QI portion displays accurate information. | Auditing checklist | QI Department | N/A | No | Ongoing | N/A |
| QIC | | | | | | | | |
| N/A | Quarterly Reporting for QIC Oversight | QIC Approval | HEDIS Report, DM Report, CC Report, MAC Summary, QI Work Plan Summary | QI Coordinator | 1/24/2015 4/24/2015 7/24/2015 10/24/2015 | No | Quarterly | QIC |
| N/A | Annually Reporting for QIC Oversight | QIC Approval | Member Satisfaction Results, Provider Satisfaction Results, Geo-Access Report, CLAS | QI Coordinator | 1/24/2015 | No | Annually | QIC |
| Annual Report | | | | | | | | |
| Annual Report | DM Program Evaluation Included in Annual Report | Define DM Barriers and Goals | Asthma Program Description, Diabetes Program Description, CVD Program Description, COPD Program Description, CHE Program Description | QI Director | 7/31/2015 | | Annually | |
| Annual Report | CM Program Evaluation Included in Annual Report | Define CM Barriers and Goals | CM Program Description | QI Director | 7/1/2015 | | Annually | |
| Annual Report | Annual Reporting of Member Satisfaction results | | Member Satisfaction Results | QI Director | 7/1/2015 | | Annually | |
| Annual Report | EPSDT Reporting, included in the Annual Report | 80% of recipients under age 21 must receive EPSDT screenings | Quality Improvement Claims | QI Director | 7/1/2015 | | Annually | |
| Annual Report | Immunizations, included in the Annual Report | 90% by age 2 95% by age 6 | Quality Improvement Claims | QI Director | 7/1/2015 | | Annually | |
| Annual Report | Annual evaluation of Cultural Competency for Annual Report - Care Coordination | Identify barriers and goals | | QI Director, Care Coordination | 7/1/2015 | | Annually | |
| Annual Report | Weight Management program for members included in the Annual Report | Provide follow-up for all members enrolled in MHP's Weight Watchers® Program to ensure compliance and overall weight loss | | Care Coordination, Nutrition Coordinator | 7/1/2015 | | Annually | |
| Annual Report | Annual report of high volume specialists for Geo-Access Analysis to be included in the Annual Report | Geographic Standards: PCP, SPC, and BH practitioner within 30 minutes drive; Practitioner to member ratios: 1 : 750 members for PCP or 2 within each county; 1: 3,000 for SPC; 1: 3,000 or 2 within each county for BH | Network Availability Analysis (ratio and geo-access) | QI Director | 7/1/2015 | | Annually | |
| Annual Report | Pre-Visit Information Forms | Complete forms necessary prior to the EORRO onsite visit | PIPs and PMs | QI Director | 5/6/2015 | | Annually | |
| Medicaid Expansion | | | | | | | | |
| Medicaid Expansion | Review Requirements and establish a process for tracking data in 2014 | Identify action plan and deliverables, if applicable | Summary and action plan if applicable | QI Director and Coordinator | 8/31/2014 | No | | |

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**Meridian Health Plan
HEDIS 2015 (Hybrid)
Operations Report (Medicaid)**

- This Operations Report is inclusive of state performance, accreditation and ranking measures as defined by state contracts or NCQA.
 - Iowa does not currently have any state performance bonus measures.
- Benchmarks for Ranking Percentiles reflect the most current Rankings/Quality Compass percentiles without any regional adjustments.
- Benchmarks for Accreditation Percentiles reflect NCQA Accreditation percentiles for HEDIS 2015.
- Measures with denominators of less than 30 are marked as “NA.”
- Operations report tables reflect HEDIS 2015 hybrid data. Hybrid data will be displayed in these tables until reporting to NCQA in May.
- Trend line graphs reflect current HEDIS 2016 administrative rates.
- “HEDIS 2016 Trending to Reach by End of Year” table displays the percentile each measure is currently projected to reach.
 - A trajectory reaching a percentile by the end of the year does not guarantee the percentile will be reached.
- Additional state-specific information is available. Please contact state or corporate quality staff if needed.
- Administrative measures are still undergoing testing. Because of this there may be changes reflected in the next report.

Meridian Health Plan
 HEDIS 2015
 Reported on 04/06/2015

| Michigan | | | | | | | | | | |
|--|-------------------|--------|------------|-----------|--------------------|-----------|------------------|------------------------------|------------------------------|--------------------------|
| HEDIS Measure | Collection Method | Hits | Population | 2014 Rate | Ranking Percentile | 2013 Rate | % Difference YTD | % Change from previous month | Regional Adjustment Factor | Accreditation Rates |
| | | | | | | | | | | Adjusted Rate |
| | | | | | | | | | | Accreditation Percentile |
| Pediatric Care | | | | | | | | | | |
| Childhood Immunizations - Combo 2 | A, H | 341 | 432 | 78.94% | 50th | 84.72% | -5.78% | 0.46% | 78.94% | 50th |
| Childhood Immunizations - Combo 3 | A, H | 321 | 432 | 74.31% | 50th | 80.09% | -5.78% | 0.69% | Not an Accreditation Measure | 50th |
| Childhood Immunizations - Combo 10 | A, H | 362 | 432 | 83.96% | 50th | 38.43% | -0.47% | 1.16% | 37.96% | 50th |
| Lead Screening in Children | A, H | 364 | 432 | 84.26% | 75th | 83.10% | -1.62% | 0.00% | Not an Accreditation Measure | 50th |
| Well-Child Visits in the First 15 Months of Life (6+) | A, H | 320 | 432 | 74.07% | 75th | 76.85% | -2.78% | 1.39% | Not an Accreditation Measure | 50th |
| Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life | A, H | 339 | 432 | 78.47% | 75th | 80.93% | -2.46% | 0.89% | Not an Accreditation Measure | 50th |
| Well-Child Visits - Adolescent | A, H | 237 | 431 | 54.99% | 50th | 61.72% | -4.73% | 2.09% | Not an Accreditation Measure | 50th |
| Human Papilloma Vaccine for Adolescents | A, H | 128 | 431 | 29.70% | 90th | 24.13% | 5.57% | 0.46% | 29.70% | 90th |
| Immunizations for Adolescents - Combo 1 | A, H | 383 | 432 | 88.66% | 90th | 86.34% | 2.32% | 0.00% | 88.66% | 90th |
| Appropriate Testing for Children with Pharyngitis | A, H | 5,144 | 7,317 | 68.12% | 50th | 64.71% | 3.71% | -0.04% | 3% | 50th |
| Appropriate Treatment for Children with Upper Respiratory Infection | A | 12,302 | 17,147 | 89.68% | 50th | 86.54% | 3.14% | 0.01% | 89.68% | 50th |
| Women's Care | | | | | | | | | | |
| Breast Cancer Screening (combined rate) | A | 2,802 | 4,312 | 64.98% | 50th | 68.44% | -3.46% | -0.09% | 64.98% | 50th |
| Cervical Cancer Screening | A, H | 326 | 428 | 76.17% | 75th | 73.66% | 2.51% | 1.34% | 76.17% | 75th |
| Glycemia Screening in Women (combined rate) | A | 6,501 | 10,394 | 62.55% | 50th | 65.53% | -0.79% | 0.24% | 4% | 50th |
| PPC - Timeliness of Prenatal Care | A, H | 376 | 432 | 87.04% | 50th | 88.29% | -1.25% | 3.47% | 87.04% | 50th |
| PPC - Postpartum Care | A, H | 295 | 432 | 68.29% | 50th | 72.60% | -4.31% | 1.85% | 68.29% | 50th |
| Living with Illness | | | | | | | | | | |
| CDC - Eye Exam | A, H | 388 | 640 | 60.63% | 50th | 55.66% | 4.97% | 9.72% | 60.63% | 50th |
| CDC - Nephropathy | A, H | 509 | 640 | 79.53% | 50th | 74.31% | 5.22% | 0.72% | 79.53% | 50th |
| CDC - HbA1c Testing | A, H | 509 | 640 | 84.23% | 50th | 84.71% | -0.49% | 1.66% | 84.23% | 50th |
| CDC - HbA1c Controlled (<8%) | A, H | 264 | 640 | 41.56% | 50th | 50.92% | -9.67% | 12.63% | 41.25% | 25th |
| CDC - HbA1c Poor control (>9%) | A, H | 327 | 640 | 51.09% | 50th | 40.46% | 10.63% | NA | 51.09% | 50th |
| Use of Appropriate Medications for People with Asthma (5-11) | A | 947 | 1,044 | 90.71% | 90th | 91.44% | -0.73% | 0.13% | Not an Accreditation Measure | 50th |
| Use of Appropriate Medications for People with Asthma (combined) | A | 2,471 | 2,982 | 82.86% | 90th | 84.08% | -1.22% | -0.09% | 82.86% | 25th |
| Medication Management for People with Asthma (75% rate - total) | A | 1,204 | 2,471 | 48.73% | 50th | 50.45% | -1.72% | -0.71% | 48.73% | 90th |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | A | 297 | 950 | 31.26% | 50th | 34.06% | -2.80% | -0.07% | 2% | 50th |
| Pharmacotherapy Management of COPD Exacerbation - Bronchodilator | A | 937 | 1,090 | 85.96% | 50th | 85.97% | -0.01% | 0.02% | 85.96% | 50th |
| Pharmacotherapy Management of COPD Exacerbation - Corticosteroid | A | 800 | 1,090 | 73.39% | 50th | 72.90% | 0.49% | 0.04% | 73.39% | 50th |
| Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis | A | 194 | 314 | 61.78% | 50th | 69.65% | -7.87% | -2.07% | Not an Accreditation Measure | 50th |
| Behavioral Health | | | | | | | | | | |
| Antidepressant Medication Management - Acute | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Antidepressant Medication Management - Continuation | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Follow-up for Children Prescribed ADHD Medication - Initiation Phase | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Follow-up for Children Prescribed ADHD Medication - C&M Phase | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Follow-up After Hospitalization for Mental Illness - 7 days | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Follow-up After Hospitalization for Mental Illness - 30 days | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder | A | 542 | 625 | 86.72% | 90th | 91.22% | -4.50% | 0.87% | Not an Accreditation Measure | 50th |
| Access and Availability of Care | | | | | | | | | | |
| Children's Access to Primary Care Practitioners - 12-24 mos | A | 8,528 | 8,729 | 97.70% | 50th | 97.72% | -0.02% | 0.09% | Not an Accreditation Measure | 50th |
| Children's Access to Primary Care Practitioners - 25 mos - 6 years | A | 94,861 | 38,096 | 91.51% | 50th | 91.65% | -0.14% | 0.59% | Not an Accreditation Measure | 50th |
| Children's Access to Primary Care Practitioners - 7-11 years | A | 24,678 | 26,591 | 92.81% | 50th | 93.77% | -0.96% | 0.09% | Not an Accreditation Measure | 50th |
| Children's Access to Primary Care Practitioners - 12-19 years | A | 28,449 | 30,650 | 92.82% | 75th | 93.50% | -0.68% | 0.10% | Not an Accreditation Measure | 50th |
| Adult Access 20-44 Yrs | A | 36,579 | 42,791 | 85.48% | 50th | 86.89% | -1.41% | 0.35% | Not an Accreditation Measure | 50th |
| Adult Access 45-64 Yrs | A | 16,794 | 18,172 | 92.42% | 90th | 92.38% | 0.04% | 0.14% | Not an Accreditation Measure | 50th |
| Adult Access - Total | A | 53,640 | 61,258 | 87.56% | 50th | 88.51% | -0.95% | 0.28% | Not an Accreditation Measure | 50th |
| Alcohol/Drug Dependence Treatment - Engagement of Treatment | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Alcohol/Drug Dependence Treatment - Initiation of Treatment | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Hybrid Measures | | | | | | | | | | |
| WCC - BMI Percentile | A, H | 304 | 431 | 70.53% | 50th | 54.29% | 16.24% | 26.45% | 70.53% | 75th |
| WCC - Nutrition | A, H | 265 | 431 | 61.48% | 50th | 57.54% | 3.94% | 32.25% | 61.48% | 50th |
| WCC - Physical Activity | A, H | 211 | 431 | 48.96% | 50th | 45.71% | 3.25% | 27.61% | 48.96% | 50th |
| Adult BMI | A, H | 360 | 431 | 83.53% | 50th | 73.15% | 10.38% | 30.63% | 83.53% | 50th |
| Controlling High Blood Pressure | H | 247 | 422 | 58.53% | 50th | 57.31% | 1.22% | 44.50% | 58.53% | 50th |

Ranking Percentile Updates:

- Reached the 50th percentile in PPC - Timeliness of Prenatal Care
- Reached the 50th percentile in CDC - Eye Exam
- Reached the 50th percentile in CDC - HbA1c Testing
- Reached the 50th percentile in Adult Access - Total
- Reached the 50th percentile in WCC - BMI Percentile
- Reached the 50th percentile in WCC - Nutrition
- Reached the 50th percentile in WCC - Physical Activity
- Reached the 50th percentile in Controlling High Blood Pressure

Accreditation Percentile Updates:

- Reached the 25th percentile in WCC - BMI Percentile
- Reached the 25th percentile in Adult BMI
- Reached the 50th percentile in PPC - Timeliness of Prenatal Care
- Reached the 50th percentile in CDC - Eye Exam
- Reached the 50th percentile in CDC - HbA1c Testing
- Reached the 50th percentile in WCC - Nutrition
- Reached the 50th percentile in WCC - Physical Activity
- Reached the 25th percentile in HbA1c <8%

Hybrid Updates:

- There were 3,017 Hybrid tool entries this month.
- Michigan had 54 office visits this month conducted by the Medical Record Abstraction Team.

Additional Notes:

- Please note that the programming of administrative measures is still actively being tested. Rates may change when testing is complete.

Notes

* Lower rate is better

Hybrid data are displayed only Jan-May. Current year data will populate this grid June-Dec.

% Difference YTD is calculated by subtracting the previous YTD rate from the current YTD rate

Accreditation regional adjustments are not included in this grid.

0. These Accreditation Measures are included for tracking purposes and will not be used for Accreditation scoring until we report HEDIS 2016

In the Collection Method Column, "A" indicates an administrative only measure, "H" indicates a hybrid only measure, "A, H" indicates the use of both administrative and hybrid data collection

Ranking percentiles will adjust in October when new benchmarks become available. Accreditation benchmarks are released in July with a mid-year update.

| Meridian Health Plan HEDIS Supplemental Data Entries - Michigan | | | | | | |
|---|-----------------|---------------|----------------------|------------------------|--------------------------|-----------------------------|
| Source | Records Entered | Items Entered | Items that were Hits | Items that were misses | Items w/ matching Claims | Items w/out matching Claims |
| Meridian Internal Staff | 132 | 91 | 56 | 35 | 17 | 39 |
| EMR | 76,539 | 87,226 | 9,214 | 78,012 | 2,298 | 6,916 |
| Total | 76,671 | 87,317 | 9,270 | 78,047 | 2,315 | 6,955 |

HEDIS data as of 04/03/2015

Meridian Health Plan
 HEDIS 2015
 Reported on 04/06/2015

| Illinois | | | | | | | | | | | |
|--|-------------------|-------|------------|-----------|--------------------|-----------|------------------|------------------------------|----------------------------|------------------------------|--------------------------|
| HEDIS Measure | Collection Method | Hits | Population | 2014 Rate | Ranking Percentile | 2013 Rate | % Difference YTD | % Change from previous month | Regional Adjustment Factor | Accreditation Rates | |
| | | | | | | | | | | Adjusted Rate | Accreditation Percentile |
| Pediatric Care | | | | | | | | | | | |
| Childhood Immunizations - Combo 2 | A, H | 320 | 432 | 74.07% | | 85.88% | -11.61% | 0.93% | | 74.07% | 25th |
| Childhood Immunizations - Combo 3 | A, H | 306 | 432 | 70.83% | | 83.37% | -12.54% | 0.16% | | Not an Accreditation Measure | |
| Childhood Immunizations - Combo 10 | A, H | 102 | 432 | 23.61% | | 33.95% | -10.34% | 0.23% | | 23.61% | |
| Lead Screening in Children | A, H | 362 | 432 | 83.80% | 75th | 88.45% | -4.66% | 0.93% | | Not an Accreditation Measure | |
| Well-Child Visits in the First 15 Months of Life (6+) | A, H | 349 | 432 | 80.79% | 90th | 90.46% | -9.67% | 0.93% | | Not an Accreditation Measure | |
| Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life | A, H | 354 | 432 | 81.94% | 75th | 88.46% | -6.51% | 1.62% | | Not an Accreditation Measure | |
| Well Child Visits - Adolescent | A, H | 250 | 432 | 57.87% | 50th | 74.67% | -16.80% | 3.01% | | 31.72% | 90th |
| Human Papilloma Vaccine for Adolescents | A, H | 72 | 227 | 31.72% | 90th | 48.11% | -16.40% | 0.88% | | 31.72% | 90th |
| Immunizations for Adolescents - Combo 1 | A, H | 309 | 432 | 71.53% | 50th | 70.26% | 1.27% | 0.23% | | 71.53% | 50th |
| Appropriate Testing for Children with Pharyngitis | A | 379 | 628 | 60.35% | | 52.23% | 8.12% | 0.06% | 3% | 63.35% | 25th |
| Appropriate Treatment for Children with Upper Respiratory Infection | A | 1,021 | 1,206 | 84.66% | | 74.55% | 10.11% | -0.07% | | 84.66% | 25th |
| Women's Care | | | | | | | | | | | |
| Breast Cancer Screening (combined rate) | A | NA | NA | NA | NA | NA | NA | NA | | NA | NA |
| Cervical Cancer Screening | A, H | 288 | 430 | 66.98% | 50th | 80.57% | -13.60% | 0.85% | | 66.98% | 50th |
| Chlamydia Screening in Women (combined rate) | A | 700 | 1,150 | 60.87% | 50th | 62.00% | -1.13% | 1.13% | | 64.87% | 25th |
| HTC - Timeliness of Prenatal Care | A, H | 383 | 431 | 88.86% | 50th | 94.24% | -5.38% | 0.46% | 4% | 88.86% | 50th |
| HTC - Postpartum Care | A, H | 311 | 431 | 72.16% | 75th | 78.04% | -5.88% | 4.64% | | 72.16% | 75th |
| Living with Illness | | | | | | | | | | | |
| CDC - Eye Exam | A, H | 45 | 71 | 63.38% | 75th | NA | NA | NA | | 63.38% | 50th |
| CDC - Nephrology | A, H | 63 | 71 | 88.73% | 90th | NA | NA | NA | | 88.73% | 90th |
| CDC - HBVc Testing | A, H | 67 | 71 | 94.37% | 90th | NA | NA | NA | | 94.37% | 90th |
| CDC - HBVc Controlled (<8%) | A, H | 17 | 71 | 23.94% | | NA | NA | NA | | 23.94% | |
| CDC - HBVc Post Control (>8%) | A, H | 52 | 71 | 73.24% | | NA | NA | NA | | 73.24% | |
| Use of Appropriate Medications for People with Asthma (5-11) | A | 72 | 73 | 98.63% | 90th | 96.34% | 2.29% | 0.06% | | 96.34% | 90th |
| Use of Appropriate Medications for People with Asthma (12-24 mos) | A | 117 | 128 | 91.41% | 75th | 93.50% | -2.09% | 0.21% | | 91.41% | 90th |
| Medication Management for People with Asthma (75% rate - total) Δ | A | 88 | 117 | 75.21% | 90th | 85.22% | 10.00% | 4.16% | | 75.21% | 90th |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | A | NA | NA | NA | NA | NA | NA | NA | 2% | NA | NA |
| Pharmacotherapy Management of COPD Exacerbation - Bronchodilator | A | 217 | 272 | 87.13% | 50th | 82.35% | 4.78% | -0.26% | | 87.13% | 50th |
| Pharmacotherapy Management of COPD Exacerbation - Corticosteroid | A | 183 | 272 | 68.01% | | 82.35% | -14.34% | -0.87% | | 68.01% | 25th |
| Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis | A | 48 | 54 | 88.89% | 90th | NA | NA | -1.68% | | 88.89% | 50th |
| Behavioral Health | | | | | | | | | | | |
| Antidepressant Medication Management - Acute | A | NA | NA | NA | NA | NA | NA | NA | | NA | NA |
| Antidepressant Medication Management - Continuation | A | NA | NA | NA | NA | NA | NA | NA | | NA | NA |
| Follow-up for Children Prescribed ADHD Medication - Initiation Phase | A | NA | NA | NA | NA | NA | NA | NA | | NA | NA |
| Follow-up for Children Prescribed ADHD Medication - C&M Phase | A | NA | NA | NA | NA | NA | NA | NA | | NA | NA |
| Follow up After Hospitalization for Mental Illness- 7 days | A | 242 | 780 | 31.03% | | 39.78% | -8.76% | 3.13% | | 31.03% | |
| Follow up After Hospitalization for Mental Illness- 30 days | A | 367 | 780 | 47.05% | | 60.22% | -13.16% | 6.13% | | 47.05% | |
| Diabetes Screening for People with Schizophrenia or Bi-polar Disorder | A | NA | NA | NA | NA | NA | NA | NA | | NA | NA |
| Access and Availability of Care | | | | | | | | | | | |
| Children's Access to Primary Care Practitioners - 12-24 mos | A | 1,550 | 1,581 | 98.04% | 75th | 98.50% | -0.46% | 0.25% | | 98.50% | 50th |
| Children's Access to Primary Care Practitioners - 25 mos - 6 years | A | 4,633 | 5,127 | 90.36% | 50th | 95.31% | -4.94% | 0.88% | | 95.31% | 50th |
| Children's Access to Primary Care Practitioners - 7-11 years | A | 969 | 1,003 | 96.61% | 90th | 97.00% | -0.39% | 0.00% | | 97.00% | 50th |
| Children's Access to Primary Care Practitioners - 12-19 years | A | 998 | 1,031 | 96.80% | 90th | 97.14% | -0.34% | 0.00% | | 97.14% | 50th |
| Adult Access 20-44 Yrs | A | 6,165 | 7,382 | 83.51% | 50th | 86.86% | -3.35% | 0.94% | | 86.86% | 50th |
| Adult Access 45-64 Yrs | A | 3,132 | 3,479 | 90.03% | 50th | 87.98% | 2.05% | 0.59% | | 87.98% | 50th |
| Adult Access 65-84 Yrs | A | 9,528 | 11,110 | 85.76% | 50th | 87.01% | -1.25% | 0.81% | | 87.01% | 50th |
| Alcohol/Drug Dependence Treatment - Engagement of Treatment Δ | A | 138 | 1,085 | 12.72% | | NA | NA | NA | | 12.72% | 50th |
| Alcohol/Drug Dependence Treatment - Initiation of Treatment | A | 503 | 1,085 | 46.36% | 75th | NA | NA | 0.40% | | NA | 50th |
| Hybrid Measures | | | | | | | | | | | |
| WCC - BMI Percentile | A, H | 129 | 432 | 29.86% | | 43.75% | -13.89% | 17.13% | | 29.86% | |
| WCC - Nutrition | A, H | 84 | 432 | 19.44% | | 47.22% | -27.78% | 12.26% | | 19.44% | |
| WCC - Physical Activity | A, H | 55 | 432 | 12.73% | | 24.54% | -11.81% | 7.87% | | 12.73% | |
| Adult BMI | A, H | 300 | 429 | 69.93% | | 69.14% | 0.79% | 36.29% | | 69.93% | 25th |
| Controlling High Blood Pressure | H | 80 | 444 | 18.02% | | 42.06% | -24.04% | 15.67% | | 18.02% | |

| Meridian Health Plan HEDIS Supplemental Data Entries- Illinois | | | | | |
|--|---------------|----------------------|------------------------|--------------------------|-----------------------------|
| Records Entered | Items Entered | Items that were Hits | Items that were misses | Items w/ matching Claims | Items w/out matching Claims |
| 8 | 155 | 152 | 3 | 90 | 62 |
| 0 | 0 | 0 | 0 | 0 | 0 |
| 0 | 0 | 0 | 0 | 0 | 0 |
| 8 | 155 | 152 | 3 | 90 | 62 |
| Total | | | | | |

Health Data as of 4/09/2015

Ranking Percentile Updates:

- Reached the 50th percentile in Cervical Cancer Screening
- Reached the 50th percentile in Adult Access 20-44 years
- Reached the 75th percentile in Postpartum Care
- Reached the 75th percentile in Child Access 12-24 months

Accreditation Percentile Updates:

- Reached the 25th percentile in Chlamydia Screenings
- Reached the 75th percentile in Postpartum Care

Hybrid Updates:

- There were 799 hybrid tool entries this month
- Sent out both second and third round of faxes this month
- Illinoic had four clinical abstractions
- Received electronic access to OSF clinics

Additional Notes:

- All Comprehensive Diabetes Care measures are being rotated. HEDIS 2014 rates will be reported for these measures and are displayed in this report.
- Please note that the programming of administrative measures is still actively being tested. Rates may change when testing is complete.

Notes

*Lower rate is better

% Difference YTD is calculated by subtracting the previous YTD rate from the current YTD rate

Pay for Performance measures are highlighted in yellow on the report

Ranking Percentiles based on the most current Rankings/Quality Compass Percentiles without any regional adjustments

Accreditation Percentiles are only provided for Accreditation Measures and are based on most current Accreditation benchmarks

0 These Accreditation Measures are included for tracking purposes and will not be used for Accreditation scoring until we report HEDIS 2016

In the Collection Method Column, "A" indicates an administrative only measure, "H" indicates a hybrid only measure, "A, H" indicates the use of both administrative and hybrid data collection

Ranking percentiles will adjust in October when new benchmarks become available

Accreditation percentiles will adjust when new benchmarks become available

Meridian Health Plan
HEDIS 2015
Reported on 04/06/2015

| HEDIS Measure | Collection Method | Hits | Population | 2014 Rate | Ranking Percentile | 2013 Rate | % Difference YTD | % Change from previous month | Accreditation Rates | |
|--|-------------------|---------------|----------------------|------------------------|--------------------------|-----------------------------|------------------|------------------------------|------------------------------|---------------|
| | | | | | | | | | Regional Adjustment Factor | Adjusted Rate |
| Pediatric Care | | | | | | | | | | |
| Childhood Immunizations - Combo 2 | A, H | 332 | 430 | 77.21% | 50th | 75.96% | 1.25% | 3.26% | 77.21% | 50th |
| Childhood Immunizations - Combo 3 | A, H | 314 | 430 | 73.02% | 50th | 73.22% | -0.20% | 3.02% | Not an Accreditation Measure | 50th |
| Childhood Immunizations - Combo 10 | A, H | 146 | 430 | 33.95% | 75th | 42.08% | -8.13% | 1.40% | 33.95% | 25th |
| Lead Screening in Children | A, H | 364 | 431 | 84.45% | 75th | 85.25% | -0.80% | 0.00% | Not an Accreditation Measure | 50th |
| Well-Child Visits in the First 15 Months of Life (6+) | A, H | 316 | 432 | 73.15% | 75th | 79.37% | -6.22% | 0.93% | Not an Accreditation Measure | 50th |
| Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life | A, H | 310 | 431 | 71.93% | 50th | 79.53% | -7.60% | 1.33% | Not an Accreditation Measure | 50th |
| Well-Child Visits - Adolescent | A, H | 188 | 423 | 44.44% | 75th | 58.10% | -13.66% | 1.76% | Not an Accreditation Measure | 75th |
| Human Papilloma Vaccine for Adolescents | A, H | 70 | 283 | 24.73% | 75th | 14.55% | 10.18% | 0.44% | 24.73% | 75th |
| Immunizations for Adolescents - Combo 1 | A, H | 278 | 430 | 64.65% | 75th | 62.75% | 1.90% | 0.47% | 64.65% | 25th |
| Appropriate Testing for Children with Pharyngitis | A, H | 859 | 1094 | 78.52% | 75th | NA | NA | 0.25% | 7% | 85.52% |
| Appropriate Treatment for Children with Upper Respiratory Infection | A | 2204 | 2529 | 87.15% | 50th | NA | NA | -1.23% | 6% | 93.15% |
| WCC - BMI Percentile | | | | | | | | | | |
| Breast Cancer Screening (combined rate) | A, H | 6 | 9 | 66.67% | 50th | NA | NA | NA | NA | NA |
| Cervical Cancer Screening | A, H | 288 | 431 | 66.82% | 50th | 76.01% | -9.19% | 0.93% | 66.82% | 50th |
| Chlamydia Screening in Women (combined rate) | A, H | 751 | 1214 | 61.86% | 50th | 64.42% | -2.56% | 0.08% | 68.86% | 75th |
| PTC - Timeliness of Prenatal Care | A, H | 395 | 429 | 92.07% | 75th | 96.27% | -4.20% | 1.12% | 92.07% | 75th |
| PTC - Postpartum Care | A, H | 310 | 429 | 69.93% | 75th | 73.95% | -4.02% | 4.04% | 69.93% | 50th |
| Living with Illness | | | | | | | | | | |
| CDC - Eye Exam | A, H | 42 | 62 | 67.74% | 75th | NA | NA | NA | 67.74% | 75th |
| CDC - Nephrology | A, H | 48 | 62 | 77.42% | 75th | NA | NA | NA | 77.42% | 25th |
| CDC - HBVc Testing | A, H | 38 | 62 | 61.29% | 90th | NA | NA | NA | 61.29% | 90th |
| CDC - HBVc Testing (≤8%) | A, H | 38 | 62 | 61.29% | 90th | NA | NA | NA | 61.29% | 90th |
| CDC - HBVc Post Control (≤8%) | A, H | 18 | 62 | 29.03% | 90th | NA | NA | NA | 29.03% | 75th |
| Use of Appropriate Medications for People with Asthma (6-11) | A | NA | NA | NA | NA | NA | NA | NA | Not an Accreditation Measure | 75th |
| Use of Appropriate Medications for People with Asthma (combined) | A | 96 | 115 | 83.48% | 90th | NA | NA | 4.07% | 83.48% | 25th |
| Medication Management for People with Asthma (75% rate - total) | A | 62 | 90 | 68.89% | 90th | NA | NA | NA | 68.89% | 60th |
| Use of Spirometry Testing in the Office and Diagnosis of COPD | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Pharmacotherapy Management of COPD Exacerbation - Bronchodilator | A | 31 | 43 | 72.09% | NA | NA | NA | 31.67% | 72.09% | NA |
| Pharmacotherapy Management of COPD Exacerbation - Corticosteroid | A | 28 | 43 | 65.12% | NA | NA | NA | 36.66% | 65.12% | NA |
| Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis | A | NA | NA | NA | NA | NA | NA | NA | Not an Accreditation Measure | NA |
| Behavioral Health | | | | | | | | | | |
| Antidepressant Medication Management - Acute | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Antidepressant Medication Management - Continuation | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Follow-up for Children Prescribed ADHD Medication - Initiation Phase | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Follow-up for Children Prescribed ADHD Medication - C&M Phase | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Follow up After Hospitalization for Mental Illness: 7 days | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Follow up After Hospitalization for Mental Illness: 30 days | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Diabetes Screening for People with Schizophrenia or Bi-polar Disorder | A | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Access and Availability of Care | | | | | | | | | | |
| Children's Access to Primary Care Practitioners - 12-24 mos | A | 2114 | 2131 | 99.20% | 90th | 99.32% | -0.12% | 0.05% | 99.32% | 50th |
| Children's Access to Primary Care Practitioners - 25 mos - 6 years | A | 5795 | 5715 | 92.65% | 75th | 93.81% | -1.16% | 0.17% | 93.81% | 50th |
| Children's Access to Primary Care Practitioners - 7-11 years | A | 1098 | 1151 | 95.40% | 90th | NA | NA | 0.10% | 95.40% | 50th |
| Children's Access to Primary Care Practitioners - 12-19 years | A | 1111 | 1156 | 96.11% | 90th | NA | NA | 0.01% | 96.11% | 50th |
| Adult Access 20-44 Yrs | A | 4376 | 4912 | 89.09% | 90th | 91.70% | -2.61% | 0.24% | 91.70% | 50th |
| Adult Access - Total | A | 796 | 914 | 87.09% | 75th | 89.08% | -1.99% | 0.31% | 89.08% | 50th |
| Alcohol/Drug Dependence Treatment - Engagement of Treatment | A | 5172 | 5826 | 88.77% | 75th | 91.47% | -2.70% | 0.24% | 91.47% | 50th |
| Alcohol/Drug Dependence Treatment - Initiation of Treatment | A | 20 | 52 | 38.46% | 75th | NA | NA | 0.12% | 3.38% | 75th |
| Alcohol/Drug Dependence Treatment - Continuation of Treatment | A | 228 | 592 | 38.51% | 75th | NA | NA | 0.26% | 3.38% | 75th |
| Hybrid Measures | | | | | | | | | | |
| WCC - BMI Percentile | A, H | 254 | 429 | 59.21% | 50th | 26.64% | 32.57% | 41.03% | 9% | 68.21% |
| WCC - Nutrition | A, H | 167 | 429 | 38.93% | 75th | 24.30% | 14.63% | 28.44% | 10% | 48.93% |
| WCC - Physical Activity | A, H | 139 | 429 | 32.40% | 75th | 23.13% | 9.27% | 23.78% | 6% | 38.40% |
| Adult BMI | A, H | 333 | 432 | 77.08% | 75th | NA | NA | 22.45% | NA | 77.08% |
| Controlling High Blood Pressure | H | 185 | 407 | 45.45% | 75th | 35.90% | 9.55% | 37.60% | NA | 45.45% |
| Meridian Health Plan HEDIS Supplemental Data Entries- Iowa | | | | | | | | | | |
| Source | Records Entered | Items Entered | Items that were Hits | Items that were misses | Items w/ matching Claims | Items w/out matching Claims | | | | |
| Meridian Internal Staff | 212 | 547 | 473 | 74 | 262 | 211 | | | | |
| EMR | 3 | 0 | 3 | 0 | 0 | 0 | | | | |
| Total | 215 | 547 | 476 | 74 | 262 | 211 | | | | |

HEDIS data as of 04/02/2015

Monthly Updates

Ranking Percentile Updates:

- Reached the 50th percentile in Childhood Immunizations Combo 2 and Combo 3
- Reached the 50th percentile in Well-Child Visits in the Third, Fourth, Fifth and Sixth years of life
- Reached the 50th percentile in Cervical Cancer Screening
- Reached the 50th percentile in WCC- BMI Percentile
- Reached the 75th percentile in Postpartum Care

Accreditation Percentile Updates:

- Reached the 25th percentile in Child Physical Activity Counseling
- Reached the 25th percentile in WCC- Nutrition
- Reached the 50th percentile in Child BMI
- Reached the 50th percentile in C15- Combo 2
- Reached the 50th percentile in Adult BMI

Hybrid Updates:

- There were 902 Hybrid tool entries this month.
- Iowa had 11 office visits this month conducted by the Quality Team.

Additional Notes:

- All Comprehensive Diabetes Care measures are being rotated. HEDIS 2014 rates will be reported for these measures and are displayed in this report.
- Please note that the programming of administrative measures is still actively being tested. Rates may change when testing is complete.

Notes

***Lower rate is better**

Hybrid data are displayed only Jan-Jan-May. Current year data will populate this grid June-Dec.

% Difference YTD is calculated by subtracting the previous YTD rate from the current YTD rate

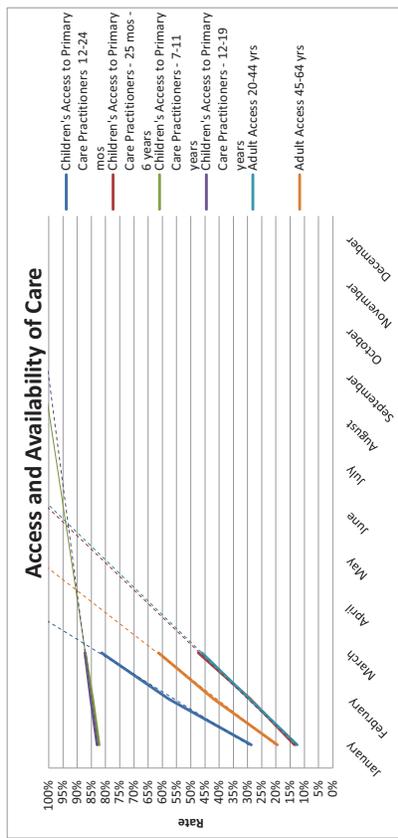
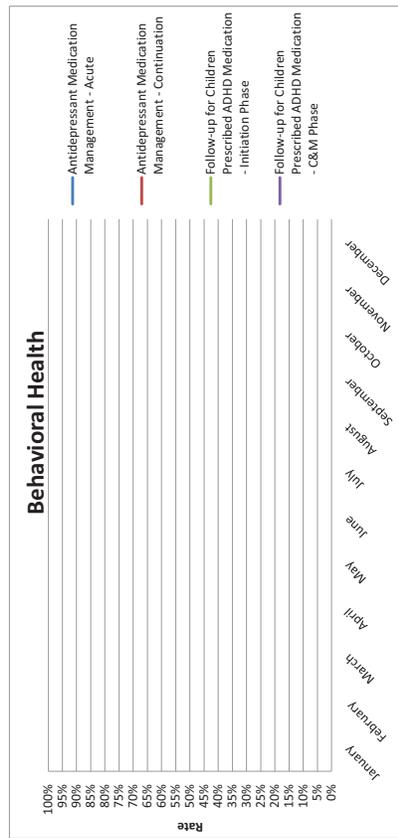
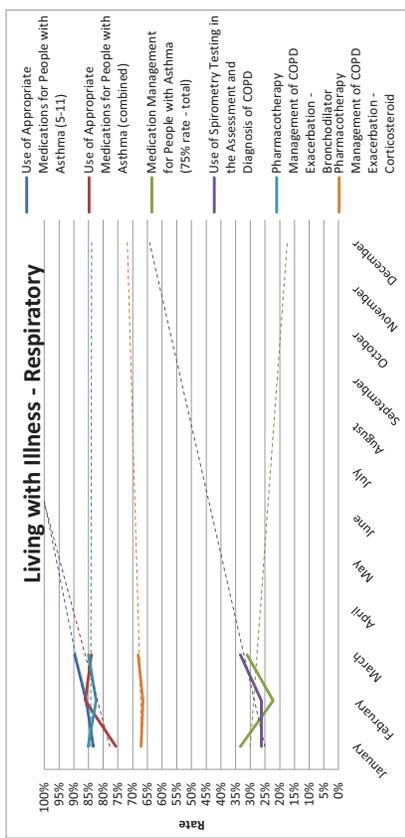
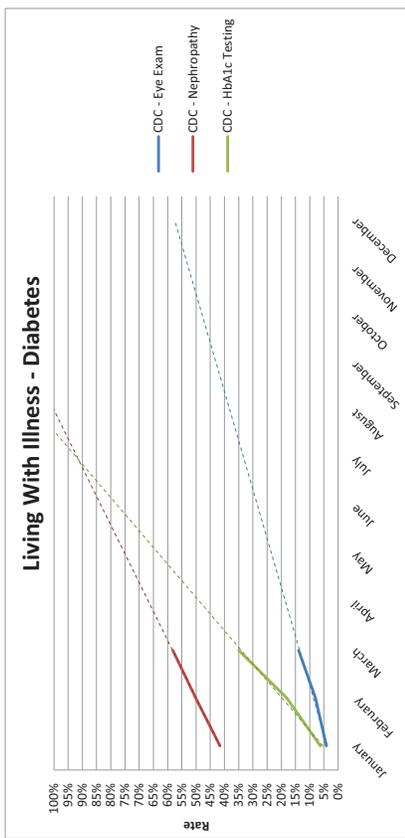
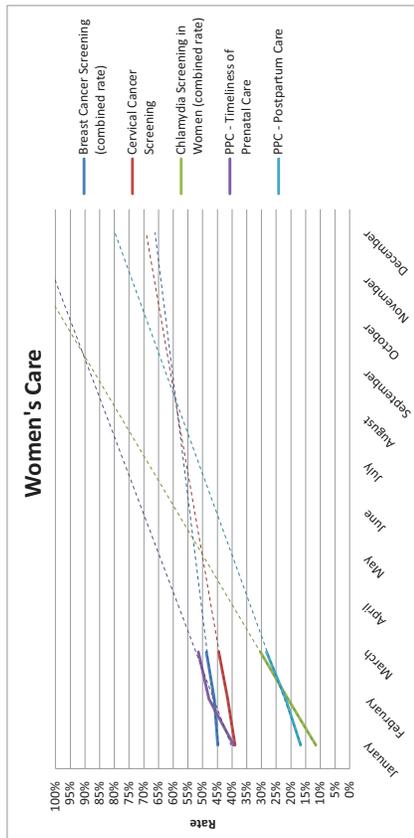
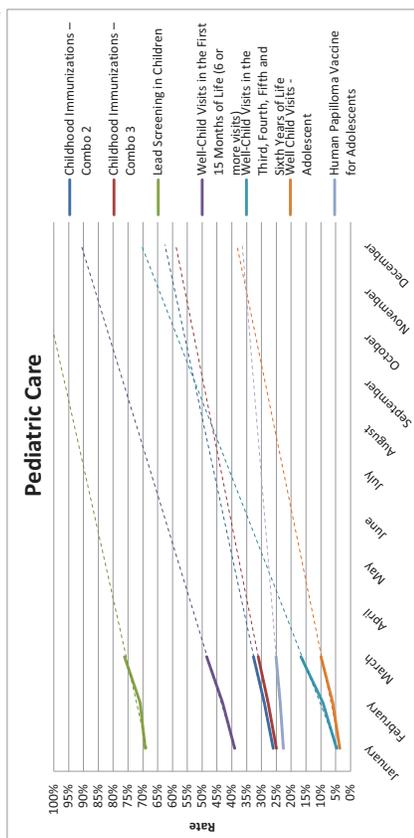
Accreditation regional adjustments are not included in this grid.

These Accreditation Measures are included for tracking purposes and will not be used for Accreditation scoring until we report HEDIS 2016

In the Collection Method Column, "A" indicates an administrative only measure, "H" indicates a hybrid only measure, "A, H" indicates the use of both administrative and hybrid data collection

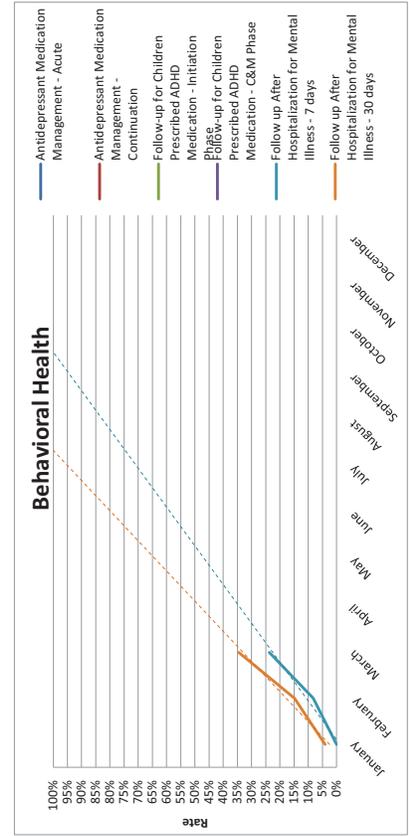
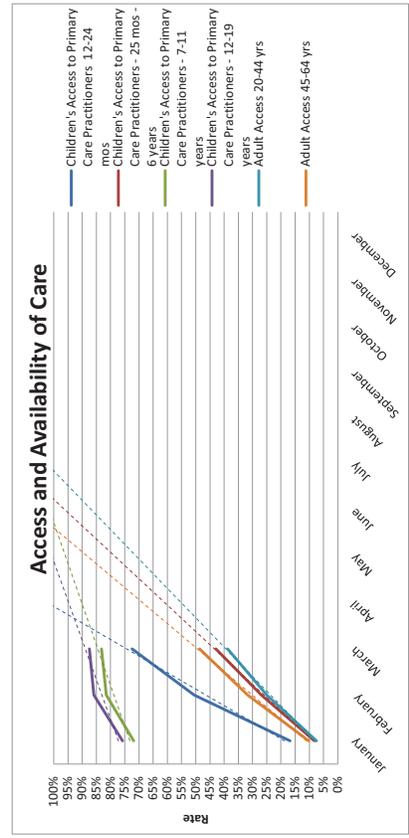
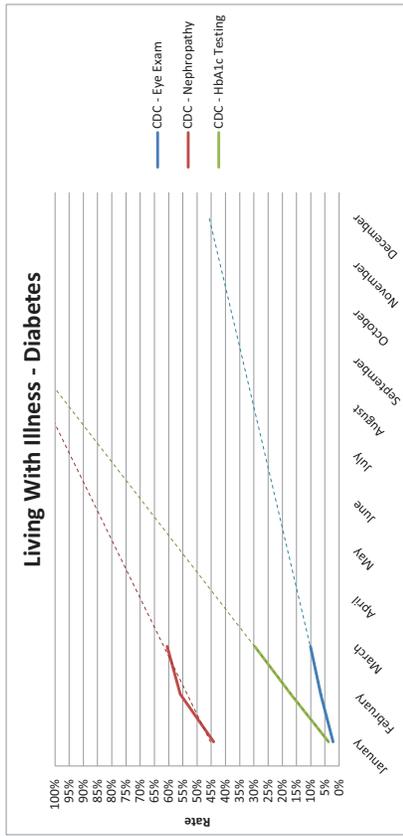
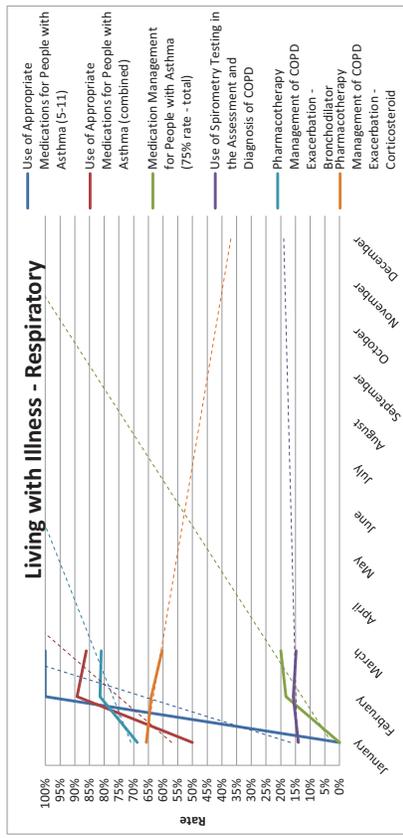
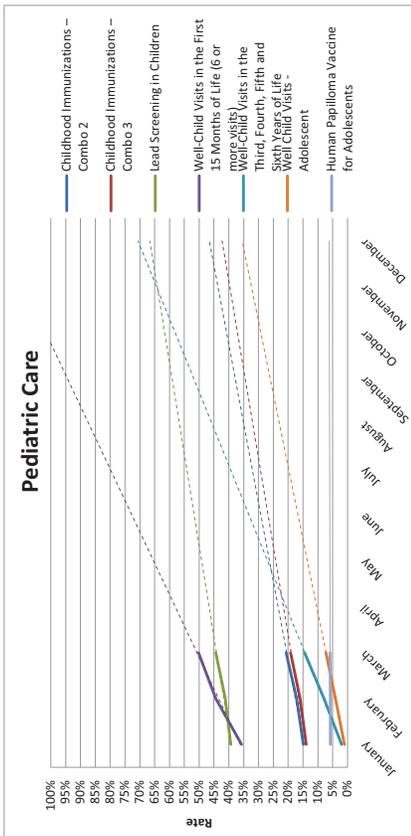
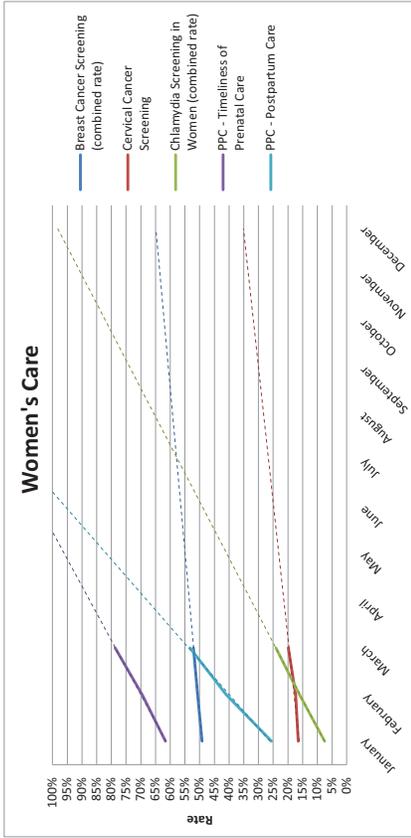
Ranking percentiles will adjust in October when new benchmarks become available. Accreditation benchmarks are released in July with a mid-year update.

Meridian Health Plan
 HEDIS 2016 Administrative Rates - Michigan Medicaid
 Reported on 04/06/2015



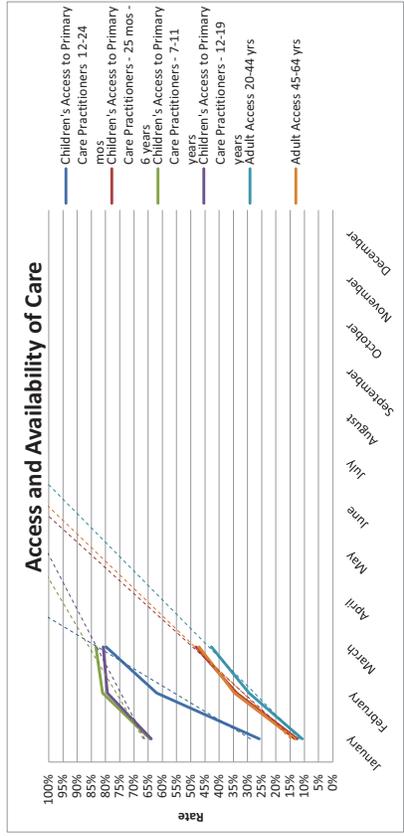
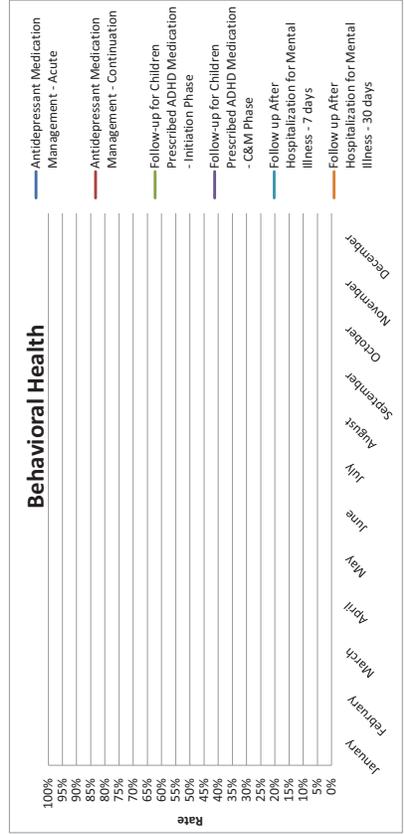
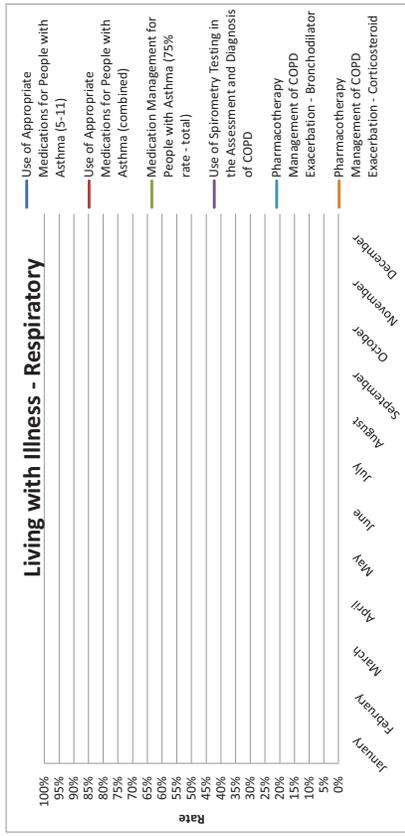
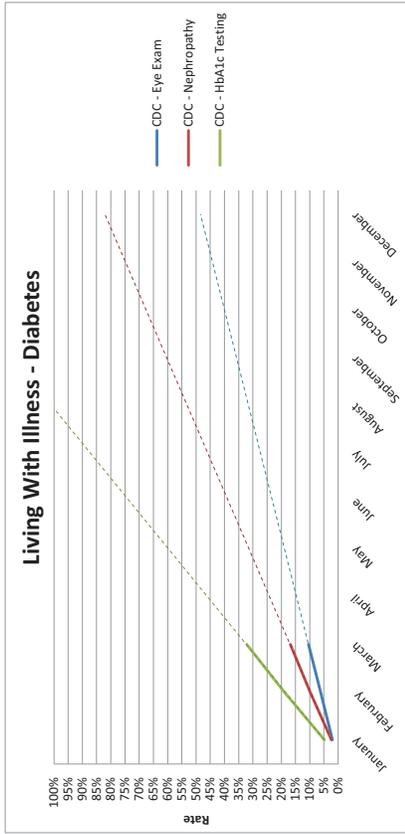
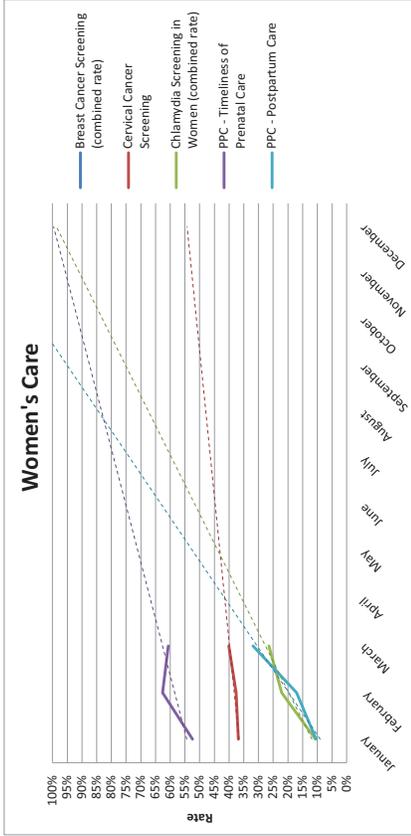
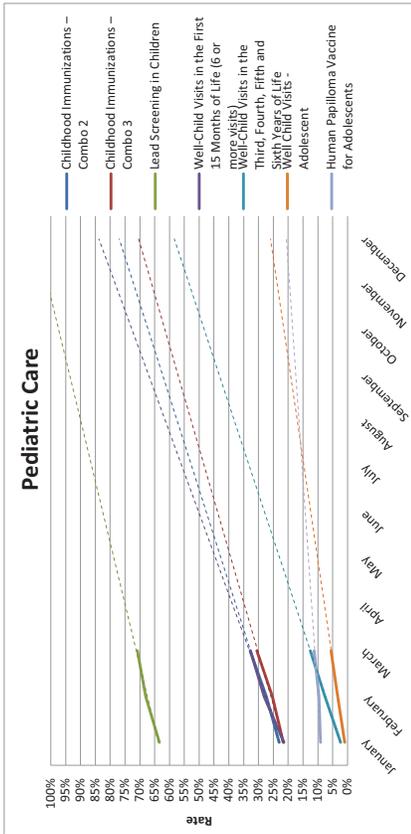
HEDIS data as of 03/30/15
 * Month over month change slows significantly as the percentage reaches upper percentiles. A trajectory reaching a percentile by EOY does not guarantee the percentile will be reached. Behavioral Health measures are currently not available in MCS. Once data is available BH measures will be added to the graphs.

Meridian Health Plan
 HEDIS 2016 Administrative Rates - Illinois Medicaid
 Reported on 04/06/2015

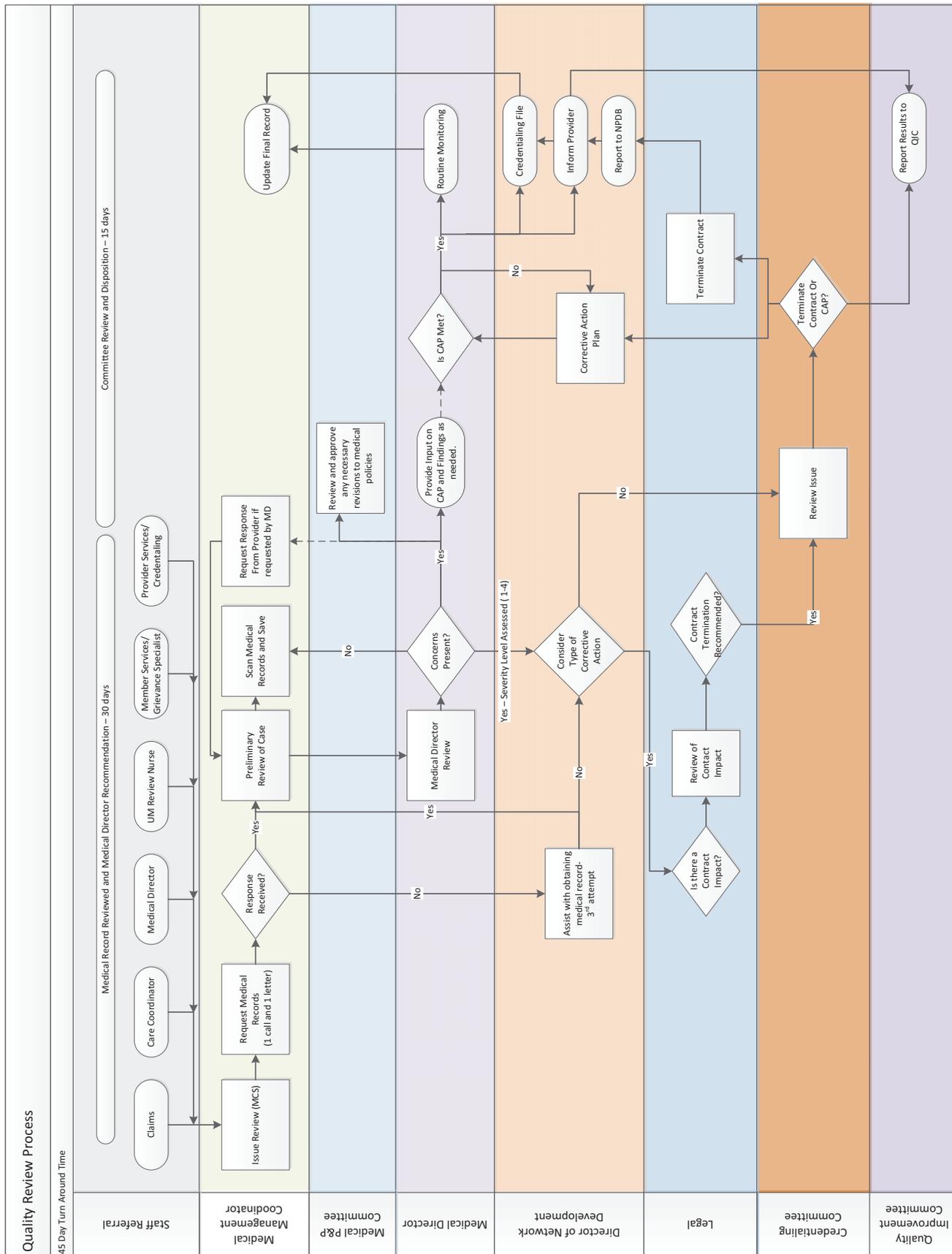


HEDIS data as of 3/29/15
 * Month over month change slows significantly as the percentage reaches upper percentiles. A trajectory reaching a percentile by EOY does not guarantee the percentile will be reached. All Behavioral Health measures are not currently available in MCS. Once data is available all BH measures will be added to the graphs.

Meridian Health Plan
 HEDIS 2016 Administrative Rates - Iowa Medicaid
 Reported on 04/06/2015



HEDIS data as of 03/30/15
 * Month over month change slows significantly as the percentage reaches upper percentiles. A trajectory reaching a percentile by EOY does not guarantee the percentile will be reached.
Pharmacy and Behavioral Health measures for Iowa are currently not available in MCS. Once data is available pharmacy and BH measures will be added to the graphs.



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Attachment 35 (Sample Provider FWA Report)

| Plan Code | Service Provider ID | Service Provider Name | Service Provider Specialty | Procedure Code | Mbr Count | Paid Amt Sum | Avg Cost/Code |
|-----------|---------------------|-----------------------|----------------------------|----------------|-----------|--------------|---------------|
| HPM | 1234 | Doe, John | Hematology,Oncology | J9035 | 2 | \$38,634.00 | \$5,519.14 |
| HPM | 1234 | Doe, John | Hematology,Oncology | J2505 | 3 | \$27,158.80 | \$3,394.85 |
| HPM | 1234 | Doe, John | Hematology,Oncology | J9305 | 1 | \$14,469.60 | \$4,823.20 |
| HPM | 1234 | Doe, John | Hematology,Oncology | J9310 | 1 | \$11,329.20 | \$5,664.60 |
| HPM | 1234 | Doe, John | Hematology,Oncology | J9070 | 2 | \$5,417.25 | \$1,083.45 |
| HPM | 1234 | Doe, John | Hematology,Oncology | J2469 | 5 | \$2,563.80 | \$197.22 |
| HPM | 1234 | Doe, John | Hematology,Oncology | J1453 | 4 | \$2,331.00 | \$259.00 |
| HPM | 1234 | Doe, John | Hematology,Oncology | J1442 | 1 | \$891.00 | \$297.00 |
| HPM | 1234 | Doe, John | Hematology,Oncology | J9263 | 1 | \$690.00 | \$172.50 |
| HPM | 1234 | Doe, John | Hematology,Oncology | J9217 | 1 | \$458.52 | \$458.52 |
| HPM | 1234 | Doe, John | Hematology,Oncology | J9265 | 2 | \$280.80 | \$46.80 |
| HPM | 1234 | Doe, John | Hematology,Oncology | J0640 | 1 | \$218.12 | \$54.53 |
| HPM | 1234 | Doe, John | Hematology,Oncology | J9000 | 2 | \$181.80 | \$36.36 |

High Cost J-Code Report was run for 4th Q 2014. The top ten (10) providers were reviewed by paid amount on the report to assess for suspicious billing. This is a random sampling of over 5000 claims reviewed.

1. Dr. 1.– Hematology/Oncology – Members who he was billing J codes for, cancer patients with prior authorizations for treatment.
2. Dr. 2. – Oncology – Members were cancer patients with prior auths. Large associated vendor, CANCER & HEMATOLOGY CENTERS ID 382777354
3. Dr. 3.– Oncology – Cancer patients with prior auths. Large associated vendor, CANCER & HEMATOLOGY CENTERS ID 382777354
4. Dr.4. – Hematology/Oncology – patients with prior auths. Large associated vendor, CANCER & HEMATOLOGY CENTERS ID 382777354
5. Dr. 5. – Family Practice – Only provider in top ten on report who was not cancer-oriented, works at Planned Parenthood. Vendor is XYZ Planned Parenthood based out of XYZ, seems to be one the larger contraceptive service providers in the state. He billed one particular code J1050, birth control injection, on 131 unique members in the 4th Q 2014, which did stand out; I then ran a report on that code for 4th Q 2014, several other providers associated with this vendor XYZ Planned Parenthood showed up in the top 10 billers for that particular code. Given that he works for Planned Parenthood, providing contraceptive services is obviously going to be his main task. No further-follow up.
6. Dr. 6. – Internal Medicine –patients with prior auths
7. Dr. 7.– Hematology/Oncology – patients with prior auths
8. Dr. 8.- Hematology/Oncology – patients with prior auths. Large associated vendor, CANCER & HEMATOLOGY CENTERS ID 382777354
9. Dr. 9. – Hematology/Oncology – patients with prior auths
10. Dr. 10 – Internal Medicine – patients with prior auths

Again, most of the these providers (9 out of 10) were rendering J code services primarily for cancer treatments or other severe illnesses, which were authorized. There was no follow-up necessary based on the review of the report.

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<DATE>

<NAME>
<ADDRESS 1>
<ADDRESS 2>
<CITY>, <STATE> <ZIP>

Dear <NAME>,

The following request for services has been approved by Meridian Health Plan:

Authorization Number:
Member Name:
Member ID:
Primary Care Provider:
Approved Services:
Servicing Provider:
Servicing Facility:

Authorization Valid from <START DATE> to <END DATE>.

This authorization approval only covers the services listed above. You must be eligible with Meridian Health Plan on the date of service. If you need authorization for services beyond what is listed, you or your doctor will need to get prior approval from Meridian Health Plan.

If you have any questions about this authorization, please call Member Services at <PHONE>, Monday – Friday from 8 a.m. to 8 p.m.

Sincerely,

Utilization Management
Meridian Health Plan

[Parent Code]
[STREETADDRESS1]
[STREETADDRESS2]
[CITY, STATE ZIP]

[CREATION DATE/LAST CHANGE DATE]

[MEMBER/PROVIDER NAME]
[MEMBER/PROVIDER ADDRESS]
[MEMBER/PROVIDER CITY, STATE ZIP]

MEMBER NAME: [MEMNAME]
MEMBER ID#: [MEMBNO]
MEMBER DATE OF BIRTH: [MEMDOB]
PROVIDER NAME: [PROVNAM]
TRACKING#: [AUTHNUM]
ADMIT/START DATE: [Admit Date]
LEVEL OF TREATMENT: [LEVEL of TX]

[COMPANY] has been selected by [CLIENT NAME] to review the requested mental health and/or substance abuse services and determine if the proposed treatment is medically necessary. This letter confirms, based on the information provided, that the below requested treatment is certified:

[# of units] Unit(s) [SVC Code] [SVC Description] From [From Date] To [To Date]
[Allow any detail line with auth approval reason code to the same provider for creation date/last change date to print on same letter.]

As of [Admit Date], we have certified a total of:
[Units Authorized To Date] Unit(s) [SVC Code] [SVC Description]
[Rollup all detail lines with auth approval reason code on SVC code and sum units]

Review for continued services must occur on or before the use of all approved units or the certification end date, whichever occurs first. FOR CONTINUATION OF SERVICES, your provider should call [insert phone#] or log onto [insert web address]. Claims payment is restricted to services for which the provider is contracted to deliver and is conditional upon services authorized, clinical necessity, and the enrolled member being eligible for services on the date of service. Clinical authorization is not a guarantee of payment. If you have any questions, please call XXX at [insert phone#].

<DATE>
<MEMBER NAME>
<STREET ADDRESS>
CITY, ST ZIP

MEMBER NAME: <NAME>
MEMBER ID#: *****
MEMBER DATE OF BIRTH:
PROVIDER NAME:
TRACKING#:
ADMIT/START DATE:
LEVEL OF TREATMENT:

Dear XXX:

<COMPANY> has been selected by <CLIENT> to review behavioral health care to decide if treatment is medically necessary. This decision procedure is a requirement of the <CLIENT>. Based on a doctor's understanding of the information provided, your benefit plan, and XXX clinical review criteria, <COMPANY> has decided that the care listed above cannot be fully certified as requested and has been partially certified. This means that part of the care requested has been certified and part has not been certified, as described below.

A decision has been made that the requested treatment has been certified as described below:

Services requested were UNITS of (Treatment requested) from ____ <DATE> to ____ <DATE>.

A decision has been made that the requested treatment has been certified as follows:
Units of (Treatment requested) from ____ <DATE> to ____ <DATE>.

As of <DATE OF ADMISSION>, <COMPANY> has certified a total of:
Units of (Treatment requested) from ____ <DATE> to ____ <DATE>.

Review for continued services must occur on or before the use of all approved units or the authorization end date, whichever occurs first.

A decision has also been made that the following treatment cannot be certified:
UNITS of (Treatment requested) from ____ <DATE> to ____ <DATE>.

<COMPANY'S> clinical rationale for this decision is:

<INSERT PICK LIST RATIONALE>

This decision is based on ____ < XXX Medical Necessity Criteria for ____<level of care> or the American Society of Addictions Medicine Criteria for ____<level of care> (Insert only the applicable criteria) (please see attachment A) and the terms of your plan as outlined in the <Summary Plan Description, Certificate of Coverage>. Please see section <insert reference> in your <SPD, Certificate of Coverage>. The <SPD, Certificate of Coverage> is provided by your <employer, Health Plan>.

You are entitled to receive, upon request and at no charge, the documents, records and information related to this claim. This includes any internal protocols or rules used in making this determination as well as an explanation of the medical, scientific or clinical judgment applied in this case. If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can choose to have your provider or another person, act as your representative in this matter. You or your representative can review the clinical criteria, guidelines or protocols used to make this decision, at no charge, through the <COMPANY> website at <COMPANY WEBSITE>. If you would like additional written information about the decision, at no charge, you can call the Customer Service Department at <INSERT CUSTOMER SVC TEL #> between the hours of 8:00 AM to 5:00 PM, Monday through Friday. You may also make a written request for this information by mail, to the address listed above, or by fax to <<INSERT PHONE #>>.

If this decision was issued without a verbal discussion having taken place between the treating practitioner and a <COMPANY> doctor, the treating practitioner can request such a conversation within 3 business days. When <COMPANY> receives such a request from your provider, the doctor who made the decision, or an alternate, will be made available to speak with your provider within 1 business day. This conversation may result in a decision to approve all or part of the requested care or to uphold the original denial. If the original denial is upheld, you will not receive additional notification. This “reconsideration” process is not considered an “appeal” and does not in any way affect your right to appeal any denial of authorization for care.

You or your representatives have the right to appeal this decision. There are typically two internal appeal processes available to you through <COMPANY>. You can find out more about your appeal rights by calling the Customer Service Department at <INSERT CUSTOMER SVC TEL #>. An appeal can be requested in one of the following ways: You can send a written request to <COMPANY> at the address listed above, you can send a fax to <INSERT FAX #>, or you can call between 8 a.m. and 5 p.m. Monday through Friday, at <INSERT CUSTOMER SVC TEL #>. <COMPANY> will notify the requestor of any information we need to decide the appeal.

Please note that a request for appeal is not considered complete until <COMPANY> has received, at a minimum, the name of the patient for whom a denial of authorization is being appealed, or a valid member number for the patient, and the dates for which a denial of care authorization is being appealed. Requests for an appeal of this decision,

and all necessary information noted above, must be received by <COMPANY> within 180 days from the receipt of this letter.

If you or your representatives believe that a delay in making an appeal decision might seriously risk your life or health, you may ask for an expedited (fast) appeal. Expedited appeal requests will be decided within 72 hours of your request.

If the request for appeal is for an inpatient level of care, the appeal will be decided within 72 hours of the request. For all other levels of care, appeal decisions are made within 15 calendar days of receipt of the request for appeal. If an appeal is requested after treatment has ended, appeal decisions are made within 30 days of the request.

If you request an appeal, you or your representative may submit any additional information you would like <COMPANY> to consider in deciding your appeal. If you appeal, we will review our decision and provide you with a written determination.

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

You may submit a claim for external review when you have exhausted the appeals provided within your benefit plan. If your claim is urgent, you may submit a claim for expedited external review before exhausting the appeals provided within your benefit plan.

To submit claims for external review, please send written request to:

<COMPANY>
Attention: <INSERT NAME AND TITLE>
<ADDRESS>
<ADDRESS>
<CITY, STATE ZIP>

If you believe your situation is urgent, please fax your claim to <INSERT FAX #>.

Please provide the following information in your external review claim:
Insurer Name, Member Name and ID #, Patient Name, Phone # and mailing address of the claimant, Tracking # in the header of the adverse determination letter.

You may have the right to challenge this adverse benefit determination on review by bringing a civil action under the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). This act governs some health benefits that are obtained through a non-government employer. For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). [Insert, if applicable in your state: Additionally, a consumer assistance program may be able to assist you at [insert contact information].]

The purpose of <COMPANY'S> review is only to decide whether requested treatment can be certified as medically necessary as your benefit plan requires. Benefits are also subject to all other benefit plan requirements and limitations at the time the services are delivered. A non-certification does not mean that you may not receive the above-named services. Instead, treatment decisions are always the responsibility of you, as the patient, and the attending provider, not <COMPANY> or your benefit plan. However, a non-certification indicates that the benefit plan will not be financially responsible for the treatment.

[Insert language assistance disclosure here, if applicable.

SPANISH (Español): Para obtener asistencia en Español, llame al [insert telephone number].

TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa [insert telephone number].

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

Sincerely,

<<Medical Director Name>>

Medical Director, <<Service Center>>



Meridian
— *Health Plan*

Meridian Health Plan

2014

Corporate Compliance and Fraud, Waste and Abuse Program

PROGRAM STATEMENT

Meridian Health Plan (“MHP”) is committed to high ethical conduct standards and full compliance with all legal and contractual obligations that apply to its business and the prevention, identification, investigation, correction and reporting of fraud, abuse and other misconduct.¹

As part of MHP’s commitment, this Corporate Compliance and Fraud, Waste and Abuse Program (“Program”) is designed to promote a high degree of integrity within the organization and to protect against unlawful or unethical activity. MHP will hold its employees, non-employee committee and board of directors, members, beneficiaries, providers, contractors and all other persons or entities involved in MHP’s business to these high ethical and moral standards.

This Program adheres to all applicable laws, regulations and guidance and has been fully implemented by MHP. MHP will adhere at all times to this Program.

MHP is also committed to tracking all applicable laws and regulations related to its business operations, and implementation of procedures designed to respond to changes in laws and regulations so that MHP is in compliance in all regards at all times.

Each MHP employee, officer and director must make a personal commitment to understand and function within the scope of this program, and specifically to:

- obey all applicable laws and regulations governing MHP;
- be honest, fair and trustworthy in all business activities and relationships;
- avoid all conflicts of interest between work and personal affairs;
- foster an atmosphere in which equal opportunity extends to every member of our diverse community;
- foster leadership at all levels that promotes a business culture where ethical conduct is recognized, exemplified and valued by all employees and others doing business with MHP;
- be accountable for compliance at all times; and
- immediately report any instance of suspected non-compliance, including fraud, waste and abuse.

See Policy and Procedure 12.6 – Code of Business Conduct and Ethics

Any questions or concerns about legal requirements or ethics may be directed to an employee’s “Code of Ethics Contact Person” (as defined in MHP’s Code of Business

¹ The term “MHP” as used in this Program document includes Meridian Health Plan and its affiliated companies. Affiliated companies include Meridian Health Plan of Michigan, Inc., Meridian Health Plan of Illinois, Inc., Meridian Health Plan of Iowa, Inc., Meridian Health Plan of New Hampshire, Inc., Caidan Management Company, LLC and MeridianRx, LLC. This Program document applies to MHP’s Medicaid, Commercial and Medicare (including Parts C & D) lines of business.

Conduct and Ethics) or the Chief Compliance Officer. Questions or concerns will be promptly addressed with care and respect.

MHP employees are expected to actively identify, question and immediately report suspected illegal or unethical conduct, including fraud, waste and abuse. MHP provides and publishes information about its toll free MHP hotline and email address through which anonymous reports of non-compliance may be made.

MHP will not attempt to identify anonymous reporters acting in good faith. The identity of non-anonymous reporters acting in good faith will be safeguarded to the fullest extent possible and reporters will be protected against retaliation or retribution, or any other form of reprisal so long as the reporter is not a party to any fraudulent or illegal activity. Any individual who threatens reprisal against a person who acts pursuant to his or her responsibilities under this Program is in violation of MHP policy and shall be subject to disciplinary action, up to and including termination of employment or the business relationship.

See Policy and Procedure 12.61 – False Claims Act.

This Program is intended to preserve and strengthen MHP's commitment to full compliance with all applicable laws and regulations and high standards of business ethics.

BENEFITS OF A COMPLIANCE PROGRAM

This Program provides a mechanism to assist MHP in reaching its goals of maximizing operational effectiveness and continuously improving the quality of care in a low resource environment by reducing the costs of health care. This Program promotes and measures adherence to all applicable laws, regulations and contractual requirements, and to prevent, detect, report and correct suspected fraud, waste and abuse. It is also designed to achieve compliance with the ethical business standards set forth in MHP's Compliance Plan and MHP's Code of Business Conduct and Ethics.

Some of the benefits that result from an effective compliance program include:

- concrete demonstration to employees and others of MHP's strong commitment to honest and responsible corporate conduct;
- an environment that encourages employees to report potential problems and suspected illegal or unethical conduct;
- increased likelihood of identifying and preventing unlawful or unethical conduct such as fraud, waste and abuse;

- formulation of effective internal controls and tracking tools to ensure compliance with applicable Federal and State law, rules and regulations, and contractual obligations;
- improved collaboration, communication, and cooperation between health care providers and MHP, as well as within the organization;
- improved collaboration, communication, and cooperation between MHP and law enforcement, regulatory agencies and agency designees (e.g. OIG, the MEDICs, etc.);
- improved communication with and satisfaction of members;
- improved clinical and non-clinical quality of care and service;
- improved assessment tools that could be used by MHP's departments; and,
- the ability to more quickly and accurately react to employee concerns and the capability of effectively targeting resources to address those concerns.

MHP CORPORATE COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM

I. Scope and Implementation

This Program applies to all employees, contracted employees, non-employee committee and board of directors members, subcontractors, providers, delegated entities, vendors, affiliated providers or anyone working on behalf of MHP or related entities of MHP who may perform Medicaid, health care related or non-health care related services.

This Program will be implemented to ensure compliance with Federal and State laws, rules and regulations, and contractual obligations applicable to MHP. Particular attention and necessary resources will be allocated to prevention, detection and correction of unlawful or unethical activity (with significant emphasis on fraud, waste and abuse) by employees, members, providers, vendors and any other person or entity involved in any of MHP's business lines, including administration of the Medicaid benefit.

II. Authority

MHP's Vice President of Legal is the Chief Compliance Officer and the chairperson of the Corporate Compliance Committee. The Chief Compliance Officer is responsible for overseeing compliance with this Corporate Ethics and Compliance Program. The Corporate Compliance Committee works in partnership with the

Chief Compliance Officer in the oversight of MHP's Corporate Ethics and Compliance Program.

The MHP Compliance Department, in coordination with the MHP Legal Department, monitors new legislation and regulations. The Compliance Department also works closely with MHP's officers, directors and employees to coordinate training, monitoring, auditing, and reporting of compliance activity. Additionally, the Compliance Department provides training, interpretation and guidance to employees with regard to matters arising under this policy, including, but not limited to, HIPAA and HITECH privacy and security issues and fraud, waste and abuse.

The Board of Directors annually affirms the MHP Corporate Compliance Program (including the Code of Business Conduct and Ethics) and retains authority to independently audit practices and performance under this Program.

Please contact the Chief Compliance Officer at (313) 324-3746 if you have questions regarding this Program.

III. Standards of Conduct

- A. MHP's standards of conduct for compliance with applicable laws, regulations, contractual requirements, and business ethics are set forth in this Compliance Plan and MHP's Code of Business Conduct and Ethics.
- B. The Compliance Plan and Code of Business Conduct and Ethics are reviewed at least once annually by the Board of Directors and revised or affirmed. However, modifications can be made to the Compliance Plan and Code of Business Conduct and Ethics as often as necessary during the year.

IV. Organizational Support

The Board of Directors shall be kept informed about the content and operation of this Program and shall exercise reasonable oversight with respect to the implementation and effectiveness of this Program. To that end, a Corporate Compliance Committee has been established by Board of Directors to oversee the development, implementation, and monitoring of this Corporate Compliance Program. The Corporate Compliance Committee Charter is attached as Appendix A. The current Compliance Committee members are as follows:

Members of the Corporate Compliance Committee

MHP's Corporate Compliance Committee is currently comprised of the following individuals:

| <u>Name</u> | <u>Position at Meridian Health Plan</u> |
|------------------------------|--|
| Michael Stines (Chairperson) | Vice President of Legal, Chief Compliance Officer, and Privacy Officer |
| Michael Cotton | Corporate Chief Operating Officer |
| Sean P. Cotton | Chief Administrative Officer |
| Jon B. Cotton | President & Chief Operating Officer of Meridian Health Plan Michigan |
| Carl Rashid | Associate General Counsel |
| Jane Goldsmith | Vice President of Regulatory Compliance and Accreditation |
| Thomas Petroff | Chief Medical Officer |
| Janice Torosian | Chief Financial Officer |
| Matthew Agnone | Director of Finance |
| Raymond Pitera | Chief Development Officer |

V. Role of the Chief Compliance Officer

The Chief Compliance Officer has the day-to-day responsibility to oversee the Compliance Program.

- A. The Chief Compliance Officer will confer with and report to senior management and the Corporate Compliance Committee on matters relating to this Program.
- B. The Chief Compliance Officer will report quarterly to the Corporate Compliance Committee on the status of this Program, including issues identified, investigated and resolved by the Program. The Chief Compliance Officer may recommend changes to this Program.
- C. The Compliance Officer will coordinate day-to-day activities to ensure compliance with all applicable Federal and State law, rules and regulations, contractual obligations and standards of business conduct. This includes verification of written policies and procedures when applicable, communication, training and education, monitoring, auditing and reporting, responding to violations, and discipline as described in this Program.

- D. As appropriate, the Chief Compliance Officer will work with the MHP Legal Department to distribute to particular employees information that explains Federal or State law, rules and regulations or contractual obligations that apply to MHP. The Chief Compliance Officer, in conjunction with MHP's Legal Department, will monitor, on a continuing basis, MHP's policies and procedures for the purpose of ensuring ongoing compliance with current legal, regulatory and contractual requirements.
- E. The Chief Compliance Officer is responsible for reporting to senior leadership with respect to any deficiencies identified or improvements needed in this Program.
- F. The General Counsel, along with the Chief Compliance Officer will ensure that all reports of suspected illegal or unethical conduct, including suspected fraud, waste and abuse, are promptly and thoroughly investigated in accordance with standard procedures.
- G. The General Counsel, along with the Chief Compliance Officer shall ensure that all suspected fraud, waste and abuse in any government program is promptly reported to the appropriate governmental authority.
- H. In cases where employee disciplinary action may be warranted, as the result of unethical or illegal conduct, the Chief Compliance Officer will coordinate with MHP's Human Resources Department, the General Counsel and appropriate supervisors and leadership to establish proper disciplinary sanctions in accordance with MHP policy and procedure.
- I. In cases where contracted provider or other contractor sanctions may be warranted as the result of unethical or illegal conduct including, but not limited to, fraud, waste and abuse, the General Counsel, along with the Chief Compliance Officer will coordinate with Medical Management, Provider Services or other appropriate leadership to establish proper disciplinary sanctions in accordance with MHP policy and procedure.
- J. In certain cases, where suspected unethical or illegal conduct warrants, the Chief Compliance Officer may report the conduct directly to the Corporate Compliance Committee, the Chief Executive Officer, the Chief Financial Officer, the General Counsel or directly to the Board of Directors as the facts and circumstances warrant.

VI. Delegation of Substantial Discretionary Authority

- A. MHP will not employ any person or engage or contract with any vendor, contractor (including first tier, downstream and related entities) or provider whose name appears on the OIG's List of Excluded individuals and Entities (LEIE) (<http://www.oig.hhs.gov/fraud/exclusions.asp>) and the GSA's Excluded Party List

System (EPLS) (<https://www.epls.gov>). MHP will review the applicable lists at the time of hire in the case of an employee or board director and prior to entering into a contract in the case of a vendor, contractor (including first tier, downstream and related entities) or provider to ensure that the person or entity at issue does not appear thereon. MHP will review the applicable lists no less than annually thereafter to ensure that none of MHP's employees, board directors, vendors, contractors (including first tier, downstream and related entities) or providers appear thereon. In the event any MHP employee, board director, vendor, contractor (including first tier, downstream and related entities) or provider appears on any of the applicable lists, MHP will immediately terminate employment or the business relationship which such person or entity.

- B. The Human Resources Department and Legal Department will review whether to hire or retain individuals or organizations with a history of felony convictions, other convictions for crimes of fraud or dishonesty, or other reported or discovered misconduct under the Code of Business Ethics and Conduct. The Chief Compliance Officer, the MHP Legal Department and MHP Human Resources Department will recommend any needed changes to this policy to the Corporate Compliance Committee.
- C. It is the policy of MHP that substantial discretionary authority will not be delegated to individuals with whom MHP knows has a propensity to engage in inappropriate, improper or illegal conduct. In particular, substantial discretionary authority will be delegated only to individuals with whom MHP is confident will not engage in illegal activities.
- D. The Chief Compliance Officer and the Human Resources Department will periodically jointly review MHP's procedures and criteria for filling positions involving substantial discretion, so as to ensure that only persons of high moral and ethical standards are selected for such positions.

VII. Elements

The Program includes the following nine elements:

A. Written Policies and Procedures

1. Standards of Conduct—MHP's standards of conduct for compliance with Federal and State law, applicable rules and regulations, and contractual obligations are set forth Code of Business Conduct and Ethics. Specific procedures have been developed and are followed by MHP employees performing duties in *de facto* risk areas, including:
 - Benefits and beneficiary protections
 - Quality assessment and performance improvement
 - Enrollment and Eligibility
 - Marketing

- Solvency, licensure and other State regulatory issues
- Claims processing; and
- Appeals and grievances

B. Tracking Laws and Regulations Affecting Business Operations

1. MHP shall track laws and regulations applicable to MHP's business operations by such activities as:
 - Reviewing policy and legislative updates received from the Association of Health Insurance Plans (AHIP).
 - Review proposed and final interim rules appearing in the Federal Register and issued by the Centers for Medicare and Medicaid Services.
 - Designate liaisons to maintain regular communication with the Department of Healthcare and Family Services, the Centers for Medicare and Medicaid Services, and other applicable governmental agencies.
 - Regular review of HIPAA, HITECH, applicable Health Maintenance Organization statutes and all applicable laws relating to licensing by the legal department.
 - Submission and approval to appropriate regulatory authorities of all contracts, marketing material and other documents prior to use in accordance with applicable regulation.
2. MHP shall react to new laws and regulations and changes to existing laws and regulations by modifying its internal business processes. Upon learning of a condition in a law or regulation requiring a change in internal business processes, MHP shall immediately notify management in affected departments of the modification necessary and document same through changes to its policies and procedures.
3. MHP department directors and managers are notified annually of their responsibility to monitor and enforce all internal policies and procedures related to core business operations. Department directors are required to report compliance status and activities to appropriate committees, senior leaders charged with oversight and, ultimately, the Board of Directors.

C. Compliance Committee

1. The Corporate Compliance Committee maintains the authority to oversee the development, implementation, and monitoring of this Program. The Corporate Compliance Committee and Chief Compliance Officer are directly accountable to the CEO and Board of Directors.

2. The Chief Compliance Officer has the day-to-day responsibility to oversee regulatory compliance this Program and the Code of Business Conduct and Ethics. The Corporate Compliance Committee shall appoint a single individual to act as the liaison to HFS, DCH, and IME for the purpose of reporting suspected fraud, waste and abuse.
3. The Chief Compliance Officer must be an employee of MHP (or MHP's parent organization or corporate affiliate) and is primarily responsible to manage the daily monitoring, auditing and reporting processes developed specifically for this Program.

D. Effective Training and Education

1. All MHP employees, officers, managers and directors, contractors, subcontractors and first tier, downstream and related entities, including contracted providers are required to provide annual, written acknowledgement of having reviewed and understood the Code of Business Conduct and Ethics as well as fraud, waste and abuse training.

Note: first tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse.

2. Specialized information and/or training on fraud, waste and abuse is provided to MHP employees whose job responsibilities implicate specific risk areas related to MHP.

See Compliance Policy and Procedure 14.10 – Effective Training and Education.

3. MHP provides HIPAA training as well as conflict of interest training to all employees on an annual basis.
4. Updates and training, as needed, to MHP employees, officers, managers and directors, contractors, subcontractors and first tier, downstream and related entities regarding implementation of new or changes to internal policies and procedures.

E. Effective Lines of Communication

1. All MHP employees, including the compliance officer, members of the compliance committee, officers, managers and directors (and contractors including first tier, downstream and related entities where appropriate) are trained on how to identify potential fraud, waste and abuse and have access

to information regarding MHP's commitment to comply with all applicable laws, regulations, contractual requirements, policies and procedures, and the respective roles of leaders and employees in reporting and in receiving reports of illegal or unethical conduct committed by any person or organization impacting MHP.

2. MHP employees are trained in the various methods by which to report suspected fraud, waste and abuse, and encouraged to contact the Chief Compliance Officer with questions or concerns. Other entities are encouraged to communicate issues to the Chief Compliance Officer. The Chief Compliance Officer has an open door policy and is available at any time to discuss any compliance concerns. Reports received will be treated confidentially to the extent permitted under applicable law and regulation.

Mechanisms for reporting non-compliant behavior and suspected fraud, waste and abuse have been established for MHP, including a hotline [1-877-218-7949], an email address (as set forth in the Meridian Health Plan Fraud, Waste and Abuse Process Manual), and an automated FWA tracking module through which employees can submit referrals directly. Reports may also be submitted directly to the Chief Compliance Officer. All submissions are documented and investigated in the manner set forth in the Meridian Health Plan Fraud, Waste and Abuse Process Manual. Procedures have been established to protect anonymity, if desired, and protect against retaliation in all circumstances. MHP will not retaliate against or intimidate any person for good faith participation in the Compliance Plan, including but not limited to: reporting potential issues, investigating issues, conducting self-evaluations, audits, and remedial actions, and reporting to appropriate officials.

3. Updates and training, as needed, to MHP employees, officers, managers and directors, contractors, subcontractors and first tier, downstream and related entities regarding implementation of new or changes to internal policies and procedures.
4. Employees, officers and directors are required to sign a confidentiality agreement, which provides for the protection of PHI and other confidential information.

See Compliance Policy and Procedure 14.20 – Effective Lines of Communication to Promote Compliance.

F. Enforcement of Well-Publicized Disciplinary Guidelines

1. MHP employees are expected to actively identify, question and report suspected illegal or unethical conduct, including fraud, waste and abuse. MHP provides and publishes information about its toll free MHP hotline and

email address through which anonymous reports of non-compliance may be made. MHP employees are further expected to assist in the resolution of the reported non-compliant or unethical behavior or activity.

2. Non-compliant or unethical behavior includes, but is not limited to, conduct that constitutes fraud, waste, and abuse, conduct in violation of any Federal or State law or regulation, or failure to perform any other legal responsibility.
3. MHP shall timely, consistently, and effectively enforce the standards set forth in this Program when non-compliant or unethical behavior or activity is determined.
4. MHP publicizes and communicates disciplinary guidelines to its employees and contractors on a regular basis. This is done through newsletters, emails and performance reviews.
5. MHP shall consistently enforce the standards set forth in the Code of Business Conduct and Ethics, this Program and all other internal policies and procedures through appropriate disciplinary mechanisms.
6. MHP shall comply with the prohibition against hiring of or entering into contracts with individuals or entities who have been convicted of a criminal offense related to health care or are listed as debarred, excluded, or otherwise ineligible for participation in any federally-funded health care program.

See Compliance Policy and Procedure 14.30 – Enforcement of Well-Publicized Disciplinary Guidelines.

G. Monitoring and Auditing

1. Monitoring
 - I. All MHP employees with leadership responsibilities are advised, at least annually, of their duty to monitor the activities of their subordinates to ensure those activities are in accordance with all applicable laws, regulations, contractual requirements, internal policies and procedures, and standards in the Code of Business Conduct and Ethics.
 - II. All MHP employees and non-employee committee and board of directors members shall sign a Confidentiality Agreement to document the understanding of such employees and non-employees of their responsibility to preserve confidentiality of sensitive or protected information they may be given or have access to.

- III. The Chief Compliance Officer will develop sampling protocols and conduct regular, periodic monitoring reviews focused on the aforementioned specific risk areas within MHP's operations. In addition, the Chief Compliance Officer will develop protocols and conduct regular, periodic reviews of whether the Program elements have been satisfied (e.g. appropriate dissemination of standards, training effectiveness, adequacy of records, etc.).

2. Internal Auditing

- I. MHP will conduct periodic audits of identified risk areas across MHP's operations. The Chief Compliance Officer is responsible for coordinating such audits. The audits will be conducted in accordance with a Workplan to be reviewed, updated and reviewed annually by the Corporate Compliance Committee. The Workplan will be designed to ensure: (1) proper capturing of documentation; and (2) execution of processes in accordance with MHP's policies and procedures. The Workplan will also be designed so as to maximize detection of fraud, waste and abuse.

3. External Auditing – Effectiveness of Compliance Program

- I. MHP will audit the effectiveness of its, including FDRs', compliance with CMS requirements and the overall effectiveness of the compliance program on an annual basis. In order to avoid self-policing, MHP will either: (1) train employees who are not part of the compliance department to perform such audit, or (2) outsource the audit to external auditors.

See Fraud, Waste and Abuse Policies and Procedures 12.2, 12.3, 12.4, 12.5, 12.9, 12.10, 12.11, 12.31, 12.32 and Compliance Policy and Procedure 14.40

H. Prompt Response to Offenses, Corrective Action, and Reporting

1. The Chief Compliance Officer will establish, publish, and oversee a reporting system comprised of several independent paths allowing employees, officers, managers and directors (and contractors including first tier, downstream and related entities where appropriate) to report (anonymously if desired) any suspected misconduct or impropriety relating to MHP operations committed by any person or organization impacting MHP.
2. MHP will act promptly in accordance with governmental agency regulations as well as internal policies and procedures to respond and resolve compliance violations and investigate suspected fraud, waste and abuse.

3. Any employee or contractor (including providers or first tier, downstream and related entities) who learns of a possible or actual fraud, waste and abuse or violation of applicable laws, rules, regulations, policies and procedures related to contractual obligations, or standard of conduct is to immediately notify the Chief Compliance Officer. Upon notification, appropriate steps will be taken to examine the information, conduct an investigation and implement corrective action in accordance with MHP policies and procedures.
 - a. All investigations of suspected fraud, waste and abuse are conducted in accordance with the Meridian Health Plan Fraud, Waste and Abuse Process Manual.
 - b. MHP shall report all instances of fraud, waste and abuse, including any required certifications, to the appropriate governmental agency, within the timeline and in the manner set forth in the Meridian Health Plan Fraud, Waste and Abuse Process Manual.
 - c. As a matter of policy, MHP shall not conduct any investigation of suspected fraud, waste or abuse by personnel of a governmental agency, but shall report such incidents in the manner set forth in the Meridian Health Plan Fraud, Waste and Abuse Process Manual.
 - d. MHP shall investigate potential fraud, waste and abuse only to the point necessary to determine whether a report to the appropriate governmental agency is required. Any investigation beyond such point shall only occur upon receipt of express authorization of the appropriate governmental agency. If an investigation discloses potential criminal acts, the appropriate governmental agency shall be immediately notified.
 - e. MHP shall fully cooperate with all investigations by a governmental agency and provide all requested information and documentation.

See Compliance Policy and Procedure 14.50 – Prompt Response to Violations and Corrective Action Plans.

Appendix A

MERIDIAN HEALTH PLAN

CORPORATE COMPLIANCE COMMITTEE CHARTER

I. Purpose and Authority

The Meridian Health Plan² Corporate Compliance Committee (the “Committee”) is established for the primary purpose of overseeing the:

- Compliance with legal and regulatory requirements;
- System of internal controls regarding legal and regulatory compliance; business ethics; fraud, waste and abuse; contracts; training and education; and guideline enforcement; and
- Performance of internal audit and regulatory functions of Meridian Health Plan

Consistent with this function, the Committee should encourage continuous improvement of, and foster adherence to, the policies, procedures and practices of Meridian Health Plan. The Committee also strives to provide an open avenue of communication among management, the internal audit and regulatory compliance functions, and the Board of Directors.

The Committee has the authority to initiate investigations and audits to address areas of particular concern to Meridian Health Plan. In addition, the Committee has the authority to obtain advice and assistance from outside legal, accounting, or other advisors as it deems appropriate to perform its duties and responsibilities.

The Committee will primarily fulfill its responsibilities by carrying out the activities enumerated in Section III of this Charter.

II. Composition and Meetings

The Committee shall be comprised of three or more members as appointed by the Board of Directors, one of whom is designated by the Board as Chairperson of the Committee. The Chief Compliance Officer shall be a member of the Committee. Each Committee member shall be free from any relationship that would interfere with the

² The term “MHP” as used in this Program document includes Meridian Health Plan and its affiliated companies. Affiliated companies include Meridian Health Plan of Michigan, Inc., Meridian Health Plan of Illinois, Inc., Meridian Health Plan of Iowa, Inc., Meridian Health Plan of New Hampshire, Inc., Caidan Management Company, LLC and MeridianRx, LLC. This Program document applies to MHP’s Medicaid, Commercial and Medicare (including Parts C & D) lines of business.

exercise of his or her independent judgment as a member of the Committee. The Committee shall meet at least monthly or more frequently as circumstances dictate. As part of its role to foster open communication, the Committee may periodically host management personnel at its regularly scheduled meeting.

III. Duties and Responsibilities

A. Regulatory Compliance and Business Ethics

- Maintain responsibility for the administration of this Program.
- Approve the appointment of and maintain a direct reporting relationship with the Chief Compliance Officer, the position responsible for day-to-day compliance oversight for Meridian Health Plan.
- Appoint a single individual to act as the liaison to state and federal governmental agencies for the purpose of reporting suspected fraud, waste and abuse.
- Approve Meridian Health Plan, Inc.'s Compliance Program and oversee the implementation and execution of the requirements of the program. Require periodic updates from the Chief Compliance Officer as to the accomplishment and maintenance of the compliance program requirements.
- Review and periodically update the Code of Business Ethics and Conduct, ensure that management has established a system to enforce the Code, and review management's monitoring of the Code.
- Advise management and the Chief Compliance Officer that they are expected to provide to the Committee a timely report and analysis of any significant regulatory compliance issues. Review and approve management corrective action plans designed to mitigate the risk of identified compliance issues. Ensure that reasonable steps are taken to respond appropriately to compliance issues and to prevent further similar issues from occurring.
- Review the effectiveness of the system for monitoring compliance with laws and regulations and the results of management's investigation and follow-up of any instances of non-compliance.
- Review with Meridian Health Plan's legal counsel any legal matter that could have significant impact on Meridian Health Plan.
- Oversee Meridian Health Plan's Conflict of Interest policy. Receive a compilation of disclosures of interests along with management's recommendations to resolve conflicts in accordance with policy. Review and

determine whether management's proposed resolution of the issues raised by the disclosures is satisfactory and, if not, require such further action as the Committee deems necessary.

- Oversee Meridian Health Plan's internal audit program. Approve annual internal audit plan. Require a summary of significant audit matters along with a description of the progress or resolution achieved during the prior year.

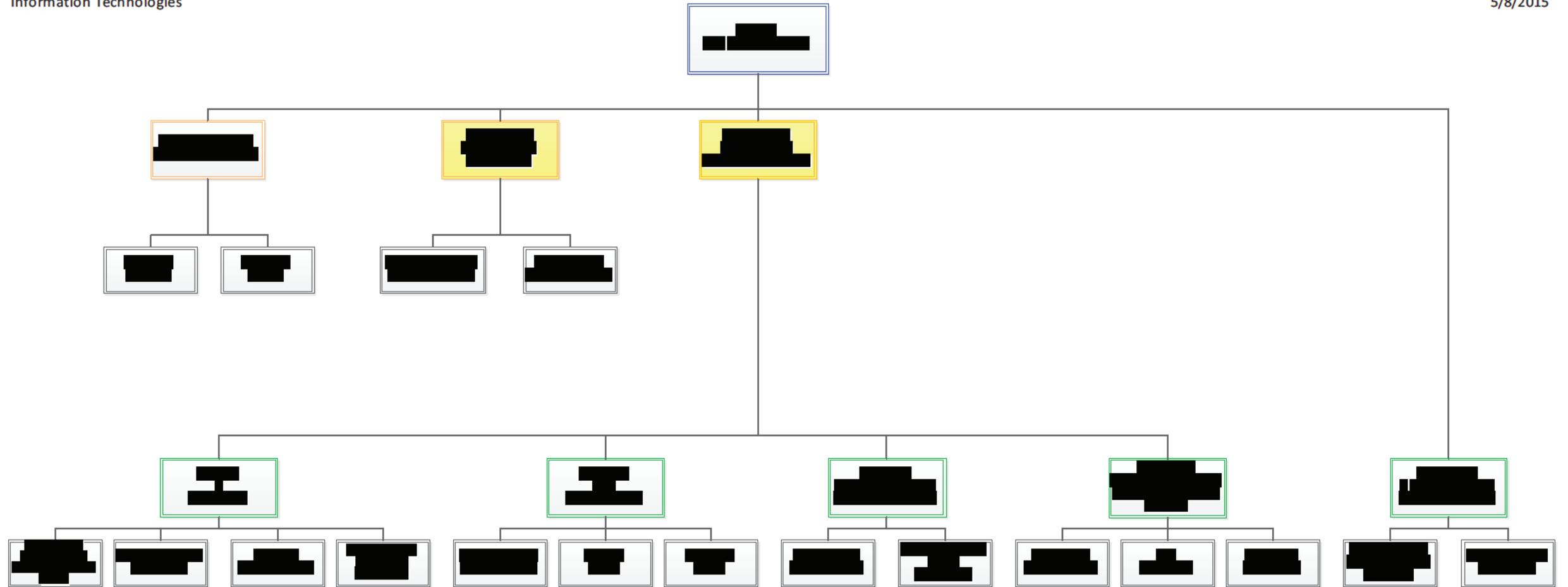
B. Responsibilities to the Board of Directors

- Provide a timely report to the Board of Directors of any Committee concern that may arise with respect to compliance with regulatory requirements for Meridian Health Plan.
- Provide the Board of Directors with periodic reports that summarize the key activities of the Committee to demonstrate the accomplishment of the Committee's duties and responsibilities.
- Following review and approval by the Committee, present for action by the Board of Directors the Code of Business Ethics and Conduct and the Compliance Plan, as deemed necessary upon significant revision.

C. Other Responsibilities

- Periodically, perform a self-assessment as to the Committee's purpose, duties and responsibilities outlined herein.
- Perform any other activities consistent with this Charter, Meridian Health Plan's By-Laws and governing law, as the Committee deems necessary or appropriate.

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Attachment 39 (Sample Release Management Plans)

| Portfolio Phase | Project ID | Project Name /Item ID | Description | Comments | Mandate | Analyst | Spec Route | Spec Approved | Lead Developer | Dev Due Date | QA Analyst | QA Due Date | UAT Due Date | Risk | Project Status | Target Go Live | Actual Go Live | Lead | Sponsor / Approver |
|-----------------|------------|-----------------------|-------------|------------|------------|------------|------------|---------------|----------------|--------------|------------|-------------|--------------|------------|----------------|----------------|----------------|------------|--------------------|
| | | | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| | | | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| | | | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

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CMC IT Development

Release Name: December

Date Range: 11/24/14 - 12/12/14

| Changepoint # | Item Name | Type | Dev Est | Requesting Dept. | Exec Sponsor | Requestor | DL | BA | Programmer | QA | RN? | Cur Phase | Rlse Status |
|---------------|------------|------------|---------|------------------|--------------|-----------|------------|------------|------------|------------|-----|------------|-------------|
| [REDACTED] | [REDACTED] | [REDACTED] | | | | | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | | [REDACTED] | Green |
| [REDACTED] | [REDACTED] | [REDACTED] | | | | | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | | [REDACTED] | Red |
| [REDACTED] | [REDACTED] | [REDACTED] | | | | | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | | [REDACTED] | Green |
| [REDACTED] | [REDACTED] | [REDACTED] | | | | | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | | [REDACTED] | Red |
| [REDACTED] | [REDACTED] | [REDACTED] | | | | | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | | [REDACTED] | Green |
| [REDACTED] | [REDACTED] | [REDACTED] | | | | | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | | [REDACTED] | Green |
| [REDACTED] | [REDACTED] | [REDACTED] | | | | | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | | [REDACTED] | Yellow |
| [REDACTED] | [REDACTED] | [REDACTED] | | | | | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | | [REDACTED] | Yellow |
| [REDACTED] | [REDACTED] | [REDACTED] | | | | | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | | [REDACTED] | Green |
| | | WO | | | | | | | | | | | |

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**Corporate Business Continuity
& Disaster Recovery Plan
2015**

A. Introduction

The senior leadership of Caidan Enterprises instituted this business continuity and disaster recovery plan to ensure that the organization is prepared to respond efficiently and effectively in the event of a disaster. This Disaster Recovery Plan addresses the needs of all subsidiaries of Caidan Enterprises, including Caidan Management Company, LLC (CMC), Meridian Health Plan (MHP), Meridian Advantage Plan of Michigan (HMO SNP), Meridian Advantage Plan of Illinois (HMO SNP), Meridian Advantage Plan of Iowa (HMO SNP), Meridian Complete, Meridian Prime, Meridian Choice, Advantage Plus - Meridian and MeridianRx.

Caidan Management Company provides administrative services, staffing and information technology support for their sister companies, Meridian Health Plan, Meridian Advantage Plan of Michigan (HMO SNP), Meridian Advantage Plan of Illinois (HMO SNP), Meridian Advantage Plan of Iowa (HMO SNP), Meridian Complete, Meridian Prime, Meridian Choice, Advantage Plus - Meridian and MeridianRx. As such, the Disaster Plan is written from the perspective of Caidan Management Company. If there are specific processes that apply only to one company, they are identified. Otherwise, the processes are applied universally throughout the organization.

1. Corporate Information

The corporate address for Caidan Management Company, Meridian Health Plan (MI), Meridian Advantage Plan of Michigan (HMO SNP), Meridian Advantage Plan of Illinois (HMO SNP), Meridian Advantage Plan of Iowa (HMO SNP), Meridian Prime, Meridian Complete and Advantage Plus - Meridian is:

777 Woodward Avenue, Suite 600
Detroit, MI 48226

Phone: (313) 324-3700
Fax: (313) 202-0006

The corporate address for MeridianRx is:

1001 Woodward Avenue, Suite 700
Detroit, MI 48226

Phone: 1-866-334-6462
Fax: 1-877-355-8070

Meridian Health Plan operates offices in Illinois and Iowa.

| Meridian Health Plan Illinois | Meridian Health Plan Iowa |
|--|--|
| 333 S. Wabash Suite 2900 Chicago, IL 60604 | 666 Grand Avenue 14 th Floor Des Moines, IA 50309 |
| Phone: (312) 705-2900 Fax: (312) 980-0404 | Phone: (515) 802-3500 Fax: (515) 802-3572 |

The primary data center for all customers of Caidan Management Company, LLC is located at



2. Purpose

The purpose of this business continuity and disaster recovery plan is to provide procedures and guidelines to ensure restoration of information systems and business operations in a timely manner.

The main objectives of CMC in a disaster situation are:

- Take immediate action to ensure the safety of CMC employees and the protection of CMC property and assets.
- Ensure the security of protected health information – both electronic and paper – that is in the possession of CMC at the time of the incident.
- Minimize the impact of any interruptions in computer systems, telephone service or other technology applications.
- Ensure that priority business operations are restored as quickly as possible.
- Communicate effectively with employees, customers and vendors to ensure a smooth and orderly recovery process.
- Mitigate any short or long-term negative consequences of the disaster situation.

In order to achieve these objectives, CMC has designated a Disaster Recovery Team responsible for making critical decisions in a disaster situation. Information about this team is provided in Section D of this plan.

B. Disaster Levels

CMC developed the following levels to classify a disaster situation. The action plan and operational activities vary based on the severity of the disaster. The severity levels are on a scale [REDACTED]

| Level | Definition | Examples | Bldg. Access | Computer System Access | Phone Access | Estimated Duration |
|-------|------------|------------|--------------|------------------------|--------------|--------------------|
| I | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| II | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

| Level | Definition | Examples | Bldg. Access | Computer System Access | Phone Access | Estimated Duration |
|-------|------------|------------|--------------|------------------------|--------------|--------------------|
| I | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| I | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| I | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

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C. Information Technology Back Up/Recovery Infrastructure

This section describes the existing technology infrastructure to reduce the risk of system failures and provide timely and complete recovery of technology applications in the event that a disaster situation should occur. [REDACTED]

1. Protection of Computer Data

CMC has an extensive network of servers to store its electronic data, including protected health information. [REDACTED]

- [REDACTED]
- [REDACTED]
- [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

CMC uses many products to monitor the critical servers and network devices (nodes):

[REDACTED]

MeridianRx Data

MeridianRx is the pharmacy benefit manager for Meridian Health Plan in Michigan and Illinois; Meridian Advantage Plan of Michigan (HMO SNP), Meridian Advantage Plan of Illinois (HMO SNP) and Meridian Advantage Plan of Iowa (HMO SNP); Meridian Prime, Meridian Complete, Meridian Choice and Advantage Plus - Meridian.

[REDACTED]

[REDACTED]

[REDACTED]

a. Data Back Up Plan

CMC currently maintains back up servers for critical applications

[REDACTED]

[Redacted]

4. Telephone System Back Up

[Redacted]

[Redacted]

Protection of Computer Room

[Redacted]

[Redacted]

Fire Prevention

The Detroit offices are equipped with a fire extinguisher on each floor and the building is equipped with a 100% water sprinkler system in the stairwells.

[Redacted]

b) Flood Prevention

[Redacted]

c) Temperature and Environmental Controls

[Redacted]

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[REDACTED]

d) Power Interruption or Power Outage

[REDACTED]

6. Building Security

CMC uses an access card system to control entry into its office suite and specific rooms within the office suite.

[REDACTED]

Michigan Locations

777 Woodward

The following is the schedule for building access for the 777 Woodward Avenue Detroit, Michigan location:

Monday through Friday Access:

The building hours are from 6:00 AM to 6:00 PM. After 6:00 PM an access card must be swiped on the outside door for entrance into the building. There is security on staff at the main desk 24/7.

Saturday and Sunday Access:

The building is open on Saturdays from 6:00 AM to 2:00 PM. After 2:00 PM an access

card must be swiped on the outside door for entrance into the building. The building is locked down on Sunday. If an employee must report to work, his or her access card must be swiped on the outside door for entrance into the building. There is security on staff at the main desk 24/7.

The building has an on-site leasing and building management office with assigned staff that monitor the safety and security of the building.

1001 Woodward

The following is the schedule for building access for the 1001 Woodward Avenue Detroit, Michigan location:

Monday through Friday Access:

The building hours are from 6:00 AM to 7:00 PM. After 7:00 PM, the building is locked and a security guard must provide access. Employees entering after 7:00 PM must swipe their employee access card on the outside door for entrance into the building. There is security on staff at the main desk 24/7.

Saturday and Sunday Access:

The building is open on Saturdays from 6:00 AM to 2:00 PM. After 2:00 PM, the building is locked and a security guard must provide access. Employees entering after 2:00 PM must swipe their employee access card on the outside door for entrance into the building. The building is locked down on Sunday. If an employee must report to work, his or her access card must be swiped on the outside door for entrance into the building. There is security on staff at the main desk 24/7.

Illinois Office

The following is the schedule for building access for the Meridian Health Plan offices located at 333 South Wabash Avenue in Chicago, Illinois:

Monday through Friday Access:

The building is open from 6:00 AM to 6:00 PM. During building hours, employees may enter through lobby doors. After hours, one revolving door is typically open. If the door is locked, employees may use their building id card at the electronic security card reader. There is also an intercom available to contact building security. Once inside the building, employees must use their building id cards to proceed through the turnstiles and get to the elevators.

Saturday and Sunday Access:

The building is open on Saturday and Sunday from 8:00 AM to 1:00 PM. It is open to employees any time; provided employees have their building id cards.

Security personnel are on duty 24 hours a day, every day of the year including holidays.

Iowa Office

Since the Des Moines office is connected to a hotel, it is accessible 24 hours per day, 7 days per week. Employees must use their building-issued badges to gain access to the elevator and the MHP office suite.

7. Asset Management and Inventory

[Redacted]

8. Location of Critical Business Information

[Redacted]

D. Disaster Recovery Team

The Corporate Disaster Recovery Team consists of key leadership of Uaidan Management Company. This team has the authority to declare a disaster situation and invoke all or part of this plan. The team will make decisions regarding what actions are to be taken in the event of a disaster and will retain primary accountability for all contingency operations. The team leader or alternate has the primary responsibility in determining when to move to the emergency operations center.

1. Membership

The following are the members of the Corporate Disaster Recovery Team:

| Team Leader | | |
|-----------------------|------------|------------|
| [Redacted] | [Redacted] | [Redacted] |
| [Redacted] | [Redacted] | [Redacted] |
| [Redacted] | [Redacted] | [Redacted] |
| Alternate Team Leader | | |
| [Redacted] | [Redacted] | [Redacted] |
| [Redacted] | [Redacted] | [Redacted] |
| [Redacted] | [Redacted] | [Redacted] |
| Team Member | | |
| [Redacted] | [Redacted] | [Redacted] |
| [Redacted] | [Redacted] | [Redacted] |
| [Redacted] | [Redacted] | [Redacted] |
| Team Member | | |
| [Redacted] | [Redacted] | [Redacted] |
| [Redacted] | [Redacted] | [Redacted] |

| | | | |
|--------------------|------------|------------|------------|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| Team Member | | | |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

DR Team – Illinois

| | | | |
|------------------------------|------------|------------|------------|
| Team Leader | | | |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| Alternate Team Leader | | | |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

DR Team – Iowa

| | | | |
|--------------------|------------|------------|------------|
| Team Leader | | | |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

2. Roles and Responsibilities

The primary responsibilities of the Disaster Recovery Team are as follows:

- Receive initial notification of a disaster situation
- Assess the damage to the corporate office and the potential impact on business operations
- Declare a disaster situation and execute the Disaster Recovery Plan
- Determine whether business operations can continue at the corporate office or if the emergency operations center should be activated
- Develop a notification strategy and coordinate communication with employees
- Notify key customers and vendors, as appropriate
- Prioritize the order in which technology applications are to be restored
- Oversee and monitor the activities of the Business Unit Recovery Teams
- Determine the long-term recovery strategy, in the event that the corporate offices are out of service for an extended period of time

In addition, the team is responsible for the ongoing maintenance, testing and updating of the Disaster Recovery Plan. These activities are outlined Section I of this document.

3. Organizational Structure

The Disaster Recovery Team includes key members of executive management within Caidan Management Company. Critical issues related to Disaster Recovery will be discussed during the executive team meetings. In addition, the Disaster Recovery Team will coordinate its activities with the IT Technology Steering Committee and the Privacy and Security Committee, where appropriate. The Chief Information Officer is the designated Security Officer for the organization. She will be responsible for ensuring compliance with all HIPAA security standards.

E. Business Unit Recovery Teams

In order to facilitate effective recovery of business operations, recovery teams have been established for each business unit. Depending upon the nature and extent of the disaster, any or all of these teams can be activated so the recovery process can occur according to the needs of the company.

1. Membership

The following are the Business Unit Recovery Teams established by CMC:

| Team | Departments | Team Leader | Alternate |
|------------|-------------|-------------|------------|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

| Team | Departments | Team Leader | Alternate |
|------------|-------------|-------------|------------|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

The full list of team members and contact information is included in Attachment A.

2. Roles and Responsibilities

Each Business Unit Recovery Team shall create its own documentation binder with the critical information needed to resume and maintain operations. The following are some of the general responsibilities of each team:

- Coordinate the department's immediate response in the event of a building evacuation and ensure that all employees are accounted for.
- Ensure initial notification of employees and maintain ongoing communication with employees throughout the disaster situation.
- Facilitate the resumption of business unit operations, as directed by the Disaster Recovery Team and in accordance with the Business Unit Recovery Plan.
- Institute manual business operations if necessary, and ensure availability of the necessary forms and supplies for employees.
- Facilitate the transfer of staff and supplies to the emergency operations location.
- Provide updates and instructions to key customers and/or vendors regarding any changes in procedures as a result of the disaster situation.

This information above is provided with the understanding that each team will have specific duties and responsibilities, dependent upon the functions of the business unit and the nature of the disaster. The Business Unit Recovery Plan outlines the activities for each department.

F. Immediate Response for Disaster Situations

Depending upon the nature of the disaster, there may be various consequences that affect business operations. The response of the organization and the Disaster Recovery Team will depend upon the nature of the disaster and the consequences. A brief assessment of the types of disasters and the possible consequences is included in the following table. The likelihood of each disaster type may differ among locations. *See Appendix A for Pandemic Plan.*

Likelihood of Occurrence by Location

| Type of Disaster | Potential Consequences | MI | IL | IA |
|--|--|----|----|----|
| Fire | Prohibited Access, Disrupted Power/Power Outage, Water Damage, Mildew or Mold Damage, Smoke Damage, Structural Damage | ■ | ■ | ■ |
| Flood | Prohibited Access, Disrupted Power/Power Outage, Water Damage, Mildew or Mold Damage, Structural Damage | ■ | ■ | ■ |
| Severe Winter Storm | Travel Restrictions, Disrupted Power/Power Outage, Communication Loss | ■ | ■ | ■ |
| Power Outage | Prohibited Access, Disrupted Power/Power Outage, Communication Loss | ■ | ■ | ■ |
| Computer System Failure | Communication Loss, Manual Operations Mode | ■ | ■ | ■ |
| Computer Hackers/Virus | Communication Loss, Manual Operations Mode | ■ | ■ | ■ |
| Civil Disorder | Prohibited Access, Disrupted Power/Power Outage, Ruptured Gas Mains, Smoke Damage, Structural Damage, Communication Loss | ■ | ■ | ■ |
| Gas Main Break | Prohibited Access, Disrupted Power/Power Outage, Ruptured Gas Mains, Communication Loss | ■ | ■ | ■ |
| Hazardous Materials Incident | Prohibited Access, Chemical Damage | ■ | ■ | ■ |
| Tornado | Prohibited Access, Disrupted Power/Power Outage, Structural Damage, Communication Loss | ■ | ■ | ■ |
| Earthquake | Prohibited Access, Disrupted Power/Power Outage, Ruptured Gas Mains, Structural Damage, Communication Loss | ■ | ■ | ■ |
| Bomb Threat/Explosion/Terrorist Attack | Prohibited Access, Disrupted Power/Power Outage, Ruptured Gas Mains, Smoke Damage, Structural Damage, Communication Loss | ■ | ■ | ■ |

Likelihood of occurrence is based upon the following scale:

| | |
|---|------------|
| ■ | [Redacted] |

This Disaster Recovery Plan outlines the general steps for immediate organizational responses to each of the potential disasters indicated above. Depending upon the nature and severity of the situation, detailed recovery and emergency operations plans may also be activated. [Redacted]

[REDACTED] They will contact the Corporate Disaster Recovery then initiate the Disaster Recovery Procedures.

The Illinois office uses a public address system to inform tenants of any problems in the building. Facilities staff is informed by building management of any issues arising after-hours.

[REDACTED]

The Iowa office uses a public address system to inform tenants of any problems in the building. The Facilities staff is informed by building management of any issues arising after-hours.

Employee Parking:

Each parking garage has a plan in place to accommodate employees in the event the employee's designated garage is inaccessible.

Michigan:

- One Kennedy Square (777 Woodward building, entrance to garage is 719 Griswold St. between Michigan Ave. and Fort St.): If there are issues getting into the garage, staff can park in another MHP garage. The parking attendants will also direct employees to street parking and any other open lots in the area (Compuware and the 'Z.')
- 1001 Woodward (Entrance to garage is on State St., between Woodward Ave. and Griswold St.): Staff can park in another MHP garage
- Trolley Plaza (1431 Washington Blvd): The garage has 2 entrances. In the event of a disaster, the attendants would open the gates at the exits to bring in the parkers.

Illinois:

- Employees will be re-routed to park on Grant Park North. The parking badges for employees would be turned on and activated to work on the north garage.

Iowa:

- There are two other garage options that ABM Parking operates where employees can park in the event of a disaster:
 - 7th and Grand
 - 9th and Locust
- MHP will work with the garages to determine if it is best to validate or issue new key cards to staff based on the severity of the issue and / or how long it will take to park back in the original garage.

1. Fire Evacuation

Immediate Response in Case of Fire

If an individual discovers a major fire, see smoke or hears the fire alarm:

- █ [REDACTED]
- █ [REDACTED]
- █ [REDACTED]

In the event that you are trapped in the building without access to an exit or window:

- █ [REDACTED]

2. Flooding

Immediate Response in Case of Flood

- MI staff should notify Facilities immediately. Facilities will notify the building management and the Disaster Recovery Team Leader
- IL and IA staff should notify the Disaster Recovery Team or Alternate immediately. The Disaster Recovery Team Leader or Alternate will notify building management.

- █ [REDACTED]

3. Severe Winter Storm

Immediate Response in Case of Severe Winter Storm

- The Disaster Recovery Team will gather to determine the extent of the storm and review travel conditions.
- If snowfall is expected to severely limit travel to or from work and jeopardize the safety of CMC employees, the team will determine whether to close for the day.

- If a decision to close early is made during normal business hours, employees will be notified via e-mail or from their department management.

█ [REDACTED]

4. Power Outage

Immediate Response in Case of Power Outage

In the event that the power outage takes place during normal business hours:

█ [REDACTED]

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[REDACTED]

5. Computer System Failure or Computer Virus

Caidan Management Company has instituted a variety of administrative, physical and technical safeguards to prevent loss of data in the event of a computer failure. All of these protections are outlined in Section C of this plan.

Immediate Response in Case of Computer Failure or Virus

[REDACTED]

Detailed procedures for restoring computer and phone systems are included in the Information Technologies Business Unit Recovery Plan.

6. Hazardous Materials Incident or Gas Main Break

Immediate Response in Case of Hazardous Materials Incident or Gas Main Break

[REDACTED]



7. Tornado

Immediate Response in Case of Tornado

- The Facilitates staff will contact the Corporate Disaster Recovery Team, building management and local authorities to determine the extent of the situation.
- The Disaster Recovery Team in each state monitors the situation to determine if and when employees should take shelter.
 - Tornado WATCH means weather conditions are right for severe weather to develop.
 - Tornado WARNING means a tornado has been sighted and you should take cover immediately.
 - Under most circumstances, you will be notified by one or more of the following, in the event of a “Tornado Warning.”
 1. City of Detroit Air Raid Sirens
 2. City of Chicago All Hazards Sirens
 3. City of Des Moines Sirens
 4. Local Radio Broadcasts
- Make sure the radio is turned to a local station for weather information. (Refrain from using the telephones. Circuit lines must remain open for emergency purposes.)
- If it is determined that employees need to take shelter, an announcement will be made via e-mail and the overhead paging system.
- Employees are to leave all exterior rooms and close the door. Move away from any area exposed to exterior glass. (If you are trapped in an outside room, take cover under a desk or table.)
- Proceed to the center corridor hallway or stairwell and protect yourself from flying debris by putting your head as close to your lap as possible. If the stairwell is crowded, move down to a lower level.
 - Do not use the elevators.
 - Do not go to the first floor lobby.
 - Do not go to the basement.
 - Do not go outside of the building.
- Each Business Unit Recovery Team Leader will be responsible for performing a walk-through of his/her area to ensure that employees have evacuated their area.

Response after the Tornado

- After the tornado has passed, employees should remain in the shelter area until notified by a member of the Disaster Recovery Team or Building Management that it is safe to return to their designated work space.
- If there are individuals that have suffered injury as a result of the tornado, offer assistance using the nearest first aid kit until emergency personnel arrives. Do not attempt to move an injured person, unless they are at immediate risk of further injury.
- If anyone detects the odor of natural gas, they should contact the nearest member of the Disaster Recovery Team as soon as possible and avoid use of electrical appliances, flashlights or cell phones.
- The Disaster Recovery Team Leader will communicate with building authorities to determine the nature and extent of any damage.
- If there is no significant damage to the building, employees will be notified to return to their work areas and complete the work day.
- If the building has sustained significant damage or there is a fear that the structure may be unstable, then employees will be notified to leave for the remainder of the day.
- Michigan Locations:

[Redacted text block containing details for Michigan Locations]

■ Illinois Location.

[Redacted text block containing details for Illinois Location]

• Iowa Location:

[REDACTED]

8. Civil Disorder

Immediate Response in Case of Civil Disorder

- Employees are to notify management immediately of any information received, factual or rumored, of a demonstration or other form of civil disorder that is planned or in progress near the building.
- Management will contact Facilities and the Corporate Disaster Recovery Team Leader who will assess the situation and inform the proper authorities.
- If a civil disturbance breaks out during the work day, at or near the building, employees should remain calm and await instructions from the Disaster Recovery Team and Building Management.
- All personnel should assist with protecting company assets, if doing so will not cause imminent harm. This includes securing computer equipment and ensuring that all protected health information is in a locked cabinet or otherwise secured.
- Stay indoors and away from windows unless directed to evacuate the building. If necessary, employees should take cover under their desk or other large furniture.
- If the Disaster Recovery Team determines that an evacuation is appropriate, follow the procedure for a fire evacuation.
- If released from work early, employees should follow instructions of the Disaster Recovery Team, Building Management and the local authorities. Employees should not remain in the vicinity of the disturbance to observe the situation.
- Michigan Location:

[REDACTED]

- Illinois Location:

[REDACTED]

- Iowa Location:

[Redacted]

- All Locations:

[Redacted]

9. Bomb Threat

Immediate Response if a Bomb Threat is Received

Written Bomb Threats:

[Redacted]

Personal Receipt of Bomb Threats

[Redacted]

Telephone Bomb Threats

[Redacted]

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- If anyone detects the odor of natural gas, they should contact the nearest member of the Disaster Recovery Team as soon as possible and avoid use of electrical appliances, flashlights or cell phones.
- If you are trapped in debris:
 - use a flashlight, if possible, to signal your location to rescuers
 - do NOT light a match
 - Tap on a pipe or wall so rescuers can hear where you are
 - If possible, use a whistle to signal rescuers
 - Shout only as a last resort. Shouting can cause a person to inhale dangerous amounts of dust
 - Avoid unnecessary movement so you don't kick up dust
 - Cover your nose and mouth with anything you have on hand. Dense-weave cotton material can act as a good filter. Try to breathe through the material
- If there are individuals that suffered injuries in the event, offer assistance using the nearest first aid kit until emergency personnel arrives. Do not attempt to move an injured person, unless they are at immediate risk of further injury.
- The Disaster Recovery Team Leader will call 911 to notify the local authorities of any injured persons.
- If there is no significant damage to the building and there is no continued threat, employees will be notified to return to their work areas and complete the work day.
- If the building has sustained significant damage or there is a fear that the structure may be unstable or other imminent threat to employee safety, employees will be notified to leave for the remainder of the day.
- If instructed to evacuate, leave quickly; do not stop to retrieve personal possessions or make phone calls. Watch for obviously weakened floors and stairways. Do not use elevators. Open doors carefully and watch for falling objects while evacuating.
- When exiting the building, continue to be especially watchful of falling debris. Be prepared for possible further after-shocks and / or explosions.
- Once outside the building, all staff should move to their building's designated meeting place and check in with their department management.
 - If the designated meeting place is not safe, follow the instructions of local authorities.
- Michigan Locations:
 - [REDACTED]
- Illinois Location:
 - [REDACTED]

[REDACTED]

- Iowa Location:

- All Locations:

11. Workplace Violence

No “profile” or litmus test exists to indicate whether an employee might become violent. Instead, it is important for employers and employees alike to remain alert to problematic behavior that, in combination, could point to possible violence. No one behavior in and of itself suggests a greater potential for violence, but all must be looked at in totality. (<http://www.fbi.gov/stats-services/publications/workplace-violence>)

Risk factors at times associated with potential violence include:

- personality conflicts (between coworkers or between worker and supervisor)
- a mishandled termination or other disciplinary action
- bringing weapons onto a work site
- drug or alcohol use on the job
- a grudge over a real or imagined grievance
- breakup of a marriage or romantic relationship
- other family conflicts
- financial or legal problems
- emotional disturbance

If a violent incident occurs, employees should notify their supervisor immediately. If there is an imminent threat to their safety, employees should dial 911.

[REDACTED]

[REDACTED]

G. Disaster Recovery Team Crisis Response Plan

This section outlines some of the general steps that will be taken by the Disaster Recovery Team in response to a potential disaster situation. The detailed action steps will depend upon

the nature of the situation and the extent of the damage to CMC facilities, equipment and assets.

Disasters at the Michigan Offices

[Redacted]

Disasters at the Illinois Office

[Redacted]

Disasters at the Iowa Office

[Redacted]

1. Procedure for Disasters Occurring During Working Hours

| Task | Timing/Contingencies | Assigned To: |
|------------|----------------------|--------------|
| [Redacted] | [Redacted] | [Redacted] |

| Task | Timing/Contingencies | Assigned To: |
|------------|----------------------|--------------|
| [REDACTED] | | |
| [REDACTED] | [REDACTED] | [REDACTED] |

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The following is a list of the supplies that may be needed during a disaster situation.

- Fire Extinguishers
- Battery Operated AM/FM Radio
- Flashlights
- Batteries

- Automated External Defibrillator (AED Machines)
 - *AED machines are used to administer an electric shock to a person who is having a cardiac arrest. AEDs are designed to allow non-medical personnel to save lives.*
- First Aid Kits / Medical Emergency Supplies
- Walkie Talkies

Disaster Toolkits are located at each office.

The Facilities staff checks the contents of these kits on a monthly basis.

Each member of the Disaster Recovery Team has a cellular phone for emergency communications within and outside of the CMC offices. Each employee also has a flashlight at his or her desk.

Locations for Disaster Toolkits, First Aid Kits, Medical Supplies & Fire Extinguishers

Detroit Offices

777 Woodward Ave Location

| Floor | Item | Location |
|------------|------------|------------|
| [REDACTED] | [REDACTED] | [REDACTED] |

■ [Redacted]
 ■ [Redacted]
 ■ [Redacted]
 ■ [Redacted]

Iowa Office:

■ [Redacted]
 ■ [Redacted]
 ■ [Redacted]

2. Procedure for Disasters Occurring During Non-Working Hours

| Task | Timing/Contingency | Assigned To: |
|------------|--------------------|--------------|
| [Redacted] | [Redacted] | [Redacted] |

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| Task | Timing/Contingencies | Assigned To: |
|------------|----------------------|--------------|
| [REDACTED] | [REDACTED] | [REDACTED] |

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3. Procedure for Restoring Operations at CMC Offices

Assuming that operations can be restored at the CMC offices within a reasonable time frame and without significant negative impact on the organization, the Disaster Recovery Team will conduct the activities listed in the following table. IT Facilities and IT Operations staff will be allowed access to the building ahead of CMC staff so they can begin to restore systems.

| Task | Timing/Contingencies | Assigned To: |
|------------|----------------------|--------------|
| [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] |

| Task | Timing/Contingencies | Assigned To: |
|------------|----------------------|--------------|
| [REDACTED] | | |
| [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | Leader |

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4. Day 1 Operations at GMC Offices

Upon returning to the GMC offices to resume operations, the Disaster Recovery Team will conduct the following activities:

- Hold an update meeting with department directors first thing in the morning to provide status and direction for the day's activities.
- [REDACTED]
- Cancel any non-critical meetings so that department directors, deputy directors and managers can focus on operational issues.
- Maintain high visibility throughout the day to respond to any new issues that may arise or provide assistance in trouble-shooting existing issues.
- Hold update meetings as needed throughout the day to notify department directors of the status of recovery efforts.
- Send communication to employees via e-mail or pager system to thank them for their patience during the disaster situation.

The Disaster Recovery Team will continue to monitor all open issues until they are resolved. After full operations have been restored, the Disaster Recovery Team should hold a de-briefing to assess the strengths and weaknesses of the organization's response and develop a plan for improvement in the future.

H. Emergency Operations at Off-Site Location

Regardless of the nature of the disaster situation, there may be times when it is not feasible to resume operations at the CMC office. This may be due to hazardous conditions at or around the building, or major damage or destruction of the building itself. This section of the disaster recovery plan outlines CMC's alternative locations for emergency operations and the process for activating those locations.

[Redacted]

[Redacted]

[Redacted]

| | | |
|------------|------------|------------|
| [Redacted] | [Redacted] | [Redacted] |
|------------|------------|------------|

[Redacted]

[Redacted]

[Redacted]

This section outlines general procedures and provides a framework for conducting operations at the emergency operations center. The detailed action steps will depend upon the nature of the disaster and the priorities of the Disaster Recovery Team. Operations will continue at the emergency operations center until a plan is made to transition the computers, phones and staff back to the CMC offices.

1. Procedure to Set Up the Emergency Operations Center

| Task | Timing/Contingencies | Assigned To: |
|------------|----------------------|--------------|
| [REDACTED] | [REDACTED] | [REDACTED] |

3. Communication Procedures

This procedure outlines the communication activities that need to take place to support and constantly update the situation at the emergency operations center.

| Task | Timing/Contingencies | Assigned To: |
|------------|----------------------|--------------|
| [REDACTED] | [REDACTED] | [REDACTED] |

| Task | Timing/Contingencies | Assigned To: |
|------------|----------------------|--------------|
| [REDACTED] | [REDACTED] | [REDACTED] |

4. Planning and Management Activities

This section outlines some of the planning and oversight activities that need to be conducted by the Disaster Recovery Team in order to effectively manage the emergency operations center.

| Task | Timing/Contingencies | Assigned To: |
|------------|----------------------|--------------|
| [REDACTED] | [REDACTED] | [REDACTED] |

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5. Administrative Support Procedures

This section outlines some of the basic administrative duties that need to be completed to support the emergency operations center.

| Task | Timing/Contingencies | Assigned To: |
|------------|----------------------|--------------|
| [REDACTED] | [REDACTED] | [REDACTED] |

| Task | Timing/Contingencies | Assigned To: |
|------------|----------------------|--------------|
| [REDACTED] | [REDACTED] | [REDACTED] |

The following is a list of the supplies and equipment that may be needed to resume operations at the emergency operations center. [REDACTED]

[REDACTED] The administrative support person will coordinate with staff from Finance, Information Technologies and other departments as needed to ensure that these items are available:

| Communications | Office Supplies | Office Equipment | Documents |
|----------------|-----------------|------------------|------------|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

[REDACTED] The remainder of the items will be obtained from one of CMC's key vendors. A list of the vendors and key contact information is included in Attachment G.

6. Migration Plan Back to CMC Offices

This section describes the general process for managing the transition from the emergency operations center back to the CMC offices. IT Facilities and IT Operations staff will be allowed access to the building ahead of CMC staff so they can begin to assess damage and restore systems. In the event that the building is severely damaged or destroyed, CMC leadership will initiate plans to move the CMC offices to another permanent location. The business will

continue to use the emergency operations location until a new space is located and prepared for occupancy.

| Task | Timing/Contingencies | Assigned To: |
|------------|----------------------|--------------|
| [REDACTED] | [REDACTED] | [REDACTED] |

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| Task | Timing/Contingencies | Assigned To: |
|------------|----------------------|--------------|
| [REDACTED] | | |
| [REDACTED] | | |
| [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] |

I. Maintenance and Testing of Disaster Recovery Plan

The Disaster Recovery Team is responsible for maintaining the Business Continuity and Disaster Recovery Plan. The team will ensure that the plan is tested and updated on an annual basis. The team will also ensure that the organization is trained and prepared to handle a disaster situation.

All CMC employees will be reminded about the disaster recovery plan on an annual basis. In addition, each Business Unit Recovery Team Leader will ensure that employees are trained on the specific departmental plans. CMC has also created an employee disaster guide to assist employees in responding to a disaster situation at their location. This guide is provided to all employees at the start of their employment with CMC.

In order to ensure that the disaster recovery process operates according to the requirements outlined in this plan, CMC will periodically test various components of the Disaster Recovery Plan, including the following:

- Building Evaluation Procedures
- Departmental Manual Processes
- Restoring Phone Services to the CMC Offices
- Restoring Computer Services to the CMC Offices
- Setting up the Emergency Operations Center
- Closing Down the Emergency Operations Center

The Disaster Recovery Team Leader will develop a schedule for testing of the various components of the Disaster Recovery Plan on an annual basis. The Disaster Recovery Team Leader will ensure that results of the testing are reviewed for potential areas of improvement. Test results and incident response plans are maintained in the Information Technologies department.

In addition to testing, it is also important to maintain and update the Disaster Recovery Plan to reflect any changes in administrative structure or operations at CMC. The following is the schedule for ongoing maintenance of the Disaster Recovery Plan:

| Task | Person Responsible | Time Frame |
|------|--------------------|------------|
|------|--------------------|------------|

| Task | Person Responsible | Time Frame |
|---|-------------------------------------|---------------------------|
| Read the entire plan and update any areas that have changed significantly | Disaster Recovery Team | Quarterly |
| Review each Business Unit Recovery Plan and update any areas that have changed significantly | Business Unit Recovery Team Leaders | Quarterly |
| Update Employee Contact List to add, change or delete contact information for employees | HR Representatives | Whenever a change is made |
| Review the list of key vendors and make any changes based on new or terminated vendor relationships | IT Department, Business Units | Quarterly |
| Review and update the agreement with the emergency operations center to meet the needs of CMC. Validate the Disaster Declaration Authorization (DDA). | Disaster Recovery Team Leader | Annually |

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NCQA HEDIS Compliance Audit™

Final Audit Report

Prepared for:
Meridian Health Plan of Iowa, Inc.

Prepared by:
HealthcareData Company, LLC
600 Bent Creek Blvd., Suite 160
Mechanicsburg, PA 17050
(800) 472-5382
www.HDCdata.com

July 2014

NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Table of Contents

As prescribed by the NCQA HEDIS Compliance Audit: Standards, Policies and Procedures, HealthcareData Company, LLC, prepared this report to document its audit findings. The report contains all elements required by NCQA.

| | |
|--|----------|
| SECTION 1: AUDIT REFERENCE INFORMATION..... | 3 |
| SECTION 2: OFFSITE ACTIVITIES..... | 4 |
| SECTION 3: SUMMARY, OBSERVATIONS AND RECOMMENDATIONS..... | 7 |
| SECTION 4: AUDIT RESULTS | 8 |
| SECTION 5: FINAL AUDIT OPINION | 9 |

Attachments:

- IDSS audit results and rates:
 - Data-filled Workbook (containing the Audit Review Table)
 - Coma Separated Values (CSV) Workbook
 - Extensible Markup Language (XML) File
- IS Compliance Tool

SECTION 1: AUDIT REFERENCE INFORMATION**A. NCQA-Licensed Organization**

HealthcareData Company, LLC (HDC)
 600 Bent Creek Blvd. Suite 160
 Mechanicsburg, PA 17050
 (800) 472-5382

Practice Leader:

Paul T. Mertel, Jr., Ph.D., FACHE, CHCA
 Senior Vice President for HEDIS Development/Project Manager

B. Audit Team¹

| Name | CHCA ² | Role |
|-----------------------|-------------------|---------------------------------------|
| Paul Mertel | Yes | Lead auditor |
| Paul Ackroyd | No | Assistant |
| Peter Ackroyd, RN-BSN | No | Medical record review validation |
| Thomas Foliano | No | Source code review |
| Thomas Foliano | No | CAHPS [®] source code review |

¹ Further information regarding audit team qualifications is available upon request.

² Certified HEDIS Compliance Auditor

CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

C. Organization Information

| | |
|---|---|
| Organization name as reported to NCQA | Meridian Health Plan of Iowa, Inc. |
| Primary contact person name and title | Vicki Boyle, Vice President of Quality Management |
| Primary contact person address | 777 Woodward Avenue, Suite 600 Detroit, MI 48226 |
| Onsite audit contact person name and title | Vicki Boyle, Vice President of Quality Management |
| Onsite audit location | Detroit, MI |
| NCQA-certified CAHPS [®] survey vendor | Morepace |

D. Reporting Entity Information

| Org. ID | Sub. ID | Product line | Product | Project or requiring agency (if applicable) |
|---------|---------|--------------|---------|---|
| 20315 | 11301 | Medicaid | HMO | |

SECTION 2: OFFSITE ACTIVITIES

This section describes key audit processes. Most of these processes are initiated and many are completed prior to the onsite portion of the audit.

- **Conference Call** – Meridian Health Plan of Iowa, Inc. and the audit team discussed the following topics during the conference call: audit program goals, communication protocol, onsite visit planning, reporting entities, measures being reported, HEDIS[®] data sources, and HEDIS report production. Participants reviewed key dates for audit milestones.
- **HEDIS Roadmap Review** – The auditor reviewed the HEDIS Roadmap prior to the onsite portion of the audit and identified missing items and/or items requiring follow-up during the onsite.
- **Survey Measure Sample Frame Validation** – The audit team verified that the organization used an NCQA-certified survey vendor. HDC staff performed sample frame review to ensure conformance with NCQA format and layout specifications. The auditor calculated the ratio of the survey eligible population (EP) to the organization's enrollment and compared the ratio to NCQA-published means and percentiles. Prior-year EP comparisons were made, as applicable. HDC completed an NCQA sample frame validation tool (previously sent to your organization) indicating *Supports Reporting* results, for the surveys the organization declared it intended to report.

For the Medicaid entities listed in Section 1:

CAHPS Health Plan Survey 5.0H, Adult Version
 Aspirin Use and Discussion¹
 Flu Vaccinations for Adults 18-64¹
 Medical Assistance with Smoking and Tobacco Use Cessation¹

¹ Collected as part of the CAHPS Health Plan Survey 5.0H, Adult Version.

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- **Core Set Selection and Manual Code Review** – Meridian Health Plan of Iowa, Inc. used internally developed code to produce its HEDIS measure results. Because of the large number of measures included in a HEDIS performance report, NCQA has defined an audit methodology to allow the code-review findings from a properly selected core set of measures to be projected upon the remaining measures. The auditor considered both programming and data issues in selecting the core set. More information on the audit methodology and measure selection rationale can be found in *2014, Volume 5, NCQA HEDIS Compliance Audit: Standards, Policies and Procedures*. For the measures included in the core set, the audit team performed a manual review of programming code and/or measure-generation logic to verify accuracy, completeness, and compliance with HEDIS technical specifications. The core set of (nonsurvey) measures for the audit of Meridian Health Plan of Iowa, Inc. included:

Immunizations for Adolescents
 Breast Cancer Screening
 Cervical Cancer Screening
 Appropriate Treatment for Children with Upper Respiratory Infection
 Cholesterol Management for Patients with Cardiovascular Conditions
 Comprehensive Diabetes Care
 Osteoporosis Management in Women Who Had a Fracture

Antidepressant Medication Management
Follow-Up After Hospitalization for Mental Illness
Ambulatory Care
Identification of Alcohol and Other Drug Services
Mental Health Utilization
Antibiotic Utilization
Relative Resource Use for People with Diabetes
Relative Resource Use for People with COPD

- **HEDIS Compliance Audit Standards Review** - HEDIS Compliance Audit standards describe requirements for HEDIS data collection and reporting; they are the foundation on which the auditor assesses the organization's ability to report HEDIS data accurately and reliably. Information Systems (IS) standards measure how the organization collects, stores, analyzes and reports medical, member, practitioner, and vendor data. The standards specify the minimum requirements for information systems and processes used in HEDIS data collection. HEDIS Measure Determination (HD) standards are used to assess an organization's adherence to HEDIS Technical Specifications and report-production protocols.

If supplemental administrative databases were proposed by the organization for HEDIS use, the auditor approved those databases according to HEDIS audit protocol. The auditor records IS review and findings in an IS Standards Compliance Tool, as required by NCQA. The final Compliance Tool is attached to this report.

- **Medical Record Review Validation (MRRV)** -The HEDIS Compliance Audit includes a protocol to validate the integrity of data obtained from medical record review for any measures calculated using the hybrid method. The audit may include a convenience sample validation for the purpose of finding procedural errors early in the medical record abstraction process so that timely corrective action can be taken.
- **Convenience Sample Exemption** – The auditor did not require the plan to complete a convenience sample and the plan elected not to request one. Additional information provided in IS HD Compliance Tool at IS 4.5.

- Statistical Validation** –An additional key component of the HEDIS Audit is the statistical validation of medical records along with the respective, completed abstraction forms for a sample of positive numerator events. Because medical record training and training materials were centralized and all plans used the same abstraction form, measures were selected across all three of the Meridian plans. In some cases, two measures were selected in one group. Please refer to IS 4.0 for audit findings regarding medical record review validation.

| Measures Selected for Review | Records requested | Records received and compliant |
|---|--------------------------|---------------------------------------|
| Group A Biometrics & (BMI, BP) & Maternity: PPC-Prenatal | 16 | 16 |
| Group A Biometrics & (BMI, BP) & Maternity: CBP | 16 | 16 |
| Group B Anticipatory Guidance & Counseling: WCC-Nutrition | 16 | 16 |
| Group C Laboratory: CDC HbA1c < 8 | 16 | 16 |
| Group D Immunizations & Other Screenings: CDC Eye Exam | 4 | 4 |
| Group E (SNP): COA-Pain Assessment | 16 | 16 |
| Group F Exclusion: All Measures | 16 | 16 |

- Audit Timeline** – Key dates for audit milestones are shown in the table below.

| Audit milestone | Date |
|---|-------------------|
| CAHPS survey sample frame(s) validated | January 17, 2014 |
| Auditor notification of HEDIS roadmap approval. | February 5, 2014 |
| Conference call held | February 4, 2014 |
| Core set final approval date | April 10, 2014 |
| Onsite audit conducted | February 20, 2014 |
| Medical record review validation completed | May 21, 2014 |

SECTION 3: SUMMARY, OBSERVATIONS AND RECOMMENDATIONS

IS Compliance

Meridian Health Plan of Iowa, Inc. was fully compliant with all NCQA-defined IS Standards for HEDIS-applied data and processes.

Observations and General Recommendations:

Meridian Health Plan of Iowa, Inc. was not previously audited by HDC as this was the first year for the organization to report HEDIS measures.

The organization continues to demonstrate exceptional performance in all areas supporting HEDIS Report production. Corporate functions are based in Detroit. Staff at the Michigan plan provide corporate support, plus guidance and support to the other Meridian plans located in different states. Both the corporate and Iowa organizations have a stable and experienced HEDIS team with a formal program to develop additional staff to step into responsible positions with minimal oversight. This program provides continuity of effort and allows for the recognition of issues and corrective action. The organization is aggressive in seeking opportunities to improve performance scores and works closely with the audit team throughout the year.

Recommendations and comments are as follows:

- The staff were faced with challenges to organize a medical record hybrid process, collection of supplemental data, and reporting the required measures. These challenges were met and fully accomplished with no major issues.
- The organization was well prepared for the new guidelines and requirements concerning the collection and use of supplemental data. Although the guidelines were not formalized until October of 2013, the organization had the required data elements in place. Additionally, the majority of the supplemental data had undergone a total review and validation before acceptance and placement in the supplemental database. Validation of the nonstandard supplemental database was completed with no issues.
- The audit team recommends the organization develop a sound HEDIS project plan that includes all of the key dates for HEDIS 2015 actions. The project plan should address starting the medical record abstraction as early as possible to ensure the MRRV can take place with sufficient time for any possible corrections.
- The audit team also recommends the organization examine the new and revised HEDIS 2015 measures plus any additional reporting required under the Affordable Care Act. Any gaps in care and data completeness issues can be addressed with the collection of additional supplemental data. The audit team is prepared to meet with plan officials to ensure the supplemental data captures the required data elements and can be validated.
- The organization made excellent use of available technology to improve upon supplemental data. The audit team recommends the plan continue to improve in this area and consider use of tablets or other devices that record services at the point of services.

SECTION 4: AUDIT RESULTS

The HEDIS Audit concludes with rates/results at the measure or indicator level as shown in the following table.

| Rate/Result | Comment |
|-------------|---|
| 0-XXX | Reportable rate or numeric result for HEDIS measures |
| NR | Not Reported: Plan chose not to report Calculated rate was materially biased Plan not required to report |
| NA | Small Denominator: The organization followed the specifications but the denominator was too small to report a valid rate |
| NB | No Benefit: The organization did not offer the health benefits required by the measure (e.g., mental health or chemical dependency) |

NCQA has defined four bias determination rules, specific to measures. These are delineated in *Volume 5: NCQA HEDIS Compliance Audit: Standards, Policies and Procedures, Appendix 10*.

- A (+/-) 5 percentage point difference in the reported rate
- A (+/-) 10 percent change in the reported rate
- A (+/-) 5 percent change in the reported rate
- A (+/-) 10 percent change in the index hospital stays or numerator

If the auditor determines that a measure is biased, the organization cannot report a rate for that measure and the auditor assigns a result of *NR*. (Bias is typically based on the degree of data completeness for the data collection method used.)

For measures in the Effectiveness of Care and Access/Availability of Care domains, as well as for a few measures in the Use of Services domain, the auditor assigns an audit designation for each individual component rate within the measure. For measures with component rates and ratios (e.g., most of the Use of Services measures), the auditor can assign a designation at the measure level, even though the organization did not calculate all potential data for the measure. In such situations, the auditor directs the organization to report only the validated and approved data.

Meridian Health Plan of Iowa, Inc. reported a rate or numeric result for all measures (unless NA or NB applied) within its audit scope.

SECTION 5: FINAL AUDIT OPINION

At the close of the audit, the auditor renders the Final Audit Opinion, containing a Final Audit Statement (below) along with rates/ results displayed in the reporting-entity-specific Audit Review Table attached to this report.

Final Audit Statement

We have examined Meridian Health Plan of Iowa, Inc.’s submitted measures for conformity with the Healthcare Effectiveness Data and Information Set (HEDIS) Technical Specifications. This audit followed the NCQA HEDIS Compliance Audit standards, policies and procedures. Audit planning and testing was constructed to measure conformance to the HEDIS Technical Specifications for all measures presented at the time of our audit.

This report is Meridian Health Plan of Iowa, Inc.’s management’s responsibility. Our responsibility is to express an opinion on the report based on our examination. Our examination included procedures to obtain reasonable assurance that the submission presents fairly, in all material respects, the organization’s performance with respect to the HEDIS Technical Specifications. Our examination was made according to HEDIS Compliance Audit standards, policies and procedures, and accordingly included procedures we considered necessary to obtain a reasonable basis for rendering our opinion. Our opinion does not constitute a warranty or any other form of assurance as to the nature or quality of the health services provided by or arranged by the organization.

In our opinion, Meridian Health Plan of Iowa, Inc. submitted measures were prepared according to the HEDIS Technical Specifications and present fairly, in all material respects, the organization’s performance with respect to these specifications.

We understand that if the signatures we submit below are electronic, they have the same legal effect, validity and enforceability as original signatures submitted on paper.



(NCQA- Certified HEDIS Compliance Auditor)

June 30, 2014
(Date)



(Responsible Officer)

June 30, 2014
(Date)

| Organization ID | Submission ID |
|-----------------|---------------|
| 20315 | 11301 |

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RAYMOND D. PITERA

PROFILE:

Business Development...Contract Negotiation...Network Development

Negotiate contractual relationships with emphasis on building business partnership and generating customer loyalty. Can plan and execute cost saving programs. Strong background in sales, marketing, managed care and customer service.

EXPERIENCE:

Caidan Management Company, LLC

Chief Development Officer/Senior Vice President/Contract Administrator/ 2011-present
Chief Executive Officer/Chief Operations Officer

- Continually identify, coordinate and successfully obtain new business opportunities for Caidan Management Company and all its subsidiaries.

Director of Provider Services & Network Development, Vice President 2008 – 2011

- Actively provided the development, credentialing and maintenance of a provider network for Health Plan of Michigan that is capable of delivering all basic, primary, specialty, hospital and ancillary health services to HPM's enrollees in its contracted service areas.
- Instrumented the largest increase in geographic service area and membership of any Michigan Medicaid HMO ever, making Health Plan of Michigan #1 in total membership and quality. Expansion included an additional 32 counties and membership of over 287,000 members.
- Assisted in the development of Meridian Health Plan of Illinois, the first new Medicaid HMO in Illinois in over 10 years.

Director, Provider Services 2002 – 2008

- Lead a team of 12 professionals in developing and servicing all Health Care Providers in 32 Michigan Counties for Health Plan of Michigan.
- Coordinated and completed service area expansion into 15 additional counties
- Oversaw all Marketing functions resulting in a membership increase of over 55,000 enrollees.

Network Development Specialist, Southfield, MI 2000 – 2002

- Developed and Maintained a Medicaid Provider Network for Health Plan of Michigan in 11 Counties, including contracting and servicing all Hospitals, Physicians and Ancillary Providers within the region
- Worked as part of the Provider Services team to expand service area by 6 counties

GREAT LAKES HEALTH PLAN

Network Development Specialist, Southfield, MI 1998 – 2000

- Developed a Commercial and Medicaid Provider Network in 21 Michigan Counties
- Coordinated and successfully implemented Capitated Agreements with Ancillary and Primary Care Providers.
- Created and Implemented cost saving programs, that produced over \$700,000 in annual savings

SELECTIVE RICOH

Account Representative, Troy, MI 1997 – 1998

- Marketing Ricoh Products, Implementing full sales cycle, including: cold calling, prospecting, qualifying, handling objections, negotiating, close.
- 131% of quota first six months

PPOM

Provider Relations Representative, Cleveland, OH 1996 – 1997

- Marketing to Health Care Providers, cold calling, selling the PPOM concept
- Developed Northeast Ohio network, growing the provider network from 1,500 physicians to over 3,000 in one year.
- Assisted in acquiring new group business for PPOM and Flora Health Care throughout Ohio.

Provider Marketing Representative, Southfield, MI 1994 – 1997

- Prospect to Health Care Providers, cold calls. Inside sales.

RAYMOND D. PITERA

- Credential Providers, primary source verified all required elements including license and board certification/eligibility

EDUCATION:

| | |
|---|------------------|
| Capitol University, Cleveland, OH (Business Administration, Marketing) | 1996-1997 |
| Oakland Community College, Farmington Hills, MI (Marketing) | 1993-1996 |
| <u>Lawrence Technical University, Southfield, MI (Mechanical Engineering)</u> | <u>1992-1993</u> |

REFERENCES AVAILABLE ON REQUEST

CHRISTINA BRANDON, MBA, PAHM**CAREER SUMMARY**

Goal-oriented quality management professional with a demonstrated ability to direct complex projects from concept to fully operational status with effective results. Strong leadership capabilities including team building, staff coaching, performance monitoring and development. Organized, highly motivated, and detail-directed problem solver. Results driven management approach. Self-starter with a very high energy level.

CAREER HISTORY

Meridian Health Plan

2011-present

Director, Member Services/Member Services Manager

Responsible for enrollment, retention, new member orientation, communications, verification of eligibility and benefits, and other procedures relating to the enrollment process. Functions as the Member Grievance Coordinator by resolving all member grievances and appeals.

- Supervision of departmental functions for verifying eligibility, issuing ID cards, membership changes, name and address changes, PCP changes, and assisting members with provider issues.
- Hire, train and supervise Member Service Staff including the development of training materials and tools to ensure the department meets telephone answering standards.
- Assumed primary responsibility for the resolution of member inquiries related to formal grievances.
- Maintain and document compliance with NCQA, URAC and state guidelines as they relate to the Member Services Department.

Health Plan of Michigan, Detroit, MI
Medicaid HMO

2004-2011

Manager, Quality Improvement

Developed, implemented and coordinated activities, efforts, and initiatives related to performance and regulations of NCQA and URAC related to Quality Improvement, Disease Management, and Member Outreach.

- Managed all Quality Improvement activities including Member Outreach Disease Management, accreditation preparation, HEDIS, and CAHPS submission, and DCH Quality Improvement Activities.
- Oversaw the medical management divisions of Member Outreach, Disease Management and Quality Management including staffing to make optimal use of resources, activities and initiatives.
- Developed and implemented disease management condition specific call training for all Outreach Staff resulting in a 1,000% increase in successful call volume.
- Developed outreach call standards, training tools, and monitoring programs to increase staff productivity and accuracy.
- Analyzed the criteria for auto-dialer campaigns creating programming changes resulting in a 33% increase in campaign contact rates and a 19% increase in agent contact rates.
- Enhanced DM programs for Asthma, Diabetes, Weight Management, and CVD by bringing printing of monthly new member and stratification mailings.
- Implemented corporate wide member, provider and employee HEDIS and CAHPS training.

Project Coordinator, Quality Management

Managed, designed, implemented and analyzed quality projects to increase HEDIS and CAHPS scores, maintain NCQA excellent accreditation, and U.S. News and World Report top 15 Medicaid status.

- Developed and maintained numerous analyses including the Member, Provider, and HEDIS Grand Analyses and individual survey analysis for state submission.
- Managed four topic specific HEDIS teams comprised of multi-departmental staff that accomplished an increase in HEDIS scores.
- Developed and managed numerous HEDIS initiatives and interventions resulting in increased HEDIS and CAHPS scores and a number one State of Michigan Quality ranking.
- Developed and analyzed interventions that directly responded to state quality activities including numerous disparity projects and PQIP-5.
- Developed effective staff, provider, and member HEDIS and CAHPS educational pieces and presentations.

Administrative Coordinator, Medical Management

Coordinated, and assisted in the design and implementation of all quality, disease, medical, and utilization management annual and quarterly reporting to the state of Michigan, NCQA and board of directors.

- Developed and coordinated programs that accomplished an increase in lead testing rates to state benchmarks.
- Navigated the NCQA ISS tool process from entry to analysis resulting in an Excellent rating after submission.
- Coordinated the departmental redesign of nursing staff from tiers to teams resulting in easier access and faster turn around time for approvals, denials and appeals.
- Managed the development, approval and distribution of all Clinical Practice Guidelines through the Physician Advisory Committee
- Managed annual physician office, medical record, appointment access, and after hours access audits. Developed system for monitoring corrective action plans for deficiencies.

Administrative Assistant, Quality and Care Management

Supported the Credentialing, Utilization Management, Quality Management, Medical Management, and Disease Management in all administrative aspects.

- Scheduled meetings, compiled packets, developed agendas and took minutes in high level meetings with little or no oversight.
- Entered medical record data into the hybrid tool based on analysis of criteria.
- Managed scheduling of nursing staff by developing a new four day work week that continued to offer maximum staff coverage with no new hires.

Great Lakes Health Plan, Southfield, MI
Medicaid HMO

2000-2002

Data Quality Analyst, Data Quality Management

Supported the Business Process Improvement Manager in designing, implementing and communicating structural changes to the Health Services Department operations.

- Developed training tools to facilitate the implementation of Facets.
- Headed the Flu Shot Call Program by individually contacting over 2,000 members at high risk for influenza infection and scheduling flu shot appointments.
- Developed a tool to audit data entry of provider information into Facets through an inter-rater reliability system.

EDUCATION/TRAINING

BA, Interdisciplinary Humanities, Concentrations in Religion, History and Family and Child Ecology
Michigan State University, East Lansing, MI

MBA, Health Care Management
University of Phoenix, Phoenix, AZ

PAHM, Academy of Health Care Management

Additional Training

Microsoft: Excel, Word, Project, PowerPoint, Publisher, Visio, Outlook, Scantron: Cogntion, E-Listen, NCQA Interactive Survey Submission Tool

COMMITTEE MEMBERSHIP

Alliance for Immunizations in Michigan (AIM) Coalition
Wayne County Asthma Coalition
Michigan State University Alumni Association
Detroit Young Professionals

PRESENTATIONS

NCQA HEDIS Update and Best Practices Presenter
San Francisco, CA
September 18th, 2008

OBJECTIVE

To obtain a Director level position that would allow me to utilize my negotiation, problem solving, operational, and communication skills in an effort to further success of the organization.

EXPERIENCE

Director of Credentialing and Provider Analytics/Provider Services Manager

05/13 - current

Meridian Health Plan (Caidan Management LLC) – Detroit MI

- Oversee and provide the direction of the Provider Data Management and Credentialing functions for Caidan Management
- Maintain compliance of all CMS, State Medicaid, NCQA, and URAC requirements for the Corporate Provider Services Department. This includes, but is not limited to, Credentialing, Appeals, Grievances, Education, and Service requirements
- Serve as steward of all in-plan and out-of-network provider databases to ensure provider directories, HEDIS databases, claims reimbursement and financial reports are accurate and in compliance with CMS, URAC and NCQA standards
- Oversee all incoming provider communications, phone, mail, online chat, including the education of providers on MHP's provider policies by all internal staff
- Oversee the automation and electronic filing for Caidan Management Provider Service Department
- Enhance current communications and create new education opportunities utilizing new technology to increase provider service and satisfaction. This includes collaboration with the Communications and IS Departments on enhancing and participating in emerging and established technology
- Collaborate with the Directors of Network Development for the external education of providers related to Quality, Utilization, Compliance, etc.
- Prepare and maintain all required State and Governing body data submissions and reports as they pertain to the provider network including any provider data files
- Prepare all accessibility analysis reports for Caidan Management
- Ensure the coordination of the Provider Services Department with all other Caidan Management departments. Including, but not limited to, Finance for efficient processing of contracting information and Quality to increase the HEDIS scores for Caidan Management
- Oversee the review of provider complaints and grievances as necessary and within all regulatory requirements. Ensure that concerns are addressed in a timely and thorough manner as described in plan policies
- Audit the provider contract negotiation process carried out by Network Development. Ensure all financial and regulatory guidelines are adhered to
- Assist in all special projects assigned by the Executive Team
- Manage and oversee Contracting and Credentialing for MeridianRx Pharmacy Networks

Manager Network Management

06/12 – 05/13

MeridianRx - Detroit MI

- Assist in planning the long term goals for the company and ensure that they are executed in the due course of time.
- Define long-term organizational strategic goals, builds key customer relationships, identifies business opportunities, negotiates and closes business deals, and maintains extensive knowledge of current market conditions.
- Work to improve the organization's market position and achieve financial growth.
- Negotiate and maintain rebate contracts with pharmaceutical manufacturers and aggregators.
- Report all important information related to the company to key staff.
- Accountable for strategic client relationship management, client account planning, managing client expectations, developing client solutions, and ensuring that the work performed meets or exceeds contract and service level obligations.
- Assist in desktop and/or on-site audits of Network and contracted customer pharmacies.
- Assist in Request for Proposals (RFPs) for potential expansion of Meridian/MeridianRx business.
- Identify and contract specific providers for Meridian/MeridianRx to meet the need of each RFP.
- Manage pharmacy relationships in regards to service delivery and competitive pricing.
- Identify and contract specific pharmacy providers to enhance the size of the MeridianRx pharmacy network.
- Ensure proper accuracy and maintenance of the MeridianRx pharmacy database system.
- Ensure proper credentialing of pharmacy providers to meet organization standards that include: a system that reviews applications for accuracy/completeness, identifying fraud and abuse, developing file and tracking system, and acquire and maintain knowledge of the credentialing requirements of all nation and State agencies (i.e. URAC, CMS).
- Maintaining extensive knowledge of the current developments in the business market in order to assess the position of the company and determine how to improve it.

Contract Manager II

Molina Healthcare of Michigan - Troy, MI

04/12 - 6/12

- Negotiate high priority physician group and facility contracts.
- Develop and maintained provider contracts in EMPTORIS contract management software.
- Negotiate and created an in-house Behavioral Health Network.
- Targeted and recruited additional providers to reduce member access grievances.
- Engage targeted contracted providers in renegotiation of rates and/or language.
- Maintain contractual relationships with significant/highly visible providers.
- Advise Network Provider Contract Coordinators and Specialists on negotiation of individual provider and routine ancillary contracts.
- Evaluate provider network and implement strategic plans with the goal of meeting Plan's network adequacy standards.
- Assess contract language for compliance with corporate standards and regulatory requirements and review revised language with assigned Plan attorney.
- Educate internal customers on provider contracts.

- Participate on the management team and other committees addressing the strategic goals of the department and organization.

Contract Administrator

Wayne State University Physician Group - Detroit, MI

06/07-04/12

- Lead Professional Group Contract negotiations and Delegated Credentialing negotiations including, evaluating proposed contract terms and reimbursement methodologies to ensure compliance with WSUPG Board approved criteria.
- Manage operational aspects of agreements with various Payors such as: Commercial plans, HMOs, PPOs, Medicare Advantage, Medicaid HMOs, Transplant, Behavioral Health, Vision, and Patient Specific Agreements.
- Complex issue resolution related to provider contract implementation and administrative operations.
- Establish and maintain positive relationships with Payors, Vendors and affiliated Hospital partners.
- Solid understanding of provider contract development, financial principles, risk arrangements, legal terminology, healthcare reimbursement methods and strategies.
- Prepare and manage filing of Health Plan Settlements and Rehabilitation on behalf of WSUPG Faculty Practice.
- Develop comprehensive job aids for WSUPG contracted health plans to aid in operational efficiency.
- Identify areas in need of operational improvement and execute improvement plans.
- Assist clinical practices with implementing Patient Centered Medical Home (PCMH) principles.
- Monitor contract performance to ensure proper payment and compliance.
- Representative for new system (Next Gen) implementation team.
- Key contact for the State of Michigan and the Medicaid HMOs for the Specialty Network Access Form (SNAF) and Medicaid FFS Program.
- Ensure agreement compliance with federal, state and plan guidelines.
- Serve as a Liaison between WSUPG and Legal Counsel on complex contracting issues. Manage and maintain all hardcopy contract files and electronic contract scanning system for managed care contracts.

Sr. Analyst

Blue Care Network – Southfield, MI

02/05-06/07

- Analyze provider contracting and pricing requests based on configuration requirements. Recommend modifications based on system requirements.
- Resolve issues related to claims payment, provider loading, pricing and credentialing to improve contract operation effectiveness.
- Provide Technical and analytical support for provider systems updates.
- Implement and maintain provider database updates, creation and maintenance of inventory controls, analysis of database configuration and reporting.
- Develop, implement and provide oversight on inventory and work request

- tools to ensure operational accuracy and quality.
- Develop and oversee process improvement initiatives as they relate to provider operations.
 - Chair and facilitate cross-functional meetings between BCN/BCBSM.
 - Serve as a liaison between corporate and all other functional areas within organization in an effort to identify and resolve operational implications as they relate to provider initiatives.
 - Create, disseminate, and maintain various procedures and policies related to BCN's operating database.
 - Designated lead role for Provider Data Operations on the implementation of National Practitioner Identifier project and implementation of Portico systems.
 - Extensive use of MS Word, Excel, Access, MACESS, BCBSM Corporate Provider File, and Facets databases/programs.

Lead Business Coordinator

Blue Care Network – Southfield, MI

07/03-02/05

- Primary contact for all operational areas of BCN and all BCBSM touch point areas (BCBSM Provider Enrollment) for Common Provider.
- Managed statewide contract oversight for Behavioral Health and Chemical Dependency provider. Streamlined OPC/IPC use of pins.
- Lead role in the assessment, development and implementation of operational improvements as they relate to Common Provider, including policies, procedures and processes.
- Identify and develop educational and training materials for various BCN/BCBSM departments to support operations.
- Chair and facilitate cross-functional meetings between BCN/BCBSM.
- Act as a project manager for provider data reconciliation between BCBSM and BCN.
- Develop, implement and oversee various work plans for provider data.
- Extensive use of MS Word, Excel, Access, MACESS, STAR and Facets databases/programs.

Contract Operations Coordinator

Blue Care Network – Southfield, MI

04/02-07/03

- Oversee and monitor contract exceptions.
- Coordinate contracting and servicing activities with Regional Provider Affairs and Network Management.
- Oversee credentialing and contracting of Value Options Mental Health Providers affiliated with BCN.
- Represent Regional Provider Affairs on corporate committees or workgroups related to provider operations and contract maintenance.
- Ensure contracts are scanned and filed in Maccess and hardcopy contracts filed.
- Responsible to assist with the implementation of all provider contracts (specialty, primary care, ancillary and hospital) to ensure accuracy, completeness and effectiveness from a comprehensive viewpoint.
- Provide support to provider contract implementation and maintenance.

- Investigate and resolve root causes for provider affiliation issues, including provider loading and claim payment errors.
- Responsible for resolving high level problems with providers by taking an interdisciplinary approach and being the main conduit within BCN to evaluate and make procedural recommendations.
- Represent Provider Affairs regarding the implementation of Common Provider and Facets.

Provider Affairs Representative

Blue Care Network – Southfield, MI

04/01-04/02

- Responsible for education of contracted providers (small and large group), ancillary and office staff regarding current BCN policies and procedures, including corporate initiatives.
- Analyze financial and utilization data of contracted physicians and primary care groups.
- Resolve ongoing provider issues that required negotiation and/or interaction with multiple internal departments.
- Assigned contracting responsibilities of ancillary, primary and specialty providers to ensure contracts are complete and fully executed.
- Facilitate resolution of ongoing claims payment, referral and benefit issues affecting providers on a daily basis.
- Participate in various external and internal committees.

Provider Relations Representative

M-CARE – Ann Arbor, MI

07/99- 4/01

- Act as a liaison between managed care organization and providers regarding claims payment issues, policy interpretations, benefit questions and procedural guidelines.
- Analyze, identify and resolve provider claims payment issues.
- Implement focused servicing plans for 12 PHO/IPAs, 17 hospitals and over 1900 physicians.
- Promote the recruitment and contracting of provider network through identification of needed specialist/ancillaries to compliment MCO/PHO/IPA network.
- Assist in facilitating the resolution of ongoing problems that affect providers/hospitals.
- Respond to providers on questions specific to their contracts, risk and reimbursement.
- Assist in the credentialing of new providers as needed by provider system.
- Facilitate changes of provider data to ensure accuracy of claims processing, authorizations and member assignment.
- Conduct site reviews in accordance with state guidelines.
- Extensive use of Amisys, MACESS, MS Word and Excel programs.

Office Assistant III

M-CARE – Southfield, MI 10/98-7/99

- Provided administrative support for Regional Manager.
- Assisted on Customer Service lines dedicated to providers.
- Resolved claim and authorization status, member eligibility and benefit information issues.
- Responsible for creating and maintaining physician databases.

Contract Administration Internship

M-CARE – Southfield, MI 05/98-08/98

- Coordinated educational seminars between contracted providers and ancillary providers.
- Organized and participated in Joint Operation Committee meetings.
- Assisted in negotiating and interpreting contract language in managed care contracts
- Created, analyzed and presented results of Genesee county provider satisfaction survey.

EDUCATION

Central Michigan University – Mt Pleasant, MI 2003-2008

Master of Science in Administration

Eastern Michigan University – Ypsilanti, MI 1994-1998

Bachelor of Science in Health Administration

Antwerp Local High School – Antwerp, OH 1990-1994

High School Diploma

SKILLS

Proficient in Microsoft Office applications including Excel, Word, and PowerPoint. Working knowledge of Access. Working knowledge of managed care information systems. Excellent negotiation and project management skills. Strong oral and written communication skills. Strong Leadership skills.

OT

References available upon request

Dana Ashley Green, MBA, CPA, PMP

Certified Project Manager and Certified Public Accountant with over 20 years of HIT management experience. Has led software implementations, policy and procedure initiatives and multi-stakeholder collaborations in several industries with extensive knowledge of Health Information Exchange (HIE) and Health Information Technology (HIT) functional requirements, architecture, standards and technical challenges. Specializes in successfully executing multi-stakeholder projects with challenging timelines and budgets. Successful author of over \$30 million in federal grant applications in a two year period.

Meridian Health Plan

Detroit, Michigan

August 2014 to present

Director, EDI/ Information Systems Manager. Develop staff and organization of EDI specialists to implement and support healthcare data exchange with external trading partners. Support organizational growth by providing strategic data exchange direction, building organizational capacity and maintaining reliable systems, as well as ensuring that business processes are supported.

Covisint

Detroit, Michigan

April 2010 to August 2014

Director, Healthcare Client Services. Develop staff and organization that create satisfied customers who rely on Covisint for strategic healthcare solutions. Support organizational growth by providing strategic client direction, building new relationships and maintaining existing client relationships, as well as ensuring that client support is efficiently and effectively executed.

HIPAA Privacy / Compliance Officer. Maintaining Covisint's privacy policy in accordance with Health Insurance Portability and Accountability Act (HIPAA). Comprehending and communicating the pertinent aspects of HIPAA to Covisint employees through a policy, and ensuring employee compliance with the policy. Crafting and sending employee communications, establishing employee training, assisting with internal process design and process documentation that adheres to policy.

Solutions Engineer. - Demonstrated how Covisint solutions address customer problems and how Covisint solutions provide cost savings to customer. Planning and performing presentations and product demonstrations to prospective customers and answering resulting technical and functional product questions. Assisting Covisint's sales team with all aspects of proposal writing, contracting and RFP/RFI processes.

Altarum Institute

Ann Arbor, Michigan

Program Manager

October 2008 to March 2010

Project Role: Interim Executive Director. Led the development of a comprehensive business and implementation plans, and compliance with ARRA funding requirements for the Southeast Michigan Health Information Exchange (SEMHE). SEMHE is working to facilitate the creation of a regional HIE in southeast Michigan including Macomb, Monroe, Oakland, St. Clair and Wayne Counties.

Project Role: Project Manager. Led the execution of a three year Agency for Healthcare and Research Quality (AHRQ) grant to analyze the effect of Cognitive Task Analysis as part of decision support software implementation in primary care facilities. The project is a coordinated effort of the University of Michigan Health System, Altarum and the Michigan Primary Care Association. The project includes: in-field training, observation, surveys, analysis and reporting.

Project Role: Senior Analyst. Centrally involved with planning efforts for two regional HIE efforts in Michigan. In addition to SEMHE, included above, developed a roadmap for HealthCurrent, the HIE for Jackson, Hillsdale, Lenawee, Livingston and Washtenaw counties. Creating an extensive inventory of existing HIT assets and stakeholder readiness, identification and prioritization required capabilities and services, value analysis, comprehensive business model, Requests for Information and Requests for Proposal. Defining evaluation metrics, developing data use agreements, privacy & security policies, communication and education plans, public policy advocacy strategy, and a technical development strategy.

Michigan Public Health Institute (MPHI)
Lansing, Michigan

Senior Project Manager
May 2002 – October 2008

- Founded the Michigan Health Information Network (MiHIN) Resource Center to assist Michigan's nine RHIOs. Achieved unanimous consensus among over thirty diverse stakeholder representatives regarding the appropriate role for the State of Michigan to support HIE and support the regional initiatives.
- Implemented four HIPAA EDI transactions for Michigan Medicaid systems. Developed innovative methods to implement seldom used transactions and significantly increase related functionality. Expanded HIPAA Administrative Simplification responsibilities to include implementation of Privacy and Security mandates.
- Collaborated with consultants and staff from MDCH and technical staff from Blue Cross Blue Shield of Michigan to develop a HIPAA compliant, Web-based eligibility verification process for Medicaid providers.
 - Project was a pilot for the use of the Rational Unified Process (RUP) Methodology at Blue Cross Blue Shield of Michigan.
- Implemented a grant from the Office of Child Support Enforcement (OCSE), Administration for Children and Families (ACF), Special Improvement Project (SIP) grant to design and implement a tool to combine data across State agencies enabling coordinated efforts to ensure that children with child support orders requiring insurance receive coverage by private insurance, Michigan's SCHIP program, or Medicaid. This initiative combined the talents of Michigan State staff from Community Health, Vital Records, Office of Child Support, the Information Technology, and municipal Friend of the Court support services.

Technical and grant writer.

- Lead architect for successful \$20.9 million application to the Federal Communication Commission (FCC) Rural Healthcare Pilot Program. The FCC Pilot Program will build infrastructure to provide broadband access for 400+ non-profit facilities in rural, medically underserved areas in Michigan.
- Drafted two successful proposals to the Centers for Medicare and Medicaid Services (CMS) Medicaid Transformation Grants for a total of \$9.2 million for the State of Michigan. The projects created a central database for medical provider state licensure which simplifies the credentialing process for Medicaid, healthcare payers, group practices, hospitals and HIEs, and assisted the Michigan Office of Vital Records in the automation of death records and the completion of an online birth record database.

Project Role: Michigan Project Director. Led the Michigan effort for the Office of the National Coordinator (ONC), Health Information Security and Privacy Collaborative (HISPC).

- Created statewide collaboration among 200 stakeholders to assess the impact of policies, practices, and state laws regarding privacy and security on Health Information Exchange (HIE) in Michigan. Worked with the multi-state team to determine national themes.
- Implemented stakeholder recommendation, including a statewide resource center to assist Michigan's RHIOs. Developed methodology to review Michigan laws and recommend ongoing updates necessary for HIE.
- Selected to chair the Provider Education (PE) multi-state collaborative, one of 7 national teams addressing key barriers to nationwide adoption of HIE. The PE Team included Michigan, Kentucky, Florida, Tennessee, Mississippi, Missouri, Louisiana and Wyoming. Strategically coordinated efforts among provider associations in the eight PE states with ONC initiatives.

Education

Masters of Business Administration - *Texas Christian University*

Bachelors of Business Administration, Systems Analysis - *University of Texas at Arlington*

Certifications

Certified Public Accountant (CPA) – Texas

Project Management Professional (PMP) – Project Management Institute

Bruce L. Wegner**Professional Profile**

- Over 25 years of experience in HMO claims and claims-related management, which includes accounting, reporting, and budgeting
- Ability to manage a number of diverse projects and tasks simultaneously
- Goal-oriented individual with strong leadership capabilities
- Organized, highly motivated, and detail-oriented problem solver
- Proven ability to work in unison with staff as well as internal and external customers
- Extremely adaptable to new systems and software programs

Education

B.S., Accounting, Minnesota State University, Mankato, MN

Relevant Experience & Accomplishments**Leadership and Analytical Skills**

- Led a successful expedited implementation of internalized processing of claims from a Third Party Administrator (TPA) arrangement.
- Successfully led the Claims department at Metropolitan Health Plan (MHP) from 1989 until 1996, then again from 1997 through September 2006, focusing on Medicaid, dual-eligible and Minnesota Care enrollees.
- Led a project which accomplished a consistent 99.9+% timely clean claim payment rate.
- Established and maintained effective controls through automation to minimize and detect claims payment errors.
- Designed, implemented and successfully managed a staffing model that effectively meets the programming and processing demands of the ever-changing Medicaid and Medicare claims adjudication requirements.
- Developed a structured tool which organized programming requests and requirements between Operations and IT.
- Managed a project to implement a document imaging and work flow system that was adopted for company-wide use.
- Manage a staff of Business Analysts who research systems adjudication issues, as well as test and implement new programs and contracts.
- Key decision maker with regard to processing changes and prioritization of configuration resources.
- Spearheaded an effort to increase MHP's risk-adjustment scores with the MN Department of Human Services (DHS), resulting in enhanced premium revenues.

Accounting/Technical

- Oversaw the completion of the annual statutory audit, as well as MN Department of Commerce audits and the timely completion of all regulatory reports pertaining to accounting.
 - Managed a staff of claims processing supervisors, lead workers and analysts.
 - Facilitated several interdepartmental quality improvement initiatives.
 - Oversaw the completion of the annual HMO budget.
 - Successfully implemented an accounting system that automated several processes between MHP and the Hennepin County government center accounting system (FARS).
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| | | |
|-------------------|--|-------------------------------------|
| Employment | Director of Claims/Claims Administrator , <i>Meridian Health Plan</i> , Detroit, MI | <i>Dec 2014 thru present</i> |
| | <ul style="list-style-type: none"> • Direct the overall functions and activities of the Claims department, including Coordination of Benefits, claims entry, claims-related phone coverage, and department training • Develop and execute staffing model that supports current and future claims operations, including performance metrics • Ensure timely and accurate processing of all types of medical and ancillary claims • Develop and maintain policies and procedures which satisfy both regulatory and internal requirements • Coordinate the development and review of core department metrics and report to management and regulators • Participate in internal and external audits involving claims processing • Recommend and assist with the review and acquisition of tools and equipment to optimize departmental performance and output | |
| | Claims Director , <i>PrimeWest Health</i> , Alexandria, MN | <i>Sept 2006 thru Sept 2014</i> |
| | <ul style="list-style-type: none"> • A County-based purchasing entity that participates as a pre-paid health plan whose primary enrollment consists of Medicare and Medicaid eligible members. • Scope of management includes claims processing, Coordination of Benefits (COB), Business Analysts, Requirements Analysts, and Provider Data Management • Process 700,000 claims annually at a rate of 99.95% within 30 days • Lead a staff of 35 employees, including two managers. | |
| | Claims Manager and Controller , <i>Metropolitan Health Plan</i> , Minneapolis, MN | <i>1997-Sept 2006</i> |
| | <ul style="list-style-type: none"> • An HMO that participates as a pre-paid health plan whose primary membership consists of Medicare and Medicaid-eligible members. • Managed the claims department as well as all accounting functions. | |
| | Business Analyst , <i>Mayo Management Services, Inc.</i> Rochester, MN | <i>1996-1997</i> |
| | <ul style="list-style-type: none"> • Facilitated and implemented programming changes in the operational departments. • Trained the accounting staff to better understand health care payment data for streamlined reporting and data collection. • Project managed various software implementations which resulted in cost savings and more accurate claims adjudication. | |
| | Claims Manager , <i>Metropolitan Health Plan</i> , Minneapolis, MN | <i>1989-2006</i> |
| | <ul style="list-style-type: none"> • Led the claims department from highly manual claims processing to a much more automated adjudication system, resulting in significant cost savings. • Led the claims department during the implementation of several State demonstration programs, including General Assistance, MinnesotaCare and the MSHO program. • Participated in several charity events, including Salvation Army food drives and other community events to support those who are disadvantaged | |

**Community
Involvement**

AAAA Theater, Alexandria, MN, Board Member, Fundraising Chair
AAAA Theater and Lakes Area Theater, voice and acting roles (2 years)
Healthcare User Group (HUG), Two-term Treasurer
Managed Care Assistance Group, Two-term Treasurer
Administrative Uniformity Committee (MN), Committee member
MHP Softball Team, Coached MHP softball team to two Hennepin County tournament championships

**Honors &
Awards**

Outstanding Leadership Award, *MHP 1999*
Several Certificates of Appreciation, *MHP*
“Rookie of The Year”, *MHP 1989*
Highest Net Profit Increase in Minnesota, *7-Eleven 1987*

References

Furnished upon request

Experience

**Deputy Director of Care Coordination/Care Management
Manager, Meridian Health Plan**
November 2014 - Present

Responsible for the strategic development and implementation of the coordination of care of high risk populations. This includes oversight of the day-to-day operations of the care coordination, CSHCS, Medicare and Compliance teams and Complex Case Management. Develop, recommend, and implement effective and efficient standards, protocols and processes, reports and benchmarks that support and further enhance the care coordination of high risk populations and quality of healthcare services. This position is also responsible for ensuring that MHP's programs are compliant regulatory (State and Federal) and accrediting requirements.

Responsible for ensuring compliance with the National Committee for Quality Assurance (NCQA), URAC or general accreditation and CMS regulatory requirements.

Ensures Care Coordination departmental policies and procedures are updated at least annually, new policies are developed as needed and that all Care Coordination staff are appropriately informed/trained in updates.

Prepare and distribute outcome and quality management reports for assigned committees indicating utilization and quality management patterns. As well as to perform all other duties as assigned.

**Care Coordination Manager, Special Needs Population, SPD, MMAI
and TOC, Meridian Health Plan**
February 2014 – November 2014

Responsible for the direct oversight and management of the MI and IA CHOWS, IL SPD and MMAI Care Coordination teams as well as development, implementation, and training of MHP's STEP OUT, TOC program for a total oversight of 60 staff members.

Ensure contractual compliance of SPD and MMAI's care coordination teams while actively working to develop, plan, implement, and enhance processes to become more efficient while reducing cost and securing quality care delivery.

Report analysis to identify trends and areas in need of improvement followed by implementation thereof. Ensure production expectations are being met while working together with care coordination training staff to ensure that quality training initiatives are focused on meeting program goals while increasing staff competency. Responsible for the evaluation of and direct process improvement of all SPD and MMAI care coordination staff.

Active implementation and evaluation of the Transition of Care program to include participation in the development of flow processes and training of the care coordination nursing staff on TOC. Also responsible for training of all CHOWS in IA, IL, and MI who are implementing TOC. Direct oversight of MI and IA field staff in all areas of the CHOW role including field attempts to complete assessments on our unable to reach population, the generation of community

resources, facilitating communication between virtual and field staff, TOC, production and performance expectations, and biweekly CHOW meetings in Detroit.

Responsible for interviewing potential care coordination candidates for the positions of CC, CC-TL, and CHOW.

Continued active participation on the CCEC committee and the Member satisfaction MHP Transformation Committee.

Seniors and Persons with Disabilities (SPD) Team Lead, Meridian Health Plan

July 2013 – February 2014

Responsible for oversight of the care of the high risk SPD population to assure adequate clinical and psychosocial assessment while assuring that the educating of members in the area of self-management is achieved. Direct assistance in the on-boarding of the SPD population to include outreach and mailing of HRA's in an effort to meet contractual timeframes.

Provide clinical direction to Care Coordination staff and identify cases that require conference/consult with ancillary staff including: BH, nutrition and pharmacy in the development of the member's plan of care.

Facilitate weekly team meetings for the purpose of case review, assist manager in evaluation of productivity and goal attainment, perform post-inpatient calls and facilitate discharge planning on members who are in the hospital, ensure that HRA's are performed within 60 days of enrollment and review the HRA to validate strat level assigned to member with a continued participation in QIA activities while adhering to all regulatory guidelines and standards. Assisted in file review for Complex Case Management files in preparation for Michigan NCQA survey.

Active participant on the CCEC committee.

Transplant Coordinator, Meridian Health Plan

December 2012 – July 2013

Single accountable point of contact for comprehensive management of the member from pre-transplant evaluation through one year post-transplant, utilizing Care Management and Utilization Management tools and resources.

Provide both supportive and comprehensive care management to determine how members will be assigned to specific stratification levels to best serve their needs. Regular telephonic health assessment to identify risk factors, mental health status, cognitive function, cultural and linguistic needs, caregiver resources, available benefits, and life planning activities.

Follow care of all transplant members when inpatient and throughout discharge. Provide discharge instruction and review once member returns home to effectively prevent readmission and provide quality care.

Registered Nurse, Diagnostic Imaging, Stroke Response Team
August, 2010 – December 2012

Act as charge nurse in coordinating care and procedures for both inpatient and outpatient Radiology patients. Scheduling and pre surgical screening of these patients. Monitor and sedate patients undergoing invasive diagnostic imaging procedures. Provide both pre-op and post-op care of the procedure patient post administration of conscious sedation.

- Respond to call for both interventional radiology and neuro endovascular stroke team. Facilitate interventional process and monitoring of emergency onset patient.
- Active participation in JCAHO preparation surveys.

Registered Nurse, CICU
February, 2006 - May 2007 University of Michigan Hospital, Ann Arbor

Act as charge nurse, provide care for the complex medical cardiac patient population including post angioplasty with intervention, Acute MI, CHF, Arrhythmias, Cardiomyopathy, Pre-cardiac transplantation, Pacemaker management, and Pulmonary Hypertension.

Experience/knowledge of vasoactive drips, hemodynamic monitoring, ventilators, CVVHD, IABP, management of Swan-Ganz Catheters, Arterial lines, and telemetry.

Provide care and education for patients and families preparing for heart transplants and other cardiac interventions.

Registered Nurse, Telemetry Step-Down
January, 2003 - February, 2006 University of Michigan Hospital, Ann Arbor

Monitor telemetry while providing care and education to patients' pre and post cardiac intervention.

Active participation in JCAHO preparation surveys.

Education

Eastern Michigan University, Ypsilanti, MI
September 2004 - April 2011
BSN

Washtenaw Community College, Ann Arbor, MI
September 2000 - December 2002
ADN

Licensure

Current RN license, State of Michigan and Illinois
Awaiting IA RN license – In process
ACLS/BLS Certified

JANE M. GOLDSMITH, RN, MBA, CSSGB

CAREER SUMMARY

Quality management professional who leads high performance cross functional teams and liaison with regulatory agencies. Strong analytical change agent and problem solver with proven, measurable results.

PROFESSIONAL EXPERIENCE

MERIDIAN HEALTH PLAN, INC., Detroit, Michigan

2012 to Present

A leading managed care organization with membership primarily from government programs. Highly focused on quality care and obtaining excellent rankings with high performance metrics.

Vice President, Regulatory Compliance and Accreditation/Compliance Officer

Provide technical guidance on compliance with requests for proposals, audits, state/federal regulatory matters and accreditation

- Ensures plan compliance with all CMS and state requirements regarding Medicare and Medicaid operations, including reporting, daily provision of care to members, enrollment
- Implement the compliance program – define the program structure, educational requirements, reporting and compliance mechanisms, response and correction procedures, and compliance expectations of all personnel, including First-tier Downstream Related Entities (FDRs)
- Develop and implement methods and programs that encourage managers and employees to report non-compliance and potential FWA without fear of retaliation
- Develops and annually reviews and updates as necessary the Code of Conduct to ensure that MHP employees receive current and relevant guidance with respect to corporate compliance expectations
- Develops and monitors methodologies and systems to build compliance awareness into daily business processes
- Consults with MHP Legal Counsel as necessary to resolve legal compliance issues

Director, Regulatory Compliance and Accreditation

Provide subject matter expertise for health plan accreditation, compliance, and state and federal regulatory audits. Responsibilities include coordinating accreditation preparation activities and providing practical advice and expertise to projects that promote innovation, efficiency, while ensuring compliance.

- Ensures plan compliance with all NCQA accreditation standards and CMS and state requirements regarding Medicare and Medicaid operations.
- Participate in the development, implementation and ongoing compliance monitoring of all vendors, contractors and subcontractors to ensure all requirements and responsibilities are addressed.
- Assists departments with the development of their policies and procedures to meet and maintain accreditation. Oversee policies and procedures library to maintain accuracy and security.
- Identify and recommend process improvement initiatives based on potential and real compliance incidents, audit trends and root cause analysis. Identifies and intervenes on high risk areas identified during new program development and implementation.
- Provides staff development by planning, developing, organizing, implementing, evaluating, and directing the staff in relation to regulatory compliance and accreditation.

HEALTH SERVICES ADVISORY GROUP, INC., Phoenix, Arizona

2006 to 2012

A leading health care quality improvement and external quality review organization in the nation with external review activities in 14 states. Offered and accepted permanent position with organization during independent consulting contract.

Associate Director

Provide subject matter expertise for quality improvement initiatives, health plan compliance, and state and federal regulatory audits. Responsibilities include providing contractual, regulatory, and operational technical assistance to state agency leaders for improved health plan performance.

- Lead development of performance improvement initiatives to meet state and federal quality improvement strategic goals and performance measures including identifying study topics and developing process measures, indicators, control mechanisms based on causal-barrier analyses.
- Develop data mining specifications to support performance improvement projects.
- Develop and present performance improvement project frameworks based on the Institute for Healthcare Improvement strategies and Centers for Medicare and Medicaid Services protocols.
- Provide technical support to managed care organizations regarding CHIPRA measures based on CMS specifications.
- Conduct readiness reviews and regulatory compliance reviews. Completed 60+ reviews over six years and five states.

Independent Consultant (October 2006 to September 2008)

Provided subject matter expertise and project management to Health Services Advisory Group (HSAG). Engagement included work for the States of Illinois, Nevada, Florida, and Ohio and a large dental provider in California.

AMERIGROUP ILLINOIS, INC., Chicago, Illinois

2003 to 2006

Managed care plan serving 40,000 Medicaid recipients in Cook County and the City of Chicago.

Associate Vice President, Quality Management and Compliance

Accountable for all contractual compliance programs, corrective action plans, performance improvement projects, performance measure results, and related internal and external auditing functions for the health plan.

- Increased health plan clinical quality performance measures by 50-200% through focused, performance improvement projects focused on primary care provider partnerships and data mining.
- Achieved 92% on State of Illinois Compliance Audit by leading interdepartmental work team.
- Realized a reduction in marketing fraud allegations by 85% through strategic cause and effect analysis and targeted sales team interventions.
- Led cross functional team for executive management and departmental directors including provider relations, information systems, member services, marketing, and utilization management.
- Coordinated provider advisory committees in conjunction with the medical director including quality improvement, peer review, credentialing and utilization analysis.
- Guided department staff development plans leading to staff advancement.

CAPE HEALTH PLAN, Southfield, Michigan

2000 to 2003

Managed care plan serving 60,000 Medicaid recipients in Wayne, Washtenaw, and Oakland Counties and the City of Detroit.

Director, Quality Improvement

Developed and led successful performance measure turnaround strategy through implementation of interdepartmental quality management initiatives.

- Increased HEDIS clinical performance measures by 50-100% through reengineered data mining and report generation functions and improved submission of service data from provider sites.
- Created and led first corporate cross functional high performance team. Team increased measurable performance of 30 high volume pediatric offices in the City of Detroit through systematic auditing, measurement and feedback cycles related to quality of care issues.
- Advised IT department on data mining and database development and interpreted report specifications.

ADDITIONAL PROFESSIONAL EXPERIENCE

Additional positions held include Adjunct Professor for John Hopkins School of Public Health, **6 years** as a **public health nurse**, **8 years** as Residential Manager responsible for around the clock care and staffing for several **not for profit mental health residential care facilities**, Registered Nurse in **sub-acute rehabilitation unit** at a community based hospital and Nursing Assistant at a **long term care facility**.

EDUCATION AND CERTIFICATIONS

MBA, Integrative Management, Michigan State University, East Lansing, Michigan
BS, Nursing, Eastern Michigan University, Ypsilanti, Michigan
RN, Current Michigan License
Six Sigma Green Belt Certification, Villanova University

PROFESSIONAL DEVELOPMENT

Accountable Care Organizations: An Introduction to NCQA's Accreditation Standards, NCQA
An Introduction to NCQA's Accreditation Standards for Health Plans, NCQA
Introduction to SNP Assessment, Structure and Process Measures 1 through 6, NCQA
The Reid Techniques of Interviewing and Interrogation, Reid Associates
Project Management Principles, Fred Pryor
Access Database Training - Basic, Intermediate and Advanced, Oakwood Health System
Excel Spreadsheet Training - Basic and Intermediate, Oakwood Health System

Kathryne Olver

Introduction

- Management experience in non-profit and for-profit sectors
- Curriculum developer and trainer in Person-Centered Planning, Person-Centered Thinking, Options Counseling and Cultural Diversity
- Certified State of Michigan Medicare and Medicaid Counselor (MMAP)
- Extensive knowledge and practical practice in systems development for the both state and federal reporting requirements
- Experience in contract and grant writing that has been effective in maintaining and increasing funding
- Member of State of Michigan Aging and Disability Resource Center, assisted in the development of policy to secure CMS funding
- Extensive knowledge and practical practice in billing, financials, provider management
- Vast knowledge of Aging System, Home and Community Based Waivers and MDCH operating standards and state wide regulations
- Extensive network and knowledge Home and Community Based waiver services as well as long term care services
- Comprehensive understanding on CMS rules and regulations

Education

Bachelors in Science: Health Care Administration and Community Development, 2011

Central Michigan University - *cum laude*.

Masters in Science in Health Care Administration, expected December 2015

Central Michigan University

Certifications

State of Michigan Social Service Technician-6803086409

State of Michigan Medicare and Medicaid Assistance Counselor

State of Michigan Certified Master Person Centered Thinking Trainer

State of Michigan Certified Options Counselor

State Certified MI Café Food and Medicaid Assistance counselor

Community Mental Health Certified

Michigan Department of Community Mental Health Certified Cultural Competency trainer

Kathryne Olver

Work Experience

April 2015-present Meridian Health Plan-Corporate Detroit Michigan

Long Term Care Manager/ Manager of Care Coordination- MI Health Link

Manage the Care Coordination program and SNP Model of Care and Compliance program for MI Health Link for telephonic care coordination and community care coordination program. Ensures Integration of evidence based clinical guidelines into member interventions; providing staff education both individually and on a group level; serves as the liaison for staff with the medical management leadership team; and participates with Disease Management in identification of members at risk for certain disease states. Monitors utilization reviews, member satisfaction and health based outcome measures.

Coordinates, monitors, and evaluates the activities of the various Care Coordination teams involved in managing the care of Medical, CSHCS and Medicare members. This may include, but is not limited to collaborating with physicians, family members, other managed care workers, social workers, public health departments, community mental health, inpatient case managers, discharge planners, and ancillary providers to ensure an optimal level of functional status and wellness. Establishes multiple case finding mechanisms and population specific assessment tools, identifies and assesses individuals through Predictive Model with catastrophic, complex or chronic risk factors who meet established criteria for entry into the Care Coordination program. Responsible for the development and maintenance of MHP protocols and policies specific to Care Coordination and the SNP model of care for the MI Health Link program. Initiates auditing and monitoring of the timeliness of care coordination interventions designed to optimize patient outcomes/goals and address barriers, including patient and family response and compliance with the care plan.

Works in collaboration with Pre-Paid Inpatient Health Plans to support members that are receiving self-directed care, have waiver benefits, or would benefit from waiver services. Coordinate assessment completion from members with substance abuse, diagnosed intellectual disabilities, physical disabilities and mental health diagnoses.

June 2013-April 2015 Meridian Health Plan-Corporate Detroit, MI

Manager of Community Care Coordination

Manage the community care coordination program which oversees the HCBS waiver services and long term care services and supports. This included the hiring, training, scheduling, monitoring workload, conflict resolution, performance evaluations, performance improvement, disciplinary actions, creating and implementing job performance expectations, oversight of caseloads, monitoring staff production metrics, auditing assessments and member plans of care.

Kathryne Olver

Training all community based staff, including clinical and social service staff in a person centered approach to utilizing natural supports in conjunction with medical and behavioral health services. Working with leadership in development and strategic planning, as well as, the tracking of under and over-utilization of services to identify opportunities for improvement, followed by implementation of policies and procedures to initiate and monitor the community care coordination activities.

May 2011-May 2013 **Community Living Services Inc. (CLS)** **Wayne, MI**

Manager of Long-term Care Division -June 2012 thru May 2013

Manage the day to day operations and lead in business development for the Long-term Care Division. Responsible for the overall operations of the CLS Long-term Care Division, including supervision of all staff, all aspects of financials, HR, IT and program management. Produced and developed training modules, wrote and maintained policy and contracts, assessed and implemented corrective action plans around rights and contract compliance issues. Managed the coordination and presentation of information for administrative hearings, State reviews, and all other LTSS contract reviews.

Operations Support Technician – November 2011 thru May 2012

Manage the operations for the department, report to Director of Long-term Care division on all contracts and provider changes and issues. Responsible for all audits, financials, contract compliance, and development of new business lines. Securing benefits and entitlements for people needing supports and services

Senior Services Support Broker-May 2011 thru November 2011

Advocate and broker of supports and services for people needing long term care options. Responsible for developing relationships with NFT service providers, transitioning people supported from long term care settings into home and community based settings. Monitor in-home care of people supported and providers, securing donations, completing assessments, and securing benefits and entitlements for older adults.

October 2010- December 2011 **Elite Home Care** **Novi, MI**

Lead Trainer and Staff Manager

Responsible for home management, medical training, contract management, scheduling, and business development. Business development included the development of materials, processes and working with funders for payment. Responsible for the oversight of all new caregivers in trainings on range of motion, transferring, personal care, record keeping, and person centered care. My duties included working closely with RN hospice nurses, skilled RN care, and physical therapists to increase health

Kathryne Olver

outcomes and develop plans of care. The company primarily supported people in the elderly population, developmentally disabled, traumatic brain injury, and spinal cord injury populations.

May 1998-August 2000

Holistic Environmental Services

Westland, MI

Medications Coordinator and Assistant Manager

Worked with the physically and intellectually disabled in residentially care settings. Responsible for scheduling of all staff, medications coordination, hospital visits, employment placement, all medical documents and reporting. Supervised all 15 staff on medications administration, personal care techniques and person centered care

. June 1997-June 1998

Presently called: Clare Bridge of Meridian

Okemos, MI

Afternoon Manager and Head Trainer

Worked with people with Alzheimer's and Dementia Diagnoses in Long-term care setting. Responsible for all staff in their training, monitoring, schedules, and documentation in regards to their medical plan of care. Worked to coordinate meaningful activities, evaluate care, and manage hospice or other care needs. Worked to identify potential barriers, interventions, and opportunities for improvement through training and process development.

Kimberly Foltz, B.S.N., R.N.

3705 Bluestem Rd. Norwalk, IA 50211

Phone: 515-360-8082

E-mail: Foltz11@mchsi.com

Innovative and strategic leader with diverse experience in **health care**, managed care insurance, non-profit organizations, hospital/provider markets, sales and operations, consulting and strategic planning. A **results-oriented** professional who knows how to deliver through disciplined principles and practices.

Areas of Expertise

- **Development and Communication** – Proven track record of delivering exceptional results through relationship building, effective communication and unwavering commitment. Extensive experience developing “C” level relationships both internally and externally.
- **Strategic Planning and Leadership** – Demonstrated ability to work in a matrix environment, developing a vision for success, promoting top-down focus on ROI and delivering bottom-up execution of strategy.
- **Community Leadership** – Adept at building relationships with community based organizations and key stakeholders to develop strategy, drive revenue growth and retain supporters.
- **Talent Management** – Consistently top-rated with bottom up staff reviews for creating environments for success. Consistently able to identify, hire and develop talent to provide an advantage to the organization.
- **Change agent** – A proven leader with an absolute focus on initiating, measuring, delivering and managing process improvement.

Experience

2013 – Present **Meridian Health Plan** – Des Moines, Iowa

Director of Operations 2013-present

- Leadership and oversight of health plan operations inclusive of administration, member services, finance, claims, care coordination, human resources, provider services, network development, quality improvement, project management office, communications, information systems and utilization management.
- Primary liaison with the State of Iowa, Department of Health and Human Services, Iowa Medicaid Enterprise, to facilitate communications and ensure contract compliance
- Development and implementation of strategic goals and objectives across the organization

Interim Director – Network Development 2014-present

- Day-to-day leadership and oversight of the network development and provider services/analytics team.
- Contract and Relationship Management of key provider/health systems

2012 – 2013 **UnityPoint Health/UnityPoint at Home** – Urbandale, IA

Director

- Leadership of four centralized/system level teams, driving innovation and efficiencies in clinical practice and operations. Emphasis on population health and ACO strategies:
 - Telehealth/Telemedicine – system level Executive Committee member – technology and clinical practice; leading pilot programs and use of new technologies to drive increased care coordination
 - Triage/Care Coordination – proposed and leading acquisition of infrastructure to increase capacity and improve access to care
 - WOCN’s – proposed and leading operational changes to drive increased access, efficiencies and improved outcomes
 - Clinical Coding – proposed and leading change to centralize systems and supports to drive operational efficiencies, increased revenues and decreased regulatory risks

2010 – 2013 **Iowa Alliance in Home Care** – West Des Moines, IA

Executive Director & CEO

- Executive leadership and association management for the home health care industry in Iowa, membership of approximately 170 organizations.
- Total fiscal responsibility including budgeting, revenue generation and expense management.
- Implemented policies and procedures, fiscal discipline and process improvements which resulted in over 800% improvement in organizations financials.
- Lead a data analytics project resulting in a Medicaid Reimbursement Savings Proposal to the 2012 General Assembly. Achieved success on all objectives, lobbying the General Assembly to pass key legislation for the industry.
- Appointed to executive leadership positions, representing the industry, with two national home care organizations.

1999 – 2010 **Principal Financial Group** – Des Moines, IA

Director – Contract Strategy & National Contracts 2007-2010

- Responsible for \$100MM of business consisting of contracts impacting over one million members.
- Successfully led the identification, procurement and implementation of new systems and processes resulting in \$24MM reduction in cost structure.
- Lead and manage a team of 30, with 0% turnover in 3 years, coordinated redesign of staff accountability model to foster and enable a results oriented team
- Responsible for developing and executing national contract strategy

Director – Managed care contracting 2003-2007

Senior Consultant 1999-2003

1997 - 1999 Peiser's-Invacare – Broadview, IL - Regional Director

1996 – 1997 Concept Home Care – Toledo, OH - Director, Home Care Operations

1992 – 1996 Hospital based patient care, private and commercial Home Care – Des Moines, IA

EDUCATION

Grand View University, Des Moines, IA

- **Bachelors of Science in Nursing**

Greater Des Moines Leadership Institute - Community Leadership Program

- **Graduate 2011**

ADDITIONAL EXPERIENCE

- ▶ US Attorney General's Health Care Fraud Task Force 2013-Present
- ▶ Medicaid Fraud Control Unit 2013-Present
- ▶ American Heart Association
 - Board of Directors 2007-present
 - 2013- 2015 Passion Committee Chair
 - 2013-2014 Executive Leadership Team
 - 2008-2010 Go Red for Women Event Chair
 - 2007 Go Red for Women Committee Chair
- ▶ National Association for Home Care Forum of States Executive Committee 2011 - 2013
- ▶ Council of State Home Care Associations Board of Directors 2011 - 2013
- ▶ Iowa Health Home Care – Board of Directors 2006-2010
- ▶ United Way
 - Women's Leadership Connection member, Fundraising Committee, Social Events Committee
 - Emerging Leadership Initiative member, Investment Committee
 - Social Venture Partners Charter member
 - Principal Financial Group United Way Cabinet 2009, Leadership Giving Chair 2007-2009
- ▶ 2008 Member of Des Moines Business Record "Forty under 40"
- ▶ Principal Financial Group Women's Network-for-Leaders Membership Chair 2008-2010
- ▶ 2010 Lite 104.1 Outstanding Women award honoree

C. David Smith, MD, FACS

Medical Consultation

Medical Director; Meridian Health Plan, Des Moines, IA

2014-Present

- Utilization Management; Provide excellent clinical insight while helping develop and adapt UM, Pharmacy, and Quality Management programs with effective medical necessity criteria and definitions to best benefit our members; leading UM team in processing decisions involving authorizations, possible complaints, denials and appeals
- Care Coordination Leadership: Oversee education and training of employees regarding medical care delivery, quality assurance, and effective utilization while acting as a liaison between our organization and community members to ensure best possible care
- Fraud, Waste, and Abuse: Responsible for the overall monitoring and investigating of potential FWA reports involving member's care and compliance of our providers; continuous reviewing/screening of credentialing policies and procedures, updating and reporting to Chief Compliance Officer when necessary; collaborating with MHP Directors to ensure and exceed compliance with National and State guidelines including NCQA, URAC, and others

State of Iowa Department of Disability Determination Services

2006-2014

Disability determination for Social Security Disability

Principal Financial Group 2005-2008

Extensive Utilization Review

Iowa Foundation for Medical Care/Encompass

2001-2008

Extensive Utilization Review

Clinical Practice

Broadlawns Medical Center, Des Moines, IA 2010-Present

- Teaching faculty for Family Practice residents in endoscopy and dermatology procedures clinic

Iowa Surgery Center, Des Moines, IA 1986-2004

- Continued private practice of general surgery

Surgical Associates, Des Moines, IA 1985-1986

- Began a multidisciplinary surgical group serving primarily Mercy Medical Center

Private Practice of General Surgery

- Established a solo general surgical practice serving community of about 15,000 members

Administrative Experience

Chief of Trauma Care; Mercy Medical Center, Des Moines, IA 1998-2001

Chief of Surgery; Mercy Medical Center, Des Moines, IA 1992-1993

Medical Director of Helicopter Ambulance; Mercy Medical Center, Des Moines, IA

1986-1987

Education

University of Iowa

Iowa City, IA

MD 1980

JANICE TOROSIAN

PROFESSIONAL
EXPERIENCE:

Meridian Health Plan, Detroit, Michigan

Chief Financial Officer (February 2001 – present)

Responsible for the oversight and maintenance of all financial records of the organization, and the day to day management of the Finance Department, including accounting, financial reporting (GAAP and Statutory Accounting Basis), data reporting and analysis, payroll, accounts payable, and annual budget preparation. Additional areas of responsibility include cash management and investments, reporting to the Board of Directors, annual audit coordination, preparation and submission of state required reports, periodic State examinations coordination, coordination of external actuary activities, reconciliation of revenue amounts to contract, oversight of capitated provider payments, oversight of stop loss recovery processing, contract review and analysis, and oversight of corporate insurance policy renewals.

The Detroit Medical Center, Detroit, Michigan

Director of Finance - Managed Care (January 2000 – January 2001)

Manager, Financial Services, Managed Care (November 1997 - January 2000)

Manager, Accounting and Financial Reporting (April 1992 - November 1997)

Financial Reporting Group Leader (March 1991 - April 1992)

Senior Financial Analyst (December 1987 - March 1991)

Responsible for managing the activities of the managed care finance department, which provides support to DMC owned health plans (Medicaid Clinic Plan and Employee PPO Plan), IPA groups and the DMC PSO. This support includes financial statement preparation and analysis; capitation rate analysis and payment distribution; review of financial risk models; financial analysis for proposed contracts; budget preparation; supervision of department staff, employee hiring and performance reviews.

Previous responsibilities included review and analysis of monthly consolidated financial statements; coordination of annual audit; benefit trust plan accounting; development of accounting policies/procedures with department director; supervision of general accounting department for a hospital subsidiary; supervision of Accounts Receivable for corporate division.

Detroit Receiving Hospital, Detroit, Michigan

Budget Analyst (March 1986 - December 1987)

Responsible for preparation of components of annual budget; forecast data; and accumulation and reporting of statistical data.

Martin M. Manoogian, C.P.A., Berkley, Michigan
Accountant (January 1983 - March 1986)

Responsible for the preparation of financial statements; individual, partnership and corporate income tax returns; and payroll tax returns.

EDUCATION: Bachelor of Science Degree in Business Administration, June 1982
Major - Accounting
Lawrence Institute of Technology, Southfield, Michigan

CERTIFICATION: Certified Public Accountant, State of Michigan, April 1985

PROFESSIONAL AFFILIATIONS: Member - Michigan Association of Certified Public Accountants

REFERENCES: References and transcripts available upon request.

JANE M. GOLDSMITH, RN, MBA, CSSGB

CAREER SUMMARY

Quality management professional who leads high performance cross functional teams and liaison with regulatory agencies. Strong analytical change agent and problem solver with proven, measurable results.

PROFESSIONAL EXPERIENCE

MERIDIAN HEALTH PLAN, INC., Detroit, Michigan

2012 to Present

A leading managed care organization with membership primarily from government programs. Highly focused on quality care and obtaining excellent rankings with high performance metrics.

Vice President, Regulatory Compliance and Accreditation/Compliance Officer

Provide technical guidance on compliance with requests for proposals, audits, state/federal regulatory matters and accreditation

- Ensures plan compliance with all CMS and state requirements regarding Medicare and Medicaid operations, including reporting, daily provision of care to members, enrollment
- Implement the compliance program – define the program structure, educational requirements, reporting and compliance mechanisms, response and correction procedures, and compliance expectations of all personnel, including First-tier Downstream Related Entities (FDRs)
- Develop and implement methods and programs that encourage managers and employees to report non-compliance and potential FWA without fear of retaliation
- Develops and annually reviews and updates as necessary the Code of Conduct to ensure that MHP employees receive current and relevant guidance with respect to corporate compliance expectations
- Develops and monitors methodologies and systems to build compliance awareness into daily business processes
- Consults with MHP Legal Counsel as necessary to resolve legal compliance issues

Director, Regulatory Compliance and Accreditation

Provide subject matter expertise for health plan accreditation, compliance, and state and federal regulatory audits. Responsibilities include coordinating accreditation preparation activities and providing practical advice and expertise to projects that promote innovation, efficiency, while ensuring compliance.

- Ensures plan compliance with all NCQA accreditation standards and CMS and state requirements regarding Medicare and Medicaid operations.
- Participate in the development, implementation and ongoing compliance monitoring of all vendors, contractors and subcontractors to ensure all requirements and responsibilities are addressed.
- Assists departments with the development of their policies and procedures to meet and maintain accreditation. Oversee policies and procedures library to maintain accuracy and security.
- Identify and recommend process improvement initiatives based on potential and real compliance incidents, audit trends and root cause analysis. Identifies and intervenes on high risk areas identified during new program development and implementation.
- Provides staff development by planning, developing, organizing, implementing, evaluating, and directing the staff in relation to regulatory compliance and accreditation.

HEALTH SERVICES ADVISORY GROUP, INC., Phoenix, Arizona

2006 to 2012

A leading health care quality improvement and external quality review organization in the nation with external review activities in 14 states. Offered and accepted permanent position with organization during independent consulting contract.

Associate Director

Provide subject matter expertise for quality improvement initiatives, health plan compliance, and state and federal regulatory audits. Responsibilities include providing contractual, regulatory, and operational technical assistance to state agency leaders for improved health plan performance.

- Lead development of performance improvement initiatives to meet state and federal quality improvement strategic goals and performance measures including identifying study topics and developing process measures, indicators, control mechanisms based on causal-barrier analyses.
- Develop data mining specifications to support performance improvement projects.
- Develop and present performance improvement project frameworks based on the Institute for Healthcare Improvement strategies and Centers for Medicare and Medicaid Services protocols.
- Provide technical support to managed care organizations regarding CHIPRA measures based on CMS specifications.
- Conduct readiness reviews and regulatory compliance reviews. Completed 60+ reviews over six years and five states.

Independent Consultant (October 2006 to September 2008)

Provided subject matter expertise and project management to Health Services Advisory Group (HSAG). Engagement included work for the States of Illinois, Nevada, Florida, and Ohio and a large dental provider in California.

AMERIGROUP ILLINOIS, INC., Chicago, Illinois

2003 to 2006

Managed care plan serving 40,000 Medicaid recipients in Cook County and the City of Chicago.

Associate Vice President, Quality Management and Compliance

Accountable for all contractual compliance programs, corrective action plans, performance improvement projects, performance measure results, and related internal and external auditing functions for the health plan.

- Increased health plan clinical quality performance measures by 50-200% through focused, performance improvement projects focused on primary care provider partnerships and data mining.
- Achieved 92% on State of Illinois Compliance Audit by leading interdepartmental work team.
- Realized a reduction in marketing fraud allegations by 85% through strategic cause and effect analysis and targeted sales team interventions.
- Led cross functional team for executive management and departmental directors including provider relations, information systems, member services, marketing, and utilization management.
- Coordinated provider advisory committees in conjunction with the medical director including quality improvement, peer review, credentialing and utilization analysis.
- Guided department staff development plans leading to staff advancement.

CAPE HEALTH PLAN, Southfield, Michigan

2000 to 2003

Managed care plan serving 60,000 Medicaid recipients in Wayne, Washtenaw, and Oakland Counties and the City of Detroit.

Director, Quality Improvement

Developed and led successful performance measure turnaround strategy through implementation of interdepartmental quality management initiatives.

- Increased HEDIS clinical performance measures by 50-100% through reengineered data mining and report generation functions and improved submission of service data from provider sites.
- Created and led first corporate cross functional high performance team. Team increased measurable performance of 30 high volume pediatric offices in the City of Detroit through systematic auditing, measurement and feedback cycles related to quality of care issues.
- Advised IT department on data mining and database development and interpreted report specifications.

ADDITIONAL PROFESSIONAL EXPERIENCE

Additional positions held include Adjunct Professor for John Hopkins School of Public Health, **6 years** as a **public health nurse**, **8 years** as Residential Manager responsible for around the clock care and staffing for several **not for profit mental health residential care facilities**, Registered Nurse in **sub-acute rehabilitation unit** at a community based hospital and Nursing Assistant at a **long term care facility**.

EDUCATION AND CERTIFICATIONS

MBA, Integrative Management, Michigan State University, East Lansing, Michigan
BS, Nursing, Eastern Michigan University, Ypsilanti, Michigan
RN, Current Michigan License
Six Sigma Green Belt Certification, Villanova University

PROFESSIONAL DEVELOPMENT

Accountable Care Organizations: An Introduction to NCQA's Accreditation Standards, NCQA
An Introduction to NCQA's Accreditation Standards for Health Plans, NCQA
Introduction to SNP Assessment, Structure and Process Measures 1 through 6, NCQA
The Reid Techniques of Interviewing and Interrogation, Reid Associates
Project Management Principles, Fred Pryor
Access Database Training - Basic, Intermediate and Advanced, Oakwood Health System
Excel Spreadsheet Training - Basic and Intermediate, Oakwood Health System

Rene L. Acker, R.Ph.

OBJECTIVE Seeking a position where my successful pharmaceutical experience will be utilized toward a challenging position offering professional growth.

EDUCATION

Wayne State University – Detroit, Michigan
College of Pharmacy – B.S. Pharmacy 1997
Licensed Pharmacist in Michigan

Wayne State University – Detroit, Michigan
College of Science – B.A. Biology 1994

Central Michigan University – Detroit, Michigan
College of Business – M.S. Business (In Progress)

EXPERIENCE

7/2010 to Present

Chief Operating Officer/Pharmacy Director/Coordinator
MeridianRx– Detroit, Michigan

- Functions as the primary liaison between Meridian Health Plan (MHP), its pharmacy benefits manager and its participating providers
- Oversees the activities of MHP's pharmacy benefit's manager, including monitoring of performance metrics, utilization and reporting data
- Works cooperatively with Finance and other departments to analyze and review pharmacy cost and utilization data and takes appropriate action to address areas of concern
- Makes recommendations for new clinical program development to support MHP's utilization and quality goals for pharmacy program
- Develops processes to incorporate pharmacy data clinical information obtained in the pharmacy authorization process into MHP's HEDIS reporting
- Responds to provider and member questions regarding the pharmacy benefits program
- Assists with the preparation and distribution of communications material between the plan and participating providers
- Formulates and recommends operational policies and procedures related to pharmacy and the pharmacy department
- Keeps informed of federal and state regulations as they relate to the operations of the health plan's pharmacy programs
- Serves as the administrative liaison for the Pharmacy and Therapeutics Committee of RxAmerica. Duties include record keeping, meeting notification, and utilization reports.
- Serves as Chairperson of the health plan's Pharmacy and Therapeutics Committee
- Prepares state-required reports for review and submission at the Pharmacy and Therapeutics Committee meetings
- Performs other duties as assigned

1/2010 to 7/2010

Manager of Pharmacy
Health Plan of Michigan – Detroit, Michigan

- Directly managed pharmacists and pharmacy technicians including but not limited to hiring, scheduling, monitoring workload, conducting performance evaluations and implementing disciplinary action, when necessary
- Oversaw workload needs on a concurrent basis including monitoring phone coverage and clinical work queues in the department. Daily prioritization of staffing assignments for optimizing impact on department production.
- Performed quality monitoring on inbound and outbound calls and follow up with staff who are not meeting HPM's expectations

- Ensured compliance with regulatory and quality accreditation requirements for maintenance of a P&T Committee process, formularies, medication coverage policies that support safe, efficacious, and cost-effective prescribing and drug use
- Assisted in coordinating and scheduling appointments for health education and outreach events, such as lead fairs, in collaboration with other departments
- Completed bi-weekly payroll and track and monitor the monthly bonus payouts
- Attended P&T committee meetings
- Tracked, monitored and analyzed formulary management reports to regularly assess implementation of formulary and policy decisions
- Coordinated information from drug manufacturers related to P&T reviews, including manufacturer incentives and rebate programs

10/2009 to 1/2010

Clinical Pharmacist

Health Plan of Michigan – Detroit, Michigan

- Ensured compliance with regulatory and quality accreditation requirements for maintenance of a P&T Committee process, formularies, medication coverage policies that support safe, efficacious, and cost-effective prescribing and drug use
- Assisted in coordinating and scheduling appointments for health education and outreach events, such as lead fairs, in collaboration with other departments
- Completed bi-weekly payroll and track and monitor the monthly bonus payouts
- Attended P&T committee meetings
- Tracked, monitored and analyzed formulary management reports to regularly assess implementation of formulary and policy decisions
- Coordinated information from drug manufacturers related to P&T reviews, including manufacturer incentives and rebate programs

9/2002 to 10/2009

Pharmacist – Medication Therapy Management Specialist

Rite Aid – Port Huron, Michigan

- Favorite Pharmacist Awards based on customer feedback
- Customer Service, Order Entry, Utilization of Automation
- Managing, Leading, Training Associates, Inventory Management
- New Store Openings, High Volume Store Experience

10/2001 to 9/2006

Pharmacist

Vollmer Pharmacy – Port Huron, Michigan

- Retail coverage for pharmacy

9/2001 to 9/2002

Pharmacist – Per Diem

- Mercy Health System- Hospital Shifts
- Coverage of all Hospital Units including ICU and Pediatrics
- IV, TPN, and Pharmacokinetic dosing
- Retail coverage for group of small independent pharmacies

3/1998 to 10/2000

Pharmaceutical Sales Representative

Hoffman La Roche – Southfield, Michigan

- Interviewed and Trained new Sales Representatives
- Promoted to Highest Level for Sales Representatives
- Special Achievement Award Winner
- Outstanding Sales Performance
- Cardiovascular, Antibiotic, Hospital Experience

10/2000 to 3/2001

Pharmacist

Hollywood Drugs – Grosse Pointe Woods, Michigan

- Retail coverage for pharmacy

3/1998 to 10/2000

Pharmacist

Hoffman La Roche – New Jersey

- Cardiovascular, Injectable, Hospital Experience

5/1997 to 2/1998

Pharmaceutical Sales Representative

Hoechst Marion Roussel – Kansas City, Missouri

- Cardiovascular, Injectable, Hospital Experience

PHARMACY PRACTICE CLINICAL ROTATION

3/1997 to 6/1997

Pharmacy/Externship

Detroit Receiving Hospital – Detroit, Michigan

1/1997 to 3/1997

Pharmacy/Externship

Bon Secour Pharmacy – Roseville, Michigan

10/1994 to 2/1997

Pharmacist / Pharmacy Intern – Critical Care

St. John Hospital – Detroit, Michigan

- Participation in Pharmacokinetic Monitoring
- Preparation of IV Admixtures and Neonatal Medications
- Covered ICU, CCU, Cardiology, Pediatrics, and Neonatal

6/1993 to 10/1994

Pharmacy/Externship

Mercy Hospital – Detroit, Michigan

6/1992 to 6/1993

Pharmacy/Internship

Perry Drugs – Grosse Pointe, Michigan

9/1991 to 5/1992

Pharmacy/Internship

Kroger Pharmacy – Rochester Hills, Michigan

LICENSURE/CERTIFICATION

CS – Pharmacist

Number: 5302029417

Issue Date: 07/23/1997

Expiration Date: 06/30/2016

Pharmacist, Preceptor

Number: 5302029417

Issue Date: 02/04/2011

Expiration Date: 06/30/2016

Licensed Pharmacist, IA – application in process

MARIA MOUBADDER, LPN



Qualifications

Licensed Practical Nurse with 18 years of experience in the managed care setting including Utilization Review, Quality Assurance and Credentialing

Excellent knowledge of Accreditation and Regulatory guidelines

Experienced in knowledge of and in analyzing provisions and exclusions of policies in order to decide eligible benefits

Results oriented and customer focused leadership

Highly motivated, accurate, thorough and precise in attention to details

Excellent analytical and organizational skills

Major strength is completing multi-faceted tasks with time constraints allotted

Proficient in developing excellent relationships with clients and consultants

Experience

2002-Present

Meridian Health Plan

Director/Grievance & Appeals Manager December 2014 to present

- Responsible for managing all aspects of the appeal and grievance processes within the department
- Assume primary responsibility for the resolution of member inquiries related to formal grievances
- Daily prioritization of staffing assignments for optimizing impact on department production
- Responsible for clinical coordination and presentation of information for administrative hearings and external reviews
- Participate in team meetings focused on communication, feedback, problem solving, process improvement, staff training and evaluation, and the sharing of results
- Provide strategic input when participating in organizational committees and, projects
- Identify issues and root causes of grievances and appeals for plan management and compliance
- monitor changes to laws and regulations to ensure compliance with State and Federal laws, regulations and mandates
- Provide support for the investigation, analysis and resolution of CTM cases
- Provide support and direction for the clinical pharmacist and medical staff on Part D cases.
- Provide interdepartmental coordination to ensure that all appeals decisions are effectuated and documented in a timely manner
- Ensure that all cases files are complete and current
- Manage the staff that will receive and track all cases from any source
- Ensure that representatives receive an Appointment of Representative Form when necessary
- Oversee that all cases are properly documented and tracked

- Ensure that clinical staff making the organization determination is not the same medical professional making the reconsideration or redetermination
- Maintain strict confidentiality of employee and organizational information in accordance with HIPAA and State privacy regulations
- Ensure that there are appropriate policies and procedures in place to support all Grievance and Appeal activity
- Responsible for ensuring that all department activities are in compliance with the NCQA, URAC or general accreditation standards, as well as State and federal regulatory requirements

Director of Utilization Management January 2013 to December 2014

- Design, develop and implement a comprehensive utilization management strategy for the organization that includes the following:
 - Use of Regional Teams to respond to member and provider concerns
 - Case Management programs for high cost or complex members
 - Support corporate HEDIS improvement goals through utilization management
- Use of a centralized tracking system (MCS) to ensure documentation of all contacts with members and providers related to utilization management
- Oversee the development, implementation and annual evaluation of the corporate utilization management program
- Oversee the identification, tracking, resolution and response to all denials and appeals in compliance with NCQA, URAC or general accreditation standards
- Represent MHP at external meetings with provider groups to address issues, improve communication and educate providers regarding MHP's utilization management process
- Ensure that there are appropriate policies and procedures in place to support all utilization management and case management activities
- Ensure that all department activities are in compliance with the NCQA, URAC or general accreditation standards, as well as State and federal regulatory requirements
- Identify and implement opportunities to enhance efficiency through the use of the MCS system as well as departmental process improvements
- Coordinate activities with other department directors to meet MHP's goals
- Provide leadership for the Utilization Management Committee and participate on other committees as appropriate.
- Develop and monitor the budget for utilization management activities and ensure that sufficient resources are assigned to meet department goals.
- Prepare monthly and quarterly utilization management reports for submission to the MHP leadership team and the Board of Directors
- Maintain strict confidentiality of employee and organizational information in accordance with HIPAA and State privacy regulations

Deputy Director of Utilization Management April 2012- January 2013

- Assist with development and implementation of effective and efficient standards, protocols and processes, reports and benchmarks that support and further enhance utilization management function and quality of healthcare services
- Responsible for oversight of day to day operation of UM
- Responsible for ensuring compliance with National Committee for Quality Assurance(NCQA), URAC or general accreditation and CMS regulatory requirements.
- Develop, plan, implement and enhance processes within the department to gain efficiencies and reduce costs while ensuring quality of care
- Assure department adherence to company and/or departmental confidentiality standards

- Analyze and reports data focusing on problematic areas and/or trends
- Review and recommend appropriate action based on weekly and monthly clinical and production reports
- Ensure UM departmental policies are updated at least annually, new policies are developed as needed and that all UM staff are informed/ trained in updates
- Prepare and distribute utilization and quality management reports for assigned committees indicating utilization and quality management patterns

Manager of Clinical Services August 2010 – April 2012

- Directly responsible for the following UM activities, inpatient review, pre-service review, Transitional Case Management, Referral Management, Denial and Appeal process
- Responsibilities include; hiring, training, process improvement activities, conflict resolution, conducting performance evaluations and implementing performance improvement and disciplinary actions, when necessary

Manager of Acute Inpatient Services December 2009 to August 2010

- Responsible for the daily operational management and supervision of the Inpatient Nurse Reviewer and support staff
- Responsible for interviewing, hiring and providing training, education, orientation and evaluations of new employees
- Conduct performance evaluations and monthly audits of staff, implementing performance improvement actions as needed
- Provide oversight of inpatient denials and appeals ensuring compliance with regulatory and accrediting requirements

Senior Nurse Reviewer/Team Lead 2005 to December 2009

- Provided oversight for workload/workflow for the inpatient utilization review team
- Final review and approval of all denial letters
- Appeals processing
- Coordinate clinical information to submit for IRO reviews
- Serve as mentor and provide ongoing education for inpatient review staff
- Review inpatient cases for consistent application of InterQual criteria, State guidelines, NCQA guidelines and Plan policies and procedures
- Monitor cases for discharge planning, case management referrals, continued stay reviews and prolonged hospitalizations
- Review transplant cases, add to log and provide financial notifications
- Coordinate the prolonged hospitalization report every week
- Serve as primary contact person for Meridian providers and staff for authorizations

Nurse Reviewer 2002-2005

- Review inpatient cases for consistent application of InterQual criteria, State guidelines, NCQA guidelines and Plan policies and procedures
- Monitor cases for discharge planning, case management referrals, continued stay reviews and prolonged hospitalizations

1998 -2001 The Wellness Plan, (Health Source)

Authorization Analyst / Utilization Review

- Telephonic review

- Participated in pre-certification and authorization processes
- Determined appropriateness of elective inpatient admissions and selected outpatient services.
- Evaluated up to 100 active claims in process
- Received and evaluated medical records
- ICD- 9 coding
- Claims adjudication

1997-1998 United Home Health Care

Community Health Nurse, Acute Care

Quality Assurance, Credentialing, HEDIS

Authorization Analyst / Utilization Review

- Private duty and skilled nursing services to adult and pediatric clients
- Contract work –Health Plans and Hospitals
- Extraction HEDIS data
- Performed on-site reviews and medical record audits
- Evaluated medical records and onsite reviews for NCQA requirements
- Utilization review
- Acute care nursing

1994-1998 Hope Nursing Care Center

Charge Nurse

- Provided skilled nursing for up to 64 patients
- Supervised 6 nursing assistants

1992-1994 Greenery Sub-acute Care Center

Charge Nurse

- Sub-acute rehab services
- Provided skilled nursing services for sub-acute and ventilator dependent patients
- Supervised up to 6 nursing assistants
- Acted as Midnight Supervisor for staffing

Licensures and Certifications

Practical Nurse license- Michigan

Practical Nurse license- Illinois

InterQual CPUR certification (Certified Professional in Utilization Review)

InterQual CPUM certification (Certified Professional in Utilization Management)

InterQual ICQI certification (Certified InterQual Instructor)

Education

1992 ▪ Practical Nurse Degree, Oakland Community College, Graduated Cum Laude

Amy Muhlenbruck, MSN, RN

Professional Summary

Registered Nurse and content expert in transitional care coordination throughout the healthcare continuum. Demonstrated foundational experience in assessment, intervention, and care planning for a complex, chronically ill population. Intuitive innovation and strategic planning focused on delivering best practice clinical care and patient outcomes. Care coordination strategies are consistently evaluated, analyzed, and communicated to key stakeholder. Practitioner of root cause analysis methodologies in the evaluation of gaps in care for identification of research and development of best practice care delivery aligned with system strategies and quality clinical performance measures.

Professional Highlights

- Team Lead with physician partner in developing innovative clinical integration processes promoting efficient transitions in care through the continuum
- Specialized in root cause analysis and process improvement reflecting quality indicators in care coordination
- Leader of system affiliate strategies and collaboratives including care coordination and hospital readmissions teams
- Clinical work group member of Accountable Care Organization (ACO) strategic planning and care delivery in preparation of application to the Center for Medicare and Medicaid Innovations 2012 Pioneer ACO Model Project
- Executive Leadership reporting responsibility regarding ongoing observation and evaluation of initiatives with best practice recommendations
- Nursing experience in care transitions: hospital, clinic, home care, hospice and long term care

Professional Experience

Director of Quality Improvement/Quality Management Manager

April 2015 to Present

Meridian Health Plan – Des Moines, Iowa

- Achieves and maintains quality and performance goals of Meridian Health Plan
- Leads, coordinates, and ensures documentation of quality improvement, accreditation, and regulatory activity
- Develops and implements comprehensive corporate strategy to ensure HEDIS and CAHPS improvements
- Directs all preparations for NCQA, URAC, or general accreditation to maintain NCAQ “Excellent” or URAC equivalent status
- Accountable for timely revisions to meet NCQA, URAC, or general accreditation, and other regulatory requirements

Chief Nursing Officer

January 2012 to March 2015

Saint Jude Hospice – Urbandale, Iowa

- Provided oversight to the Saint Jude Hospice clinical leadership
- Assisted in responding to identified opportunities for clinical improvement
- Collaborated with VP of Operations in development of strategic planning for local market plans growth
- Collaborated with CFO in the maintenance of clinical budget parameters
- Ensured compliance with state, federal and CHAP accreditation standards, safety, and quality
- Provided ongoing innovation, education, and process improvement in driving best practice care
- Championed Saint Jude Hospice Mission, Vision, and Values

Advanced Medical Team Clinical Lead, Guided Care Nurse

May 2010 to November 2011

Iowa Health Physicians – Johnston, Iowa

- Developed and executed sustainable model of care delivery supportive of the Primary Care Physicians in the care of a complex, chronically ill population
- Ongoing evaluation and analysis of care coordination strategies across the care continuum

Palliative Care Nurse

September 2007 to April 2010

Iowa Health - Des Moines – Des Moines, Iowa

- Advocacy based collaboration and coordination with patient, caregivers and interdisciplinary team in developing advanced care planning reflective of appropriate health care utilization
- Demonstrated cost avoidance and best practice patient care and outcomes, meeting goals and objectives of palliative care service

Director of Marketing

August 2006 to August 2007

Iowa Hospice – Johnston, Iowa

- Led state-wide marketing liaison team in ongoing strategic program development, education, deployment and goal achievement in the delivery of hospice services of expanding market service area from 21 to 66 Iowa counties.
- Cultivated relationships and contractual service agreements with providers, CEOs, administrators and DONs in health care settings including hospitals, clinics and long term care facilities.

Registered Nurse - Adult Medical Surgical Staff Nurse

February 2004 to July 2006

Iowa Lutheran Hospital – Des Moines, Iowa

Registered Nurse - Adult Oncology Staff Nurse

February 1997 to March 2001

Iowa Methodist Medical Center – Des Moines, Iowa

RN Case Manager

December 1994 to March 1996

Hospice of Central Iowa – West Des Moines, Iowa

- RN Case Manager coordinating interdisciplinary team care and needs analysis for terminally ill hospice population.
- Demonstrated autonomous best practice clinical care delivery to terminally ill hospice population in the home setting.

Registered Nurse - Adult Oncology Staff Nurse

May 1993 to November 1994

Iowa Methodist Medical Center – Des Moines, Iowa

Education and Credentials

The University of Nebraska Medical Center 2015

Omaha, Nebraska
Nurse Executive Leadership
Master of Science in Nursing 2015

The University of Iowa 2011

Iowa City, Iowa
Registered Nursing
Bachelor of Science in Nursing

Mercy School of Nursing 1993

Des Moines, Iowa
Registered Nursing
Diploma in Nursing

Certifications and Licenses

Registered Nurse (RN) Iowa Board of Nursing
Certification in Guided Care Nursing (GCN), The Institute for Johns Hopkins Nursing
Trainer, End of Life Nursing Education Consortium (ELNEC)
Basic Cardiac Life Support (BCLS)

Research

Co-Principal Investigator Initiated Internal Review Board Approved Study:
"Developing Methods for the Prediction, Screening, and Intervention supporting Physicians in the Care of the Complex Chronically Ill," Des Moines, Iowa, 2011.

Professional Presentations

Poster Presentation, "HOPE Goals of Care: A Clinical Demonstration of Proactive Conversation", *The Art of Nursing: Beyond Technology*, National Association of Catholic Nurses Annual Meeting, Nashville, TN, March 2014.

Speaker, "Ethical and Religious Directives in Catholic Health Care Services in Hospice Care: A Clinical Demonstration of Integration," *Catholic Nurses on the Frontline: Christ's Ministry in Action*, National Association of Catholic Nurses Annual Meeting, Nashville, TN, March 2013.

Poster Presentation, "Ethical and Religious Directives in Catholic Health Care Services in Hospice Care: A Clinical Demonstration of Integration," *A Witness to Hope: Medicine and the New Evangelization*, Catholic Medical Association 81st Annual Educational Conference, St. Paul, MN, September 2012.

Speaker, "Guided Care and the Advanced Medical Team," Iowa Health Physicians Services Annual Retreat, West Des Moines, Iowa, 2010.

Speaker, "The Advanced Medical Team: A Historical Perspective," Iowa Organization of Nurse Leaders Nursing Meeting, Des Moines, Iowa 2011.

Poster Presentation, "Developing Methods for Prediction, Screening and Intervention Supporting Physicians in the Care of the Complex, Chronically Ill," Iowa Health Des Moines Nursing Research Symposium, Des Moines, Iowa, 2011.

Professional Associations

Member, Sigma Theta Tau International Nursing Honor Society

Keywords

MSN; BSN; BCLS; Accountable Care Organization and continuum of care coordination expertise; collaborative team leader, educator and consultant; innovative strategist in transitional health care delivery, process improvement and clinical quality performance initiatives; articulate, approachable communicator with patients, caregivers, physicians, clinicians, executive leadership and community; palliative care and hospice expertise.

Catherine Cimini Smith

EXECUTIVE PROFILE

Results oriented healthcare executive with broad experience in Hospital and Physician Medical Group Management. Utilize process improvement evaluation, human resource collaboration and implementation skills to efficiently assess operations and develop plans that drive improvements to completion. Successfully accomplish program development and department organization and efficiency which lead to improved cost savings and employee/customer engagement. Areas of Expertise:

- **Case Management and Utilization**
- **Managed Care**
- **Customer and Employee Engagement**
- **Service Excellence Champion**
- **Human Resource Management**
- **Operations Management**
- **New Program Development**
- **Compliance and Regulation**
- **Service Excellence Champion**
- **Budget Planning and Management**
- **Facilities Management**
- **Vendor Relations**

EXPERIENCE SUMMARY

MERIDIAN HEALTH PLAN, Detroit Michigan

Meridian Health Plan is a physician-owned, physician-operated group of health plans and related companies. Our mission is to continuously improve the quality of care in a low resource environment.

Director of Utilization Management/Utilization Management Manager 2014-Present

Responsible for developing and implementing a utilization management program. Oversight of the utilization management and case management programs. Responsible for ensuring that MHP's programs are compliant with National Committee for Quality Assurance (NCQA), URAC or general accreditation standards as well as State and federal regulatory requirements. Oversee the development, implementation and annual evaluation of the corporate utilization management program.

HENRY FORD HEALTH SYSTEM, Detroit MI

Henry Ford Medical Group

One of the nation's largest group practices, with 1,200 physicians and researchers in 40+ specialties. The physicians and leaders work in conjunction with Henry Ford Hospital and Health Network which is associated with multiple hospitals and medical centers.

New Center One Site Director/Practice Director Department of Medical Genetics 2011-2014

Responsible for Medical Center and Ambulatory Clinic Operations.

- Developed cohesive Center Operations team to improve cross department coverage which decreased building overtime by 2% in the first 6 months of implementation.

- Led team that developed Henry Ford Medical Group Real Rounding Project, which provided leaders across the group exposure to all clinical areas to interview patients / staff and deliver unbiased feedback to clinical, administrative and senior leadership.
- Implemented new Electronic Medical Record product. Led team that provided concierge services for patients and support for staff during initial 4 week period following implementation.
 - New Center One specific patient feedback for opportunities averaged 3/week by end of 4 week period which was a decrease of 5% from week 1.
- Led team that implemented patient check-in Kiosks which improved patient check in time and decreased backup at Clinic check in desks.
- Managed building wide projects including development of EPIC training center, Rheumatology Infusion Clinic, Sleep Medicine and Allergy Clinic and overall building refresh project.
- Collaborated with Service Excellence Team to implement Clinic Appearance Standards throughout building. Improved clinic environment, provided consistent System wide experience.

Henry Ford Hospital

802-bed tertiary care hospital, education and research complex is the flagship hospital for HFHS. The hospital is recognized for clinical excellence and innovation and is a Level 1 trauma center. Inpatient admissions 96,000+, Emergency Room visits 100,000+ and 88,000 surgical procedures on an average annual basis. 14,000 FTE's with annual net revenue \$53 million.

Henry Ford Hospital (continued)

Director Patient Access/ Care Coordination

2005-2011

Responsible for the Admission Transfer Management Team, Inpatient Case Management and Utilization Review. Total staff including professional and support over 115 FTE's.

- Integral in development of the Out State Growth Strategy initiative. Collaborated with physician and administrative leadership, marketing executives and Referring Physician Office Leadership.
 - Provided transfer in, treatment, safe and appropriate discharge to inpatients outside the Henry Ford Hospital area that require a higher level of care.
- Provided leadership and membership on multiple process improvement teams resulting in the Hospital receiving the 2011 Malcolm Baldrige National Quality Award.
- Streamlined and improved patients continuum of care from admission through discharge by developing and implementing a Department Wide Care Management documentation System.
 - Incidental decrease in use of paper of 47% within the first year.
- Executed restructure of InterQual program from booklet to electronic format.
- Implemented Quality Control program using a call recording system improving communication and ensuring accuracy of all calls in the Admission and Transfer Management Office.
- Maximized use of a Bed Board Management system that improved accuracy of inpatient placement, monitoring of housekeeping turn-around time and nursing data that impacted patient ER wait times.
- Executed a staff restructure for RN and MSW Case Managers that optimized their scope of practice and best utilized their skills.
- Worked with Hospital CEO to establish relationships with Nursing Homes and Extended Care facilities to implement plan to accept discharging patients on weekends and holidays.
 - Decrease in LOS from 6.9 to 5.7 in a 6 month timeframe.
- Collaborated with Inpatient Nursing, developed a Discharge Planning Begins at Admission project resulting in an additional decrease in LOS to 5.5.

- Developed and maintained significant relationships with System Business Units which fostered a continuity of care approach for inpatients.
- Developed a Physician Advisor role for Case Management and Utilization resulting in a dramatic improvement in utilization, reporting and discharge planning.
- Designed and established an Observation Unit, in association with Physician and Emergency Room leadership that streamlined patient flow and reduced denials by 15%.
- Facilitated resident education of the Case Management and Utilization Departments.
- Led Ethics Case Consultation Committee achieving management of complex medical issues.

Henry Ford Medical Group

Administrative Manager III

2002-2005

Responsibility for multiple Ambulatory Clinical Operations within the Department of Medicine.

Combined budget responsibility over \$37 million with total FTE's 66. Increased prior responsibilities to include management of the Division of Nephrology and Hypertension.

- Expanded Nephrology Clinic Operations to 4 Dialysis Centers. Patient satisfaction improved from the 74th to 85th percentile in 1 quarter.

Henry Ford Medical Group (continued)

Administrative Manager II

2001- 2002

Provide Administrative leadership to the Divisions of Pulmonary/Critical Care Medicine, Sleep Disorders and Research and Allergy and Immunology. Managed Divisional Clinics at multiple #? Medical Centers.

Responsible for budget preparation and management for numerous product line revenue centers.

- Researched and executed site consolidation plan which decreased total direct expenses by 30%.
- Converted Division of Sleep Disorders and Research to an Electronic Medical Record which increased referrals by 34%.
- Expanded Sleep Disorder and Research overnight sleep clinics to 2 additional locations resulting in net patient revenue increase of 200K/yr.

Administrative Manager I

1998-2001

Responsible for Medical Center and Ambulatory Clinic Operations. Managed overall clinic operations with a total 23 FTE's.

- Developed and implemented conversion to Electronic Medical Record.
- Created and implemented electronic Registration process improving patient cash collection by 89% in the first 6 months.
- Expanded Medical Center, including design and construction from 16 to 34 exam rooms, moved radiology, added pharmacy and podiatry services.
- Increased patient volume in first quarter after renovation by 45% and net patient revenue by \$150K.
- Facilitated decreased Emergency Room visits and unnecessary inpatient admissions by developing panel management program.
- Ensured appropriate scheduling of patients with a same day appointment by developing Triage Nurse /

Open Access program at Medical Center.

Nurse Manager

1994-1998

Responsible for Daily Ambulatory Clinic Operations, assigning duties of daily staff. Assisted and resolved patient concerns. Prepared for and participated in all JCAHO inspections. Assisted in budget preparation and facility operations. Developed and implemented physician panel assignment.

EDUCATION / CERTIFICATION / Licensure

Bachelor of Science, Speech Pathology and Audiology, Western Michigan University, Kalamazoo, MI

Registered Nurse – Diploma, Henry Ford Hospital School of Nursing, Detroit, MI

Registered Nurse - State of MI

Registered Nurse - State of IA, application in process

Management Development Program, University of Michigan – Dearborn, Dearborn MI

PROFESSIONAL AFFILIATIONS

Member – American Case Management Association - 2006-present

Member – Medical Group Management Association - 2003-present

Chief Executive Officer Advisory Board - **Chair**, 2008; **Member**, 2006

MARY CLARE SOLKY, MA

PROFESSIONAL EXPERIENCE

MERIDIAN HEALTH PLAN, Detroit, Michigan 2014 - Present

Director of Behavioral Health/Behavioral Health Manager (2014 – Present)

- Lead clinical and administrative operations, process improvement and outcome monitoring design, development, and implementation of a comprehensive and integrated behavioral health program at MHP, for both existing and emerging programs and lines of business.
- Collaborate with the Corporate Operations Director in development and maintenance of an operationally aligned and integrated behavioral health department within the corporate MHP organizational structure, while identifying and articulating and identifying unique operational needs for appropriate procedural development and support.
- Oversee the development, implementation and annual evaluation of corporate behavioral health operations, including: systems, processes, Member Services, Care Coordination, Utilization Management and Communications.
- Develop plans to assure integrated, timely and appropriate behavioral health services.
- Create and monitor the budget for behavioral health activities and ensure that sufficient resources are assigned to meet department goals.
- Ensure that all department activities are in compliance with NCQA, URAC or general accreditation standards, as well as State and federal regulatory requirements.
- Provide Behavioral Health leadership representation to the Utilization Management Committee, Quality Management Committee, corporate and state-specific operations committees.
- Serve as liaison for the health plan concerning behavioral health departmental activities, including participation in external meetings, work groups or committees, and coordination with external entities.
- Develop and maintain relationships with State Medicaid and Medicare Directors and other managed care BH directors.

HEALTH ALLIANCE PLAN, Detroit, Michigan 1993 – 2014

Director, Coordinated Behavioral Health Management (2001 – 2014)

- Lead the implementation of new clinical and administrative programs that improve clinical outcomes, ensure high quality, reduce utilization oversight, control costs and improve satisfaction.
- Direct operations and oversee staff engaged in utilization and disease management activities.
- Coordinate efforts of multi-disciplinary teams to review and improve the quality of behavioral medicine care and services.
- Oversee HAP's medical and behavioral utilization management program, including a call center, to ensure compliance with quality standards specified by the National Committee for Quality Assurance (NCQA) and Center for Medicare & Medicaid Services (CMS).
- Develop and maintain cooperative affiliations with national clinical workgroups, national business groups and health care agencies.
- Establish and administer department business plan and budget.

PROFESSIONAL EXPERIENCE

(Continued)

Manager, Coordinated Behavioral Health Management (1995 – 2001)

- Responsible for clinical and administrative oversight of project manager, clinical team and clerical staff, including a high volume call center.
- Developed, implemented and monitored departmental policies, procedures and quality management initiatives.
- Organized and facilitated regular clinical conferences and staff meetings.
- Performed annual performance appraisals for clinical and clerical staff.
- Responsible for the preparation and presentation of various statistical reports related to utilization, quality management and employee performance.

Managed Care Specialist, Coordinated Behavioral Health Management (1993 – 1995)

- Responsible for case management of mental health and chemical dependency services.
- Provided telephone triage, crisis intervention and level-of-care decisions.
- Performed on-call duties to support the department's 24/7 operations.

CONSORTIUM FOR HUMAN DEVELOPMENT, Novi, Michigan

1986 –1993

Clinic Director (1991 - 1993)

- Responsible for oversight of day-to-day operations of an outpatient behavioral medicine clinic.
- Facilitated the acquisition of contracts and managed care relationships.
- Provided clinical supervision of staff.
- Ensured that quality standards were met related to JCAHO Accreditation.
- Developed, wrote and monitored clinical and operational policies and procedures.
- Maintained previous responsibilities as Behavioral Health Clinician.

Behavioral Health Clinician (1986 – 1991)

- Provided mental health and chemical dependency individual and group psychotherapy for adults, couples, and families.
- Performed crisis intervention and made referrals to community agencies.
- Provided psychological testing.
- Organized, developed and ran intensive outpatient chemical dependency treatment program.

LICENSURE

- Michigan Limited Licensed Psychologist (LLP)
- Michigan Licensed Professional Counselor (LPC)

EDUCATION

WESTERN MICHIGAN UNIVERSITY, Kalamazoo, Michigan

- Master of Arts in Counseling Psychology, 1986
- Specialty Degree in Alcohol and Drug Abuse, 1986
- Bachelor of Science in Psychology with a Business Minor, 1984

Exhibit A: Release of Information

(Return this completed form behind Tab 6 of the Bid Proposal.)

Meridian Health Plan of Iowa, Inc. (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.

MERIDIAN HEALTH PLAN of Iowa
Printed Name of Bidder Organization


Signature of Authorized Representative

5/8/15
Date

Raymond Peters
Printed Name

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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: | Raymond Pitera |
| Address: | 666 Grand Avenue, 14th Floor, Des Moines, IA 50309 |
| Tel: | (515) 802-3500 |
| Fax: | 313-202-0050 |
| E-mail: | raymond.pitera@mhplan.com |

| Primary Bidder Detail | |
|--|--|
| Business Legal Name (“Bidder”): | Meridian Health Plan of Iowa, Inc. |
| “Doing Business As” names, assumed names, or other operating names: | N/A |
| NAIC Number: | 14145 |
| Parent Corporation, if any: | Caidan Holding Company, Inc. |
| Form of Business Entity (i.e., corp., partnership, LLC, etc.): | Corporation |
| State of Incorporation/organization: | Iowa |
| Primary Address: | 666 Grand Avenue, 14th Floor, Des Moines, IA 50309 |
| Tel: | (515) 802-3500 |
| Fax: | (515) 802-3572 |
| Local Address (if any): | 666 Grand Avenue, 14th Floor, Des Moines, IA 50309 |
| Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract: | 777 Woodward Avenue, Suite 600, Detroit, MI 48226 |
| Number of Employees: | 82 |
| Number of Years in Business: | 4 |
| Primary Focus of Business: | Medicaid and Medicare Managed Care |
| Federal Tax ID: | 45-1749180 |
| Bidder’s Accounting Firm: | Deloitte & Touche, LLP |
| If Bidder is currently registered to do business in Iowa, provide the Date of Registration: | 4/15/2011 |
| 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 |
| Bound and labeled separately from proposal | I.C.A. § 22.7(3) and (6) | This section contains detailed, audited financial statements for the bidder and its holding group constituting the trade secrets of the bidder and its holding group. Additionally, as these financial statements contain extremely detailed information about the company's financial health and operations, their release would give considerable advantage to the company's competitors and would serve no public purpose. Our financial health is monitored by the Iowa Insurance Division to ensure that the public is adequately protected. |
| Page 69 | I.C.A. § 22.7(3) | This section contains details regarding the operation of Meridian's proprietary managed care software and is thus a trade secret protected from disclosure. |
| Page 112-115 | I.C.A. § 22.7(3) | The structure of Meridian's incentive program is an important trade secret. It provides Meridian with a competitive advantage and represents a key component of our quality initiatives. |
| Page 116-117 | I.C.A. § 22.7(3) | Meridian's incentive programs for member preventive care and other services are a key component of quality improvement and are proprietary. |
| Pages 164-66 and 168 | I.C.A. § 22.7(3) | These images show important details of a Meridian trade secret, its proprietary MCS software. |
| Page 345-348 | I.C.A. § 22.7(3) | The structure of Meridian's incentive program is an important trade secret. It provides Meridian with a competitive advantage and represents a key component of our quality initiatives. |
| Pages 391-92 | I.C.A. § 22.7(3) | These images show important details of a Meridian trade secret, its proprietary MCS software. |
| Page 408-415 | I.C.A. § 22.7(3) | These pages contain narrative sections and charts containing details about the operation and structure of Meridian's proprietary managed care software, data warehouse, and database and server structure. These items represent a considerable investment and competitive advantage for the company and are protected as trade secrets under the law. |
| Pages 415-16 | I.C.A. § 22.7(3) and (6) | These sections contain sensitive information about Meridian's disaster recovery and backup protocols and locations, which are trade secrets whose disclosure would also jeopardize Meridian's security and provide a competitive advantage to other entities without serving any public purpose. |

| Request for Confidential Treatment (See Section 3.1) | | |
|--|--|--|
| Location in Bid (Tab/Page) | Statutory Basis for Confidentiality | Description/Explanation |
| Pages 416-20; Page 421, Pages 422-25, Pages 427-28, Pages 431-32, Pages 434-35 | I.C.A. § 22.7(3) | The redacted sections in these pages contain considerable detail about Meridian’s proprietary, trade secret managed care software, including information about Meridian’s proprietary Care Coordination module and Provider Portal. They additionally contain information about the structure and processes of Meridian’s IT department, which itself is a closely guarded trade secret. |
| Attachment 38 | I.C.A. § 22.7(3) and (6) | Attachment 38 contains detailed information about the structure of Meridian’s IT department. This structure is key to developing and maintaining Meridian’s technological competitiveness and is a trade secret. Additionally, disclosure of this information would competitively advantage other parties at no benefit to the public. |
| Attachment 39 | I.C.A. § 22.7(3) and (6) | Attachment 39 contains proprietary, trade secret information regarding Meridian’s process and structure for addressing new IT needs and performing system repairs, modification, and maintenance. It contains specific information about ongoing Meridian projects in its IT space. In addition to the process itself being a trade secret, the elements discussed within are components of Meridian’s proprietary managed care software. Disclosure of this information would additionally provide a considerable competitive advantage to Meridian’s competitors at no benefit to the public. |
| Attachment 40 | I.C.A. § 22.7(3) and (6) | Attachment 40 contains Meridian’s Disaster Recovery Plan. The document contains trade secret information regarding Meridian’s proprietary managed care software and the internal structure of its IT network. Disclosure of this information would provide a competitive advantage to Meridian’s competitors and would also jeopardize the security of Meridian’s IT network, ability to continue functioning in the event of a disaster, and employee safety, as it contains sensitive information about the location and behavior of personnel during a crisis. Disclosure of this information would have no public benefit. |

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/tax/business/business.html>.

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.

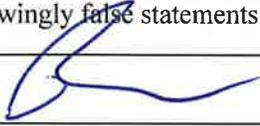
| | |
|----------------------------|---|
| Signature: |  |
| Printed Name/Title: | Raymond Pitera, President/COO |
| Date: | 5/19/15 |

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

| | |
|---|--|
| Primary Bidder (“Primary Bidder”): | Meridian Health Plan of Iowa, Inc. |
| Subcontractor Contact Information (individual who can address issues re: this RFP) | |
| Name: | Rene Acker, Chief Operating Officer |
| Address: | 1001 Woodward Ave. Suite 700 Detroit, Michigan 48226 |
| Tel: | 855-323-4580 |
| Fax: | 877-355-8070 |
| E-mail: | <u>rene.acker@mhplan.com</u> |

| | |
|--|--|
| Subcontractor Detail | |
| Subcontractor Legal Name (“Subcontractor”): | MeridianRx, LLC |
| “Doing Business As” names, assumed names, or other operating names: | N/A |
| Form of Business Entity (i.e., corp., partnership, LLC, etc.) | LLC |
| State of Incorporation/organization: | Michigan |
| Primary Address: | 1001 Woodward Ave. Suite 700 Detroit, Michigan 48226 |
| Tel: | 855-323-4580 |
| Fax: | 877-355-8070 |
| Local Address (if any): | N/A |
| Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract: | 1001 Woodward Ave. Suite 700 Detroit, Michigan 48226 |
| Number of Employees: | 155 |
| Number of Years in Business: | 6 (2009-present) |
| Primary Focus of Business: | Third Party Administrator – Pharmacy Benefit Management Services |
| Federal Tax ID: | 27-1339224 |
| Subcontractor’s Accounting Firm: | Plante & Moran, PLLC |
| If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration: | 10/15/2012 |
| Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract. | 1.26% |
| General Scope of Work to be performed by this Subcontractor | |
| MeridianRx will provide Pharmacy Benefit Management for Meridian Health Plan of Iowa, Inc. | |

(Meridian). MeridianRx will deliver members pharmacy benefits under the oversight of Meridian. MeridianRx provides members with integrated pharmacy benefit management through the MERLIN (MeridianRx Live Integrated Network) solution. MERLIN, offered by MeridianRx, is a twenty-four (24) hours a day, seven (7) days a week system for processing pharmacy claims for client health care companies. The system consists of a powerfully integrated network of Membership, Physician, Pharmacy, and Drug information built around a robust, rules-based adjudication engine. The combination of these elements working together within a state of the art, integrated platform allows the MERLIN system to:

- * Accurately adjudicate member pharmacy claims
- * Quickly deliberate prior authorization and step therapy requests
- * Manage drug coverage and formulary rules
- * Configure member copays and cost sharing
- * Supply business optimization reporting to improve efficiencies and reduce costs
- * Provide timely invoicing and payment to clients and member pharmacies

Detail the Subcontractor's qualifications for performing this scope of work

Meridian contracts with MeridianRx, LLC (MeridianRx), a full-service PBM, to perform pharmacy benefit management services for its membership. Similar to Caidan Management Company, MeridianRx shares the same ultimate parent organization as Meridian, which results in superior access to information and a greater overall level of service. MeridianRx maintains a comprehensive national network that covers all 50 States, the District of Columbia, the United States Virgin Islands, American Samoa, the Northern Mariana Islands, Puerto Rico and Guam. The breadth of the MeridianRx network ensures convenient access to prescriptions at deeply discounted rates. MeridianRx uses a variety of tools such as drug utilization review and disease management to encourage the best clinical outcomes for patients. They also provide patient information in multiple formats, including a user-friendly web portal, mailings, newsletters and our award-winning call center. MeridianRx utilizes panels of highly-qualified, independent physicians, pharmacists and other clinical experts to develop lists of drugs approved for reimbursement in order to encourage clinically appropriate and cost-effective prescribing. MeridianRx offers access to highly efficient mail-service pharmacies that safely and accurately supply home-delivered prescriptions at a substantial savings. MeridianRx utilizes cutting-edge e-prescribing technology, which provides physicians with clinical and cost information on prescription options allowing them to better counsel patients on the safest and most affordable medication choices. MeridianRx offers a 24/7 toll-free hotline with access to pharmacy service representatives and pharmacy technicians, provider service representatives and pharmacists to address any client or patient related issues.

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor 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;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor'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 obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

| | |
|-------------------------------------|---|
| Signature for Subcontractor: |  |
| Printed Name/Title: | Rene Acker, Chief Operating Officer |
| Date: | 5-11-15 |

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

| | |
|---|--|
| Primary Bidder (“Primary Bidder”): | Meridian Health Plan of Iowa, Inc. |
| Subcontractor Contact Information (individual who can address issues re: this RFP) | |
| Name: | Michael Stines, General Counsel |
| Address: | 777 Woodward Ave. Suite 600 Detroit, Michigan 48226 |
| Tel: | 313-324-3746 |
| Fax: | 313-202-1273 |
| E-mail: | Michael.stines@mhplan.com |

| | |
|--|--|
| Subcontractor Detail | |
| Subcontractor Legal Name (“Subcontractor”): | Caidan Management Company, LLC |
| “Doing Business As” names, assumed names, or other operating names: | N/A |
| Form of Business Entity (i.e., corp., partnership, LLC, etc.) | LLC |
| State of Incorporation/organization: | Michigan |
| Primary Address: | 777 Woodward Ave. Suite 600 Detroit, Michigan 48226 |
| Tel: | 313-324-3700 |
| Fax: | 313-202-0009 |
| Local Address (if any): | N/A |
| Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract: | 777 Woodward Ave. Suite 600 Detroit, Michigan 48226 |
| Number of Employees: | 1,010 |
| Number of Years in Business: | 6 (2009-present) |
| Primary Focus of Business: | Third Party Administrator – Administrative and Staffing Services |
| Federal Tax ID: | 26-4004494 |
| Subcontractor’s Accounting Firm: | Plante & Moran, PLLC |
| If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration: | 10/15/2012 |
| Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract. | 10% |
| General Scope of Work to be performed by this Subcontractor | |
| Pursuant to an Administrative Services contract, CMC will perform the following services: 1. Claims processing and adjudication | |

2. Member enrollment and eligibility verification
3. Medical management
4. Behavioral health
5. Quality improvement activities
6. Authorizations, denials, and appeals
7. Complaints and grievances
8. Provider recruitment and education
9. Support staff for credentialing activities
10. Member services / call center operations
11. Member compliance program
12. Risk management
13. Administrative, technical, and day-to-day operational duties
14. Information technology and management services
15. Banking, accounting, and financial matters
16. Support staff for compliance and fraud, waste and abuse activities

Detail the Subcontractor's qualifications for performing this scope of work

Meridian Health Plan of Iowa, Inc. ("Meridian") contracts with Caidan Management Company, LLC (CMC) to perform an array of administrative services which will allow Meridian to provide the services described in the Statement of Work. CMC shares the same parent organization as Meridian and, thus enjoys the efficiencies through integration. CMC has been providing the described services for over 15 years to Medicaid and Medicare plans in Michigan, Illinois and Iowa. CMC hires locally-based personnel in each of the states in which it operates and the same will be the case for the 2015 IHQHI.

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor 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;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor'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 obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

| | |
|-------------------------------------|---|
| Signature for Subcontractor: |  |
| Printed Name/Title: | Michael Stines, General Counsel |
| Date: | 5/11/15 |

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

| | |
|---|--|
| Primary Bidder (“Primary Bidder”): | Meridian Health Plan of Iowa, Inc. |
| Subcontractor Contact Information (individual who can address issues re: this RFP) | |
| Name: | Mariela Fermin, VP, Market Operations |
| Address: | 5200 Blue Lagoon Drive, Suite 500, Miami, FL 33126 |
| Tel: | 305-262-1292, Extension 6402 |
| Fax: | 212-808-4772 |
| E-mail: | mfermin@ilshealth.com |

| | |
|--|--|
| Subcontractor Detail | |
| Subcontractor Legal Name (“Subcontractor”): | Independent Living Systems, LLC |
| “Doing Business As” names, assumed names, or other operating names: | Same As Above |
| Form of Business Entity (i.e., corp., partnership, LLC, etc.) | Limited Liability Company |
| State of Incorporation/organization: | Florida |
| Primary Address: | 5200 Blue Lagoon Drive, Suite 500, Miami, FL 33126 |
| Tel: | 305-262-1292, ext. 6402 |
| Fax: | 305-262-9322 |
| Local Address (if any): | To be determined. ILS will open offices in the State of Iowa to support delivery of local services. |
| Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract: | 5200 Blue Lagoon Drive, Suite 500, Miami, FL 33126 |
| Number of Employees: | 645 |
| Number of Years in Business: | 13 |
| Primary Focus of Business: | Management services, care coordination and technology solutions for special needs populations and providers of community services and long term care supports. |
| Federal Tax ID: | 45-0481642 |
| Subcontractor’s Accounting Firm: | Marcum LLP (Audit) |
| If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration: | April 7, 2015 |

| | |
|---|---------------------|
| Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract. | 27.6% of Total Work |
| General Scope of Work to be performed by this Subcontractor | |
| <p>Meridian Health Plan has executed a Letter of Intent with Independent Living Services (ILS) to administer Care Coordination services to the LTSS population and care management for the following services:</p> <ul style="list-style-type: none"> • Adult Companion Services • Adult Day Care/Health Services • Assisted Living Services • Chore Services • Consumable Medical Supply Services • Environmental Accessibility Adaptation Services • Escort Services • Family Training Services • Financial Assessment/Risk Reduction Services • Home Delivered Meals • Home Healthcare Services • Homemaker Services • Nursing Facility Services • Nutritional Assessment/Risk Reduction Services • Occupational Therapy • Personal Care Services • Personal Emergency Response Systems (PERS) • Physical Therapy • Respite Care Services • Speech Therapy <p>In addition to care coordination services, ILS will work with Meridian Health Plan to provide administrative services, including a technology platform to support seamless coordination of a person centered care plan and management, and claims administration for the long term care services and HCBS provider network. ILS and Meridian will work closely to develop the necessary interfaces and processes to ensure seamless integration across systems and the interdisciplinary care planning process. ILS will also create the necessary reports to ensure the accuracy and quality of services and functions.</p> | |
| Detail the Subcontractor's qualifications for performing this scope of work | |
| <p>ILS was founded in 2001 with the intent to provide administrative services to managed care organizations that take on the capitated risk of LTC costs for Medicaid participants. To do this, ILS has developed certain capabilities, including:</p> <ul style="list-style-type: none"> • Systems for the administration and payment of claims to providers; • Procedures for credentialing and re-credentialing providers and maintaining the provider data base; • Systems for recording assessments, care planning, case management and referral and authorization of services; • Systems for enrollment and membership tracking and processing; and | |

- Procedures for management reporting, financial statement preparation and encounter reporting as required by the State's contracting agency.

In addition to management services for the administration of capitated LTC programs, ILS also has program offerings that include Case Management of specialty populations, Care Transitions and Nutritional Management services. ILS works with multiple large payors to develop and administer MLTSS programs. ILS' recent experience includes working with various established health plans in the administration of Medicaid only LTCSS programs and integrated care demonstrations in 7 states.

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor 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;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor'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 obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

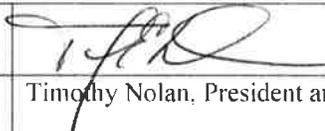
| | |
|-------------------------------------|---|
| Signature for Subcontractor: |  |
| Printed Name/Title: | Timothy Nolan, President and Chief Operating Officer |
| Date: | May 8, 2015 |

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

| | |
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| Primary Bidder ("Primary Bidder"): | Meridian Health Plan of Iowa, Inc. |
| Subcontractor Contact Information (individual who can address issues re: this RFP) | |
| Name: | Scott Henderson, Vice President of Strategy and Development |
| Address: | 200 State Street, Suite 200 Boston, MA 02110 |
| Tel: | (860) 510-6340 |
| Fax: | (617) 747-1230 |
| E-mail: | scott.henderson@beaconhealthoptions.com |

| | |
|--|---|
| Subcontractor Detail | |
| Subcontractor Legal Name ("Subcontractor"): | Beacon Health Strategies, LLC |
| "Doing Business As" names, assumed names, or other operating names: | Beacon Health Strategies is a member of the family of companies under Beacon Health Options. |
| Form of Business Entity (i.e., corp., partnership, LLC, etc.) | Limited Liability Company |
| State of Incorporation/organization: | Massachusetts |
| Primary Address: | 200 State Street, Suite 200 Boston, MA 02110 |
| Tel: | (617) 747-1100 |
| Fax: | (617) 747-1230 |
| Local Address (if any): | N/A |
| Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract: | We will have a local office in Des Moines, IA. Other offices that may contribute to performance under this contract include our headquarters in Boston, MA and support office in Norfolk, VA. |
| Number of Employees: | 4,300 |
| Number of Years in Business: | 20 years |
| Primary Focus of Business: | Administration of managed behavioral health services |
| Federal Tax ID: | 04-3324848 |
| Subcontractor's Accounting Firm: | KPMG |
| If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration: | 9/12/2011 |
| Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract. | 8.6% of Total Work |
| General Scope of Work to be performed by this Subcontractor | |

Beacon is subcontracted to perform all behavioral health services including, the delivery of behavioral health and substance use treatment and support services, behavioral health claims processing and payment, behavioral health network development, maintenance, and engagement, member engagement regarding behavioral health and substance use services, and behavioral health clinical functions, including utilization management and care coordination.

Detail the Subcontractor's qualifications for performing this scope of work

Beacon is behavioral health management organization serving more than 45 million individuals across the country and in the UK, including more than 13 million Medicaid beneficiaries. By providing best-in-class clinical programming across all market segments, Beacon's mission is to help individuals live their lives to the fullest potential. Serving Medicaid individuals in 21 states across the country, Beacon has accrued expertise and experience meeting the needs of individuals with co-occurring disorders and co-morbidities particularly vulnerable and disenfranchised within the current health delivery system. Bringing over 30 years of direct-to-state, county contract, and health plan experience providing integrated behavioral health management service with a focus on those serving the Medicaid and Medicare programs, Beacon is a pioneer in the field of managed behavioral health for Medicaid populations.

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor 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;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor'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 obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

| | |
|-------------------------------------|--|
| Signature for Subcontractor: |  |
| Printed Name/Title: | Tim Murphy, CEO Beacon Health Options |
| Date: | April 13, 2015 |

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

| | |
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| Primary Bidder ("Primary Bidder"): | Meridian Health Plan of Iowa, Inc. |
| Subcontractor Contact Information (individual who can address issues re: this RFP) | |
| Name: | LogistiCare Solutions, LLC |
| Address: | 1275 Peachtree Street, NE, 6 th Floor, Atlanta, GA 30309 |
| Tel: | 1-800-486-7647 x-413 |
| Fax: | 1-877-352-5640 |
| E-mail: | Brooks.williams@logisticare.com |

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| Subcontractor Detail | |
| Subcontractor Legal Name ("Subcontractor"): | LogistiCare Solutions, LLC |
| "Doing Business As" names, assumed names, or other operating names: | LogistiCare Solutions, LLC |
| Form of Business Entity (i.e., corp., partnership, LLC, etc.) | LLC |
| State of Incorporation/organization: | Delaware |
| Primary Address: | 1275 Peachtree Street, NE, 6 th Floor Atlanta, GA 30309 |
| Tel: | 1-800-486-7647 x-413 |
| Fax: | 1-877-352-5640 |
| Local Address (if any): | |
| Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract: | 2335 City View Drive, Suite 200 Madison, WI 53718 |
| Number of Employees: | 3200 |
| Number of Years in Business: | 25 |
| Primary Focus of Business: | Non-emergency medical transportation brokerage services |
| Federal Tax ID: | 58-2491253 |
| Subcontractor's Accounting Firm: | KPMG |
| If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration: | March 12, 2010 |
| Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract. | 0.2% of Total Work |
| General Scope of Work to be performed by this Subcontractor | |
| Non-emergency medical transportation brokerage services including network development, provider | |

credentialing, call center operations, ride scheduling and monitoring, field monitoring, complaint and grievance handling, client reporting, provider payments and performance tracking

Detail the Subcontractor's qualifications for performing this scope of work

25 years of industry experience with State Medicaid programs and private managed care organizations with Medicare and Medicaid memberships in 40 states.

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor 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;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor'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 obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

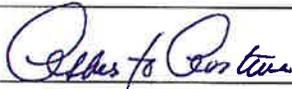
| | |
|-------------------------------------|---|
| Signature for Subcontractor: |  |
| Printed Name/Title: | ALBERTO CORTINA /CAO |
| Date: | 4/13/2015 |

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

| | |
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| Primary Bidder (“Primary Bidder”): | Meridian Health Plan of Iowa, Inc. |
| Subcontractor Contact Information (individual who can address issues re: this RFP) | |
| Name: | PALS INTERNATIONAL |
| Address: | 900 Wilshire Drive, Suite 105, Troy MI 48084-1600 |
| Tel: | (248) 362-2060 |
| Fax: | (248) 362-0626 |
| E-mail: | president@palsintl.com |

| | |
|--|---|
| Subcontractor Detail | |
| Subcontractor Legal Name (“Subcontractor”): | Pan American Languages & Services, Inc. |
| “Doing Business As” names, assumed names, or other operating names: | PALS INTERNATIONAL |
| Form of Business Entity (i.e., corp., partnership, LLC, etc.) | S-Corporation |
| State of Incorporation/organization: | Michigan |
| Primary Address: | 900 Wilshire Drive, Suite 105, Troy MI 48084-1600 |
| Tel: | (248) 362-2060 |
| Fax: | (248) 362-0626 |
| Local Address (if any): | |
| Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract: | <p>-All activities are managed through PALS Troy, Michigan location.</p> <p>-Translations use a network of contracted individuals located worldwide.</p> <p>-Phone interpretations use a network of contracted individuals located throughout the US. Our phone interpretation customer service representatives (CSRs) work out of two call centers, one located at 4130 E. Van Buren St., Ste. 150, Phoenix, AZ 85008 and the other at 4800 SW Macadam Ave., Ste. 400, Portland, OR 97239</p> |
| Number of Employees: | 8 Full Time, 25 part-time, and a network of over 2000 pre-qualified translators and interpreters contracted as needed. |
| Number of Years in Business: | 32 |
| Primary Focus of Business: | PALS INTERNATIONAL is a Michigan-based, language services company that provides on-site and phone interpretation services, translation services, language |

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| | <p>instruction, and cross-cultural training programs. Founded 32 years ago by the President and CEO, Brenda Arbeláez, it was her 35 years of teaching experience and her passion for languages and culture which made her decide to start PALS INTERNATIONAL. Brenda has established a network of 2,000 professionals in over 100 countries that can assist with the language and cultural needs of her clients. Brenda is involved in various global business organizations and associations to keep her finger on the pulse of the global business community with respect to cultural changes and business trends.</p> <p>PALS INTERNATIONAL has grown from a one-person, home-based business to a successful corporation. Today, the company continues to grow and is set apart in the global marketplace because of its reputation for valuable global language and cultural services. The mission of PALS INTERNATIONAL is to provide the highest quality interpretation, translation, language instruction, cross-cultural training, and related services by building relationships that lead to global success. We share a passion for languages and cultures which fosters an environment that enhances the learning process while providing our clients with personal attention, continuous support, and a long-term commitment. Our goal is to provide our PALS clients with a valued investment into their global expansion.</p> <p>For the past 32 years, PALS INTERNATIONAL has created strategic partnerships with businesses that require 100% human translation and specialized solutions that are supported by our experienced translation services group. PALS INTERNATIONAL's certifications include 8(a)/SDB, WOSB, WBENC, and MBE. Our core competencies include but are not limited to, on-site and phone-interpretation services, written document translation, individual and group English and Foreign language instruction, and business cultural training. PALS INTERNATIONAL employs a global team of intercultural experts to respond to specific business cultural requests. This Global team is constantly reviewing the current cultural aspects of countries to stay up to date on any changes that may affect our PALS clients' business environments. PALS INTERNATIONAL also uses clearly defined quality control procedures to insure accurate translation and interpretation services for each company we serve.</p> |
| Federal Tax ID: | 38-3025317 |
| Subcontractor's Accounting Firm: | Davison & Associates - 3259 W. Big Beaver Rd, Troy Michigan 48084 |
| If Subcontractor is currently registered | |

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| to do business in Iowa, provide the Date of Registration: | |
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| Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract. | Less than 1% of Total Work |
|--|----------------------------|

General Scope of Work to be performed by this Subcontractor

I. PALS INTERNATIONAL will provide high quality Document Translation of a variety of materials (i.e., marketing, correspondence, etc.) for Meridian Health Plan. Specifically, translating client-provided source documents from one language into 25+ other languages, as requested.

II. PALS INTERNATIONAL will also provide high quality Phone Interpretation Services for Meridian Health Plan's call center. PALS meets the need for spontaneous, unscheduled access to an interpreter over the phone. Integrated state-of-the-art computer telephony high-quality services with speed and reliability. Immediate 24/7 access with over 150 languages supported.

Detail the Subcontractor's qualifications for performing this scope of work

PALS INTERNATIONAL has been a subcontractor to Meridian Health Plan since 2008, providing language services including document translations and phone interpretations. PALS currently partners with Meridian Health in four states; Michigan, Illinois, New Hampshire and Iowa.

I. Document Translation

In its 32 years in business, PALS has managed a very large number of translation projects with a wide range of varying requirements. Led by a dedicated Account Manager as well as a Dedicated Senior Project Manager and with a network of over 2,000 partners in 100 countries comprised of translators, proofreaders, editors, linguists, desktop publishers, and multimedia professionals, PALS INTERNATIONAL stands ready and able to guarantee Meridian's satisfaction with every translation we provide.

These numerous translation projects have ranged from the simple single language projects with a handful of steps to the very complicated projects with numerous languages (over 20 languages in some cases). Translation projects often require strict adherence to space restraints, use client proprietary software, and/or the management of a multiple files, each with their own unique requirements.

PALS has also provided the translation and talent for voice-over projects, as well as software validation assignments, again in a multitude of languages in some cases. Still other projects have very fast turnarounds needs, thus requiring PALS to assemble a large team of translators, distribute and manage the materials. This is not unusual and completely manageable for our team.

Additionally, PALS utilizes a Translation Management System (TMS) to offer our clients access to greater automation, ease of engagement, efficiency, accessibility, and transparency throughout the translation process. This flexible, cloud-based system offers the ability to automate workflows, manage teams, track and execute project reports as well as provide clients accessibility to their materials from any location with an internet connection via a secure portal 24 hours a day every day of the year. This

includes the ability to upload/download project assets.

Translation Services Methodology

PALS provides high quality translation services to organizations that need to communicate to a diverse community and global companies that need to conduct business in a variety of countries and languages. To insure the highest quality, efficiency and consistency, PALS has designed its translation process in line with the industry standard process flow. This process is adjusted during the assessment phase of project initiation based on client requirements. The typical steps are:

Step 1: Project Review

The Project Manager (PM) completes a review of the overall scope of the project: timeline, inventory of files, glossaries (if applicable), and final file delivery. Working with the client, the Project Manager identifies all text that should remain in the source language and develops a list for the translator's and editor's use. It is at this point in the project life cycle that the Project Manager also identifies any typos, inconsistencies, missing text, etc. in the source document (or any other area requiring client clarification) and reviews these concerns with the client.

Step 2: Template Building/Translation Preparation

During the project review, we will determine whether a template needs to be built for the translation phase. There are several reasons this might be necessary. For example, the client's source file might need to be cleaned up or recreated if it is in a non-editable format. By creating a template, we're able to easily process your formatted documents through TRADOS, a translation memory software program. ☐

Step 3: Glossary Development

For large-scale projects, we recommend a standard glossary be developed that all translators can reference when working with your materials. If time constraints prevent us from developing a glossary upfront, we recommend compiling one after the project has been completed. That way, you will have an established list of approved terms to ensure the consistency in subsequent projects. The glossary is the key to ensuring the highest levels of quality and consistency and is an ongoing process that we continually update as the volume and unique nature of the work we perform evolves over time.

Step 4: Translation

At this stage, the Project Manager places the translation with an appropriately qualified and experienced target language translator, based on the content and translator's subject matter expertise. Only translators who are native speakers of the target language are utilized. The translator will translate the materials and return it to the project manager for review.

Step 5: Copy Editing

All initial translations are reviewed by a second, and equally qualified, professional translator/editor to ensure the quality of the translation. Because language translation is a human endeavor, we're realistic about the fact that errors or stylistic differences may occur, regardless of how qualified a translator may be. That's why we have more than one set of qualified eyes review every translation, specifically targeting grammar, typography, word choice, etc.

Step 6: Translator/Client Review

Once the editor has reviewed the initial translation, he/she incorporates the comments and submits them to the original translator. The original translator will use his/her discretion to accept or reject the suggested changes. If a client asks to review the translation prior to formatting, we will ask them to track the changes in the submitted drafts.

Step 7: Formatting

Our desktop publishing team will precisely format each translation to match the original material, while also being sensitive to the audience's cultural nuances. Normally, we will format your translation with the same application that was used to lay out your source document. However, in some cases we may choose to use an application that is better suited to a target language's fonts and other requirements. Your Project Manager will work with you to ensure all our deliverables meet your requirements.

Step 8: Quality Control/Proofreading

After we have finished formatting your material, we will produce a mechanical proof to determine that:

- o The layout matches the source language document
- o The correct fonts have been used
- o The headers and footers are consistent with the source language document
- o Proper names are spelled correctly
- o The pagination matches the source document and the text flows correctly
- o All source language updates have been incorporated
- o Margins, graphics and positioning are correct

Step 9: Final Translator Review

One of our in-house translators or the original translator will conduct a final review of your project to ensure that the text has been formatted correctly. He/she will verify that words have been hyphenated properly and nothing has been omitted from the text during the formatting stage. The reviewer will proof a hard copy printout and/or perform an on-screen review, depending on the need of each particular project.

Step 10: Final Check/Delivery

Your Project Manager will gather all the final deliverables, verifying that they meet your original specifications. He/she will make sure the layout, page numbers, proper names and other details match your source document one last time. Our delivery schedule depends on the volume of material we're translating and the timeline we discussed with you during the project review. We can guarantee a specific delivery date if you discuss this with us upfront.

PALS Promise of Quality - Translations

To guarantee the results only a world leading provider of translation services can promise, PALS INTERNATIONAL translators must meet the following requirements:

- o Minimum three years of proven professional translation experience
- o Language proficiency skills demonstrated through testing criteria or certification by a professional certifying body such as the American Translators Association
- o Native speakers who are aware of cultural context and have subject matter background and/or proven translation experience with the subject matter
- o Must be experienced in the use of appropriate software, including MS Office suite, HTML and CAT tools such as TRADOS
- o Must utilize TRADOS software to ensure consistency and improve the quality of translations. This software also assists PALS in creating and maintaining a translation memory database for our clients to reduce the cost of future translations that are similar in content

II. Phone Interpretation

PALS INTERNATIONAL's Phone Interpretation Service supports over 174 languages. Phone interpretation services are available 24 hours a day, 7 days a week.

Below you will find a list of industry guidelines for professional telephone interpreting. Every Interpreter is required to abide by these rules while handling calls for PALS INTERNATIONAL'S clients.

Customer Service Skills

Good customer service skills are essential in any industry and interpreting is no different. PALS INTERNATIONAL'S interpreters are expected to be pleasant, polite and professional at all times. Being rude or unprofessional to either the "LEP" (persons of limited English proficiency) or customer is grounds for termination of contractual agreement.

Listening Skills

It is important that the interpreter be a good listener in order to avoid continually asking for something to be repeated.

Interpreter Role

Interpreters should maintain the boundaries of their professional role and refrain from personal involvement or offering unsolicited opinions. Interpreters must always remain neutral.

Professional Demeanor/Sensitivity

Interpreters should be prepared and professional throughout the duration of the interpreting assignment, demonstrating an awareness and respect for the culture of the LEP and the English-speaking client.

Conflict of Interest

Interpreters should refrain from providing service in a situation that would be considered a conflict of interest (i.e. interpreting for relatives or friends).

PALS Promise of Quality – Phone Interpretation

PALS INTERNATIONAL's Phone Interpretation Service has a Quality Assurance Department which will randomly review some of your calls. After the review, interpreters will be e-mailed a report card style form with notes regarding possible areas needing improvements.

Interpreters are required to pass a yearly HIPAA exam online and sign off saying that they agree with the confidentiality terms and conditions. Also, at the time of hiring the Interpreter, they must sign and date the Confidentiality and Protection of Customer Information Agreement.

PALS INTERNATIONAL'S Phone Interpretation Service records telephonic interpretation sessions for billing and quality control purposes as a matter of standard practice. Recordings are stored for 90 days in

a secure, off-site location and then destroyed. However, clients have the option to request their sessions not be recorded.

PALS INTERNATIONAL'S Phone Interpretation Service has recently completed a full scale, third party Risk Assurance Audit of our IT policies and procedures. This audit included reviewing existing policies and procedures and the supporting documentation. Some of the areas reviewed were: network security, administration, safeguards, change management, user rights, roles and access, data classification, business continuity plans, disaster recovery plans, risk registers etc.

PALS INTERNATIONAL'S Phone Interpretation Service only uses U.S. based interpreters which is not only unique within the phone interpretation industry but also beneficial to its clients for several reasons. First, U.S. based interpreters truly understand the American culture for which they're interpreting. Also, the telephone infrastructure is typically vastly more reliable here in the U.S., reducing the propensity for dropped calls and allowing for consistent clear connections. Lastly, using U.S. based interpreters provides for easier enforcement of HIPAA, information privacy laws and regulations which means you have better protection against identity theft. (Jurisdiction off our U.S. soil is difficult if even enforceable at all).

Interpreters are held to the strictest confidentiality when dealing with PII controls. Interpreters must shred ALL notes after speaking to the PALS INTERNATIONAL client and they are prohibited from recording any conversation that is held over the phone.

Interpreters are required to be in an environment conducive to interpreting and free from distractions and background noise. During the auditing process, our employees make sure that the interpreters space is adequate and follows the guidelines we require.

- Area must be a dedicated space free from distractions and background noise
- Area must contain a door which can be shut for privacy purposes
- Area containing pens, paper, note paper
- Area MUST contain a paper shredder
- Must have a dedicated landline for phone interpretation

The use of cell phones or Voice-Over Internet Phones (VOIP) for interpreting is strictly prohibited. Land line phones (without the call waiting feature) are far superior in quality to other types of phones.

On-site audits are completed for all Interpreters. These audits are conducted to ensure that the workspace the Interpreter is using follows all guidelines and regulations we have set and also to certify that the Interpreter is following all privacy rules and regulations. There are two ways on-site audits are conducted.

- a. Camera Audits- Built in computer cameras are used to audit the Interpreters workspace
- b. Random On-Site Audits- An employee will randomly choose a day and time to visit the Interpreters home without the Interpreter knowing.

PALS INTERNATIONAL'S Phone Interpretation Service records telephonic interpretation sessions for

billing and quality control purposes as a matter of standard practice. Recordings are stored for 90 days in a secure, off-site location and then destroyed. However, clients have the option to request their sessions not be recorded.

PALS INTERNATIONAL'S Phone Interpretation Service has recently completed a full scale, third party Risk Assurance Audit of our IT policies and procedures. This audit included reviewing existing policies and procedures and the supporting documentation. Some of the areas reviewed were: network security, administration, safeguards, change management, user rights, roles and access, data classification, business continuity plans, disaster recovery plans, risk registers etc.

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Each phone interpretation customer is assigned a code they must give to the CSR when calling to request an interpreter. Each month the phone interpretation customer's is provided with a complete breakdown of the month's calls, by minute. Phone Interpretation customers receive their detailed billing for the previous month's phone interpretation usage by the second week of every month.

PALS INTERNATIONAL'S Phone Interpretation Service provides a toll free number for its clients to call when needing interpretation support.

All phone interpreters undergo identity verification, a national criminal background check and reference checks. The national criminal search includes an instant and multi-state search (including the District of Columbia) of criminal records databases. Each national criminal search covers a vast list of criminal databases and will report the following types of matching criminal records: felony and misdemeanor records, sex-offender records, inmate records, and arrest records.

III. Summary

PALS INTERNATIONAL stands ready and able to provide Meridian Health Plan with a full range of language services of the highest quality. PALS is committed to providing professional service and complete customer satisfaction. We look forward to providing expanded services to Meridian Health in Iowa.

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor 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;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor'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 obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

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| Signature for Subcontractor: | <i>Brenda Arbeláez</i> |
| Printed Name/Title: | <i>Brenda Arbeláez - President</i> |
| Date: | <i>4-24-2015</i> |

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

| | |
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| Primary Bidder ("Primary Bidder"): | Meridian Health Plan of Iowa, Inc. |
| Subcontractor Contact Information (individual who can address issues re: this RFP) | |
| Name: | Lori Holmquist - Vice President, Payment Integrity Ops |
| Address: | 5720 Smetana Dr. Minnetonka, MN 55343 |
| Tel: | (952) 224-8619 |
| Fax: | (952) 949-3713 |
| E-mail: | lholmquist@tc3health.com |

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| Subcontractor Detail | |
| Subcontractor Legal Name ("Subcontractor"): | TC3 Health, Inc., an Emdeon company |
| "Doing Business As" names, assumed names, or other operating names: | N/A |
| Form of Business Entity (i.e., corp., partnership, LLC, etc.) | LLC |
| State of Incorporation/organization: | Delaware |
| Primary Address: | 3055 Lebanon Pike, Suite 1000 Nashville, TN 37214 |
| Tel: | (615) 932-3000 |
| Fax: | |
| Local Address (if any): | N/A |
| Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract: | TC3 Health, Inc. 5720 Smetana Drive, Suite 400 Minnetonka, MN 55343 TC3 Health, Inc. 1901 E Alton Avenue, Suite 100 Santa Ana, CA 92705 |
| Number of Employees: | 100 |
| Number of Years in Business: | 11 |
| Primary Focus of Business: | Provider of integrated cost containment solutions |
| Federal Tax ID: | 13-4346850 |
| Subcontractor's Accounting Firm: | Ernst & Young |
| If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration: | N/A |
| Percentage of Total Work to be performed by this Subcontractor | Less than 1% of Total Work |

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| pursuant to this RFP/Contract. | |
| General Scope of Work to be performed by this Subcontractor | |
| <p>Pre-Payment Fraud, Waste, and Abuse Services. This includes detection and investigation of fraudulent claims, or otherwise wasteful or abusive claims; application of automated correct coding edits; appeal research and resolution. These services are applied to claims that have not been paid (pre-pay).</p> <p>Post-Payment Fraud, Waste, and Abuse Services. This includes the above services and is applied to paid claims to identify overpayments that may be recovered.</p> | |
| Detail the Subcontractor's qualifications for performing this scope of work | |
| <p>TC3 Health, Inc. has been a successful vendor in the FWA space for the past 11 years, providing FWA detection and investigation and correct coding edits to claims for healthcare payers (TPA's, Health Plans, Taft Hartley Plans, and Self-Funded groups). TC3 Health has a proven history of assisting healthcare payers to identify and prevent unnecessary claims costs associated with incorrect, aberrant or fraudulent billing. Clients realize savings at a rate of 1-2% of total yearly medical claims costs.</p> | |

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor 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;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor'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 obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

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| Signature for Subcontractor: | <i>Lori Holmquist</i> |
| Printed Name/Title: | Lori Holmquist / VP, Payment Integrity Operations |
| Date: | 4/21/2015 |

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

| | |
|---|---|
| Primary Bidder (“Primary Bidder”): | Meridian Health Plan of Iowa, Inc. |
| Subcontractor Contact Information (individual who can address issues re: this RFP) | |
| Name: | Melissa Westrick |
| Address: | 309 Grand River Ave, Port Huron MI 48060 |
| Tel: | (810) 985-3438 |
| Fax: | (810) 985-5432 |
| E-mail: | mawestrick@thems.org |

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| Subcontractor Detail | |
| Subcontractor Legal Name (“Subcontractor”): | Tri Hospital Emergency Medical Service Corporation |
| “Doing Business As” names, assumed names, or other operating names: | Med Connection |
| Form of Business Entity (i.e., corp., partnership, LLC, etc.) | Corporation |
| State of Incorporation/organization: | Michigan |
| Primary Address: | 309 Grand River Ave. Port Huron, MI 48060 |
| Tel: | (810) 985-7115 |
| Fax: | (810) 985-5432 |
| Local Address (if any): | Not applicable |
| Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract: | Not applicable |
| Number of Employees: | Corporation- 110 Med Connection- 13 |
| Number of Years in Business: | 15 Years |
| Primary Focus of Business: | Medical Answering Service |
| Federal Tax ID: | 38-2485700 |
| Subcontractor’s Accounting Firm: | Not applicable |
| If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration: | Not applicable |
| Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract. | Less than 1% of Total Work |
| General Scope of Work to be performed by this Subcontractor | |
| Provide after-hour phone coverage for Meridian Health Plan of Iowa. | |

Detail the Subcontractor's qualifications for performing this scope of work

- Can Provide a telephone system that is capable of supporting anticipated call volumes of Customer combined with other clients on a 24/7 basis.
- Able to respond to after-hours inquiries from member and providers based on training and instructor provided to the Contractor's contact person by customer.
- Able to gather necessary information to fulfill members request for PCP changes and other information so that the customer's staff member can follow up next business day
- Due to sufficient training by Customer, able to complete each call with the most accurate ability.
- Have the ability to speak to customer members in any language, as well as the ability to communicate with the hearing impaired.
- Able to provide excellent customer service to all caller sand project a positive image of the customer

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor 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;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor'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 obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

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| Signature for Subcontractor: |  |
| Printed Name/Title: | Kenneth Cummings Chief Executive Officer |
| Date: | April 21, 2015 |

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

| | |
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| Primary Bidder ("Primary Bidder"): | Meridian Health Plan of Iowa, Inc. |
| Subcontractor Contact Information (individual who can address issues re: this RFP) | |
| Name: | David Rosen |
| Address: | 26899 Northwestern Hwy, Suite 250, Southfield, MI 48033-8420 |
| Tel: | (248) 443-4800 ext. 222 |
| Fax: | (248) 443-4804 |
| E-mail: | drosen@firstrecoverygroup.com |

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| Subcontractor Detail | |
| Subcontractor Legal Name ("Subcontractor"): | First Recovery Group, LLC |
| "Doing Business As" names, assumed names, or other operating names: | First Recovery Group |
| Form of Business Entity (i.e., corp., partnership, LLC, etc.) | LLC |
| State of Incorporation/organization: | Michigan |
| Primary Address: | 26899 Northwestern Highway, Suite 250, Southfield, MI 48033-8420 |
| Tel: | (866) 449-4800 |
| Fax: | (248) 443-4804 |
| Local Address (if any): | Not applicable |
| Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract: | Not applicable |
| Number of Employees: | 125 |
| Number of Years in Business: | 15 |
| Primary Focus of Business: | Subrogation/reimbursement |
| Federal Tax ID: | 36-4381191 |
| Subcontractor's Accounting Firm: | Frank, Hirsch, Subelsky & Freedman, P.C. |
| If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration: | Not applicable |
| Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract. | Less than 1% of Total Work |

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| General Scope of Work to be performed by this Subcontractor |
| Subrogation/reimbursement. |
| Detail the Subcontractor's qualifications for performing this scope of work |
| We're the leading subrogation vendor for government programs. Our leadership team has over 100 years of combined experience with government health plans. We currently represent over 80 Medicaid Managed Care Organizations in 35 states and have experience resolving liens in all 50 states and U.S. territories. |

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor 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;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor'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 obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

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| Signature for Subcontractor: |  |
| Printed Name/Title: | David A. Rosen, CEO |
| Date: | 4/22/15 |

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3.2.7.4.2 Table

1. Identify in table format all of your publicly-funded managed care contracts for Medicaid, CHIP and other low-income populations within the last five (5) years. If a Bidder does not have direct experience, it may include the experience of its parent company if it includes a parent guarantee with its proposal. For each prior experience identified, provide a brief description of the following:
 - a. Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope);
 - b. Duration of the contract;
 - c. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s);
 - d. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s);
 - e. Contact name, phone number, and email address;
 - f. Number of members served by population type;
 - g. Annual contract payments and description if payment was capitated;
 - h. Any improvements made in utilization trends and quality indicators;
 - i. How the contract emphasizes member choice, access, safety, independence, and responsibility; and
 - j. The role of subcontractors, if any.

| A. Current Contract between Meridian Health Plan of Michigan, Inc. and the Michigan Department of Community Health (MDCH). | |
|--|--|
| Item | Brief Description |
| Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope); | <p>Through this current contract, The Michigan Medicaid program arranges for and administers medical assistance to beneficiaries who meet the requirements for Medicaid assistance as defined by MDCH. This includes those individuals eligible for, or receiving, federally aided financial assistance, those deemed categorically needy by the Department of Human Services (DHS) and the medically needy populations. Eligibility for Michigan's Medicaid program is based on a combination of financial and non-financial factors. The State has the sole authority for determining whether individuals or families meet any of the eligibility requirements as specified for enrollment in the CHCP.</p> <p>Individuals who attain eligibility due to a pregnancy are usually guaranteed eligibility for comprehensive services through two months post-partum or post-loss of pregnancy. Their newborns are usually guaranteed coverage for two months and may be covered for one full year.</p> <p>Services in Scope</p> <ul style="list-style-type: none"> • Physical Health Services • Behavioral Health Services (Outpatient services only) • LTSS Services (In-scope for MMP) <p>Benefits:</p> |

A. Current Contract between Meridian Health Plan of Michigan, Inc. and the Michigan Department of Community Health (MDCH).

| Item | Brief Description |
|--|--|
| | <ul style="list-style-type: none"> • Skilled Nursing Facility • Inpatient Hospital services (No Limit to inpatient days. Inpatient Admissions for Substance abuse and Behavioral Health are carved out and managed by Community Mental Health. • DME • Rehabilitation Services • Physical/Occupational/Speech/Language Therapies • Meals and Lodging • Hospice • Chiropractic Services • Vision • Pharmacy <p>Additional Special Healthcare Programs:</p> <ul style="list-style-type: none"> • Care Coordination • Maternity Care Coordination • Tobacco Cessation • Weight Management • Nutritional Counseling |
| Duration of Contract | The term of this Agreement will begin on October 10, 2009 and end on December 30, 2012, unless terminated earlier as noted in this section. Option for renewal 3 years + 3 one-year options + 3 month extension. |
| Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s); | <p>October 10, 2009 –December 31, 2015</p> <p>Alterations: The Contract was renewed in: 2012,2013,2014</p> |

| A. Current Contract between Meridian Health Plan of Michigan, Inc. and the Michigan Department of Community Health (MDCH). | | |
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| Item | Brief Description | |
| Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s); | \$3.9 Billion | |
| Contact name, phone number, and email address | Kevin Dunn, Director, Services Division Department of Technology, Management and Budget 530 West Allegan – Mason Building – 2nd Floor Lansing, MI 48933 (517) 241-4225 Email: dunnk3@michigan.gov | |
| Number of members served by population type | Medicaid (TANF/ABD): 283,394 Medicaid (CSCHS/Title 21): 4,402 Medicaid Expansion (Healthy Michigan): 117,031 Total Membership: 404,827 | |
| Annual contract payments and description if payment was capitated; | All payments Capitated 2009: \$660,893,125.00 2010: \$873,845,058.00 2011: \$960,865,729.00 2012: \$955,274,981.00 2013: \$1,056,234,761.00 2014: \$1,391,705,226.00 | |
| Improvements made in utilization trends and quality indicators | Utilization trends: | Recent Improvements made in Utilization Trends : Reduction in Children’s Special Health Care Services (CSHCS) Inpatient Admissions: Medicaid Inpatient Admissions per 1,000 CSHCS members decreased from 847/1000 in Quarter 2 of 2012 and ended at 377/1000 in Quarter 3 of 2014. This is a significant reduction in inpatient admissions for the CSHCS population. Reduction in Emergency and Urgent Care: Decrease in Emergency room (ER) and Urgent Care (UC) visits per 1000 members declined by 4% from Quarter 4 2012 to |

A. Current Contract between Meridian Health Plan of Michigan, Inc. and the Michigan Department of Community Health (MDCH).

| Item | Brief Description |
|------|--|
| | <p>Quarter 4 2013, from 950.29 to 911.34 respectively.</p> <p>Reduction in CSHCS 1-Day DRG Admits per 1,000 members 1-Day DRG Admissions for the CSHCS population is generally the driver of this data, however between Quarter 4 of 2012 and Quarter 2013 1-day DRG admissions decreased from 91 per 1000 members to 60 per 1000 members.</p> <p>Reduction in CSHCS 2-Day DRG Admits per 1,000 members Between Quarter 4 2012 and Quarter 4 of 2013 2-Day DRG admission per 1000 CSHCS members decreased from 106 per 1000 to 60 per 1,000 members.</p> <p>Reduction in ER/UC Utilization overall population: ER/UC visits per 1000 members declined by 4% from Quarter 4 2012 to Quarter 4 2013, from 950.29 to 911.34 per 1000 members</p> |
| | <p>Quality Indicators:</p> <p>Routine Preventive Services for Infants and Children (Birth – 24 months) Meridian saw a 3.22% increase to 80.79% in Childhood Immunizations Combination 3 over the 2013 rate, which put this measure above the benchmark performance goal. Lead Screening in Children also met the benchmark performance goal at 83.33%.</p> <p>Adult Preventive Services (Ages 18-49) Both the Adult BMI and Breast Cancer Screening measures saw an increase in rates for 2014, and both measures exceeded the NCQA 75th percentile performance goal. Adult BMI increased 4.67%, and BCS increased 5.81%.</p> <p>Scoring for NCQA Accreditation-CAHPS® (Consumer Assessment of Healthcare Providers and Systems) measures: Meridian Health Plan of Michigan reach the 90th percentile for the following measures in 2014 (2013 Data Set)</p> <p>Measures in the 90th Percentile</p> <ul style="list-style-type: none"> • Getting Needed Care • Customer Service • Getting information or Help Needed |

A. Current Contract between Meridian Health Plan of Michigan, Inc. and the Michigan Department of Community Health (MDCH).

| Item | Brief Description |
|------|--|
| | <ul style="list-style-type: none"> • Easy to get appointment with Specialists • Treated you with courtesy and respect • Got Information or Help needed • Easy to Get Appointment with specialists <p>Company Quality Indicators:</p> <ul style="list-style-type: none"> • Partner with the MI Postpartum Care QI Project • Member of Maternal Health Task Force in IA and MI • MI ranked 9th among Medicaid plans according to NCQA Health Plan Insurance Rankings 2014-2015 • Excellent Accreditation for MI • Pinnacle Award- 2014- Strong Start for Women and Infants • Meridian Health Plan is ranked #1 in Michigan according to NCQA Health Plan Insurance Rankings 2014-2015. • Meridian of MI scored number one in the state for women’s healthcare measures in Medicaid plans • Meridian was selected by NAHQ for a best practices award, and QI staff presented at the annual conference in Tennessee. • Meridian’s (MI) overall Medicaid enrollment rose above 350,000 members for the first time in the company’s history • Meridian has continued to work on the CMS Innovations Grant in regards to lowering the rate of preterm deliveries. Meridian has been recognized by CMS as a high performing awardee, and has presented in forums to assist other organizations on multiple occasions. • Meridian has been active in piloting different programs throughout the State of MI with Access Alliance, CareConnect 360 (formerly known as “FRANK”), and the CMS Adult Measures Grant (elective deliveries and asthma). • Developed partnerships with a variety of community organizations such as the Detroit Lead Partnership, Asthma Initiative of Michigan, Alliance for Immunizations in Michigan, WCHAP, Help Me Grow, the WIN Network, the Detroit Infant Mortality Task Force, DIEBO, GDAHC, MQIC, and SCHA-MI. <ul style="list-style-type: none"> ○ A Meridian staff member is co-leading the Adolescent sub-committee for the Alliance for Immunizations in Michigan <p>HEDIS® Quality Measures: Meridian Health Plan of Michigan reached the 90th percentile in the following HEDIS® measures: Pregnant women received timely prenatal care 94.13%</p> |

A. Current Contract between Meridian Health Plan of Michigan, Inc. and the Michigan Department of Community Health (MDCH).

| Item | Brief Description | |
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| | | <ul style="list-style-type: none"> • Adults 45-64 years of age had an ambulatory or preventive care visit during the year 92.41% • Adolescents received their meningococcal and Tdap immunizations by their 13th birthday 89.73% • Children received six or more well-care visits in the first 15 months of life 78.24% • Women received appropriate postpartum care 76.35% |
| How the contract emphasizes member choice, access, safety, independence, and responsibility | Choice | The State is required to contract for services to help beneficiaries make informed choices regarding their healthcare, assist with client satisfaction and access surveys, and assist beneficiaries in the appropriate use of the Contractor's complaint and grievance systems. MDCH contracts with an Enrollment Services Contractor to contact and educate general Medicaid beneficiaries about managed care and to enroll, disenroll, and change enrollment for these beneficiaries. |
| | Access | Meridian must maintain a network of qualified providers in sufficient numbers and locations within the counties in the service area, including counties contiguous to Meridian's service area, to provide required access to covered services. Meridian's network must include pediatric subspecialists, children's hospitals, pediatric regional centers, and ancillary providers that provide services to CSHCS enrollees. Meridian must also provide or arrange accessible care 24 hours per day, 7 days per week to the enrolled population. Meridian is solely responsible for arranging and administering covered services to enrollees. Covered services must be medically necessary and administered, or arranged for, by a designated PCP. Meridian must demonstrate that it can maintain a delivery system of sufficient size and resources to offer quality care that accommodates the needs of all enrollees within each enrollment area. The delivery system (in- and out-of network) must include sufficient numbers of providers with the training, experience, and specialization to furnish the covered services of the contract to all enrollees. |
| | Safety | Provider contracts between Meridian and contracted providers must include provisions for the immediate transfer of enrollees to another Meridian PCP if their health or safety is in jeopardy. Inspection of Work Performed-The State's authorized representatives must at all reasonable times and with 10 days prior written request, have the right to enter Meridian's premises, or any other places, where the Services are being performed, and must have access, upon reasonable request, to interim drafts of Deliverables or work-in-progress. Upon 10 Days prior written notice and at all reasonable times, the State's representatives must be allowed to inspect, monitor, or otherwise evaluate the work being performed and to the extent that the access will not reasonably interfere or jeopardize the safety or operation of the systems or facilities. Meridian must provide all reasonable facilities and assistance for the State's representatives. |
| | Independence | Enrollee Education: Meridian is responsible for developing and maintaining enrollee education programs designed to provide the enrollee with clear, concise, and accurate information about the Meridian's services. Materials for enrollee education should include: <ul style="list-style-type: none"> (a) Member handbook (b) Contractor bulletins or newsletters sent to the Contractor's enrollees at least two times a year that provide updates related to covered services, access to providers and updated policies and procedures (c) Literature regarding health/wellness promotion programs offered by the Contractor |

A. Current Contract between Meridian Health Plan of Michigan, Inc. and the Michigan Department of Community Health (MDCH).

| Item | Brief Description | |
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| | | (d) A website, maintained by the Contractor, that includes information on preventive health strategies, health/wellness promotion programs offered by the Contractor, updates related to covered services, access to providers, complete provider directory, and updated policies and procedures |
| | Responsibility | Meridian is required to include in the member handbook, How enrollees can contribute towards their own health by taking responsibility, including appropriate and inappropriate behavior. Meridian must make available the process for accessing covered services that are not the responsibility of the Meridian, but are available to its enrollees, such as dental care, behavioral health, and developmental disability services which enables members to take responsibility for benefits available to them. |
| The role of subcontractors if any | Administrative Services | <p>Meridian contracts with Caidan Management Company, LLC (CMC) to perform an array of administrative services which will allow Meridian to provide the services described in the Statement of Work. CMC shares the same parent organization as Meridian and, thus enjoys the efficiencies through integration. Pursuant to an Administrative Services contract, CMC will perform the following services:</p> <ol style="list-style-type: none"> 1.Claims processing and adjudication 2.Member enrollment and eligibility verification 3.Medical management 4.Behavioral health 5.Quality improvement activities 6.Authorizations, denials, and appeals 7.Complaints and grievances 8.Provider recruitment and education 9.Support staff for credentialing activities 10.Member services / call center operations 11.Member compliance program 12.Risk management 13.Administrative, technical, and day-to-day operational duties 14.Information technology and management services 15.Banking, accounting, and financial matters 16.Support staff for compliance and fraud, waste and abuse activities <p>CMC has been providing the described services for over 15 years to Medicaid and Medicare plans in Michigan, Illinois and Iowa. CMC hires locally-based personnel in each of the states in which it operates and the same will be the case for the 2015 IHQHI.</p> |

A. Current Contract between Meridian Health Plan of Michigan, Inc. and the Michigan Department of Community Health (MDCH).

| Item | Brief Description |
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| Pharmacy Benefit Management | Meridian contracts with MeridianRx, LLC (MeridianRx), a full-service PBM, to perform pharmacy benefit management services for its membership. Similar to Caidan Management Company, MeridianRx shares the same parent organization as Meridian, which results in superior access to information and a greater overall level of service. MeridianRx maintains a comprehensive national network that covers all 50 States, the District of Columbia, the United States Virgin Islands, American Samoa, the Northern Mariana Islands, Puerto Rico and Guam. The breadth of the MeridianRx network ensures convenient access to prescriptions at deeply discounted rates. MeridianRx uses a variety of tools such as drug utilization review and disease management to encourage the best clinical outcomes for patients. They also provide patient information in multiple formats, including a user-friendly web portal, mailings, newsletters and our award-winning call center. MeridianRx utilizes panels of highly-qualified, independent physicians, pharmacists and other clinical experts to develop lists of drugs approved for reimbursement in order to encourage clinically appropriate and cost-effective prescribing. MeridianRx offers access to highly efficient mail-service pharmacies that safely and accurately supply home-delivered prescriptions at a substantial savings. MeridianRx utilizes cutting-edge e-prescribing technology, which provides physicians with clinical and cost information on prescription options allowing them to better counsel patients on the safest and most affordable medication choices. MeridianRx offers a 24/7 toll-free hotline with access to pharmacy service representatives, provider service representatives and pharmacists to address any client or patient related issues. |
| Non-Emergency Medical Transportation | Meridian subcontracts non-emergency medical transportation services to Logisticare. LogistiCare is a go-between for getting from your house to the doctor's office and back. The company brokers non-emergency transportation services for commercial health plans, government entities (such as state Medicaid agencies), and hospitals throughout the US. Using its nearly 20 call centers and a network of some 1,500 independent, contracted transportation providers, the company coordinates the medical-related travel arrangements of its clients' members. In addition, it contracts with local school boards to coordinate transportation for special needs students. The company provides more than 26 million trips each year for clients in some 40 states. LogistiCare is a subsidiary of Providence Service. Logisticare is responsible for all non-emergent transportation services. |
| Translation Services: | Meridian subcontracts with Pan American Languages & Services DBA PALS International (PALS) to provide foreign language translation services. PALS is a woman-owned business that has been operating since 1983. PALS provides written translation services in 170 languages, including Spanish, French, German, English, Arabic, Chinese, Japanese, Korean, Italian, Polish, Russian, Portuguese, and Hmong. Using state-of-the-art computer phone technology with high-quality, professional linguists, PALS are capable of producing unique oral interpretation services of extraordinary speed and reliability. PALS provides immediate 24/7 access to over 150 languages supported by over 1,000 professional, certified linguists within an average connect time of 30 seconds. |
| Claims Recovery | Meridian subcontracts with First Recovery Group (FRG) for claims recovery services. FRG is the largest independent healthcare cost management company focused solely on subrogation claims recovery. FRG represents HMOs, TPAs, insurance companies, self-insured corporations, PHOs, IPAs, and MSOs that cover over six million lives nationwide. FRG |

A. Current Contract between Meridian Health Plan of Michigan, Inc. and the Michigan Department of Community Health (MDCH).

| Item | Brief Description |
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| | receives a data feed of all paid claims from a healthcare payor and, using its exclusive SubroMAX® system, analyzes ICD-9 codes, CPT codes and episodes of care, to identify cases with recovery potential. They are also able to search court records, insurance databases, and workers compensation records. |
| After-Hours Call Center | Meridian contracts with Tri-Hospital EMS dba Med-Connection to provide after-hours call center services. Med-Connection was founded in 2001 and provides high-quality, customizable call center services to healthcare organizations. Med-Connection maintains stringent hiring guidelines and employs a robust and continuous training program based on health plan needs and requirements. Med-Connection dedicates staff to a single account in order to provide the maximum level of attention to callers. Their focus is on resolving issues in a single call and to the satisfaction of the caller 100% of the time. |
| Dental Services: | Meridian Health Plan of Michigan subcontracts with Delta Dental for dental benefit services. Delta Dental is the largest dental plan system in the United States. The Delta Dental Plans Association is composed of 39 independent Delta Dental member companies operating in all 50 states, the District of Columbia and Puerto Rico |
| Sign Language: | Meridian Health Plan of Michigan subcontracts with ABS Translation services for sign language interpretation services. |

B. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS).

| Item | Brief Description |
|---|--|
| <p>Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope);</p> | <p>Through this current contract, Meridian Health Plan of Illinois administers services for, adults that are Illinois residents and U.S. citizens or qualified immigrants. Children are eligible regardless of immigration status. All individuals must meet income and asset requirements that vary by group.</p> <p>The Voluntary Managed Care Organization (VMCO) has been replaced with the FHP/ACA contract, which now includes the following populations:</p> <p>Services in Scope</p> <ul style="list-style-type: none"> • Physical Health Services • Behavioral Health Services (Inpatient BH services require prior auth) <p>Services out of Scope</p> <ul style="list-style-type: none"> • LTSS Services (Out of Scope) <p>Benefits:</p> <ul style="list-style-type: none"> • Skilled Nursing Facility • Inpatient Hospital services (No Limit to inpatient days. Inpatient Admissions for Substance abuse and Behavioral Health are carved out and managed by Community Mental Health. • DME • Rehabilitation Services • Physical/Occupational/Speech/Language Therapies • Hospice (Requires Prior Auth) • Personal Care Attendant • Adult Day Care • Chiropractic Services • Dental (Liberty Dental) • Vision • Pharmacy <p>Additional Special Healthcare Programs:</p> <ul style="list-style-type: none"> • Care Coordination • Maternity Care Coordination • Tobacco Cessation |

| B. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS). | |
|--|---|
| Item | Brief Description |
| | <ul style="list-style-type: none"> • Weight Management • Nutritional Counseling |
| Duration of Contract | (VMCO Contract) The term of this Agreement will begin on July 1, 2009 through June 30,2010 with one year renewals through June 30,2014. The FHP/ACA term began on July 1, 2014 and will continue through June 30, 2019 |
| Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s); | <p>July 1, 2009-present</p> <p>Alteration: This contract transferred from a Voluntary Managed Care Organization contract to the Family Health Plan/Affordable Care Act which commenced on July 1, 2014 and will continue through June 30, 2019.</p> |
| Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s); | \$736.2 Million |
| Contact name, phone number, and email address | <p>Michelle Maher, Chief Bureau of Managed Care Department of Healthcare and Family Services 201 South Grand Avenue East Springfield, IL 62763 (217) 524-7478 email: Michelle.Maher@Illinois.gov</p> |
| Number of members served by population type | <p>Family Health Plan (Traditional): 173,394</p> <p>Affordable Care Act: (Expansion):</p> |

B. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS).

| Item | Brief Description | |
|--|--|--|
| | 34,252 | |
| Annual contract payments and description if payment was capitated; | All Payments Capitated: 2009:\$736,198.00 2010: \$1,929,885.00 2011: \$6,692,662.00 2012: \$11,490,679.00 2013: \$40,945,705.00 2014: \$254,552,731.00 | |
| Improvements made in utilization trends and quality indicators | Utilization Trends | <p>Recent Improvements made in Utilization Trends: Reduction Medical/Surgical inpatient Length of Stay (LOS): Between Quarter 4 of 2011 and Quarter 4 of 2012 Meridian Health Plan of Illinois reduced the average length of stay per 1000 members from 4.43 in Q4 of 2011 to 4.04 in Q4 of 2012</p> <p>Reduction in Readmission rates: 15 Day Readmissions- Between Quarter 1 of 2012 and Quarter 1 of 2013 Meridian Health Plan of Illinois reduced the 15 day readmission rate from 0.64% in Q1 2012 to 0.57% for 15 day readmissions in Q1 2013 per 1000 members</p> <p>30 Day Readmissions- Between Quarter 1 of 2012 and Quarter 1 of 2013 Meridian Health Plan of Illinois reduced the 30 day readmission rate from 1.34% in Q1 2012 to 0.56% in Q1 2013 per 1,000 members.</p> <p>1-Day DRG Admits per 1,000 members (Excludes neonates) Quarter 2 of 2012 reported 1-Day DRG admits per 1000 TANF members at 4.41/1000 by Quarter 3 of 2012, 1-Day DRG Admits had decreased to 2.64 per 1000. This trend remained stable for the TANF population through Quarter 4 of 2013.</p> <p>2-Day DRG Admits per 1,000 (excluding neonates, including TANF) Quarter 2 of 2012 posted 10.48 2-day DRG Admits per 1,000 members. By Quarter 3 of 2014 the number of 2-Day Admits per 1000 members ended at 8.74</p> |
| | Quality Indicators: | Scoring for NCQA Accreditation-CAHPS® (Consumer Assessment of Healthcare Providers and Systems) |

B. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS).

| Item | Brief Description |
|------|---|
| | <p>Adult Medicaid measures: Meridian Health Plan of Illinois reached the 90th percentile for the following measures in 2014(2013 data set):</p> <p>Measures in 90th Percentile</p> <ul style="list-style-type: none"> • Customer Service • Overall rating of Healthcare • Overall rating of Specialist <p>HEDIS® Quality Measures: Meridian Health Plan of Illinois reached the HEDIS® 90th percentile for the following measures in 2014 (2013 Data Set)</p> <p>Measures reaching the 90th Percentile</p> <ul style="list-style-type: none"> • Diabetic members 18-75 years of age had a HbA1c test during the year • Pregnant women received timely prenatal care • Children received six or more well-care visits in the first 15 months of life • Diabetic members 18-75 years of age had a nephropathy screening or nephropathy treatment during the year • Children had at least one test for lead poisoning by age 2 • Children 3-6 years of age had at least one well-care visit with a primary care provider • Women received appropriate postpartum care • Members ages 12-21 had at least one well-care visit during the year • Female adolescents received three doses of the HPV vaccine by their 13th birthday <p>Company Quality Indicators:</p> <ul style="list-style-type: none"> • IL ranked 10th among Medicaid plans according to NCQA Health Plan Insurance Rankings 2014-2015 • Commendable accreditation • Meridian Health Plan of Illinois is ranked #1 Medicaid health plan in the states based on NCQA Health Plan Insurance Rankings 2014-2015. • Meridian was selected by the National Association for Healthcare Quality for a best practices award, and Meridian’s QI staff presented at the annual conference in Tennessee. |

B. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS).

| Item | Brief Description | |
|---|-------------------|--|
| | | <ul style="list-style-type: none"> Meridian has continued to work on the CMS Innovations Grant in regards to lowering the rate of preterm deliveries. Meridian has been recognized by CMS as a high performing awardee, and has presented in forums to assist other organizations on multiple occasions. |
| How the contract emphasizes member choice, access, safety, independence, and responsibility | Choice | This contract requires that all Potential Enrollees will have an opportunity to freely choose, from among the available Health Plans, the one in which they want to enroll. Meridian will afford to each Enrollee a choice of PCP, which may be, where appropriate, a Women’s Health Care Provider. |
| | Access | The contract mandates that Enrollees shall not be required to travel more than thirty (30) minutes or thirty (30) miles to receive primary health care services in urban areas, or sixty (60) minutes or sixty (60) miles to receive primary health care services in rural areas. An Enrollee may elect to travel beyond the distance standards when the Enrollee exercises choice in selecting a PCP or specialty care Provider. The free exercise of such choice by the Enrollee will not negatively impact the results of any reporting by Meridian on access to care. Provider locations shall be accessible for Enrollees with disabilities. Meridian collects sufficient information from Providers to assess compliance with the Americans With Disabilities Act. As necessary to serve Enrollees, Provider locations where Enrollees receive services shall be ADA compliant. In addition, Meridian includes within its network Provider locations that are able to accommodate the needs of individual Enrollees. PCPs and specialty Provider contracts shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable. |
| | Safety | As outline in our contract with IDHFS, Meridian provides the Department, upon request, with our protocols for assuring the health and safety of all Enrollees after an allegation of Abuse, Neglect or exploitation, or a critical incident, is reported. Meridian’s Quality Improvement Program works to continuously improve and monitor medical care, Enrollee safety, behavioral health services, and the delivery of services to Enrollees, including ongoing assessment of program standards to determine the quality and appropriateness of care, Care Management and coordination. |
| | Independence | As required by our contract Meridian takes every opportunity to maintain Enrollee’s independence in the community by ensuring the coordination of referrals for other necessary services that are not Covered Services, such as supportive housing and other social services. |
| | Responsibility | Meridian is required to maintain a Disease Management Program and with services which provide enrollees self-management education. Our care coordination and member services teams provide enrollees with |

B. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS).

| Item | Brief Description | |
|-----------------------------------|-----------------------------|--|
| | | education on primary prevention and behavioral modifications that emphasize member responsibility for their health. |
| The role of subcontractors if any | Administrative Services | <p>Meridian contracts with Caidan Management Company, LLC (CMC) to perform an array of administrative services which will allow Meridian to provide the services described in the Statement of Work. CMC shares the same parent organization as Meridian and, thus enjoys the efficiencies through integration. Pursuant to an Administrative Services contract, CMC will perform the following services:</p> <ol style="list-style-type: none"> 1.Claims processing and adjudication 2.Member enrollment and eligibility verification 3.Medical management 4.Behavioral health 5.Quality improvement activities 6.Authorizations, denials, and appeals 7.Complaints and grievances 8.Provider recruitment and education 9.Support staff for credentialing activities 10.Member services / call center operations 11.Member compliance program 12.Risk management 13.Administrative, technical, and day-to-day operational duties 14.Information technology and management services 15.Banking, accounting, and financial matters 16.Support staff for compliance and fraud, waste and abuse activities <p>CMC has been providing the described services for over 15 years to Medicaid and Medicare plans in Michigan, Illinois and Iowa. CMC hires locally-based personnel in each of the states in which it operates and the same will be the case for the 2015 IHQHI.</p> |
| | Pharmacy Benefit Management | Meridian contracts with MeridianRx, LLC (MeridianRx), a full-service PBM, to perform pharmacy benefit management services for its membership. Similar to Caidan Management Company, MeridianRx shares the same parent organization as Meridian, which results in superior access to information and a greater overall level of service. MeridianRx maintains a comprehensive national network that covers all 50 States, the District of Columbia, the United States Virgin Islands, American Samoa, the Northern Mariana Islands, Puerto Rico and Guam. The breadth of the MeridianRx network ensures convenient access to prescriptions at deeply |

B. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS).

| Item | Brief Description |
|--------------------------------------|--|
| | <p>discounted rates. MeridianRx uses a variety of tools such as drug utilization review and disease management to encourage the best clinical outcomes for patients. They also provide patient information in multiple formats, including a user-friendly web portal, mailings, newsletters and our award-winning call center. MeridianRx utilizes panels of highly-qualified, independent physicians, pharmacists and other clinical experts to develop lists of drugs approved for reimbursement in order to encourage clinically appropriate and cost-effective prescribing. MeridianRx offers access to highly efficient mail-service pharmacies that safely and accurately supply home-delivered prescriptions at a substantial savings. MeridianRx utilizes cutting-edge e-prescribing technology, which provides physicians with clinical and cost information on prescription options allowing them to better counsel patients on the safest and most affordable medication choices. MeridianRx offers a 24/7 toll-free hotline with access to pharmacy service representatives, provider service representatives and pharmacists to address any client or patient related issues.</p> |
| Non-Emergency Medical Transportation | <p>Meridian subcontracts non-emergency medical transportation services to Logisticare. LogistiCare is a go-between for getting from your house to the doctor's office and back. The company brokers non-emergency transportation services for commercial health plans, government entities (such as state Medicaid agencies), and hospitals throughout the US. Using its nearly 20 call centers and a network of some 1,500 independent, contracted transportation providers, the company coordinates the medical-related travel arrangements of its clients' members. In addition, it contracts with local school boards to coordinate transportation for special needs students. The company provides more than 26 million trips each year for clients in some 40 states. LogistiCare is a subsidiary of Providence Service. Logisticare is responsible for all non-emergent transportation services.</p> |
| Translation Services | <p>Meridian subcontracts with Pan American Languages & Services DBA PALS International (PALS) to provide foreign language translation services. PALS is a woman-owned business that has been operating since 1983. PALS provides written translation services in 170 languages, including Spanish, French, German, English, Arabic, Chinese, Japanese, Korean, Italian, Polish, Russian, Portuguese, and Hmong. Using state-of-the-art computer phone technology with high-quality, professional linguists, PALS are capable of producing unique oral interpretation services of extraordinary speed and reliability. PALS provides immediate 24/7 access to over 150 languages supported by over 1,000 professional, certified linguists within an average connect time of 30 seconds.</p> |
| After-Hours Call Center | <p>Meridian contracts with Tri-Hospital EMS dba Med-Connection to provide after-hours call center services. Med-Connection was founded in 2001 and provides high-quality, customizable call center services to healthcare organizations. Med-Connection maintains stringent hiring guidelines and employs a robust and continuous training program based on health plan needs and requirements. Med-Connection dedicates staff to a single account in order to provide the maximum level of attention to callers. Their focus is on resolving</p> |

B. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS).

| Item | Brief Description | |
|------|-------------------|--|
| | | issues in a single call and to the satisfaction of the caller 100% of the time. |
| | Dental Services | Meridian Health Plan of Illinois subcontracts to Liberty Dental for the administration of dental benefit services. LIBERTY is a privately held company that specializes in dental only administrative services to over 2 million members across the United States for well over a decade. LIBERTY proudly provides full service administration for some of the Nation's largest (Fortune 100) health plans (MCOs), as well as labor groups, employer groups, and federal, state and local government agencies. |
| | Sign Language | Meridian subcontracts with Illinois Language Services for sign language interpretation services. Meridian subcontracts with ABS Translation services for sign language interpretation services. |

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C. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS) to provide services for the Seniors and Persons with Disabilities (SPD) population

| Item | Description |
|---|---|
| <p>Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope);</p> | <p>Through this current contract, Meridian Health Plan of Illinois administers services for the Seniors and Persons with Disabilities (SPD) populations. Eligibility is determined based on income, assets, healthcare needs, family status, and other considerations. The State has sole authority to determine eligibility. Members must be enrolled in the Illinois Medicaid program and part of the Seniors and Persons with Disabilities (SPD) population. Eligible members will not have Third Party Liability (TPL), be part of the Spend Down Program, or have dual eligibility (Medicare and Medicaid eligibility).</p> <p>Note: For the SPD Population LTSS Eligibility determination is under either the Department on Aging or the Department of Rehabilitative Services to determine eligibility for Home and Community Based Services (HCBS) Waiver Program or the Nursing Facility Program.</p> <p>Services in Scope</p> <ul style="list-style-type: none"> • Physical Health Services • Behavioral Health Services (Inpatient BH services require prior auth) • LTSS Services <p>Benefits:</p> <ul style="list-style-type: none"> • Skilled Nursing Facility • Inpatient Hospital services (No Limit to inpatient days. Inpatient Admissions for Substance abuse and Behavioral Health are carved out and managed by Community Mental Health. • DME • Rehabilitation Services • Physical/Occupational/Speech/Language Therapies • Hospice (Requires Prior Auth) • Personal Care Attendant • Adult Day Care • Chiropractic Services (Under 21) • Dental (Routine dental services for SPD members under 21, over 21 emergency only) • Vision • Pharmacy <p>Additional Special Healthcare Programs:</p> <ul style="list-style-type: none"> • Care Coordination |

| C. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS) to provide services for the Seniors and Persons with Disabilities (SPD) population | |
|--|---|
| Item | Description |
| | <ul style="list-style-type: none"> • Maternity Care Coordination • Tobacco Cessation • Weight Management • Nutritional Counseling |
| Duration of Contract | The term of this Agreement will begin July 1, 2013 and continue through June 30, 2018, unless terminated prior by either party. |
| Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s); | July 1, 2013-Present |
| Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s); | \$52.5 Million |
| Contact name, phone number, | Michelle Maher, Chief Bureau of Managed Care Department of Healthcare and Family Services 201 South Grand Avenue East |

| C. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS) to provide services for the Seniors and Persons with Disabilities (SPD) population | | |
|--|--|--|
| Item | Description | |
| and email address | Springfield, IL 62763 (217) 524-7478 Michelle.Maher@Illinois.gov | |
| Number of members served by population type | SPD (Seniors and Persons with Disabilities): 10,602 | |
| Annual contract payments and description if payment was capitated; | 2010: No Contract 2011: No Contract 2012: No Contract 2013: \$ 10,507,570 2014: \$ 112,790,472 | |
| Improvements made in utilization trends and quality indicators | Utilization Trends: | <p>Recent Improvements made in Utilization Trends</p> <p>Reduction in Inpatient Facility Utilization: The IL SPD membership experienced a slight decline in Inpatient facility utilization between Quarter 4 of 2013 and Quarter 2 of 2014. Utilization dropped from 350 inpatient visits per 1,000 SPD member in Q4 2013 to 296 per 1,000 members in Q2 of 2014. These rates can be expected to fluctuate due to members having multiple co-morbidities and requiring highly coordinated care.</p> <p>Reduction in 2-Day DRG Admits: The SPD population experienced a decreasing trend in 2-Day DRG Admits per 1,000 members between Quarter 1 of 2014 which resulted in 48 admits per 1,000 members and fell to 38 admits per 1,000 members in Quarter 2 2014. These rates can be expected to fluctuate due to members having multiple co-morbidities and requiring highly coordinated care.</p> |
| | Quality Indicators: | <p>Scoring for NCQA Accreditation-CAHPS® (Consumer Assessment of Healthcare Providers and Systems) Adult Medicaid measures:</p> <p>Meridian Health Plan of Illinois reached the 90th percentile for the following measures in 2014(2013 data set):</p> |

C. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS) to provide services for the Seniors and Persons with Disabilities (SPD) population

| Item | Description |
|------|--|
| | <p>Measurement Reaching the 90th Percentile:</p> <ul style="list-style-type: none"> • Customer Service • Overall rating of Healthcare • Overall rating of Specialist <p>HEDIS® Quality Measures: Meridian Health Plan of Illinois reached the HEDIS® 90th percentile for the following measures in 2014:</p> <ul style="list-style-type: none"> • Diabetic members 18-75 years of age had a HbA1c test during the year • Pregnant women received timely prenatal care • Children received six or more well-care visits in the first 15 months of life • Diabetic members 18-75 years of age had a nephropathy screening or nephropathy treatment during the year • Children had at least one test for lead poisoning by age 2 • Children 3-6 years of age had at least one well-care visit with a primary care provider • Women received appropriate postpartum care • Members ages 12-21 had at least one well-care visit during the year • Female adolescents received three doses of the HPV vaccine by their 13th birthday <p>Company Quality Indicators:</p> <ul style="list-style-type: none"> • IL ranked 10th among Medicaid plans according to NCQA Health Plan Insurance Rankings 2014-2015 • Commendable accreditation • Meridian Health Plan of Illinois is ranked #1 Medicaid health plan in the states based on NCQA Health Plan Insurance Rankings 2014-2015. • Meridian was selected by the National Association for Healthcare Quality for a best practices award, and Meridian’s QI staff presented at the annual conference in Tennessee. • Meridian has continued to work on the CMS Innovations Grant in regards to lowering the rate of preterm deliveries. Meridian has been recognized by CMS as a high performing awardee, and has presented in forums to assist other organizations on multiple occasions. |

| C. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS) to provide services for the Seniors and Persons with Disabilities (SPD) population | | |
|--|-------------------------|---|
| Item | Description | |
| How the contract emphasizes member choice, access, safety, independence, and responsibility | Choice | As outlined in the Contract between IDHFS and Meridian, all potential Enrollees will have an opportunity to freely choose, from among the available MCOs, the one in which they want to enroll. On a daily basis, the Illinois Client Enrollment broker will inform Meridian of the Prospective Enrollees who have voluntarily chosen Meridian and the PCPs that were selected. |
| | Access | As required by our agreement, Meridian has established and maintains and monitors a network of Affiliated Providers, including hospitals, PCPs, WHCPs, specialist Physicians in individual and group practices, clinical laboratories, dentists, including oral surgeons, pharmacies, behavioral health Providers, substance abuse Providers, Community Mental Health Clinics, and all other Provider types. |
| | Safety | As part of our Provider education, Meridian includes information related to identifying, preventing and Reporting Abuse, Neglect, Exploitation and critical incidents. |
| | Independence | Per our agreement, Meridian makes possible every opportunity to maximize opportunities for on Enrollee's independence in the community by ensuring the coordination of referrals for other necessary services that are not Covered Services, such as supportive housing and other social services. |
| | Responsibility | Meridian is required to maintain a Disease Management Program and with services which provide enrollees self-management education. Our care coordination and member services teams provide enrollees with education on primary prevention and behavioral modifications that emphasize member responsibility for their health. |
| The role of subcontractors if any | Administrative Services | <p>Meridian contracts with Caidan Management Company, LLC (CMC) to perform an array of administrative services which will allow Meridian to provide the services described in the Statement of Work. CMC shares the same parent organization as Meridian and, thus enjoys the efficiencies through integration. Pursuant to an Administrative Services contract, CMC will perform the following services:</p> <ol style="list-style-type: none"> 1.Claims processing and adjudication 2.Member enrollment and eligibility verification 3.Medical management 4.Behavioral health 5.Quality improvement activities 6.Authorizations, denials, and appeals 7.Complaints and grievances 8.Provider recruitment and education 9.Support staff for credentialing activities 10.Member services / call center operations 11.Member compliance program |

C. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS) to provide services for the Seniors and Persons with Disabilities (SPD) population

| Item | Description |
|--------------------------------------|--|
| | <p>12.Risk management 13.Administrative, technical, and day-to-day operational duties 14.Information technology and management services 15.Banking, accounting, and financial matters 16.Support staff for compliance and fraud, waste and abuse activities</p> <p>CMC has been providing the described services for over 15 years to Medicaid and Medicare plans in Michigan, Illinois and Iowa. CMC hires locally-based personnel in each of the states in which it operates and the same will be the case for the 2015 IHQHI.</p> |
| Pharmacy Benefit Management | <p>Meridian contracts with MeridianRx, LLC (MeridianRx), a full-service PBM, to perform pharmacy benefit management services for its membership. Similar to Caidan Management Company, MeridianRx shares the same parent organization as Meridian, which results in superior access to information and a greater overall level of service. MeridianRx maintains a comprehensive national network that covers all 50 States, the District of Columbia, the United States Virgin Islands, American Samoa, the Northern Mariana Islands, Puerto Rico and Guam. The breadth of the MeridianRx network ensures convenient access to prescriptions at deeply discounted rates. MeridianRx uses a variety of tools such as drug utilization review and disease management to encourage the best clinical outcomes for patients. They also provide patient information in multiple formats, including a user-friendly web portal, mailings, newsletters and our award-winning call center. MeridianRx utilizes panels of highly-qualified, independent physicians, pharmacists and other clinical experts to develop lists of drugs approved for reimbursement in order to encourage clinically appropriate and cost-effective prescribing. MeridianRx offers access to highly efficient mail-service pharmacies that safely and accurately supply home-delivered prescriptions at a substantial savings. MeridianRx utilizes cutting-edge e-prescribing technology, which provides physicians with clinical and cost information on prescription options allowing them to better counsel patients on the safest and most affordable medication choices. MeridianRx offers a 24/7 toll-free hotline with access to pharmacy service representatives, provider service representatives and pharmacists to address any client or patient related issues.</p> |
| Non-Emergency Medical Transportation | <p>Meridian subcontracts non-emergency medical transportation services to Logisticare. LogistiCare is a go-between for getting from your house to the doctor's office and back. The company brokers non-emergency transportation services for commercial health plans, government entities (such as state Medicaid agencies), and hospitals throughout the US. Using its nearly 20 call centers and a network of some 1,500 independent, contracted transportation providers, the company coordinates the medical-related travel arrangements of its clients' members. In addition, it contracts with local school boards to coordinate transportation for special needs students. The company provides more than 26 million trips each year for clients in some 40 states. LogistiCare is a subsidiary of Providence Service. Logisticare is</p> |

C. Current Contract between Meridian Health Plan of Illinois, Inc. and the Illinois Department of Healthcare and Family Services (HFS) to provide services for the Seniors and Persons with Disabilities (SPD) population

| Item | Description |
|---|--|
| | responsible for all non-emergent transportation services. |
| Translation Services | Meridian subcontracts with Pan American Languages & Services DBA PALS International (PALS) to provide foreign language translation services. PALS is a woman-owned business that has been operating since 1983. PALS provides written translation services in 170 languages, including Spanish, French, German, English, Arabic, Chinese, Japanese, Korean, Italian, Polish, Russian, Portuguese, and Hmong. Using state-of-the-art computer phone technology with high-quality, professional linguists, PALS are capable of producing unique oral interpretation services of extraordinary speed and reliability. PALS provides immediate 24/7 access to over 150 languages supported by over 1,000 professional, certified linguists within an average connect time of 30 seconds. |
| After-Hours Call Center | Meridian contracts with Tri-Hospital EMS dba Med-Connection to provide after-hours call center services. Med-Connection was founded in 2001 and provides high-quality, customizable call center services to healthcare organizations. Med-Connection maintains stringent hiring guidelines and employs a robust and continuous training program based on health plan needs and requirements. Med-Connection dedicates staff to a single account in order to provide the maximum level of attention to callers. Their focus is on resolving issues in a single call and to the satisfaction of the caller 100% of the time. |
| Dental Services | Meridian Health Plan of Illinois subcontracts to Liberty Dental for the administration of dental benefit services. LIBERTY is a privately held company that specializes in dental only administrative services to over 2 million members across the United States for well over a decade. LIBERTY proudly provides full service administration for some of the Nation's largest (Fortune 100) health plans (MCOs), as well as labor groups, employer groups, and federal, state and local government agencies. |
| Sign Language | Meridian subcontracts with Illinois Language Services for sign language interpretation services. Meridian subcontracts with ABS Translation services for sign language interpretation services. |
| Nurse Advice Line for SPD and MMAI members: | Meridian Health Plan of Illinois subcontracts nurse advice services for members to CareNet. CareNet provides care management programs, such as Nurse Advice, Care Navigation and Post-Discharge Support, provide immediate access to medical information, improving member vitality, satisfaction and resource utilization. And our ER Diversion outreach educates members on alternative options significantly reducing unwarranted ER visits and associated costs. Carenet's live and automated services, such as agentless messaging, ensure your members receive expert care 24x7 via the web, email, chat, phone and SMS text. |

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D. Current Contract between Meridian Health Plan of Iowa, Inc. and Iowa Department of Human Services (DHS) - Iowa Medicaid Enterprise (IME).

| Item | Description |
|---|---|
| <p>Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope);</p> | <p>Through this contract, Meridian Health Plan of Iowa currently administers services for the TANF and Health and Wellness beneficiaries in Iowa. Meridian provides, manages, and coordinates Medicaid covered services to eligible enrollees within the TANF and WELLNESS programs through a network of contracted providers. Eligibility is determined based on income, assets, healthcare needs, family status, and other considerations. The State has sole authority to determine eligibility.</p> <p>Services in Scope</p> <ul style="list-style-type: none"> • Physical Health Services <p>Services Not in Scope</p> <ul style="list-style-type: none"> • Behavioral Health Services • LTSS Services <p>Benefits:</p> <ul style="list-style-type: none"> • Inpatient Hospital services (Inpatient admissions for Substance Abuse and Behavioral Health are carved out and managed by IME and Magellan) • DME • Rehabilitation Services • TANF: Physical/Occupational/Speech/Language Therapies • Wellness: Covers Physical/Occupational/Speech/Language Therapies • Hospice (Requires Prior Auth) • Chiropractic Services • Vision <p>Additional Special Healthcare Programs:</p> <ul style="list-style-type: none"> • Care Coordination • Maternity Care Coordination • Weight Management • Nutritional Counseling |
| <p>Duration of</p> | <p>The term of this Agreement will begin on February 1, 2012 and end June 20, 2016 unless terminated earlier by either party.</p> |

D. Current Contract between Meridian Health Plan of Iowa, Inc. and Iowa Department of Human Services (DHS) - Iowa Medicaid Enterprise (IME).

| Item | Description |
|--|---|
| Contract | |
| Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s); | February 2, 2012-present |
| Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s); | \$42 Million |
| Contact name, phone number, and email address | Elizabeth Matney, Managed Care Director Iowa Medicaid Enterprise 100 Army Post Road Des Moines, IA 50315 515-974-3204 Email: ematney@dhs.state.ia.us |
| Number of members served by population type | TANF (Temporary Assistance for Needy Families): 39,082 WELLNESS (Medicaid Expansion): 13,392 |

D. Current Contract between Meridian Health Plan of Iowa, Inc. and Iowa Department of Human Services (DHS) - Iowa Medicaid Enterprise (IME).

| Item | Description | |
|--|---|--|
| | Total:52,474 | |
| Annual contract payments and description if payment was capitated; | Annual Capitated Payments 2010-N/A 2011- N/A 2012-\$ 8,588,205.00 2013: \$ 57,371,041.00 2014: \$ 141,809,145.00 | |
| Improvements made in utilization trends and quality indicators | Utilization Trends: | <p>Recent Improvements made in Utilization Trends</p> <p>Reduction in Inpatient Facility Utilization: In Quarter 1 of 2012, there were 279 inpatient admissions for TANF members. By Quarter 2 of 2012, the number of inpatient facility admissions fell to only 136 admissions per 1000. This trend remained stable through Quarter 3 of 2014.</p> <p>Reduction in 1-Day DRG Admits: Meridian Health Plan of Iowa experienced a sharp decline in 1-Day DRG admits from Quarter 1 of 2012 (which posted 28 1-Day DRG admits per 1,000 members) to Quarter 3 of 2014, (which posted only 3 per 1,000 Medicaid members)</p> <p>Reduction in 2-Day DRG Admits: The TANF population experienced a decrease throughout the reported months from 28 per 1,000 TANF members in Q1 2012 to 4 per 1,000 in Q3 2014.</p> <p>Lowest Observations per 1,000 members compared to Meridian’s Medicaid plans in Illinois and Michigan Overall Meridian Health Plan of Iowa posted lower observations per 1,000 members compared to Meridian’s other Medicaid plans, the most significant trend was the decrease from Quarter 1 2013 (74 observations per 1,000 members) to Quarter 2, 2014 (50 observations per 1,000 members)</p> <p>Reduction in Emergency Room and Urgent Care visits: -In Quarter 4 2013, Emergency Room and Urgent Care visits per 1000 members was lower than the previous quarter (Quarter 3 2013) as well as the same quarter in the previous year (Q4 2012). The largest decrease is seen when looking at Q4 2012 and Q4 2013, where ER/UC visits per 1000 members decreased by 14.8%.</p> |

D. Current Contract between Meridian Health Plan of Iowa, Inc. and Iowa Department of Human Services (DHS) - Iowa Medicaid Enterprise (IME).

| Item | Description |
|------|---|
| | <p>In comparing Q4 2012 and 2013, the following demographics saw the greatest decrease in ER/UC visits per 1000 members:</p> <p>TANF, Female, 15-20 years old (23% decrease) TANF, 5-14 years old (21% decrease) TANF, 1-4 years old (17% decrease)</p> <p>Reduction in Inpatient Admissions:</p> <p>Inpatient Admissions per 1000 members in Quarter 4 2013 dropped 8.88% from Quarter 4 2012. A significant drop in inpatient admissions occurred between Quarter 3 of 2014 and Quarter 4 of 2014. Inpatient admission dropped 12.51% during this time period. The drop can mainly attribute to the admission per 1000 members for female age group 15 – 20 decreasing for 29% and male age group <1 decreasing for 20%.</p> |
| | <p>Quality Indicators:</p> <p>Scoring for NCQA Accreditation-CAHPS® (Consumer Assessment of Healthcare Providers and Systems) Adult Medicaid measures: Meridian Health Plan of Iowa reached the 90th and 75th percentile for the following measures in 2014(2013 data set):</p> <p>Measures in the 90th Percentile</p> <ul style="list-style-type: none"> • How well doctors communicate • Show respect for what you say • Listen carefully to you • Explain things so you understand • Rating of personal doctor <p>Measures in the 75th Percentile</p> <ul style="list-style-type: none"> • Spent enough time with you • Getting needed care • Appointment with specialists • Discussing Strategies <p>HEDIS® Measures:</p> <p>Meridian Health Plan of Iowa reached the 90th percentile in the following HEDIS® Measures for 2014 (2013 Data Set)</p> <p>Infants were seen by their primary care provider by age 2</p> <ul style="list-style-type: none"> • Pregnant women received timely prenatal care • Diabetic members 18-75 years of age had a HbA1c test during the year • Children received six or more well child visits in the first 15 months of life |

D. Current Contract between Meridian Health Plan of Iowa, Inc. and Iowa Department of Human Services (DHS) - Iowa Medicaid Enterprise (IME).

| Item | Description | |
|---|-------------|---|
| | | <ul style="list-style-type: none"> • Women received appropriate postpartum care • Members had controlled high blood pressure • Diabetic members received an eye exam <p>Maternal and child health is a strong area of focus for Meridian. Care Coordination supports member access to routine prenatal screenings and as well as baby visits following delivery. The following population metrics on accessing care, as determined by HEDIS® measure reporting.</p> <ul style="list-style-type: none"> * Ninety-seven (97) percent of mothers received prenatal care and seventy-five (75) percent receive postpartum care * Eighty (80) percent of children received all ACIP recommended immunizations by age two (2) * Eighty-six (86) percent of children were screened for lead poisoning by age two (2) * Ninety-nine (99) percent of infants were seen by their PCP by age two (2) * There were 228 boarder babies requiring NICU stays greater than three (3) days <ul style="list-style-type: none"> o In 2012, fifteen (15) percent of deliveries resulted in a prolonged NICU stay o In 2013, this rate dropped to eleven point five (11.5) percent o The national average as reported by the March of Dimes ranges between ten (10) to fifteen (15) percent <p>Company Quality Indicators:</p> <ul style="list-style-type: none"> • State representative for Iowa Child Death Review Team • Lead for the Iowa Access to Primary Care Pilot Project • IA ranked 38th among Medicaid plans according to NCQA Health Plan Insurance Rankings 2014-2015 • IA plan accesses 45% of member records through remote or electronic means • IA ranked the #1 Medicaid plans in Iowa according to NCQA Health Plan Insurance Rankings 2014-2015. • Meridian was selected by the National Association for Healthcare Quality for a best practices award, and QI staff presented at the annual conference in Tennessee. |
| How the contract emphasizes member choice, access, safety, independence, and responsibility | Choice | Per our agreement with the Iowa Medicaid enterprise, Meridian allows each new Enrollee the opportunity to choose a PCP to the extent possible and appropriate. Meridian offers our Members freedom of choice in selecting a Primary Care Provider. |
| | Access | As outlined in our agreement Meridian provides coverage for all services covered under the State Plan and assures that Covered Services are available and accessible to Enrollees. Meridian requires its Providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Meridian ensures that our network Providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or comparable to Medicaid fee-for-service, if the Provider serves only Medicaid Enrollees. |

D. Current Contract between Meridian Health Plan of Iowa, Inc. and Iowa Department of Human Services (DHS) - Iowa Medicaid Enterprise (IME).

| Item | Description | |
|-----------------------------------|-------------------------|---|
| | Safety | Because the Iowa Medicaid enterprise takes member safety seriously, The Department may terminate this Contract effective immediately without penalty and without advance notice or opportunity to cure for any of the following reasons: The Department determines or believes the MCO has engaged in conduct that: (1) has or may expose the Department or the State to material liability; or (2) has caused or may cause a person's life, health, or safety to be jeopardized. |
| | Independence | Meridian strives to provide all members the opportunity and resources to maintain a high level of independence. As required by our contract, Meridian provides all enrollees and potential enrollees must with information that any educational material and programs are available in alternative formats and how to access those materials. |
| | Responsibility | As required by our contract, Meridian provides members with a Member Services phone number, website information, member portal, and a live chat program. Our member services representatives educating the family about managed care in general, including the way services typically are accessed under managed care, the role of the Primary Care Provider, the Member's right to choose a Primary Care Provider subject to the capacity of the Provider, the responsibilities of the Enrollee, and the Member's rights to file grievances and appeals and to request a Fair hearing. |
| The role of subcontractors if any | Administrative Services | <p>Meridian contracts with Caidan Management Company, LLC (CMC) to perform an array of administrative services which will allow Meridian to provide the services described in the Statement of Work. CMC shares the same parent organization as Meridian and, thus enjoys the efficiencies through integration. Pursuant to an Administrative Services contract, CMC will perform the following services:</p> <ol style="list-style-type: none"> 1.Claims processing and adjudication 2.Member enrollment and eligibility verification 3.Medical management 4.Behavioral health 5.Quality improvement activities 6.Authorizations, denials, and appeals 7.Complaints and grievances 8.Provider recruitment and education 9.Support staff for credentialing activities 10.Member services / call center operations 11.Member compliance program 12.Risk management 13.Administrative, technical, and day-to-day operational duties 14.Information technology and management services 15.Banking, accounting, and financial matters 16.Support staff for compliance and fraud, waste and abuse activities |

D. Current Contract between Meridian Health Plan of Iowa, Inc. and Iowa Department of Human Services (DHS) - Iowa Medicaid Enterprise (IME).

| Item | Description |
|-------------------------|---|
| | <p>CMC has been providing the described services for over 15 years to Medicaid and Medicare plans in Michigan, Illinois and Iowa. CMC hires locally-based personnel in each of the states in which it operates and the same will be the case for the 2015 IHQHI.</p> |
| After-Hours Call Center | <p>Meridian contracts with Tri-Hospital EMS dba Med-Connection to provide after-hours call center services. Med-Connection was founded in 2001 and provides high-quality, customizable call center services to healthcare organizations. Med-Connection maintains stringent hiring guidelines and employs a robust and continuous training program based on health plan needs and requirements. Med-Connection dedicates staff to a single account in order to provide the maximum level of attention to callers. Their focus is on resolving issues in a single call and to the satisfaction of the caller 100% of the time.</p> |
| Translation Services | <p>Meridian subcontracts with Pan American Languages & Services DBA PALS International (PALS) to provide foreign language translation services. PALS is a woman-owned business that has been operating since 1983. PALS provides written translation services in 170 languages, including Spanish, French, German, English, Arabic, Chinese, Japanese, Korean, Italian, Polish, Russian, Portuguese, and Hmong. Using state-of-the-art computer phone technology with high-quality, professional linguists, PALS are capable of producing unique oral interpretation services of extraordinary speed and reliability. PALS provides immediate 24/7 access to over 150 languages supported by over 1,000 professional, certified linguists within an average connect time of 30 seconds.</p> |

E. Former Contract between Granite Care – Meridian Health Plan of New Hampshire, Inc. and the New Hampshire Department of Health and Human Services

| Item | Description |
|---|---|
| <p>Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope);</p> | <p>Through this former contract, Meridian administered Medicaid covered services to eligible enrollees through a network of providers beginning in 2012.</p> <p>Services in Scope:</p> <ul style="list-style-type: none"> • Physical Health • Behavioral Health (Outpatient/Inpatient services under Age 22) <p>Not in Scope</p> <ul style="list-style-type: none"> • LTSS (Not in Scope) <p>Covered Benefits:</p> <ul style="list-style-type: none"> • Medical and Behavioral Health services covered by Meridian include, but are not limited to, the following: • Inpatient Hospital • Outpatient Hospital • Physicians Services • Advanced Practice Registered Nurse • Rural Health Clinic & FQHC • Prescribed Drugs • Community Mental Health Center Services • Psychology • Psychotherapy • Ambulatory Surgical Center • Laboratory and Pathology • X-Ray Services • Family Planning Services • Medical Services Clinic • Physical Therapy |

E. Former Contract between Granite Care – Meridian Health Plan of New Hampshire, Inc. and the New Hampshire Department of Health and Human Services

| Item | Description |
|--|--|
| | <ul style="list-style-type: none"> • Occupational Therapy • Speech Therapy • Audiology Services • Podiatrist Services • Home Health Services • Private Duty Nursing • Adult Medical Day Care • Personal Care Services • Hospice • Optometric Services Eyeglasses • Furnished Medical Supplies & Durable Medical Equipment • Non-Emergent Medical Transportation • Ambulance Service • Wheelchair Van • Fluoride Varnish by Primary Care Providers • Emergency Care |
| Duration of Contract | <p>This agreement will begin May 09, 2012 through May 09, 2015 unless terminated by either party. *One24-month renewal (Total of 5 years)</p> |
| Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s); | <p>May 09, 2012-July 31, 2014</p> <p>Alterations: Contract was mutually terminated between Meridian Health Plan of New Hampshire and the State of New Hampshire in July 2014.</p> |
| Total value of the | \$16.6 million |

E. Former Contract between Granite Care – Meridian Health Plan of New Hampshire, Inc. and the New Hampshire Department of Health and Human Services

| Item | Description | |
|---|--|---|
| Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s); | | |
| Contact name, phone number, and email address | Walter Faasen, Director of Contracts & Procurement New Hampshire Department of Health and Human Services Brown Building 129 Pleasant Street Concord, NH 03301 (603) 271-7367 email: WFaasen@dhhs.state.nh.us | |
| Number of members served by population type | TANF: 25,263 | |
| Annual contract payments and description if payment was capitated; | Annual Capitated Payments 2010-N/A 2011- N/A 2012- N/A 2013: \$8,588,205 2014: \$63,160,475 | |
| Improvements made in utilization trends and quality indicators | Utilization Trends: | <p>Meridian Health Plan New Hampshire (Granite Care) Utilization trends:</p> <p>Reduction in Inpatient Admissions per 1,000 members: Meridian reduced the number of inpatient admissions per 1,000 members from 96.02 claims per 1,000 in December of 2013 to 75.37 claims per 1,000 in July of 2014.</p> <p>Reduction in Length of Stay (LOS) for both Vaginal and Cesarean Section Deliveries</p> |

E. Former Contract between Granite Care – Meridian Health Plan of New Hampshire, Inc. and the New Hampshire Department of Health and Human Services

| Item | Description | | | | | | | | | | | | | | | | | | | | | | | | |
|---|-------------------------|--|------|------|------|------|--|--|--|----------------|----|----|----|----|---------|------------------|------|------|------|------|------------------|------|------|------|------|
| | | <p>Over a four quarter period beginning in Q4 of 2013 through Q3 of 2014 members delivering over this time period revealed a declining trend in average LOS for delivery services:</p> <table border="1" data-bbox="550 425 1444 589"> <thead> <tr> <th colspan="2"></th> <th>2013</th> <th colspan="3">2014</th> </tr> <tr> <th></th> <th>Admission Type</th> <th>Q4</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> </tr> </thead> <tbody> <tr> <td rowspan="2">Avg LOS</td> <td>Cesarean Section</td> <td>3.41</td> <td>3.16</td> <td>3.49</td> <td>3.27</td> </tr> <tr> <td>Vaginal Delivery</td> <td>2.31</td> <td>2.39</td> <td>2.28</td> <td>2.11</td> </tr> </tbody> </table> | | | 2013 | 2014 | | | | Admission Type | Q4 | Q1 | Q2 | Q3 | Avg LOS | Cesarean Section | 3.41 | 3.16 | 3.49 | 3.27 | Vaginal Delivery | 2.31 | 2.39 | 2.28 | 2.11 |
| | | | 2013 | 2014 | | | | | | | | | | | | | | | | | | | | | |
| | Admission Type | Q4 | Q1 | Q2 | Q3 | | | | | | | | | | | | | | | | | | | | |
| Avg LOS | Cesarean Section | 3.41 | 3.16 | 3.49 | 3.27 | | | | | | | | | | | | | | | | | | | | |
| | Vaginal Delivery | 2.31 | 2.39 | 2.28 | 2.11 | | | | | | | | | | | | | | | | | | | | |
| | Quality Indicators: | <p>Meridian participates in annual NCQA Quality Compass reporting, which includes annual submission of HEDIS® and CAHPS® data for Medicaid plans. Plans must be operational with active, continuous enrollment for approximately two years before an adequate population is attained. NCQA technical specifications for most HEDIS® measures require a minimum of one year of continuous enrollment. This requirement was not met for the Medicaid plan operating in New Hampshire; therefore, Meridian does not have adequate HEDIS® measure data to support quality improvement initiatives in that state.</p> | | | | | | | | | | | | | | | | | | | | | | | |
| How the contract emphasizes member choice, access, safety, independence, and responsibility | Choice | As required by our agreement, Meridian allows each member to choose his or her health professional to the extent possible and appropriate. | | | | | | | | | | | | | | | | | | | | | | | |
| | Access | Meridian’s network maintains providers in sufficient numbers, and with sufficient capacity and expertise for all covered services and for timely provision of services and reasonable choice by members to meet their needs. | | | | | | | | | | | | | | | | | | | | | | | |
| | Safety | DHHS shall have the right to terminate this Agreement, without liability to the State, in whole or in part if Meridian takes any action or fails to prevent an action that threatens the health, safety or welfare of any member, including significant marketing abuses. Meridian is required to ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements. | | | | | | | | | | | | | | | | | | | | | | | |
| | Independence | Each managed care member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand; Each managed care member is guaranteed the right to participate in decisions regarding his/her health care, including the right to refuse treatment; | | | | | | | | | | | | | | | | | | | | | | | |
| | Responsibility | Meridian is required, as outlined in our agreement to develop and initiate a member health education program that supports the overall wellness, prevention, and care management programs, with the goal of empowering patients to actively participate in their healthcare. | | | | | | | | | | | | | | | | | | | | | | | |
| The role of subcontractors if any | Administrative Services | Meridian contracts with Caidan Management Company, LLC (CMC) to perform an array of administrative services which will allow Meridian to provide the services described in the Statement of Work. CMC shares the same parent organization as Meridian and, thus enjoys the efficiencies through integration. Pursuant to an Administrative Services contract, CMC | | | | | | | | | | | | | | | | | | | | | | | |

E. Former Contract between Granite Care – Meridian Health Plan of New Hampshire, Inc. and the New Hampshire Department of Health and Human Services

| Item | Description |
|-----------------------------|--|
| | <p>will perform the following services:</p> <ol style="list-style-type: none"> 1. Claims processing and adjudication 2. Member enrollment and eligibility verification 3. Medical management 4. Behavioral health 5. Quality improvement activities 6. Authorizations, denials, and appeals 7. Complaints and grievances 8. Provider recruitment and education 9. Support staff for credentialing activities 10. Member services / call center operations 11. Member compliance program 12. Risk management 13. Administrative, technical, and day-to-day operational duties 14. Information technology and management services 15. Banking, accounting, and financial matters 16. Support staff for compliance and fraud, waste and abuse activities <p>CMC has been providing the described services for over 15 years to Medicaid and Medicare plans in Michigan, Illinois and Iowa. CMC hires locally-based personnel in each of the states in which it operates and the same will be the case for the 2015 IHQHI.</p> |
| Pharmacy Benefit Management | <p>Meridian contracts with MeridianRx, LLC (MeridianRx), a full-service PBM, to perform pharmacy benefit management services for its membership. Similar to Caidan Management Company, MeridianRx shares the same parent organization as Meridian, which results in superior access to information and a greater overall level of service. MeridianRx maintains a comprehensive national network that covers all 50 States, the District of Columbia, the United States Virgin Islands, American Samoa, the Northern Mariana Islands, Puerto Rico and Guam. The breadth of the MeridianRx network ensures convenient access to prescriptions at deeply discounted rates. MeridianRx uses a variety of tools such as drug utilization review and disease management to encourage the best clinical outcomes for patients. They also provide patient information in multiple formats, including a user-friendly web portal, mailings, newsletters and our award-winning call center. MeridianRx utilizes panels of highly-qualified, independent physicians, pharmacists and other clinical experts to develop lists of drugs approved for reimbursement in order to encourage clinically appropriate and cost-effective</p> |

E. Former Contract between Granite Care – Meridian Health Plan of New Hampshire, Inc. and the New Hampshire Department of Health and Human Services

| Item | Description |
|--------------------------------------|---|
| | <p>prescribing. MeridianRx offers access to highly efficient mail-service pharmacies that safely and accurately supply home-delivered prescriptions at a substantial savings. MeridianRx utilizes cutting-edge e-prescribing technology, which provides physicians with clinical and cost information on prescription options allowing them to better counsel patients on the safest and most affordable medication choices. MeridianRx offers a 24/7 toll-free hotline with access to pharmacy service representatives, provider service representatives and pharmacists to address any client or patient related issues.</p> |
| Coordination of Benefits | <p>Meridian subcontracts with HMS, Inc. (HMS) for assistance with coordination of benefits and third-party recoveries. HMS has 25 years of practical experience and a host of services available to help government-funded healthcare payor programs, such as Medicaid, uncover healthcare benefits available to their beneficiaries so that these programs can coordinate healthcare benefits properly and recover claims that were paid erroneously. HMS’s COB-related services include the following:</p> <ul style="list-style-type: none"> • Other coverage identification and recovery • Cost avoidance • Case management and systems • Child support • Military services <p>HMS applies proven data mining techniques to locate valid other coverage available to healthcare program beneficiaries, and can pursue recoveries for healthcare overpayments or claims that were paid inappropriately.</p> |
| Non-Emergency Medical Transportation | <p>Meridian subcontracts non-emergency medical transportation services to Access2Care fka TMS Management Group, Inc. LogistiCare is the leading provider of outsourced transportation management programs to managed care organizations. Logisticare is experienced in utilizing our network of local transportation companies to provide reliable and timely service to a plan's Medicaid and/or Medicare members. The managed care organization receives the benefit and simplicity of having one transportation contract to provide a wide range of transportation options (livery, mobility assisted, stretcher, ambulance, air) without the risks of relying on only one transportation source.</p> |
| Translation Services | <p>Meridian subcontracts with Pan American Languages & Services DBA PALS International (PALS) to provide foreign language translation services. PALS is a woman-owned business that has been operating since 1983. PALS provides written translation services in 170 languages, including Spanish, French, German, English, Arabic, Chinese, Japanese, Korean, Italian, Polish, Russian, Portuguese, and Hmong. Using state-of-the-art computer phone technology with high-quality, professional linguists, PALS are capable of producing unique oral interpretation services of extraordinary speed and reliability. PALS provides immediate 24/7 access to over 150 languages supported by over 1,000 professional, certified linguists within an average connect time of 30 seconds.</p> |
| After-Hours | <p>Meridian contracts with Tri-Hospital EMS dba Med-Connection to provide after-hours call center services. Med-</p> |

E. Former Contract between Granite Care – Meridian Health Plan of New Hampshire, Inc. and the New Hampshire Department of Health and Human Services

| Item | Description | |
|------|--------------------|---|
| | Call Center | Connection was founded in 2001 and provides high-quality, customizable call center services to healthcare organizations. Med-Connection maintains stringent hiring guidelines and employs a robust and continuous training program based on health plan needs and requirements. Med-Connection dedicates staff to a single account in order to provide the maximum level of attention to callers. Their focus is on resolving issues in a single call and to the satisfaction of the caller 100% of the time. |
| | Claims Recovery | Meridian subcontracts with First Recovery Group (FRG) for claims recovery services. FRG is the largest independent healthcare cost management company focused solely on subrogation claims recovery. FRG represents HMOs, TPAs, insurance companies, self-insured corporations, PHOs, IPAs, and MSOs that cover over six million lives nationwide. FRG receives a data feed of all paid claims from a healthcare payor and, using its exclusive SubroMAX® system, analyzes ICD-9 codes, CPT codes and episodes of care, to identify cases with recovery potential. They are also able to search court records, insurance databases, and workers compensation records. |
| | Utilization Review | Meridian subcontracts utilization management and review services to American Medical Response (AMR). AMR is a medical transportation company in the United States that serves more than 2,100 communities in 40 states plus the District of Columbia, and provides more than 3 million emergency and non-emergency patient transports each year. As an employer of more than 18,000 paramedics, emergency medical technicians (EMTs), nurses, doctors and support staff, AMR provides emergency response and dispatch services, air ambulance services, event medical services, managed transportation services and paramedic and EMT training. |
| | Sign Language: | Meridian subcontracts with Lutheran Social Services for sign language interpretation services. |

F. Meridian Complete-Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The State of Michigan and Meridian Health Plan of Michigan, Inc.

| Item | Description |
|---|---|
| <p>Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope);</p> | <p>This current contract is a Joint program between the Centers for Medicare & Medicaid Services (CMS) and the State of Michigan Department of Community Health (MDCH).</p> <p>Through this current contract, Meridian administers services for eligible persons meeting the following criteria: Age 21 or older at the time of enrollment; Eligible for full benefits under Medicare Part A, and enrolled under Parts Band D, and receiving full Medicaid benefits. (This includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a nursing facility and have a monthly PPA); and Reside in a Demonstration region.</p> <p>Services in Scope:</p> <ul style="list-style-type: none"> • Physical Health Services • LTSS <p>Services Out of Scope</p> <ul style="list-style-type: none"> • Behavioral Health: Services carved out to PIHP provider <p>Covered Benefits:</p> <ul style="list-style-type: none"> • All State Plan Services • All services Provided under Medicare Part A • All services Provided under Medicare Part B • All Services provided under Part D • Palliative Care • OTC • Barbiturates for indications not covered by Part D • Prescription Vitamins and Minerals • Waiver and Supplemental Benefits: • Adaptive Medical Equipment • Adult Day Program • Assistive Technology • Chore Services • Expanded Community Living Supports • Community Transition Services |

F. Meridian Complete-Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The State of Michigan and Meridian Health Plan of Michigan, Inc.

| Item | Description |
|--|---|
| | <ul style="list-style-type: none"> • Environmental Modifications • Home Delivered Meals • NEMT • Personal Emergency Response System • Preventive Nursing Services • Private Duty Nursing • Respite |
| Duration of Contract | This Agreement will begin on March 1, 2015 through December 31 st , 2015 unless terminated by either party. The contract may be renewed for One-year terms through December 31,2017 |
| Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s); | March 1, 2015-present |
| Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s); | \$33,600 |
| Contact name, | Susan Yontz, Director |

F. Meridian Complete-Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The State of Michigan and Meridian Health Plan of Michigan, Inc.

| Item | Description | |
|---|---|---|
| phone number, and email address | Integrated Care Division Medical Services Administration MDCH PO Box 30479 Lansing, MI 48909-7979 yontzs@2michigan.gov | |
| Number of members served by population type | Medicare Medicaid Alignment Initiative: 73 | |
| Annual contract payments and description if payment was capitated; | Annual Capitated Payments: 2010: No Contract 2011: No Contract 2012: No Contract 2013: No Contract 2014: No Contract 2015: March-\$2,868.00 | |
| Improvements made in utilization trends and quality indicators | Utilization Trends: | Meridian Health Plan of Michigan began this program in March of 2015. Utilization data is too limited to create a fair trend analysis. |
| | Quality Indicators: | Meridian participates in annual NCQA Quality Compass reporting, which includes annual submission of HEDIS® and CAHPS® data for Medicaid plans. Plans must be operational with active, continuous enrollment for approximately two years before an adequate population is attained. NCQA technical specifications for most HEDIS® measures require a minimum of one year of continuous enrollment. This requirement was not met for the Medicare Medicaid Alignment Initiative administered by Meridian Health Plan of Michigan; therefore, Meridian does not have adequate HEDIS® measure data to support quality improvement initiatives for this population group at this time. |
| How the contract emphasizes member choice, access, safety, independence, and responsibility | Choice | As outlined within the contract, Enrollees must be assured choice of all Providers, including Meridian’s Care Coordination team and others that will participate in their Interdisciplinary Care Team. The ICT will honor the Enrollee's choice about his or her level of participation. This choice will be revisited periodically by the Meridian Care Coordinator as it may change. |
| | Access | As outlined within the contract, Meridian must reasonably accommodate persons and shall ensure that the programs and services are as accessible (including physical and geographic access) to an individual with disabilities as they are to an individual without disabilities. Meridian and its network providers must comply with the American with Disabilities Act (ADA) as outlined in Section 2.8.12.1 of this Contract. Meridian has written policies and procedures to assure compliance, |

F. Meridian Complete-Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The State of Michigan and Meridian Health Plan of Michigan, Inc.

| Item | Description | |
|-----------------------------------|-------------------------|---|
| | | including ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all Covered Services from Meridian. |
| | Safety | As outlined within the contract, both CMS and MDCH shall retain discretion to take immediate action where the health, safety or welfare of any Enrollee is imperiled or where significant financial risk is indicated. |
| | Independence | As required by the contract, Meridian has developed and implemented a strategy to manage the Provider Network with a focus on access to services for Enrollees, quality, consistent practice patterns, recovery and resilience, Independent Living Philosophy, Cultural Competence, integration and cost effectiveness. The management strategy addresses all providers. |
| | Responsibility | As prescribed within this contract, Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. |
| The role of subcontractors if any | Administrative Services | <p>Meridian contracts with Caidan Management Company, LLC (CMC) to perform an array of administrative services which will allow Meridian to provide the services described in the Statement of Work. CMC shares the same parent organization as Meridian and, thus enjoys the efficiencies through integration. Pursuant to an Administrative Services contract, CMC will perform the following services:</p> <ol style="list-style-type: none"> 1.Claims processing and adjudication 2.Member enrollment and eligibility verification 3.Medical management 4.Behavioral health 5.Quality improvement activities 6.Authorizations, denials, and appeals 7.Complaints and grievances 8.Provider recruitment and education 9.Support staff for credentialing activities 10.Member services / call center operations 11.Member compliance program 12.Risk management 13.Administrative, technical, and day-to-day operational duties 14.Information technology and management services 15.Banking, accounting, and financial matters 16.Support staff for compliance and fraud, waste and abuse activities |

F. Meridian Complete-Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The State of Michigan and Meridian Health Plan of Michigan, Inc.

| Item | Description |
|-----------------------------|--|
| | <p>CMC has been providing the described services for over 15 years to Medicaid and Medicare plans in Michigan, Illinois and Iowa. CMC hires locally-based personnel in each of the states in which it operates and the same will be the case for the 2015 IHQHI.</p> |
| Pharmacy Benefit Management | <p>Meridian contracts with MeridianRx, LLC (MeridianRx), a full-service PBM, to perform pharmacy benefit management services for its membership. Similar to Caidan Management Company, MeridianRx shares the same parent organization as Meridian, which results in superior access to information and a greater overall level of service. MeridianRx maintains a comprehensive national network that covers all 50 States, the District of Columbia, the United States Virgin Islands, American Samoa, the Northern Mariana Islands, Puerto Rico and Guam. The breadth of the MeridianRx network ensures convenient access to prescriptions at deeply discounted rates. MeridianRx uses a variety of tools such as drug utilization review and disease management to encourage the best clinical outcomes for patients. They also provide patient information in multiple formats, including a user-friendly web portal, mailings, newsletters and our award-winning call center. MeridianRx utilizes panels of highly-qualified, independent physicians, pharmacists and other clinical experts to develop lists of drugs approved for reimbursement in order to encourage clinically appropriate and cost-effective prescribing. MeridianRx offers access to highly efficient mail-service pharmacies that safely and accurately supply home-delivered prescriptions at a substantial savings. MeridianRx utilizes cutting-edge e-prescribing technology, which provides physicians with clinical and cost information on prescription options allowing them to better counsel patients on the safest and most affordable medication choices. MeridianRx offers a 24/7 toll-free hotline with access to pharmacy service representatives, provider service representatives and pharmacists to address any client or patient related issues.</p> |
| Coordination of Benefits | <p>Meridian subcontracts with HMS, Inc. (HMS) for assistance with coordination of benefits and third-party recoveries. HMS has 25 years of practical experience and a host of services available to help government-funded healthcare payor programs, such as Medicaid, uncover healthcare benefits available to their beneficiaries so that these programs can coordinate healthcare benefits properly and recover claims that were paid erroneously.</p> <p>HMS's COB-related services include the following:</p> <ul style="list-style-type: none"> • Other coverage identification and recovery • Cost avoidance • Case management and systems • Child support • Military services <p>HMS applies proven data mining techniques to locate valid other coverage available to healthcare program beneficiaries, and can pursue recoveries for healthcare overpayments or claims that were paid inappropriately.</p> |
| Non- | <p>Meridian subcontracts non-emergency medical transportation services to Access2Care fka TMS Management Group, Inc.</p> |

F. Meridian Complete-Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The State of Michigan and Meridian Health Plan of Michigan, Inc.

| Item | Description |
|----------------------------------|--|
| Emergency Medical Transportation | LogistiCare is the leading provider of outsourced transportation management programs to managed care organizations. Logisticare is experienced in utilizing our network of local transportation companies to provide reliable and timely service to a plan's Medicaid and/or Medicare members. The managed care organization receives the benefit and simplicity of having one transportation contract to provide a wide range of transportation options (livery, mobility assisted, stretcher, ambulance, air) without the risks of relying on only one transportation source. |
| Translation Services | Meridian subcontracts with Pan American Languages & Services DBA PALS International (PALS) to provide foreign language translation services. PALS is a woman-owned business that has been operating since 1983. PALS provides written translation services in 170 languages, including Spanish, French, German, English, Arabic, Chinese, Japanese, Korean, Italian, Polish, Russian, Portuguese, and Hmong. Using state-of-the-art computer phone technology with high-quality, professional linguists, PALS are capable of producing unique oral interpretation services of extraordinary speed and reliability. PALS provides immediate 24/7 access to over 150 languages supported by over 1,000 professional, certified linguists within an average connect time of 30 seconds. |
| After-Hours Call Center | Meridian contracts with Tri-Hospital EMS dba Med-Connection to provide after-hours call center services. Med-Connection was founded in 2001 and provides high-quality, customizable call center services to healthcare organizations. Med-Connection maintains stringent hiring guidelines and employs a robust and continuous training program based on health plan needs and requirements. Med-Connection dedicates staff to a single account in order to provide the maximum level of attention to callers. Their focus is on resolving issues in a single call and to the satisfaction of the caller 100% of the time. |
| Claims Recovery | Meridian subcontracts with First Recovery Group (FRG) for claims recovery services. FRG is the largest independent healthcare cost management company focused solely on subrogation claims recovery. FRG represents HMOs, TPAs, insurance companies, self-insured corporations, PHOs, IPAs, and MSOs that cover over six million lives nationwide. FRG receives a data feed of all paid claims from a healthcare payor and, using its exclusive SubroMAX® system, analyzes ICD-9 codes, CPT codes and episodes of care, to identify cases with recovery potential. They are also able to search court records, insurance databases, and workers compensation records. |
| Behavioral Health Services | Meridian subcontracts with Southwest Michigan Behavioral Health for the deliver y of behavioral health services for the MI Health Link population. SWMBH is one of Michigan’s ten Medicaid Prepaid Inpatient Health Plans, responsible for benefits management in eight counties – Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren. |
| Sign Language: | Meridian subcontracts with Lutheran Social Services for sign language interpretation services. |

G. Meridian Complete-Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The State of Illinois Department of Healthcare and Family Services and Meridian Health Plan of Illinois, Inc.

| Item | Description |
|---|---|
| <p>Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope);</p> | <p>This is a Joint program between the Centers for Medicare & Medicaid Services (CMS) and the State of Illinois (HFS) and Meridian Health Plan of Illinois. Through this current contract, Meridian administers benefits for enrollees who are 21 years and older entitled to benefits under Medicare Part A, enrolled under Medicare Parts B receive full Medicaid benefits, live within the Service Area of Cook, DuPage, Kane, Lake & Will counties, and those receiving HCBS waivers or individuals with End Stage Renal Disease (ESRD) at the time of enrollment.</p> <p>Services in Scope:</p> <ul style="list-style-type: none"> • Physical Health • Behavioral Health: (Inpatient and Outpatient services including sub-acute alcohol and substance abuse services are covered once every 60 days for adults 21 years and older) • LTSS <p>Covered Services:</p> <ul style="list-style-type: none"> • All Services Provided under Illinois State Plan services • All State Plan Services • All services Provided under Medicare Part A • All services Provided under Medicare Part B • All Services provided under Part D <p>Waiver Benefits and Supplemental Benefits also included:</p> <ul style="list-style-type: none"> • Adult Day Service • Adult Day Service Transportation • Environmental Accessibility • Supported Employment • Home Health Aide • Intermittent Nursing • Skilled Nursing • Occupational Therapy • Physical Therapy • Speech Therapy • Prevocational Services |

G. Meridian Complete-Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The State of Illinois Department of Healthcare and Family Services and Meridian Health Plan of Illinois, Inc.

| Item | Description |
|--|--|
| | <ul style="list-style-type: none"> • Habilitation • Homemaker • Home Delivered Meals • Personal Assistant • Personal Emergency Response System • Respite • Specialized Medical Equipment and Supplies • Behavioral Services (M.A and P.H.D) • Assisted Living |
| Duration of Contract | This Agreement will begin on November 1, 2013 through December 31 st , 2015 |
| Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s); | November 1, 2013-present |
| Total Value of the contract at the time it was executed | \$13.2 million |
| Contact name and phone number | Lauren Tomko Illinois Department of Healthcare and Family Services |

G. Meridian Complete-Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The State of Illinois Department of Healthcare and Family Services and Meridian Health Plan of Illinois, Inc.

| Item | Description | |
|---|--|---|
| | Bureau of Managed Care 201 South Grand Avenue East Springfield, IL 62763 217-524-7478 email: Lauren.tomko@illinois.gov | |
| Number of members served by population type | MMAI: 9446 | |
| Annual Contract payments | 2010: N/A 2011: N/A 2012: N/A 2013: N/A 2014: \$13,202,368.54 | |
| Improvements made in utilization trends and quality indicators | Utilization Trends | Meridian Health Plan of Illinois began this Medicare Medicaid Alignment Initiative on November 1, 2013. Utilization data is too limited to create a fair trend analysis. |
| | Quality Indicators | Meridian participates in annual NCQA Quality Compass reporting, which includes annual submission of HEDIS® and CAHPS® data for Medicaid plans. Plans must be operational with active, continuous enrollment for approximately two years before an adequate population is attained. NCQA technical specifications for most HEDIS® measures require a minimum of one year of continuous enrollment. This requirement was not met for the Medicare Medicaid Alignment Initiative administered by Meridian Health Plan of Illinois; therefore, Meridian does not have adequate HEDIS® measure data to support quality improvement initiatives for this population group at this time |
| How the contract emphasizes member choice, access, safety, independence, and responsibility | Choice | As outlined in our agreement, Meridian must provide services to Enrollees as follows: Offer adequate choice and availability of primary, specialty, acute care, behavioral health and long term services and support Providers that meet CMS and the Department standards. |
| | Access | Meridian is required by our agreement, to reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical and geographic access) to an individual with disabilities as they are to an individual without disabilities. The Contractor and its Network Providers must comply with the ADA and 504 of the Rehabilitation Act of 1973 and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees. Meridian maintains written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all Covered Services from Meridian. |

G. Meridian Complete-Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The State of Illinois Department of Healthcare and Family Services and Meridian Health Plan of Illinois, Inc.

| Item | Description | |
|-----------------------------------|-------------------------|--|
| | Safety | Meridian complies with all health, safety and welfare monitoring and reporting required by State or federal statute or regulation, or that is otherwise a condition for a HCBS Waiver, including, but not limited to, the following: critical incident reporting regarding Abuse, Neglect, and exploitation; critical incident reporting regarding any incident that has the potential to place an Enrollee, or an Enrollee's services, at risk, but which does not rise to the level of Abuse, Neglect, or exploitation; and performance measures relating to the areas of health, safety and welfare and required for operating and maintaining a HCBS Waiver. |
| | Independence | Meridian strives to provide members with the highest level of independence. As outlined in our agreement, Meridian will support the Enrollee in actively participating in the development of the Enrollee Care Plan. Meridian will also encourage Providers to support Enrollee in directing their own care and Enrollee Care Plan development. This will include giving PCPs a copy of the Enrollee Care Plan. |
| | Responsibility | As required by contract, Enrollees must be guaranteed: The right to participate in all aspects of care and to exercise all rights of appeal. Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. |
| The role of subcontractors if any | Administrative Services | <p>Meridian contracts with Caidan Management Company, LLC (CMC) to perform an array of administrative services which will allow Meridian to provide the services described in the Statement of Work. CMC shares the same parent organization as Meridian and, thus enjoys the efficiencies through integration. Pursuant to an Administrative Services contract, CMC will perform the following services:</p> <ol style="list-style-type: none"> 1.Claims processing and adjudication 2.Member enrollment and eligibility verification 3.Medical management 4.Behavioral health 5.Quality improvement activities 6.Authorizations, denials, and appeals 7.Complaints and grievances 8.Provider recruitment and education 9.Support staff for credentialing activities 10.Member services / call center operations 11.Member compliance program 12.Risk management 13.Administrative, technical, and day-to-day operational duties |

G. Meridian Complete-Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The State of Illinois Department of Healthcare and Family Services and Meridian Health Plan of Illinois, Inc.

| Item | Description |
|-----------------------------|--|
| | <p>14.Information technology and management services 15.Banking, accounting, and financial matters 16.Support staff for compliance and fraud, waste and abuse activities</p> <p>CMC has been providing the described services for over 15 years to Medicaid and Medicare plans in Michigan, Illinois and Iowa. CMC hires locally-based personnel in each of the states in which it operates and the same will be the case for the 2015 IHQHI.</p> |
| Pharmacy Benefit Management | <p>Meridian contracts with MeridianRx, LLC (MeridianRx), a full-service PBM, to perform pharmacy benefit management services for its membership. Similar to Caidan Management Company, MeridianRx shares the same parent organization as Meridian, which results in superior access to information and a greater overall level of service. MeridianRx maintains a comprehensive national network that covers all 50 States, the District of Columbia, the United States Virgin Islands, American Samoa, the Northern Mariana Islands, Puerto Rico and Guam. The breadth of the MeridianRx network ensures convenient access to prescriptions at deeply discounted rates. MeridianRx uses a variety of tools such as drug utilization review and disease management to encourage the best clinical outcomes for patients. They also provide patient information in multiple formats, including a user-friendly web portal, mailings, newsletters and our award-winning call center. MeridianRx utilizes panels of highly-qualified, independent physicians, pharmacists and other clinical experts to develop lists of drugs approved for reimbursement in order to encourage clinically appropriate and cost-effective prescribing. MeridianRx offers access to highly efficient mail-service pharmacies that safely and accurately supply home-delivered prescriptions at a substantial savings. MeridianRx utilizes cutting-edge e-prescribing technology, which provides physicians with clinical and cost information on prescription options allowing them to better counsel patients on the safest and most affordable medication choices. MeridianRx offers a 24/7 toll-free hotline with access to pharmacy service representatives, provider service representatives and pharmacists to address any client or patient related issues.</p> |
| Coordination of Benefits | <p>Meridian subcontracts with HMS, Inc. (HMS) for assistance with coordination of benefits and third-party recoveries. HMS has 25 years of practical experience and a host of services available to help government-funded healthcare payor programs, such as Medicaid, uncover healthcare benefits available to their beneficiaries so that these programs can coordinate healthcare benefits properly and recover claims that were paid erroneously.</p> <p>HMS's COB-related services include the following:</p> <ul style="list-style-type: none"> • Other coverage identification and recovery • Cost avoidance • Case management and systems • Child support • Military services |

G. Meridian Complete-Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The State of Illinois Department of Healthcare and Family Services and Meridian Health Plan of Illinois, Inc.

| Item | Description |
|--------------------------------------|--|
| | HMS applies proven data mining techniques to locate valid other coverage available to healthcare program beneficiaries, and can pursue recoveries for healthcare overpayments or claims that were paid inappropriately. |
| Non-Emergency Medical Transportation | Meridian subcontracts non-emergency medical transportation services to Access2Care fka TMS Management Group, Inc. LogistiCare is the leading provider of outsourced transportation management programs to managed care organizations. Logisticare is experienced in utilizing our network of local transportation companies to provide reliable and timely service to a plan's Medicaid and/or Medicare members. The managed care organization receives the benefit and simplicity of having one transportation contract to provide a wide range of transportation options (livery, mobility assisted, stretcher, ambulance, air) without the risks of relying on only one transportation source. |
| Translation Services | Meridian subcontracts with Pan American Languages & Services DBA PALS International (PALS) to provide foreign language translation services. PALS is a woman-owned business that has been operating since 1983. PALS provides written translation services in 170 languages, including Spanish, French, German, English, Arabic, Chinese, Japanese, Korean, Italian, Polish, Russian, Portuguese, and Hmong. Using state-of-the-art computer phone technology with high-quality, professional linguists, PALS are capable of producing unique oral interpretation services of extraordinary speed and reliability. PALS provides immediate 24/7 access to over 150 languages supported by over 1,000 professional, certified linguists within an average connect time of 30 seconds. |
| After-Hours Call Center | Meridian contracts with Tri-Hospital EMS dba Med-Connection to provide after-hours call center services. Med-Connection was founded in 2001 and provides high-quality, customizable call center services to healthcare organizations. Med-Connection maintains stringent hiring guidelines and employs a robust and continuous training program based on health plan needs and requirements. Med-Connection dedicates staff to a single account in order to provide the maximum level of attention to callers. Their focus is on resolving issues in a single call and to the satisfaction of the caller 100% of the time. |
| Claims Recovery | Meridian subcontracts with First Recovery Group (FRG) for claims recovery services. FRG is the largest independent healthcare cost management company focused solely on subrogation claims recovery. FRG represents HMOs, TPAs, insurance companies, self-insured corporations, PHOs, IPAs, and MSOs that cover over six million lives nationwide. FRG receives a data feed of all paid claims from a healthcare payor and, using its exclusive SubroMAX® system, analyzes ICD-9 codes, CPT codes and episodes of care, to identify cases with recovery potential. They are also able to search court records, insurance databases, and workers compensation records. |
| Sign Language: | Meridian subcontracts with Lutheran Social Services for sign language interpretation services. |

H. Dual Eligible Special Needs Plan Coordination Agreement between Michigan Department of Community Health and Meridian Advantage Plan of Michigan, Inc.

***Also serving members in Lucas County Ohio under this contract**

| Item | Description |
|---|---|
| <p>Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope);</p> | <p>Through this current contract, Meridian administers a Dual Eligible Special Needs Plan, Meridian Advantage Plan.</p> <p>Services In Scope:</p> <ul style="list-style-type: none"> • Physical Health Services • Behavioral Health (Outpatient Mental Health and Substance Abuse/Individual and Group Therapy) <p>Services out of Scope:</p> <ul style="list-style-type: none"> • LTSS <p>Covered Services:</p> <ul style="list-style-type: none"> • Ambulatory Surgical Center • Public Health & Mental Health Clinics • FQHC • Inpatient Hospital Services • Outpatient Hospital Services • Chiropractor Services • Dental Services (Limited to Service to relieve pain or infection/Emergency Diagnostic preventive and therapeutic services for dental disease which I left untreated would become acute dental problem) • Nurse Midwife Services • Nurse practitioner services • Optometrist Services • Physician Services • Podiatrist Services • Prescription Drugs • Therapies: Speech, Occupational and Physical • Eyeglasses • Ambulance (Medically Necessary) • Targeted Case Management • Home Health-Intermittent skilled home care services-Medicare service coverage |

| H. Dual Eligible Special Needs Plan Coordination Agreement between Michigan Department of Community Health and Meridian Advantage Plan of Michigan, Inc. *Also serving members in Lucas County Ohio under this contract | |
|--|--|
| Item | Description |
| | <ul style="list-style-type: none"> • Inpatient Psychiatric services (under 21) • SNF- 100 days for each benefit period |
| Duration of Contract | <p>This Agreement shall replace and supersede that certain Dual Eligible Special Needs Plan Coordination Agreement executed by the Michigan Department of Community Health on February 2, 2010. All other agreements between the parties shall remain intact.</p> <p>The initial term of this Agreement will begin on May 1, 2012 (the "Effective Date") and end on December 31, 2013. Upon expiration of the initial term, the term of this Agreement shall automatically renew for successive twelve (12) month renewal terms on each applicable January 1, unless either Party provides the other with written notice of nonrenewal no later than October 1st of the previous year.</p> |
| Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s); | May 1, 2012-present |
| Total Value of the contract at the time it was executed | \$2.5 million |
| Contact name and phone number | Stacey Duncan-Jackson Managed Care Plan Division 400 S. Pine Street Capitol Common Center Lansing, Michigan 48933 |

H. Dual Eligible Special Needs Plan Coordination Agreement between Michigan Department of Community Health and Meridian Advantage Plan of Michigan, Inc.
***Also serving members in Lucas County Ohio under this contract**

| Item | Description | |
|--|---|--|
| | Fax: 517-241-8231 Email: duncanjacksons@michigan.gov | |
| Number of members served by population type | Dual Eligible Special Needs Plan: 2,211 | |
| Annual contract payments and description if payment was capitated; | 2010: No Contract 2011: \$851,296 2012: \$6,917,398 2013: \$ 11,281,055 2014: \$ 26,669,998 | |
| Improvements made in utilization trends and quality indicators | Utilization Trends | Recent Improvements made in Utilization Trends Reduction in Inpatient Admissions for MI Dual Eligible Special Needs Plan Members (D-SNP) per 1000 members Between Quarter 2 of 2012 and Quarter 4 of 2012 Meridian reduced D-SNP inpatient admissions from 450 per 1000 members to 300 per 1000 members Reduction in 1-Day DRG Admits per 1,000 members (Includes our D-SNP and MAPD population) The overall population 1-Day admits per 1,000 decreased between Quarter 3 2013 (59 per 1,000) to Quarter 3 2014 (38 per1,000) Reduction in 2-Day DRG admissions per 1,000 members (Includes D-SNP and MAPD populations) For both the D-SNP and MAPD populations there was a decrease in 2-Day DRG admits from 98 per 1000 in Quarter 2 2014 to 40 per 1000 members in Quarter 3 2014. Reduction in D-SNP ER/UC visits per 1000 members From Quarter 1 of 2012 to Quarter 4 of 2012 D-SNP ER/UC visits declined from 1804 visits per 1000 members to 797 visits per 1000 members |

H. Dual Eligible Special Needs Plan Coordination Agreement between Michigan Department of Community Health and Meridian Advantage Plan of Michigan, Inc.

***Also serving members in Lucas County Ohio under this contract**

| Item | Description | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--------------------|--|------|------|------|-------|------|--|--------------|--------|------|--|------|--|------|--|------|------|------|------|------|------|---|----|---|-----|-----|---|-----|---|--|----|---|-----|-----|---|-----|---|---|----|---|-----|-----|---|-----|---|-----------------------|----|--|--|--|--|-------|---|
| | Quality Indicators | <p>Meridian’s Michigan D-SNP plan received the following CMS Star-Ratings from year 2013-2015 for these critical measures:</p> <table border="1" data-bbox="552 451 1896 740"> <thead> <tr> <th rowspan="2">Measure Name</th> <th rowspan="2">Domain</th> <th colspan="2">2013</th> <th colspan="2">2014</th> <th colspan="2">2015</th> </tr> <tr> <th>Rate</th> <th>Star</th> <th>Rate</th> <th>Star</th> <th>Rate</th> <th>Star</th> </tr> </thead> <tbody> <tr> <td>Care for Older Adults - Medication Review</td> <td>C2</td> <td>-</td> <td>New</td> <td>92%</td> <td>5</td> <td>89%</td> <td>5</td> </tr> <tr> <td>Care for Older Adults - Functional Status Assessment</td> <td>C2</td> <td>-</td> <td>New</td> <td>92%</td> <td>5</td> <td>89%</td> <td>5</td> </tr> <tr> <td>Care for Older Adults - Pain Assessment</td> <td>C2</td> <td>-</td> <td>New</td> <td>86%</td> <td>4</td> <td>95%</td> <td>5</td> </tr> <tr> <td>SNP - Care Management</td> <td>C2</td> <td></td> <td></td> <td></td> <td></td> <td>67.8%</td> <td>4</td> </tr> </tbody> </table> <p>Company Quality Indicators:</p> <ul style="list-style-type: none"> • Partner with the MI Postpartum Care QI Project • Member of Maternal Health Task Force in IA and MI • MI ranked 9th among Medicaid plans according to NCQA Health Plan Insurance Rankings 2014-2015 • Excellent Accreditation for MI • Pinnacle Award- 2014- Strong Start for Women and Infants • Meridian Health Plan is ranked #1 in Michigan according to NCQA Health Plan Insurance Rankings 2014-2015. • Meridian of MI scored number one in the state for women’s healthcare measures in Medicaid plans • Meridian was selected by NAHQ for a best practices award, and QI staff presented at the annual conference in Tennessee. • Meridian’s (MI) overall Medicaid enrollment rose above 350,000 members for the first time in the company’s history • Meridian has continued to work on the CMS Innovations Grant in regards to lowering the rate of preterm deliveries. Meridian has been recognized by CMS as a high performing awardee, and has presented in forums to assist other organizations on multiple occasions. • Meridian has been active in piloting different programs throughout the State of MI with Access Alliance, CareConnect 360 (formerly known as “FRANK”), and the CMS Adult Measures Grant (elective deliveries and | | | | | | | Measure Name | Domain | 2013 | | 2014 | | 2015 | | Rate | Star | Rate | Star | Rate | Star | Care for Older Adults - Medication Review | C2 | - | New | 92% | 5 | 89% | 5 | Care for Older Adults - Functional Status Assessment | C2 | - | New | 92% | 5 | 89% | 5 | Care for Older Adults - Pain Assessment | C2 | - | New | 86% | 4 | 95% | 5 | SNP - Care Management | C2 | | | | | 67.8% | 4 |
| Measure Name | Domain | 2013 | | 2014 | | 2015 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Rate | Star | Rate | Star | Rate | Star | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care for Older Adults - Medication Review | C2 | - | New | 92% | 5 | 89% | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care for Older Adults - Functional Status Assessment | C2 | - | New | 92% | 5 | 89% | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care for Older Adults - Pain Assessment | C2 | - | New | 86% | 4 | 95% | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SNP - Care Management | C2 | | | | | 67.8% | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| H. Dual Eligible Special Needs Plan Coordination Agreement between Michigan Department of Community Health and Meridian Advantage Plan of Michigan, Inc. *Also serving members in Lucas County Ohio under this contract | | |
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| Item | Description | |
| | | asthma). <ul style="list-style-type: none"> • Developed partnerships with a variety of community organizations such as the Detroit Lead Partnership, Asthma Initiative of Michigan, Alliance for Immunizations in Michigan, WCHAP, Help Me Grow, the WIN Network, the Detroit Infant Mortality Task Force, DIEBO, GDAH, MQIC, and SCHA-MI. <ul style="list-style-type: none"> ○ A Meridian staff member is co-leading the Adolescent sub-committee for the Alliance for Immunizations in Michigan |
| How the contract emphasizes member choice, access, safety, independence, and responsibility | Choice: | As required by this contract, unless a Dual Eligible is otherwise excluded under federal Medicare Advantage Health Plan rules, Meridian must accept all Dual Eligibles who select Meridian health plan. Meridian will provide members with a robust provider network to provide a wide range of services. |
| | Access | As required by this contract Meridian uses MDCH’s Medicaid provider listing to identify in its provider directory those Medicare Network Providers and Subcontractors who accept both Medicare and Medicaid insurances in order to meet Federal requirements and provide information to the recipient of which providers accept insurance from both Medicare and Medicaid. Having this available to members ensures members are able to access care when necessary and utilize in-network providers |
| | Safety: | In order to ensure members safety, Meridian is required, by contract, to represents that neither it nor any of its principles is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any state or federal health care program. |
| | Independence: | In order to ensure members receive high quality care, and are provided with the utmost independence, Meridian and the Department use reasonable best efforts to coordinate care of Dual Eligible Members. Meridian meets with MDCH on a periodic basis to discuss care coordination efforts by both parties and to identify potential areas for collaboration. |
| | Responsibility: | In order to ensure this programs resources are utilized properly, Meridian works with members to ensure members are enrolled into the proper benefit programs and to provide members with the information they need when presenting for services. |
| The role of subcontractors if any | Administrative Services | Meridian contracts with Caidan Management Company, LLC (CMC) to perform an array of administrative services which will allow Meridian to provide the services described in the Statement of Work. CMC shares the same parent organization as Meridian and, thus enjoys the efficiencies through integration. Pursuant to an Administrative Services contract, CMC will perform the following services: <ol style="list-style-type: none"> 1.Claims processing and adjudication 2.Member enrollment and eligibility verification |

H. Dual Eligible Special Needs Plan Coordination Agreement between Michigan Department of Community Health and Meridian Advantage Plan of Michigan, Inc.
***Also serving members in Lucas County Ohio under this contract**

| Item | Description |
|-----------------------------|--|
| | <p>3. Medical management 4. Behavioral health 5. Quality improvement activities 6. Authorizations, denials, and appeals 7. Complaints and grievances 8. Provider recruitment and education 9. Support staff for credentialing activities 10. Member services / call center operations 11. Member compliance program 12. Risk management 13. Administrative, technical, and day-to-day operational duties 14. Information technology and management services 15. Banking, accounting, and financial matters 16. Support staff for compliance and fraud, waste and abuse activities</p> <p>CMC has been providing the described services for over 15 years to Medicaid and Medicare plans in Michigan, Illinois and Iowa. CMC hires locally-based personnel in each of the states in which it operates and the same will be the case for the 2015 IHQHI.</p> |
| Pharmacy Benefit Management | <p>Meridian contracts with MeridianRx, LLC (MeridianRx), a full-service PBM, to perform pharmacy benefit management services for its membership. Similar to Caidan Management Company, MeridianRx shares the same parent organization as Meridian, which results in superior access to information and a greater overall level of service. MeridianRx maintains a comprehensive national network that covers all 50 States, the District of Columbia, the United States Virgin Islands, American Samoa, the Northern Mariana Islands, Puerto Rico and Guam. The breadth of the MeridianRx network ensures convenient access to prescriptions at deeply discounted rates. MeridianRx uses a variety of tools such as drug utilization review and disease management to encourage the best clinical outcomes for patients. They also provide patient information in multiple formats, including a user-friendly web portal, mailings, newsletters and our award-winning call center. MeridianRx utilizes panels of highly-qualified, independent physicians, pharmacists and other clinical experts to develop lists of drugs approved for reimbursement in order to encourage clinically appropriate and cost-effective prescribing. MeridianRx offers access to highly efficient mail-service pharmacies that safely and accurately supply home-delivered prescriptions at a substantial savings. MeridianRx utilizes cutting-edge e-prescribing technology, which</p> |

H. Dual Eligible Special Needs Plan Coordination Agreement between Michigan Department of Community Health and Meridian Advantage Plan of Michigan, Inc.
***Also serving members in Lucas County Ohio under this contract**

| Item | Description |
|--------------------------------------|--|
| | provides physicians with clinical and cost information on prescription options allowing them to better counsel patients on the safest and most affordable medication choices. MeridianRx offers a 24/7 toll-free hotline with access to pharmacy service representatives, provider service representatives and pharmacists to address any client or patient related issues. |
| Non-Emergency Medical Transportation | Meridian subcontracts non-emergency medical transportation services to Logisticare. LogistiCare is a go-between for getting from your house to the doctor's office and back. The company brokers non-emergency transportation services for commercial health plans, government entities (such as state Medicaid agencies), and hospitals throughout the US. Using its nearly 20 call centers and a network of some 1,500 independent, contracted transportation providers, the company coordinates the medical-related travel arrangements of its clients' members. In addition, it contracts with local school boards to coordinate transportation for special needs students. The company provides more than 26 million trips each year for clients in some 40 states. LogistiCare is a subsidiary of Providence Service. Logisticare is responsible for all non-emergent transportation services. |
| Translation Services: | Meridian subcontracts with Pan American Languages & Services DBA PALS International (PALS) to provide foreign language translation services. PALS is a woman-owned business that has been operating since 1983. PALS provides written translation services in 170 languages, including Spanish, French, German, English, Arabic, Chinese, Japanese, Korean, Italian, Polish, Russian, Portuguese, and Hmong. Using state-of-the-art computer phone technology with high-quality, professional linguists, PALS are capable of producing unique oral interpretation services of extraordinary speed and reliability. PALS provides immediate 24/7 access to over 150 languages supported by over 1,000 professional, certified linguists within an average connect time of 30 seconds. |
| Claims Recovery | Meridian subcontracts with First Recovery Group (FRG) for claims recovery services. FRG is the largest independent healthcare cost management company focused solely on subrogation claims recovery. FRG represents HMOs, TPAs, insurance companies, self-insured corporations, PHOs, IPAs, and MSOs that cover over six million lives nationwide. FRG receives a data feed of all paid claims from a healthcare payor and, using its exclusive SubroMAX® system, analyzes ICD-9 codes, CPT codes and episodes of care, to identify cases with recovery potential. They are also able to search court records, insurance databases, and workers compensation records. |
| After-Hours Call Center | Meridian contracts with Tri-Hospital EMS dba Med-Connection to provide after-hours call center services. Med-Connection was founded in 2001 and provides high-quality, customizable call center services to healthcare organizations. Med-Connection maintains stringent hiring guidelines and employs a robust and continuous training program based on health plan needs and requirements. Med-Connection dedicates staff to a single account in order to provide the maximum level of attention to callers. Their focus is on resolving issues in a single call and to the satisfaction of the caller 100% of the time. |

H. Dual Eligible Special Needs Plan Coordination Agreement between Michigan Department of Community Health and Meridian Advantage Plan of Michigan, Inc.
***Also serving members in Lucas County Ohio under this contract**

| Item | Description | | |
|----------------|---|----------------|--|
| | <table border="1"> <tr> <td data-bbox="331 380 537 448">Sign Language:</td> <td data-bbox="537 380 2003 448">Meridian Health Plan of Michigan subcontracts with ABS Translation services for sign language interpretation services.</td> </tr> </table> | Sign Language: | Meridian Health Plan of Michigan subcontracts with ABS Translation services for sign language interpretation services. |
| Sign Language: | Meridian Health Plan of Michigan subcontracts with ABS Translation services for sign language interpretation services. | | |

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I. Dual Eligible Special Needs Plan (D-SNP) Contract between the Illinois Department of Healthcare and Family Services and Meridian Health Plan of Illinois, Inc.

| Item | Brief Description |
|---|--|
| <p>Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope);</p> | <p>Through this current contract, Meridian administers a Dual Eligible Special Needs Plan, Meridian Advantage Plan.</p> <p>Services in Scope:</p> <ul style="list-style-type: none"> • Physical Health Services • Behavioral Health (Outpatient) <p>Services out of Scope:</p> <ul style="list-style-type: none"> • LTSS <p>Covered Benefits:</p> <ul style="list-style-type: none"> • Advanced Practice Nursing Services • Ambulatory Surgical Treatment Center Services • Audiology Services • Chiropractic Services • Limited Dental Services • Family Planning services and supplies • FQHCs RHCs and other encounter rate clinic visits • Home Health agency visits • Hospital Emergency room visits • Hospital inpatient services • Hospital ambulatory services • Laboratory and x-ray services • Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies • Mental Health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation option • Nursing Facility services; • Optical services and supplies; • Optometrist services; • Palliative and Hospice services; |

I. Dual Eligible Special Needs Plan (D-SNP) Contract between the Illinois Department of Healthcare and Family Services and Meridian Health Plan of Illinois, Inc.

| Item | Brief Description |
|--|---|
| | <ul style="list-style-type: none"> • Pharmacy Services; • Physical, Occupational and Speech Therapy services; • Physician services; • Podiatric services; • Post-Stabilization Services; • Renal Dialysis services; • Respiratory Equipment and Supplies; • Subacute alcoholism and substance abuse services pursuant • Transportation to secure Covered Services. |
| Duration of Contract | The term of this Contract shall be from October 1, 2012, through December 31, 2014, unless the Contract is otherwise terminated as set forth herein. Renewal. This Contract may be renewed upon the same terms and conditions for up to two additional one year terms. |
| Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s); | <p>October 1, 2012-December 31,2014 January 1, 2015-January 31, 2015</p> <p>Alterations: *Contract was amended 6-24-2014 **Contract was amended 8-20-2014</p> |
| Total Value of the contract at the time it was executed | \$558,796 |
| Contact name, phone number, | Julie Hamos Director |

I. Dual Eligible Special Needs Plan (D-SNP) Contract between the Illinois Department of Healthcare and Family Services and Meridian Health Plan of Illinois, Inc.

| Item | Brief Description | |
|--|--|---|
| and email | Illinois Department of Healthcare and Family Services 201 South Grand Avenue East Springfield, IL62763-0001 Phone:312-793-1587 Fzx:312-739-5278 Email: hfs.webmaster@illinois.gov (attn. Julie Hamos) | |
| Number of members served by population type | D-SNP (Dual Eligible Special Needs Plan): 248 | |
| Annual Contract payments | 2010: Plan not active 2011: Plan not active 2012: Plan not active 2013: \$139,699 2014: \$ 2,451,382 | |
| Improvements made in utilization trends and quality indicators | Utilization Trends | <p>Recent Improvements made in Utilization Trends</p> <p>Reduction in Inpatient Admissions for IL Dual Eligible Special Needs Plan Members (D-SNP) per 1000 members Inpatient admissions per 1,000 D-SNP members decreased by more than half for the total population from Quarter 3 2013 (600 per 1,000) to Quarter 3 2014 (255 per 1,000).</p> <p>Decrease in 1-Day DRG Admits per 1,000 members (Excluding neonates) The overall population experienced a decreasing trend between Quarter 4 2013 (500 per 1,000) and Quarter 3 2014 (29 per 1,000) in Quarter 3 2014</p> <p>Decrease in Observations per 1,000 members (Includes MAPD population) Between Quarter 2 of 2014 and Quarter 3 of 2014 the population experienced a decrease for both the DSNP and MAPD from over 500 observations per 1,000 members to 384 per 1,000 members in Quarter 3 of 2014.</p> |
| | Quality Indicators | Meridian’s D-SNP plan received the following CMS Star-Ratings from year 2013-2015 for these critical measures: |

I. Dual Eligible Special Needs Plan (D-SNP) Contract between the Illinois Department of Healthcare and Family Services and Meridian Health Plan of Illinois, Inc.

| Item | Brief Description | | | | | | | | | | | | | | | | | | | | | | | |
|---|-------------------|---|--------------|--------|------|-------|------|--|------|--|------|------|------|------|------|------|-----------------------|----|--|--|--|--|-------|---|
| | | <p>Meridian’s Illinois Dual-Eligible program was too new to be measured in 2013 and 2014. In 2015 Meridian had a 5-star rating for SNP-Care Management</p> <table border="1" data-bbox="552 391 1745 550"> <thead> <tr> <th rowspan="2">Measure Name</th> <th rowspan="2">Domain</th> <th colspan="2">2013</th> <th colspan="2">2014</th> <th colspan="2">2015</th> </tr> <tr> <th>Rate</th> <th>Star</th> <th>Rate</th> <th>Star</th> <th>Rate</th> <th>Star</th> </tr> </thead> <tbody> <tr> <td>SNP - Care Management</td> <td>C2</td> <td></td> <td></td> <td></td> <td></td> <td>94.1%</td> <td>5</td> </tr> </tbody> </table> <p>Company Quality Indicators:</p> <ul style="list-style-type: none"> • IL ranked 10th among Medicaid plans according to NCQA Health Plan Insurance Rankings 2014-2015 • Commendable accreditation • Meridian Health Plan of Illinois is ranked #1 Medicaid health plan in the states based on NCQA Health Plan Insurance Rankings 2014-2015. • Meridian was selected by the National Association for Healthcare Quality for a best practices award, and Meridian’s QI staff presented at the annual conference in Tennessee. • Meridian has continued to work on the CMS Innovations Grant in regards to lowering the rate of preterm deliveries. Meridian has been recognized by CMS as a high performing awardee, and has presented in forums to assist other organizations on multiple occasions. | Measure Name | Domain | 2013 | | 2014 | | 2015 | | Rate | Star | Rate | Star | Rate | Star | SNP - Care Management | C2 | | | | | 94.1% | 5 |
| Measure Name | Domain | 2013 | | | 2014 | | 2015 | | | | | | | | | | | | | | | | | |
| | | Rate | Star | Rate | Star | Rate | Star | | | | | | | | | | | | | | | | | |
| SNP - Care Management | C2 | | | | | 94.1% | 5 | | | | | | | | | | | | | | | | | |
| How the contract emphasizes member choice, access, safety, independence, and responsibility | Choice | As outlined in our agreement, unless a Dual Eligible is otherwise not eligible to enroll Meridian accepts all Dual Eligibles who choose and select the Meridian’s Product without regard to physical or mental condition, health status or need for or receipt of health care services, claims experience, medical history, genetic information, disability, marital status, age, sex national origin, race, color or religion, and will not use any policy or practice that has the effect of such discrimination. | | | | | | | | | | | | | | | | | | | | | | |
| | Access | As required by contract, Meridian coordinates access to all services members in this program may be eligible for, including Medicaid covered services. Such coordination may include identification and referrals to needed services, assistance in care planning, and assistance in obtaining appointments for needed services. | | | | | | | | | | | | | | | | | | | | | | |
| | Safety | This contract may be terminated if the Department determines that the actions or inactions of Meridian or Meridian's agents, employees or subcontractors have caused, or reasonably could cause, jeopardy to health or safety of Dual Eligible Members. | | | | | | | | | | | | | | | | | | | | | | |
| | Independence | Meridian must provide each prospective DSNP enrollee, prior to enrollment, with a comprehensive written statement of benefits and cost-sharing protections under Contractor's SNP as compared to protections under the relevant State Medicaid | | | | | | | | | | | | | | | | | | | | | | |

I. Dual Eligible Special Needs Plan (D-SNP) Contract between the Illinois Department of Healthcare and Family Services and Meridian Health Plan of Illinois, Inc.

| Item | Brief Description |
|-----------------------------------|--|
| | <p>Plan. This allows enrollees to understand and feel independent when presenting for services.</p> <p>Responsibility Meridian realizes that some members may be unsatisfied with our services. While our goal is to provide members with the highest level of quality services, if members are dissatisfied, Members must exhaust Meridian's internal processes and procedures, including appeal provisions, prior to seeking an external hearing or review as permitted under Medicare Law.</p> |
| The role of subcontractors if any | <p>Administrative Services Meridian contracts with Caidan Management Company, LLC (CMC) to perform an array of administrative services which will allow Meridian to provide the services described in the Statement of Work. CMC shares the same parent organization as Meridian and, thus enjoys the efficiencies through integration. Pursuant to an Administrative Services contract, CMC will perform the following services:</p> <ol style="list-style-type: none"> 1.Claims processing and adjudication 2.Member enrollment and eligibility verification 3.Medical management 4.Behavioral health 5.Quality improvement activities 6.Authorizations, denials, and appeals 7.Complaints and grievances 8.Provider recruitment and education 9.Support staff for credentialing activities 10.Member services / call center operations 11.Member compliance program 12.Risk management 13.Administrative, technical, and day-to-day operational duties 14.Information technology and management services 15.Banking, accounting, and financial matters 16.Support staff for compliance and fraud, waste and abuse activities <p>CMC has been providing the described services for over 15 years to Medicaid and Medicare plans in Michigan, Illinois and Iowa. CMC hires locally-based personnel in each of the states in which it operates and the same will be the case for the 2015 IHQHI.</p> |
| | <p>Pharmacy Benefit Management Meridian contracts with MeridianRx, LLC (MeridianRx), a full-service PBM, to perform pharmacy benefit management services for its membership. Similar to Caidan Management Company, MeridianRx shares the same parent organization as Meridian, which results in superior access to information and a greater overall level of service. MeridianRx maintains a</p> |

I. Dual Eligible Special Needs Plan (D-SNP) Contract between the Illinois Department of Healthcare and Family Services and Meridian Health Plan of Illinois, Inc.

| Item | Brief Description |
|--------------------------------------|---|
| | <p>comprehensive national network that covers all 50 States, the District of Columbia, the United States Virgin Islands, American Samoa, the Northern Mariana Islands, Puerto Rico and Guam. The breadth of the MeridianRx network ensures convenient access to prescriptions at deeply discounted rates. MeridianRx uses a variety of tools such as drug utilization review and disease management to encourage the best clinical outcomes for patients. They also provide patient information in multiple formats, including a user-friendly web portal, mailings, newsletters and our award-winning call center. MeridianRx utilizes panels of highly-qualified, independent physicians, pharmacists and other clinical experts to develop lists of drugs approved for reimbursement in order to encourage clinically appropriate and cost-effective prescribing. MeridianRx offers access to highly efficient mail-service pharmacies that safely and accurately supply home-delivered prescriptions at a substantial savings. MeridianRx utilizes cutting-edge e-prescribing technology, which provides physicians with clinical and cost information on prescription options allowing them to better counsel patients on the safest and most affordable medication choices. MeridianRx offers a 24/7 toll-free hotline with access to pharmacy service representatives, provider service representatives and pharmacists to address any client or patient related issues.</p> |
| Non-Emergency Medical Transportation | <p>Meridian subcontracts non-emergency medical transportation services to Logisticare. LogistiCare is a go-between for getting from your house to the doctor's office and back. The company brokers non-emergency transportation services for commercial health plans, government entities (such as state Medicaid agencies), and hospitals throughout the US. Using its nearly 20 call centers and a network of some 1,500 independent, contracted transportation providers, the company coordinates the medical-related travel arrangements of its clients' members. In addition, it contracts with local school boards to coordinate transportation for special needs students. The company provides more than 26 million trips each year for clients in some 40 states. LogistiCare is a subsidiary of Providence Service. Logisticare is responsible for all non-emergent transportation services.</p> |
| Translation Services | <p>Meridian subcontracts with Pan American Languages & Services DBA PALS International (PALS) to provide foreign language translation services. PALS is a woman-owned business that has been operating since 1983. PALS provides written translation services in 170 languages, including Spanish, French, German, English, Arabic, Chinese, Japanese, Korean, Italian, Polish, Russian, Portuguese, and Hmong. Using state-of-the-art computer phone technology with high-quality, professional linguists, PALS are capable of producing unique oral interpretation services of extraordinary speed and reliability. PALS provides immediate 24/7 access to over 150 languages supported by over 1,000 professional, certified linguists within an average connect time of 30 seconds.</p> |
| After-Hours Call Center | <p>Meridian contracts with Tri-Hospital EMS dba Med-Connection to provide after-hours call center services. Med-Connection was founded in 2001 and provides high-quality, customizable call center services to healthcare organizations. Med-Connection maintains stringent hiring guidelines and employs a robust and continuous training program based on health plan needs and requirements. Med-Connection dedicates staff to a single account in order to provide the maximum level of attention to callers. Their focus is on resolving issues in a single call and to the satisfaction of the caller 100% of</p> |

I. Dual Eligible Special Needs Plan (D-SNP) Contract between the Illinois Department of Healthcare and Family Services and Meridian Health Plan of Illinois, Inc.

| Item | Brief Description | |
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| | | the time. |
| | Dental Services | Meridian Health Plan of Illinois subcontracts to Liberty Dental for the administration of dental benefit services. LIBERTY is a privately held company that specializes in dental only administrative services to over 2 million members across the United States for well over a decade. LIBERTY proudly provides full service administration for some of the Nation's largest (Fortune 100) health plans (MCOs), as well as labor groups, employer groups, and federal, state and local government agencies. |
| | Sign Language | Meridian subcontracts with Illinois Language Services for sign language interpretation services. Meridian subcontracts with ABS Translation services for sign language interpretation services. |

J. Dual Eligible Special Needs Plan (D-SNP) Agreement between the Iowa Department of Human Services and Meridian Health Plan of Iowa, Inc.

| Item | Brief Description |
|--|--|
| Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope); | <p>Services in Scope:</p> <ul style="list-style-type: none"> • Physical Health • Behavioral Health: (Outpatient mental health and substance abuse services) <p>Services Out of Scope:</p> <ul style="list-style-type: none"> • LTSS <p>Covered Services:</p> <ul style="list-style-type: none"> • Ambulance • Dialysis • Health Education for Diabetes and Health Disease • Home Health and Hospice Care • Inpatient Hospital Care • Immunizations • Lab Services • X-Ray Services • Medical Supplies & Equipment • Inpatient Mental Health Care (190 days) • Doctor's office Visits • Oxygen Respiratory Therapy • Pharmacy |
| Duration of Contract | The term of this Agreement will begin on July 1, 2013 and six years from that date, unless terminated earlier as noted in this section. |
| Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s); | July 1, 2014-present |
| Total Value of the contract at the | \$16.8 million |

J. Dual Eligible Special Needs Plan (D-SNP) Agreement between the Iowa Department of Human Services and Meridian Health Plan of Iowa, Inc.

| Item | | Brief Description |
|--|--------------------|---|
| time it was executed | | |
| Contact name and phone number | | Dennis Janssen Iowa Medicaid Enterprise 1 00 Army Post Rd. Des Moines, IA 503 15 e-mail: Djansse@dhs.statc.ia. us |
| Number of members served by population type | | D-SNP (Dual Eligible Special Needs Plan): 160 |
| Annual Contract payments | | 2010: No Contract 2011: No Contract 2012: No Contract 2013: No Contract 2014: \$2,811,972 |
| Improvements made in utilization trends and quality indicators | Utilization Trends | Recent Improvements made in Utilization Trends: Reduction in Inpatient admissions Overall inpatient admission did rise for the D-SNP population; however this increase was concurrent with an increase in membership during the same time period. From Quarter 3 of 2014 to Quarter 4 of 2014 there was an identifiable decline in D-SNP inpatient admissions. Q3 of 2014 posted 471.3 inpatient admissions per 1,000 members and ended Quarter 4 of 2014 with only 280.47 admissions per 1,000 members Reduction in Non Emergent ER Admissions: Between Quarter 1 of 2014 and Quarter 3 of 2014 the number of non-emergent admissions declined steadily: Q1 posted 489.8, Q2 posted 217.52, and Q3 posted 12.2 admissions per 1,000 members. |
| | Quality Indicators | Scoring for NCQA Accreditation-CAHPS® (Consumer Assessment of Healthcare Providers and Systems) Adult measures: Meridian Health Plan of Iowa reached the 90 th and 75 th percentile for the following measures in 2014(2013 data set): Measures in the 90th Percentile <ul style="list-style-type: none"> • How well doctors communicate • Show respect for what you say • Listen carefully to you |

J. Dual Eligible Special Needs Plan (D-SNP) Agreement between the Iowa Department of Human Services and Meridian Health Plan of Iowa, Inc.

| Item | | Brief Description |
|---|--------------|--|
| | | <ul style="list-style-type: none"> • Explain things so you understand • Rating of personal doctor <p>Measures in the 75th Percentile</p> <ul style="list-style-type: none"> • Spent enough time with you • Getting needed care • Appointment with specialists • Discussing Strategies <p>Company Quality Indicators:</p> <ul style="list-style-type: none"> • State representative for Iowa Child Death Review Team • Lead for the Iowa Access to Primary Care Pilot Project • IA ranked 38th among Medicaid plans according to NCQA Health Plan Insurance Rankings 2014-2015 • IA plan accesses 45% of member records through remote or electronic means • IA ranked the #1 Medicaid plans in Iowa according to NCQA Health Plan Insurance Rankings 2014-2015. • Meridian was selected by the National Association for Healthcare Quality for a best practices award, and QI staff presented at the annual conference in Tennessee. • Meridian has continued to work on the CMS Innovations Grant in regards to lowering the rate of preterm deliveries. Meridian has been recognized by CMS as a high performing awardee, and has presented in forums to assist other organizations on multiple occasions. |
| How the contract emphasizes member choice, access, safety, independence, and responsibility | Choice | Meridian must provide each prospective Dual Eligible Special Needs Plan enrollee , prior to enrollment, with a Comprehensive written statement of benefits provided under Meridian’s plan. This allows members to make an informed decision in regards to choosing a D-SNP. |
| | Access | As required by contract, Meridian maintains contracts with participating providers whereby Meridian assures adequate access and availability for Dual Eligible enrollees for all medically necessary covered services under Meridian’s Plan, following access standards and guidelines. |
| | Safety | As outlined in our contract Meridian protects the confidentiality of Protected Health Information and shall otherwise comply with the requirements of the Privacy Rule and with all other State and Federal Laws governing the confidentiality of medical information. |
| | Independence | As required by contract, Meridian must provide each prospective Dual Eligible Special Needs Plan enrollee, prior to enrollment, with a comprehensive written statement of benefit and cost-sharing protections under Meridian’s SNP as |

J. Dual Eligible Special Needs Plan (D-SNP) Agreement between the Iowa Department of Human Services and Meridian Health Plan of Iowa, Inc.

| Item | | Brief Description |
|-----------------------------------|-------------------------|--|
| | | <p>compared to protections under the relevant State Medicaid plan. Meridian is prohibited from imposing cost-sharing requirements on Dual Eligible enrollees that would exceed the amounts permitted under the State Medicaid plan if the enrollee were not enrolled in the Meridian’s Dual Eligible SNP. This requirement is to assist a prospective dual-eligible enrollee to determine if he/she will receive any value from enrolling in the Dual Eligible SNP that is not already available under the State Medicaid program. This exercising the member’s right to independently choose what is best for them.</p> |
| | Responsibility | <p>Under Meridian’s Dual Eligible Special Needs Plans the participating providers may only collect such enrollee cost sharing as specified by federal and state laws. Members are only responsible as specified by federal and state laws.</p> |
| The role of subcontractors if any | Administrative Services | <p>Meridian contracts with Caidan Management Company, LLC (CMC) to perform an array of administrative services which will allow Meridian to provide the services described in the Statement of Work. CMC shares the same parent organization as Meridian and, thus enjoys the efficiencies through integration. Pursuant to an Administrative Services contract, CMC will perform the following services:</p> <ol style="list-style-type: none"> 1. Claims processing and adjudication 2. Member enrollment and eligibility verification 3. Medical management 4. Behavioral health 5. Quality improvement activities 6. Authorizations, denials, and appeals 7. Complaints and grievances 8. Provider recruitment and education 9. Support staff for credentialing activities 10. Member services / call center operations 11. Member compliance program 12. Risk management 13. Administrative, technical, and day-to-day operational duties 14. Information technology and management services 15. Banking, accounting, and financial matters 16. Support staff for compliance and fraud, waste and abuse activities <p>CMC has been providing the described services for over 15 years to Medicaid and Medicare plans in Michigan, Illinois and Iowa. CMC hires locally-based personnel in each of the states in which it operates and the same will be the case for the 2015 IHQHI.</p> |

J. Dual Eligible Special Needs Plan (D-SNP) Agreement between the Iowa Department of Human Services and Meridian Health Plan of Iowa, Inc.

| Item | Brief Description |
|-------------------------|--|
| After-Hours Call Center | Meridian contracts with Tri-Hospital EMS dba Med-Connection to provide after-hours call center services. Med-Connection was founded in 2001 and provides high-quality, customizable call center services to healthcare organizations. Med-Connection maintains stringent hiring guidelines and employs a robust and continuous training program based on health plan needs and requirements. Med-Connection dedicates staff to a single account in order to provide the maximum level of attention to callers. Their focus is on resolving issues in a single call and to the satisfaction of the caller 100% of the time. |
| Translation Services | Meridian subcontracts with Pan American Languages & Services DBA PALS International (PALS) to provide foreign language translation services. PALS is a woman-owned business that has been operating since 1983. PALS provides written translation services in 170 languages, including Spanish, French, German, English, Arabic, Chinese, Japanese, Korean, Italian, Polish, Russian, Portuguese, and Hmong. Using state-of-the-art computer phone technology with high-quality, professional linguists, PALS are capable of producing unique oral interpretation services of extraordinary speed and reliability. PALS provides immediate 24/7 access to over 150 languages supported by over 1,000 professional, certified linguists within an average connect time of 30 seconds. |

2. **Identify and describe any debarment or suspension, regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity within the last five (5) years.**

Neither Meridian Health Plan of Iowa, nor any of its related or affiliated organizations have ever been, debarred, suspended, sanctioned, penalized or required to pay monetary restitution to any state Medicaid agency or CMS.

3. **Identify and describe any letter of deficiency issued by or corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relates to Medicare, Medicaid, CHIP, or the Substance Abuse Use Prevention and Treatment Block Grant.**

2013 CMS Review of Iowa Medicaid Enterprise (IME) and contracted Medicaid Managed Care Organizations (MCOs):

CMS conducted an audit of Iowa Medicaid Enterprise (IME), inclusive of IME's contracted Managed Care Organizations (MCOs). A corrective action plan (CAP) was identified for Meridian Health Plan of Iowa, one of IME's contracted MCOs. It was submitted to IME, for the comprehensive submission to CMS, in March of 2014.

2014 (January) IME field audit of Meridian Health Plan of Iowa's Program Integrity activities:

Meridian Health Plan of Iowa underwent a field audit reviewing MCO Program Integrity activities; the audit was conducted by IME. The audit findings resulted in a program integrity corrective action plan. Meridian Health Plan of Iowa submitted this CAP to IME in March 2014, with refined submission in April 2014.

CMS mandated External Quality Review Organization annual review- 2013 and 2014:

Meridian Health Plan of Iowa underwent CMS required annual reviews by a CMS designated EQRO. Both reviews identified minor deficiencies which resulted in corrective actions plans. Meridian Health Plan of Iowa addressed the necessary corrections and received a score of 87 in 2013 and 98 in 2014.

3.2.7.4.3 Description of all contracts and projects currently undertaken by the bidder. This shall include all contracts that have not expired, have not been completed, or have not been terminated. Descriptions of similar services (above) do not need to be repeated again in this section.

All Contracts and Projects currently undertaken by Meridian Health Plan:

| Meridian's Medicaid Affiliate in Michigan | | |
|--|-------------------------------|---|
| Plan Type: | Contract/Project Name: | Contract Description |
| Medicaid/Medicaid Expansion | Meridian Health Plan | Administration of Medicaid benefits for TANF and CSHCS. Meridian also administers benefits for the Medicaid expansion population eligible under the Healthy Michigan Plan. |
| Marketplace | Meridian Choice (Bronson) | Bronson participates as a Meridian preferred network provider for the purpose of providing medical services to Meridian Exchange (Meridian Choice) product enrollees residing in the Michigan counties of Allegan, Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Saint Joseph, and Van Buren |
| Medicare Medicaid Plan (Demonstration) | Meridian Complete | Joint program between the Centers for Medicare & Medicaid Services (CMS) and the State of Michigan Department of Community Health (MDCH). This program provides services for eligible person meeting the following criteria: Age 21 or older at the time of enrollment; Eligible for full benefits under Medicare Part A, and enrolled under Parts Band D, and receiving full Medicaid benefits. (This includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a nursing facility and have a monthly PPA); and Reside in a Demonstration region. |

| Meridian's Medicare Affiliate in Michigan | | |
|--|-------------------------------|---|
| Plan Type: | Contract/Project Name: | Contract Description |
| Dual Eligible Special Needs Plan (DSNP) | Meridian Advantage Plan | Medicare Advantage Plan Agreement ("MA Agreement") with the centers for Medicare and Medicaid Services ("CMS") whereby MA Health Plan provides or desires to provide Medicare covered health care benefits to qualified Medicare beneficiaries under a Dual Eligible Special Needs Plan in the State of Michigan |
| Medicare Advantage Prescription Drug (MAPD) | Meridian Prime | <p>Meridian Prime is a Medicare Advantage Prescription Drug Plan (MAPD).</p> <p>In order to join, must be:</p> <ul style="list-style-type: none"> • Entitled to Medicare Part A and enrolled in Medicare Part B, and • A Medicaid QMB or QMB+ • Live in service area: Barry, Kalamazoo, Kent, Genesee, Oakland, Macomb, Muskegon and Wayne counties, and • Must not have ESRD prior to enrolling (unless already an Meridian Medicaid member) |
| Medicare Prescription Drug Plan (PDP) | Advantage-Plus Meridian | Advantage-Plus Meridian is a Medicare Prescription Drug Plan. This plan is available to anyone who has Medicare. |

| Meridian's Medicare Affiliate in Ohio | | |
|--|-------------------------------|---|
| Plan Type: | Contract/Project Name: | Contract Description |
| Dual Eligible Special Needs Plan (DSNP) | Meridian Advantage Plan | Medicare Advantage Plan Agreement ("MA Agreement") with the centers for Medicare and Medicaid Services ("CMS") whereby MA Health Plan provides or desires to provide Medicare covered health care benefits to qualified Medicare beneficiaries under a Dual Eligible Special Needs Plan in the State of Ohio |
| Medicare Advantage Prescription Drug (MAPD) | Meridian Prime | <p>Meridian Prime is a Medicare Advantage Prescription Drug Plan (MAPD).</p> <p>In order to join, must be:</p> <ul style="list-style-type: none"> • Entitled to Medicare Part A and enrolled in Medicare Part B, and • A Medicaid QMB or QMB+ • Live in Lucas County, OH • Must not have ESRD prior to enrolling (unless already an Meridian Medicaid member) |
| Medicare Prescription Drug Plan (PDP) | Advantage-Plus Meridian | Advantage-Plus Meridian is a Medicare Prescription Drug Plan. This plan is available to anyone who has Medicare. |

| Meridian's Medicaid Affiliate in Illinois | | |
|--|--|---|
| Plan Type: | Contract/Project Name: | Contract Description |
| Medicaid | Meridian Health Plan of Illinois | Administration of Medicaid benefits for Family Health Plan and Accountable Care Act populations |
| Medicaid | Meridian Health Plan of Illinois-Integrated Care Plan | Administration of benefits for members eligible for Medicaid and also a part of the seniors and persons with disabilities population. |
| Medicare-Medicaid Plan (Demonstration) | Meridian Complete-Medicare Medicaid Alignment Initiative | Joint program between the Centers for Medicare & Medicaid Services (CMS) and the State of Illinois (HFS). Enrollees who are 21 years and older entitled to benefits under Medicare Part A, enrolled under Medicare Parts B receive full Medicaid benefits, live within the Service Area of Cook, DuPage, Kane, Lake & Will counties, and those receiving HCBS waivers or individuals with End Stage Renal Disease (ESRD) at the time of enrollment. |

| Meridian's Medicaid Affiliate in Illinois | | |
|--|-------------------------------------|--|
| Plan Type: | Contract/Project Name: | Contract Description |
| Dual Eligible Special Needs Plan (DSNP) | Meridian Advantage Plan of Illinois | Medicare Advantage Plan Agreement ("MA Agreement") with the centers for Medicare and Medicaid Services ("CMS") whereby MA Health Plan provides or desires to provide Medicare covered health care benefits to qualified Medicare beneficiaries under a Dual Eligible Special Needs Plan in the State of Illinois. |
| Medicare Advantage Prescription Drug (MAPD) | Meridian Prime | <p>Meridian Prime is a Medicare Advantage Prescription Drug Plan (MAPD).</p> <p>In order to join, must be:</p> <ul style="list-style-type: none"> • Entitled to Medicare Part A and enrolled in Medicare Part B, and • A Medicaid QMB or QMB+ • Live in service area: Boone, Knox, Mercer, McHenry, Rock Island, Peoria, Tazewell, and Warren counties, and • Must not have ESRD prior to enrolling (unless already an Meridian Medicaid member) |
| Medicare Prescription Drug Plan (PDP) | Advantage-Plus Meridian | Advantage-Plus Meridian is a Medicare Prescription Drug Plan. This plan is available to anyone who has Medicare. |

| Meridian's Medicaid Affiliate in Iowa | | |
|--|---|---|
| Plan Type: | Contract/Project Name: | Contract Description |
| Medicaid | Current Contract between Meridian Health Plan of Iowa, Inc. and Iowa Department of Human Services (DHS) - Iowa Medicaid Enterprise (IME). | Provide, manage, and coordinate Medicaid covered services to eligible enrollees within the TANF and WELLNESS programs through a network of contracted providers. Eligibility is determined based on income, assets, healthcare needs, family status, and other considerations. The State has sole authority to determine eligibility. |

| Meridian's Medicare Affiliate in Iowa | | |
|--|---------------------------------|---|
| Plan Type: | Contract/Project Name: | Contract Description |
| Dual Eligible Special Needs Plan (DSNP) | Meridian Advantage Plan of Iowa | Medicare Advantage Plan Agreement ("MA Agreement") with the centers for Medicare and Medicaid Services ("CMS") whereby MA Health Plan provides or desires to provide Medicare covered health care benefits to qualified Medicare beneficiaries under a Dual Eligible Special Needs Plan in the State of Iowa. |
| Medicare Advantage Prescription Drug Plan (MAPD) | Meridian Prime | <p>Meridian Prime is a Medicare Advantage Prescription Drug Plan (MAPD).</p> <p>In order to join, must be:</p> <ul style="list-style-type: none"> • Entitled to Medicare Part A and enrolled in Medicare Part B, and • A Medicaid QMB or QMB+ • Live in service area: Polk and Scott counties, and • Must not have ESRD prior to enrolling (unless already an Meridian Medicaid member) |

| Other Markets | | |
|--|-------------------------------|--|
| Plan Type: | Contract/Project Name: | Contract Description |
| Kentucky (Medicare Prescription Drug Plan) | Advantage-Plus Meridian | Advantage-Plus Meridian is a Medicare Prescription Drug Plan. This plan is available to anyone who has Medicare. |
| Indiana (Medicare Prescription Drug plan) | Advantage-Plus Meridian | Advantage-Plus Meridian is a Medicare Prescription Drug Plan. This plan is available to anyone who has Medicare. |



ANCILLARY PROVIDER AGREEMENT

This Ancillary Provider Agreement (“Agreement”) shall be effective as of the _____ day of _____ 20__ between Meridian Health Plan of Iowa, Inc. (“Plan”) an Iowa corporation and Health Maintenance Organization (“HMO”) under the laws of the State of Iowa, and _____, (“Ancillary Provider”) (collectively the “Parties.”)

Recitals

Whereas, Plan has a certificate of authority to operate as a HMO in the State of Iowa;

Whereas, Plan desires to contract with Ancillary Provider for the provision of Covered Services to Enrollees; and

Whereas, Ancillary Provider desires to provide Covered Services as specified in this Agreement to Enrollees for the consideration, and under the terms and conditions set forth in this Agreement;

Whereas, Ancillary Provider desires to provide prior authorized medically necessary services to all of Plan’s covered Enrollees for all products.

In consideration of the foregoing and other good and valuable consideration, the sufficiency of which is hereby acknowledged, the Parties agree as follows:

1 DEFINITION OF TERMS

As used in this Agreement, the following terms have the following meaning:

1.1 Ancillary Provider means a facility or health care provider duly licensed, if applicable, to provide diagnostic, therapeutic, primary/urgent, medical and outpatient ancillary services, which provides such services to Enrollees pursuant to a Participation Agreement, and, where applicable, has been credentialed in accordance with Plan’s requirements and procedures for credentialing and re-credentialing. As used in this Agreement, the term “Ancillary Provider” shall be deemed to include the Ancillary Provider executing this Agreement and each and every facility operated by Ancillary Provider.

1.2 Ancillary Provider Services means those Covered Services to be provided by an Ancillary Provider to Enrollees as set forth in the Schedule of Ancillary Provider Services.

1.3 Ancillary Services Agreements means the agreement, including all Attachments thereto, under which Ancillary Providers participate in Plan.

1.4 Anniversary Date means the date one year from the date on which this Agreement was first signed by both Parties.

1.5 CMS means the Centers for Medicare & Medicaid Services.

1.6 Clean Claim means a claim as defined as follows:

- a) Is submitted within the time frame required under this Agreement;
- b) Identifies the name and appropriate tax identification number of the health professional or the health facility that provided treatment or service and includes a matching provider ID number assigned by Plan;
- c) Identifies the patient (Enrollee/Subscriber ID number assigned by Plan, address, and date of birth);
- d) Identifies Plan (Plan name and/or ID number);
- e) Lists the date (m/d/y) and place of service;

- f) Is for covered service (Services must be described using uniform billing coding and instructions (ANSI X12 837) and ICD-9/10-CM diagnosis. Claims submitted solely for the purpose of determining if a service is covered are not considered clean claims);
- g) If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if prior authorization is required by Plan;
- h) Includes additional documentation based upon services rendered as reasonably required by Plan Policies;
- i) Is certified by Ancillary Provider that the claim is true, accurate, prepared with the knowledge and consent of Ancillary Provider, and does not contain untrue, misleading, or deceptive information, that identifies each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim;
- j) Is a claim for which Ancillary Provider has verified the Enrollee's eligibility and enrollment in Plan before the claim was submitted;
- k) Is not a duplicate of a claim submitted within 45 days of the previous submission;
- l) Is submitted in compliance with all of Plan's prior authorization and claims submission guidelines and procedures;
- m) Is a claim for which Ancillary Provider has exhausted all known other insurance resources;
- n) Is submitted electronically if Ancillary Provider has the ability to submit claims electronically; and
- o) Uses the data elements of UB-04, as appropriate.

1.7 Commercial Enrollee means a Subscriber in any of Plan's commercial products.

1.8 Contracting Organization means the Physician Organization or Physician Hospital Organization identified on the signature page which has executed an Organization Master Agreement with Plan pursuant to which the Participating Provider has executed a Participation Agreement.

1.9 Covered Services means those Medically Necessary health care services covered under the terms of the applicable Payor Contract and rendered in accordance with the terms of this Agreement and the Provider Manual.

1.10 DHS means the Iowa Department of Human Services and includes the Iowa Medicaid Enterprise ("IME").

1.11 Emergency Services means those Medically Necessary Covered Services provided in connection with an "Emergency" which the Enrollee receives after the onset of such Emergency (or as soon thereafter as care can be made available but not more than twenty-four (24) hours after onset). Emergency shall have that meaning as defined in the Medicaid program. An "Emergency" is usually defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention, in the judgment of a reasonably prudent layperson prior to an initial medical screening, could be expected to result in the Enrollee's death or permanent impairment of the Enrollee's health.

1.12 Enrollee means an individual who, pursuant to the applicable individual or group Enrollee contract with Plan, is eligible to receive Covered Services. The term Enrollee includes eligible dependents of a Subscriber, Medicaid Enrollees, Medicare Enrollees, MMAI Enrollees and Commercial Enrollees.

1.13 Health Maintenance Organization means any person or entity which directly or through contracts with providers furnishes at least basic comprehensive health services on a prepaid basis to enrollees in a designated geographic area pursuant to Title XIII of the Public Health Services Act and Iowa Code 514B.1 *et. seq.*, as amended, and the applicable regulations promulgated thereunder.

1.14 IID means the Iowa Insurance Division.

1.15 Medically Necessary means services and/or supplies provided by a Participating Provider required to identify or treat an Enrollee's medical condition, illness or injury as appropriate with regard to standards of good medical practice as recommended and accepted by the medical community in the area in which the services are furnished, all as determined by Plan's Medical Director or authorized designee. When specifically applied to an inpatient Enrollee, it further means that the Enrollee's medical symptoms or condition requires that the diagnosis or

treatment cannot be safely provided to the Enrollee in an outpatient setting, as determined by Plan's Medical Director or authorized designee.

1.16 Medicaid Enrollee means an Enrollee in any of Plan's Medicaid or SCHIP products.

1.17 Medicare Enrollee means an Enrollee in any of Plan's Medicare Advantage products.

1.18 MMAI means the program to test new service delivery and payment methods and models for those individuals dually eligible for Medicare and Medicaid.

1.19 MMAI Enrollee means an individual who is eligible to receive Covered Services pursuant to Plan's agreements with MDCH and IID as a participant in the MMAI.

1.20 Organization Provider means a physician, hospital or other provider of health care services who or which has executed a Participation Agreement or an Organization Provider Acknowledgement incorporating a Participation Agreement pursuant to an Organization Master Agreement.

1.21 Outpatient Services means those Covered Services that a Participating Hospital provides or arranges to provide to Enrollees in the outpatient departments of the Participating Hospital.

1.22 Participating Physician means a Participating Primary Care Physician or Participating Specialist.

1.23 Participating Primary Care Physician ("PCP") shall mean a Physician who is duly licensed to practice allopathic or osteopathic medicine in the State of Iowa, who has executed a Participation Agreement to function as the Physician case manager for Enrollees by providing, arranging for and coordinating the provision of Primary Care Services to Enrollees, and has been credentialed in accordance with the Plan's requirements and procedures for credentialing and re-credentialing.

1.24 Participating Provider means a physician, hospital or other provider of health care services who or which has executed a Participation Agreement.

1.25 Participating Skilled Nursing Facility means an institution, primarily engaged in providing to residents skilled nursing care and related services or rehabilitation services and which is not primarily engaged in the care and treatment of mental disease, which has executed a Participation Agreement.

1.26 Participating Specialist or Consultants means a Physician duly licensed to practice medicine or osteopathy in the State of Iowa who is Board certified or Board eligible in his/her area of specialty and has executed a Participation Agreement for the provision of Specialty Care Services to Enrollees, and who has been credentialed in accordance with the Plan's requirements and procedures for credentialing and re-credentialing.

1.27 Participation Agreement means a contract between Plan and a provider of health care services, through which the provider obtains Participating Provider status and which establishes the terms and conditions under which the provider provides services to Enrollees.

1.28 Payor means either Plan or another entity that is responsible for the payment for Covered Services to Enrollees.

1.29 Payor Contract means Plan's contract with any Payor that governs provision of Covered Services to Enrollees. Where Plan is the Payor, "Payor Contract" means Plan's contract with the state or federal agency or other entity that has contracted with Plan to arrange for the provision of Covered Services to eligible Enrollees.

1.30 Plan's License means a certificate issued by the Commissioner of Insurance, authorizing the establishment and operation of a health maintenance organization pursuant to Iowa Code 514B.1 *et. seq.*, as amended, and the applicable regulations promulgated thereunder.

1.31 Quality Improvement Plan means an on-going program for systematic monitoring of the various aspects

of Plan, its systems, services, practitioners and providers to identify and act upon events or occasions where standards are not met, and to continuously improve Plan's ability to meet the needs and expectations of Enrollees.

1.32 Specialty Agreement means the agreement, including all Attachments thereto, under which Specialty Physicians participate in Plan.

1.33 Specialty Care Services means those Covered Services set forth in the Schedule of Covered Services to be provided by a Participating Specialist on referral from a PCP.

1.34 Subscriber means an Enrollee who: (a) Has entered into a contract with Plan for health maintenance services, or on whose behalf a contract is entered into with Plan for health maintenance services; (b) Meets all applicable eligibility criteria; (c) Has completed an enrollment application form which has been received by Plan; and (d) For whom Plan has received prepaid amounts of money (premiums on a monthly basis).

1.35 Subscriber Group shall mean a group of eligible Enrollees with which Plan has agreed, via a Subscriber Group agreement, to provide a defined set of Covered Services for a specified premium.

1.36 Utilization Management Plan means a program for evaluating and determining the appropriateness of the use of health care services provided to Enrollees.

2 RESPONSIBILITIES OF ANCILLARY PROVIDER

2.1 Licenses, Certification and Participation – Ancillary Provider shall maintain in good standing all licenses and other certificates required to provide the Ancillary Provider Services in Iowa; submit all licenses, certifications, accreditations and any other credentials as required by Plan for review by Plan in accordance with the policies and procedures set forth in Plan's Quality Improvement Plan; maintain participation in the Medicare and Medicaid program; and notify Plan immediately upon any lapse in good standing of any license, certification or accreditation represented herein, including, but not limited to, revocation or suspension of any license, The Joint Commission ("TJC") or other accreditation or certification; and notify Plan of any licensure or TJC contingencies and/or any penalty assessments.

2.2 Credentials – Ancillary Provider agrees to submit for review by Plan all required information necessary to credential and re-credential Ancillary Provider in accordance with the standards established by Plan and described in the Quality Improvement Plan and the requirements of all applicable state and federal regulatory agencies. Plan may delegate responsibility for credentialing Ancillary Provider pursuant to a written delegation agreement. Ancillary Provider agrees that its Participating Provider status is dependent upon its successful completion of credentialing and re-credentialing in accordance with the Quality Improvement Plan. Ancillary Provider further agrees to participate in Plan's credentialing and re-credentialing processes, including any credentialing and re-credentialing processes conducted by another entity pursuant to a delegation agreement between Plan and such entity, and to be bound by all Plan decisions with respect thereto. Ancillary Provider agrees to execute an Ancillary Provider Acknowledgement, if the Ancillary Provider is employed by or has a contract with an organization that has executed an Organization Master Agreement, attached hereto as Appendix I and incorporated herein by reference, prior to rendering health care services to Enrollees.

2.3 Ancillary Provider Services – Ancillary Provider will render services to Enrollees in the Medicaid, Medicare and Commercial insurance programs in which Plan engages.

A. Ancillary Provider shall provide culturally competent Ancillary Provider Services for Enrollees which are set forth in Attachment B in accordance with Plan's Medicaid, Medicare Advantage and Commercial contract obligations, upon the authorization of such services by Plan or a Participating PCP. Ancillary Provider recognizes and agrees that Ancillary Provider Services (other than Emergency Services) are considered Covered Services only when pre-authorized by Plan or by a Participating Provider in accordance with Plan's Quality Improvement Plan and Provider Manual.

B. If an Enrollee requests services which are not Covered Services, Ancillary Provider will advise the

Enrollee of his or her financial responsibility for such services prior to rendering such services.

C. Ancillary Provider will notify Plan immediately of significant changes affecting Ancillary Provider's provision of services or performance under this Agreement, including but not limited to relocation of Ancillary Provider's practice or facility.

D. Ancillary Provider will notify Plan within a reasonable time period of any significant changes in Enrollee information, such as death or change of address.

E. Plan shall not prohibit Ancillary Provider from advocating on behalf of Enrollees in any grievance or utilization review process, individual authorization process to obtain necessary health care services or regarding Plan quality assurance programs.

F. Plan will not prohibit Ancillary Provider from discussing Ancillary Provider's financial relationship with Enrollees.

G. No Plan policy or procedure shall prohibit Ancillary Provider from discussing treatment options (including non-covered benefits) with Enrollees.

H. Ancillary Provider, when acting within the lawful scope of practice is not prohibited or otherwise restricted from advising or advocating on behalf of an Enrollee who is his/her patient for 1) the Enrollee's health status, medical care, or treatment options, including alternative treatment that may be self-administered, 2) for any information the Enrollee needs in order to decide among all relevant treatment options, 3) for the risks, benefits and consequences of treatment or non-treatment, 4) for the Enrollee's right to participate in decisions regarding this or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

I. Ancillary Provider shall not deny Covered Services to any Enrollee who is eligible for such Covered Services due to the Enrollee's inability to pay a co-payment.

2.4 Utilization Management and Quality Improvement – Ancillary Provider agrees to follow and be bound by all federal and state laws and regulations and to comply with, participate in, and be bound by all policies, procedures, and protocols as set forth in Plan's Quality Improvement Plan and Provider Manual, both as may be amended from time to time, and such other policies, procedures and protocols established from time to time by Plan and by any state or federal agency with respect to quality assurance, Ancillary Provider Services, claims processing and review, utilization control, and peer review. Ancillary Provider hereby acknowledges, understands and agrees that Plan will periodically modify or amend policies, procedures, and protocols governing Utilization Management and Quality Improvement and Plan agrees to notify Ancillary Provider of such proposed changes in writing.

2.5 Reimbursement – Ancillary Provider agrees to comply with the provisions of the applicable attachment, as payment in full for Ancillary Provider Services rendered to Enrollees by Ancillary Provider, except for amounts received for coordination of benefits or otherwise from third parties in accordance with the provisions hereof.

A. Ancillary Provider will submit itemized claims for Ancillary Provider Services (as defined in Section 1) using the CMS-1500 billing form or such other form(s) as may be specified as permissible in the Provider Manual. Ancillary Provider will submit claims for billable Ancillary Provider Services within one hundred eighty (180) days from the date of service, or, in those instances in which Plan is the secondary payor, forty-five (45) days from the date that Ancillary Provider receives a notice of payment decision from the primary payor.

B. Ancillary Provider may directly bill and collect from Enrollees charges for services other than Covered Services if the Enrollee has been informed prior to receiving the services that the services are not Covered Services and has agreed in writing to pay for such services.

C. If Plan pays Ancillary Provider more than is provided by this Agreement for the applicable service, Ancillary Provider agrees to return the overpayment to Plan within forty-five (45) days after notification of overpayment by Plan or discovery of overpayment by Ancillary Provider.

D. If Ancillary Provider fails to submit a claim for payment within the time periods specified herein for claim submission, Plan may deny or reduce the payment otherwise payable to Ancillary Provider for the service(s) at issue in that claim; provided, however, that payment in full will be made where the delay in submission was due, in Plan's judgment, to an act or omission of Plan or of any third party involved in the Enrollee's care and beyond Ancillary Provider's control.

E. In the event an Enrollee is eligible to receive payment for Covered Services, either in whole or in part, under any state or federal health care program or under any other contractual or legal entitlement, including but not limited to a private group health service or indemnification program, as to which coordination of benefits or similar provision in Plan's applicable individual Enrollee or group contract may be applicable, Ancillary Provider shall cooperate and coordinate with Plan for proper determination of coordination of benefits and shall bill and collect from other payors charges for which the other payor is responsible. Such collections by Ancillary Provider, including all collections from workers' compensation and all sums payable under the terms of any court judgment, may be retained by Ancillary Provider as compensation in addition to the sums paid by Plan. When the primary and secondary benefits are coordinated, Plan's compensation liability hereunder will be determined in accordance with the usual procedures employed by DHS and applicable Iowa regulations.

F. Plan may recoup from, or offset against, amounts owed to Ancillary Provider under this Agreement, any payments made by Plan to Ancillary Provider that are in violation of Medicare or Medicaid policy, Plan Policies or this Agreement. Ancillary Provider has the right to dispute any action by Plan to recoup or offset claims, or capitation.

2.6 Enrollee Hold Harmless – Ancillary Provider agrees that, in no event, including but not limited to nonpayment by Plan because of insolvency, bankruptcy, or breach of this Agreement, shall Ancillary Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from; maintain any action at law or in equity against or have any recourse against an Enrollee or person (other than Plan) acting on behalf of an Enrollee for services provided pursuant to this Agreement. In addition, consistent with 42 CFR 438.106 and 42 CFR 438.116, Enrollees shall not be held liable for any of the following: 1) Plan's debts, in case of insolvency, 2) Covered Services under the DHS Contract provided to the Enrollee for which the State did not pay Plan, c) Covered Services provided to the Enrollee for which the State or Plan did not pay Ancillary Provider due to contractual, referral, or other arrangement, or d) payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the Enrollee would owe if Plan provided the services directly. The provisions of this Section 2.6 shall not prohibit the collection of sums that are owed to Ancillary Provider for services provided after this Agreement has terminated, except as otherwise provided in this Agreement, or to services that are not Covered Services. Ancillary Provider further agrees that (1) the provisions of this Section 2.6 shall survive the termination of this Agreement, regardless of the cause giving rise to the termination, for Ancillary Provider Services rendered prior to termination of this Agreement, and shall be construed to be for the benefit of Plan's Enrollees and that (2) the provisions of this Section 2.6 supersede any and all oral and written contrary Agreements now existing or hereafter entered into between Ancillary Provider and any Enrollee or person acting on behalf of any Enrollee.

2.7 Standard of Practice – Ancillary Provider shall:

A. Render services to Enrollees in the Medicaid, Medicare and commercial insurance programs in which Plan engages; and

B. Provide quality care in accordance with accepted Ancillary Provider and professional standards; comply with standards established by the Federal Government, the State of Iowa and TJC; deliver care in such a fashion that Enrollees are accorded the same level of treatment as Non-Enrollees; and ensure that health care services are provided to Enrollees in a courteous and prompt manner and in a well-maintained, clean environment.

C. In the event Plan determines, in its sole discretion, that the health or safety of an Enrollee is in jeopardy, Ancillary Provider shall fully cooperate in the immediate transfer of such Enrollee to another Ancillary Provider.

2.8 Enrollee Grievance System – Ancillary Provider agrees to participate in, comply with and cooperate fully with Plan to facilitate the resolution of Enrollee grievances through the Enrollee grievance system described in

Plan's Quality Improvement Plan. Ancillary Provider agrees to abide by all final decisions rendered in accordance with Plan's Enrollee grievance procedures.

2.9 Confidentiality – Ancillary Provider agrees to adhere to all procedures set forth in the Quality Improvement Plan and the Provider Manual regarding Enrollee confidentiality. Ancillary Provider shall keep the terms of this Agreement confidential. Except as expressly provided herein, neither party may disclose the compensation rates or other relevant terms of this Agreement to any third party, except upon written consent of the other, or if required by law.

2.10 Inspection – Ancillary Provider shall permit authorized representatives of Plan and of any state or federal supervisory authority or agency to conduct medical audits relating to standard medical practice and quality care, to inspect Ancillary Provider's facilities during regular business hours, and to review records of services provided to Enrollees. Ancillary Provider shall also allow duly authorized agents or representatives of the state and federal government, during normal business hours, access to its premises inspect, audit, monitor or otherwise evaluate the Ancillary Provider's performance pursuant to the contracts between Plan and DHS and/or CMS, and Ancillary Provider shall produce relevant records requested as part of such review or audit.

2.11 Compliance With Laws – Ancillary Provider represents and warrants that:

A. To the best of Ancillary Provider's knowledge, Ancillary Provider has complied with and is materially complying with all applicable statutes, orders, rules, and regulations promulgated by any Federal, State, municipal, or other governmental authority relating to the conduct of Ancillary Provider's property and operations, and there are no violations of any statute, order, rule, or regulation pertaining thereto now existing or threatened.

B. Ancillary Provider shall discharge Ancillary Provider's obligations as herein provided in a manner prescribed by applicable federal and state statutes and regulations and in accordance with policies, procedures and requirements as may from time to time be promulgated by the U.S. Department of Health and Human Services ("HHS"), CMS and the Iowa Department of Human Services ("DHS"), including but not limited to those pertaining to payment, reimbursement methodology, and nondiscrimination of services in the event of insolvency.

C. Ancillary Provider does not employ or contract with: (i) any individual or entity excluded from Medicaid or Medicare participation under Sections 1128 (42 U.S.C. 132a-7) or 1128A (42 U.S.C. 1320a-7a) of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services; (ii) any entity for the provision of such services (directly or indirectly) through an excluded individual or entity; or (iii) any individual or entity excluded from Medicaid participation by DHS or Medicare participation by CMS.

2.12 Non-Discrimination – Ancillary Provider shall not unlawfully discriminate in the acceptance or treatment of an Enrollee because of the Enrollee's religion, race, color, national origin, age sex, income level, health status, marital status, disability or such other categories of unlawful discrimination as are or may be defined by federal or state law.

2.13 Disclosures – Ancillary Provider shall make all required financial disclosures in accordance with 42 CFR 434, Section 1903(m) of the Social Security Act, DHS policy, CMS requirements, and other applicable statutes and regulations for Medicare and Medicaid and MMAI Enrollees. Ancillary Provider shall comply with all applicable disclosure requirements set forth in 42 CFR 455.104-106.

2.14 Public Health Reporting – Ancillary Provider agrees to comply with specific State of Iowa law for reporting communicable disease and other health indicators.

2.15 Laboratory Services – Ancillary Provider shall adhere to the provisions of the Clinical Laboratory Improvement Amendments of 1988 ("CLIA") Public Law 100-578 requirements for supplying laboratory services.

2.16 Medical Records – Ancillary Provider will comply with all medical records requirements set forth in 42 CFR 456.101 - 145.

2.17 Non-Discriminatory Hiring and Contracting. In the performance of services pursuant to this Agreement, Ancillary Provider agrees not to discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental handicap or disability or such other categories of unlawful discrimination as are or may be defined by federal or state law. Further, Ancillary Provider agrees to comply with the provisions of the Americans with Disabilities Act of 1990 (42 USC 12101 et seq., and 47 USC 225) and all Iowa non-discrimination laws.

3 RESPONSIBILITIES OF PLAN

3.1 Enrollment and Marketing – Plan agrees to:

A. Have primary responsibility for marketing to and enrolling potential Enrollees and publish Providers name and other information deemed relevant by Plan in Plan’s Provider Directory.

B. Provide Ancillary Provider Enrollee identification and verify eligibility in accordance with procedures referenced in the Provider Manual.

3.2 Financial – Plan agrees to comply with the provisions of this section and compensate Ancillary Provider in accordance with the respective reimbursement set forth in the applicable attachment, as provided in Section 7 of this Agreement for Ancillary Provider Services rendered to Enrollees and billed in accordance with Plan’s policies and the terms hereof. Payment shall constitute payment in full for Ancillary Provider Services rendered to Enrollees by Ancillary Provider, except for amounts received for coordination of benefits or otherwise from third parties in accordance with this Agreement. All payments required by Plan hereunder shall be made by Plan to Ancillary Provider or its payee designee listed on the signature page of this Agreement unless otherwise agreed to in writing by Ancillary Provider and Plan.

A. Prompt Payment. As provided in, and subject to, the Agreement, Plan will normally pay the reimbursement calculated in accordance with the Reimbursement Schedules to Ancillary Provider within thirty days (30) days after Plan’s receipt of a completed claim.

B. Claim Fulfillment; Additional Information – Ancillary Provider claims for reimbursement for Ancillary Provider Services shall be deemed received only upon actual receipt by Plan, and shall be deemed paid by Plan only upon actual receipt of funds by Ancillary Provider. If, in compliance with this Agreement, additional information is required to pay a claim, Plan will request the information from Ancillary Provider as soon as is practicable after Plan’s receipt of a Clean Claim.

C. Coordination of Benefits – In instances in which Plan is the secondary payor and services are reimbursed on a Fee-For-Service basis, Plan will reimburse Ancillary Provider the lesser of (i) Ancillary Provider’s usual and customary charge minus the amount paid by the primary payor, or (ii) the sum calculated in accordance with the applicable attachments as provided in Section 7.

3.3 Federal and State Law – Plan agrees to carry out its obligations as herein provided in accordance with applicable federal and state statutes and regulations and with the policies, procedures and requirements as may from time to time be promulgated by HHS, DHS and/or CMS.

3.4 Provider Relations – Plan agrees to provide materials to Ancillary Provider explaining Plan’s health care benefit plans, procedures, protocols and standards, and copies of Plan’s Provider Manual and Quality Improvement Plan and copies of changes hereafter made to those documents. Further, Plan agrees to immediately notify Ancillary Provider of changes in Enrollee benefits and in Plan’s lists of Participating Providers.

4. GENERAL PROVISIONS

4.1 Additional Products – Plan reserves the right to introduce new products in addition to the current managed care products while this Agreement is in effect and to designate Ancillary Provider as a Participating or

Non-Participating Provider in any such new product. To the extent that the terms for the provision of Covered Services in new products are different than those contained herein in a manner that reduces the payment terms to Provider or would materially change Ancillary Provider's obligations hereunder, they shall be agreed to by the Parties in advance of such participation hereto if Plan offers participation in these programs to Ancillary Provider.

4.2 Assignment – This Agreement, including the rights, benefits and duties hereunder, shall not be assignable by Ancillary Provider without the prior written consent of Plan. Any attempted assignment in violation of this Section 4.2 shall be void *ab initio*. The Parties agree that the terms and conditions of this Agreement are binding upon the Parties and their respective heirs, successors and permitted assigns.

4.3 Governing Law – This Agreement shall be governed by and construed in accordance with the laws of the State of Iowa.

4.4 Insurance – Ancillary Provider will maintain current professional liability insurance to insure against any claim or claims for damages due to personal injury or death arising out of or in any way connected with the acts or omissions to act of Ancillary Provider and/or Ancillary Provider's agents or employees, in the performance of Ancillary Provider's obligations hereunder. Such insurance will have limits of at least one-hundred thousand dollars (\$100,000) per occurrence and three-hundred thousand dollars (\$300,000) aggregate for a year, or such other limits as may from time to time specified in the Quality Improvement Plan or required by state or federal law. Ancillary Provider will notify Plan at least thirty (30) days prior to the termination, cancellation, lapse or reduction of such insurance. Upon request by Plan, Ancillary Provider will provide Plan with policies or other documents evidencing such insurance. If Ancillary Provider procures a "claims-made" policy rather than an "occurrence" policy, Ancillary Provider will procure and maintain, prior to termination of such insurance, "tail" coverage to extend and maintain coverage satisfying the requirements of this Agreement for a period of three (3) years after the later of the end of the term of the "claims-made" policy, or the termination of this Agreement.

4.5 Physical Records – Ancillary Provider shall maintain records in accordance with Plan's Quality Improvement Plan.

4.6 Other Contracts – Nothing contained in this Agreement shall be construed to prevent Ancillary Provider from entering into agreements with other comprehensive health care plans or providing health care services to persons other than Plan's Enrollees. Nothing in this Agreement shall be construed to prevent Plan from contracting with other Ancillary Providers or providers in the same or other areas.

4.7 Counterparts – This Agreement may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which will together constitute one and the same instrument.

4.8 Entire Agreement – This Agreement, including all Attachments, Appendices and other written documents referenced herein, constitutes the entire Agreement of the Parties with respect to the subject matter hereof and supersedes all prior agreements, representations, negotiations, and undertakings not expressly set forth or incorporated herein. The terms of this Agreement shall prevail notwithstanding any variances with the terms and conditions of any written or verbal communication subsequently occurring, except as provided elsewhere in this Agreement. Any written amendment hereto complying with Section 6.2 hereof constitutes a material part of this Agreement as though it was fully set out herein.

4.9 Headings – The headings of this Agreement are for convenience only and will not affect the construction of this Agreement.

4.10 Severability – If any clause or provision of this Agreement is rendered invalid or unenforceable because of any state or federal statute or regulation or ruling by any tribunal of competent jurisdiction, that clause or provision shall be null and void, and any such invalidity or unenforceability shall not affect the validity or enforceability of the remainder of this Agreement.

4.11 Violation of Laws – Notwithstanding any provision contained in this Agreement to the contrary, neither of the Parties, nor any of their respective employees, agents, representatives, consultants or subcontractors shall be required to perform any act which would violate any federal or state statute, regulatory agency rule or regulation,

code, or canon of professional ethics. Ancillary Provider shall be solely responsible for the provision of quality medical care to each Enrollee in accordance with Ancillary Provider's professional judgment and standards of practice in its community.

4.12 Independent Contractors – It is understood that both Parties to this Agreement are independent contractors engaged in the operation of their own respective businesses. Neither party is, or is to be considered as, the agent or employee of the other party for any purpose whatsoever. Nothing in this Agreement shall be construed to establish a relationship of co-partners or joint ventures between the Parties. Neither party has authority to enter into contracts or to assume any obligations for the other party or to make any warranties or representations on behalf of the other party; provided, however, that Plan is expressly authorized and empowered to enter into individual Enrollee and group contracts providing for the receipt by Enrollees of Covered Services pursuant to this Agreement and to enter into Participation Agreements with other Participating Providers.

4.13 Compliance with Disclosure Law – In accordance with Section 952 of the Omnibus Reconciliation Act of 1980, the Parties agree that, until the expiration of four (4) years after the furnishing of Covered Services pursuant to this Agreement, they shall, upon written request, make available to the Secretary of HHS or the Secretary's full authorized representatives, this Agreement and such books, documents and records that are necessary to certify the nature and extent of costs under this Agreement. This provision shall apply only if the value or cost of this Agreement equals ten-thousand dollars (\$10,000) or more over a twelve (12) month period. The availability of each party's books, documents and records shall be subjected at all times to such criteria and procedures for seeking or obtaining access as may be promulgated by the Secretary of HHS in regulations and other applicable laws.

4.14 Dispute Resolution – The Parties shall make reasonable attempts to resolve any and all disputes arising hereunder through informal discussions. In the event the Parties cannot satisfactorily resolve a dispute concerning this Agreement (other than a dispute expressly specified herein as being excluded from operation of this Section 4.13), the Parties will settle the dispute by arbitration in Des Moines, Iowa, in accordance with the commercial arbitration rules of the American Arbitration Association then in effect. Either party may initiate such arbitration by making a written demand for arbitration on the other party within thirty (30) days of the time the dispute arises. Within ten (10) business days of that demand, Plan and Ancillary Provider will jointly select a single mutually agreed upon arbitrator, or, if the Parties cannot agree to such a single arbitrator within such period, then Plan and Ancillary Provider will each designate an arbitrator and give written notice of such designation to the other. The two (2) arbitrators selected by this process will select a third arbitrator and give notice of the selection to Plan and Ancillary Provider. The single arbitrator, or the three (3) arbitrators, as the case may be, will hold a hearing and decide the matter within thirty (30) days after his/her/their selection. In the case of a three (3) arbitrator arbitration, if a unanimous award by the three (3) arbitrators is not possible, the Parties will permit the third arbitrator to render the award alone. The results of the arbitration will be final and binding on both Parties. Any court that has jurisdiction may enter judgment upon an arbitration award rendered pursuant to this section. Plan will pay the fee of the arbitrator it chooses, Ancillary Provider will pay the fee of the arbitrator Ancillary Provider chooses, and the Parties will share equally the fee of the third arbitrator. The arbitrator(s) may award the prevailing party its expenses of the arbitration (including attorney fees) as part of his/her/their award. The Parties exclude the following matters from the operation of this arbitration clause: (1) any counterclaim, cross-claim or third party claim for indemnity or contribution between Ancillary Provider and Plan in any Enrollee's suit against Ancillary Provider, another Participating Provider or Plan, unless a court requires the Parties to submit the Enrollee's entire claim to arbitration; (2) any dispute concerning termination of this Agreement, which claim shall be resolved through the procedures specified for such event in Sections 5.1, 5.2 or 5.3, whichever may be applicable to the particular termination in dispute; and (3) any dispute for which a dispute resolution procedure or mechanism is specified in Plan's Provider Manual.

4.15 Recitals – The recitals are hereby incorporated into and made part of this Agreement.

5 TERMINATION OF AGREEMENT

5.1 Immediate Termination –

- A.** Either party may terminate this Agreement immediately upon written notice to the other party if

such other party: (1) applies for or consents to the appointment of a receiver, trustee, or liquidator for itself or any of its property; (2) admits in writing that it is unable to pay its debts as they become due; (3) executes an assignment for the benefit of creditors; (4) after commencement of an involuntary proceeding against it under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law, answers admitting the material allegations of the petition; or (5) has commenced against it an involuntary proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law which is not dismissed within sixty (60) days.

B. Either party may terminate this Agreement immediately upon written notice to the other party if Plan permanently loses its Plan License or dissolves, or if Ancillary Provider dissolves.

C. Plan may terminate this Agreement pursuant to the credentialing and re-credentialing policies specified in the Quality Improvement Plan. In the event that Plan terminates this Agreement pursuant to such credentialing and re-credentialing policies, Ancillary Provider shall have the appeal and/or hearing rights specified for such circumstances in the Provider Manual.

D. Plan may terminate this Agreement immediately if Ancillary Provider is suspended, terminated or excluded from participation for any length of time from a governmental health care program by any governmental agency.

5.2 Termination without Cause –

A. Either party may terminate this Agreement without cause upon sixty (60) days' prior written notice to the other party.

B. In the event that Plan terminates this Agreement without cause pursuant to this Section 5.2, Ancillary Provider shall have the appeal and/or hearing rights specified for such circumstances in the Provider Manual.

5.3 Termination for Cause –

A. Either party may terminate this Agreement upon the other party's material breach if the non-breaching party has given sixty (60) days' prior written notice specifying the material breach to the breaching party and, at the end of the sixty (60) days, the breaching party has not cured the breach specified in such notice.

B. In the event that Plan terminates this Agreement for cause pursuant to this Section 5.3, Ancillary Provider shall have the appeal and/or hearing rights specified for such circumstances in the Provider Manual.

5.4 Obligation to Enrollee on Termination – Ancillary Provider will continue to provide Ancillary Provider Services to Enrollees that Ancillary Provider is actively treating at the time of termination in accordance with dictates of medical prudence until Ancillary Provider completes such treatment or until Plan makes arrangements to have another Participating Provider provide such services. The provisions of this Agreement, including those pertaining to Ancillary Provider's compensation for Ancillary Provider Services, shall continue to apply after termination of this Agreement to all Ancillary Provider Services provided by Ancillary Provider prior to termination of this Agreement and to all post-termination Ancillary Provider Services provided by Ancillary Provider pursuant to this Section 5.4, provided that the post-termination services were medically necessary and properly authorized according to Plan's policies and procedures, and the Enrollee's coverage was in effect on the date(s) of such authorization.

5.5 Notification of Termination – In the event that this Agreement is terminated or is not renewed for any reason, Plan shall be responsible for notifying all Enrollees covered under this Agreement of the date of such termination or expiration. To the extent possible, for any termination initiated by Ancillary Provider, Ancillary Provider agrees to inform Enrollees seeking medical care thirty (30) days' prior to the date of such termination that Ancillary Provider will no longer be a Participating Provider.

5.6 Account Reconciliation – If this Agreement is terminated, Ancillary Provider will supply Plan with all

information necessary for the reimbursement of outstanding claims within ninety (90) days after the date on which service was rendered. Ancillary Provider's accounts will be reconciled within the later of ninety (90) days after the date of termination or expiration, or forty-five (45) days after Plan's receipt of Ancillary Provider's final claim for reimbursement.

6 EFFECTIVE TERM, AMENDMENT, AND NOTICE

6.1 Term of Agreement –

A. The term of this Agreement will commence on the latest of the two dates specified on the Signature Page hereof, will continue in effect for a period of twelve (12) months, and will automatically renew thereafter for successive terms of one (1) year each, unless sooner terminated pursuant to the terms and conditions hereof.

6.2 Amendments –

A. Plan may amend Plan's Provider Manual or Quality Improvement Plan and/or any of Plan's policies, procedures and protocols governing Utilization Management Plan and Quality Improvement Plan by delivering written notice of such amendment to Ancillary Provider at least thirty (30) days' prior to the effective date thereof. Plan may also amend this Agreement immediately if such amendment is necessary in order to comply with applicable statutes and/or regulations; provided that Plan shall provide Ancillary Provider with prompt written notice of such amendment.

B. Except as provided in Section 6.2(A), this Agreement can be amended, altered or varied only by a written agreement duly executed by both Plan and Ancillary Provider, which expressly references this Agreement and specifies the effective date of the amendment, which date shall be thirty (30) days after the amendment is executed or such other date as agreed to by Plan and Ancillary Provider.

C. No oral understanding or agreement shall be valid or binding on the Parties.

D. The foregoing notwithstanding, this Agreement can only be amended if neither such amendment, nor its implementation violates state or federal statutes or regulations.

6.3 Notices – Notices to the Parties as to any matter hereunder will be sufficient only if given in writing and sent by facsimile, certified mail, postage prepaid, or delivered by hand (provided that the sender maintains written evidence of receipt) to the Parties' addresses specified on the Signature Page hereof.

7 SERVICES COVERED UNDER THIS AGREEMENT

Attachment B - Meridian Health Plan of Iowa Medicaid Managed Care Network

Attachment C - Meridian Advantage Plan of Iowa (HMO SNP) Medicare MA-PD Plan Network

Attachment D - Meridian Health Plan Commercial HMO Network

Attachment E - MMAI Network []

Other _____

[Signature Page Follows]

IN WITNESS WHEREOF, to signify their agreement to all of the terms and conditions hereof, the Parties have executed this Agreement as of the date(s) stated below:

To be completed by Ancillary Provider:

To be completed by Meridian Health Plan of Iowa:

| | |
|---|--|
| <p>Ancillary Provider Name: _____</p> <p>Address: _____ _____ _____</p> <p>Telephone () _____</p> <p>Signature _____</p> <p>Title _____</p> <p>Date _____</p> | <p>Meridian Health Plan of Iowa 666 Grand Avenue, 14th Floor Des Moines, Iowa 50309 (888) 773-2647</p> <p>_____ Signature</p> <p><u>Raymond Pitera</u> Printed Name</p> <p><u>President/COO</u> Title</p> <p>_____ Date</p> |
|---|--|

Attachments and Appendices:

- Attachment A - Schedule of Ancillary Provider Services
- Attachment B - Medicaid
- Attachment C - Medicare
- Attachment D - Commercial
- Attachment E - MMAI
- Appendix I - Ancillary Provider Acknowledgement
- Appendix II - Ancillary Providers
Provider Disclosure Information Request

ATTACHMENT A
Meridian Health Plan
-Schedule of Ancillary Provider Services-

Reimbursable services are those ancillary services as indicated below which are Covered Services and for which the Ancillary Provider may submit itemized claims for Fee-For-Service payment pursuant to Attachment C Payment Administration.

- ___ Chiropractic
- ___ Home Health
- ___ Hospice
- ___ Durable Medical Equipment
- ___ Skilled Nursing Facility
- ___ Prosthetics and Orthotics
- ___ Hearing Aids
- ___ Physical Therapy
- ___ Occupational Therapy
- ___ Optometry – Vision and Optical
- ___ Speech Therapy
- ___ Pharmacy
- ___ Infusion Services
- ___ Free Standing Surgical Center
- ___ Laboratory
- ___ Nursing Homes
- ___ Free Standing Radiology Center
- ___ Free Standing Urgent Care Center

ATTACHMENT B
Meridian Health Plan
-Medicaid-

REIMBURSEMENT FOR MEDICAID ENROLLEES

Reimbursement will be rendered consistent with 100% of the prevailing Iowa Medicaid Fee Screens minus any applicable copayments, coinsurance and/or deductibles.

REGULATORY REQUIREMENTS

In accordance with regulations, laws and official guidance applicable to Medicaid plans:

1. **Subcontractors** - The parties agree that Ancillary Provider, in performing its duties and obligations hereunder, shall have the right, subject to the credentialing and re-credentialing requirements described in this Agreement, either to employ its own employees and agents or to utilize the services of persons, firms and other entities by means of subcontractual relationships; provided, however, that no such subcontract shall operate to relieve Ancillary Provider of its obligations hereunder and further provided that the format for all such subcontracts shall have been approved by the IID with the advice of the DHS, in the event that either agency requires such approval; and further provided that Plan's liability for reimbursement hereunder shall extend only to Ancillary Provider, and only to the sums provided for herein, and that Ancillary Provider shall be solely responsible for reimbursement and/or payment of any employee or agent of Ancillary Provider for services performed pursuant to this Agreement. All such subcontracts shall be in writing and fulfill requirements of 42 CFR 434.6 that are appropriate to the service or activity delegated under the subcontract.

2. **Plan Obligations to DHS** - Anything herein to the contrary notwithstanding, no term or provision of this Agreement shall operate to terminate the legal responsibility of Plan to the DHS, in concurrence with the IID, with respect to Enrollees eligible for benefits under Title XIX and Title XXI of the Social Security Act (Medicaid and SCHIP). Ancillary Provider agrees that no subcontract can terminate the legal responsibility of Ancillary Provider to DHS with respect to Enrollees eligible for benefits under Title XIX and Title XXI of the Social Security Act (Medicaid and SCHIP). Ancillary Provider will assist Plan in meeting its obligations under Plan's agreement with the DHS, in concurrence with the IID with respect to Enrollees eligible for benefits under Title XIX of the Social Security Act, and hereby agrees to the terms and conditions of such agreement as they pertain or apply to subcontractors.

3. **DHS Agreement** - Ancillary Provider will assist Plan in meeting its obligations under Plan's agreement with the DHS, in concurrence with IID with respect to Enrollees eligible for benefits under Title XIX of the Social Security Act (Medicaid), and hereby agrees to the terms and conditions of such agreement as they pertain or apply to subcontractors.

4. **Timely Access** – Ancillary Provider shall meet Iowa standards for timely access to care and services, taking into account the urgency of the need for services. Ancillary Provider shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the Ancillary Provider serves only Medicaid enrollees. Ancillary Provider shall ensure that Covered Services included in this Agreement are available 24 hours a day, 7 days a week, when medically necessary. Ancillary Provider shall cooperate with all Plan monitoring and compliance mechanisms for ensuring timely access to services under this Section 4. Plan shall take corrective action for failure to comply with this Section.

5. **Medicaid Certification** – Ancillary Provider represents that it is eligible for Medicaid Certification and warrants that it will maintain such eligibility throughout the term of this Agreement.

6. **Consumer Protection** – Ancillary Provider shall comply the consumer protection provisions outlined in the Marketing guidelines as set forth in Plan's contract with DHS.

7. **Utilization Review Policy Compliance** – Ancillary Provider shall follow and assist in the implementation of Plan’s written utilization review policies and procedures as outlined in the Utilization Management Plan and Plan Policies.

8. **State Held Harmless** – Ancillary Provider agrees that any dispute between Ancillary Provider and Plan shall be solely between such Ancillary Provider and Plan. The State of Iowa, Department and its officers, employees and agents and Enrollees shall not be responsible for any and all actions, claims, demands, damages, liabilities, or suits of any nature whatsoever arising out of this Agreement because of any breach by Plan or Ancillary Provider or employees, including but not limited to any negligent or wrongful acts, occurrence of omission of commission or negligence of the Plan or Ancillary Provider, their subcontractors, agents, providers, or employees.

9. **Disclosure of Excluded Persons** – Ancillary Provider is obligated to disclose the identity of any person described in 42 C.F.R. § 1001.1001(a)(1) to the Plan for disclosure to DHS. Plan must abide by any direction provided by the DHS regarding whether or not to permit Ancillary Provider for participation in the Iowa Plan for Behavioral Care. If any person who has ownership or control interest in Ancillary Provider, or who is an agent or managing employee of the Ancillary Provider, has been convicted of a criminal offense related to that person’s involvement in any program established under Medicare, Medicaid, or the Title XX Services program, or if DHS or the Plan determines that the Ancillary Provider did not fully and accurately make any disclosure required pursuant to 42 C.F.R. § 1001.1001(a)(1), then Plan will abide by any direction provided by DHS on whether or not to permit the applicant to be an Ancillary Provider in the Iowa Plan for Behavioral Care.

10. **Additional Disclosures** – Ancillary Provider agrees to furnish to Plan, DHS, or the Secretary on request, within 35 days of the request, a full and complete listing about:

a) The ownership of any Subcontractor with whom Ancillary Provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and

b) Any significant business transactions between Ancillary Provider and any wholly owned supplier, or between the Provider and any Subcontractor, during the 5-year period ending on the date of the request.

Federal Financial Participation (FFP) shall be denied for expenditures for services furnished by Ancillary Provider where Ancillary Provider fails to comply with requirements of this Section 13.

11. **Enrollee Hold Harmless** – Ancillary Provider, or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by Plan, Plan insolvency or breach of this agreement, shall Ancillary Provider, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than Plan acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on HMO’s behalf made in accordance with terms of (applicable Agreement) between Plan and subscriber/enrollee. Ancillary Provider, or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Plan subscriber/enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Ancillary Provider and subscriber/enrollee or persons acting on their behalf.

In addition, Medicaid Enrollees shall not be held liable for any of the following: a) Plan’s debts, in the event of Plan insolvency; b) Covered Services provided to the Enrollee, for which either DHS does not pay the Plan or DHS or the Plan does not pay the Ancillary Provider that furnishes the services under a contractual, referral, or other arrangement; or c) Payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if the Plan provided the services directly.

ATTACHMENT C
Meridian Health Plan
-Medicare-

REIMBURSEMENT FOR MEDICARE ENROLLEES

Reimbursement will be rendered consistent with 100% of the prevailing Medicare Fee Screens minus any applicable copayments, coinsurance and/or deductibles.

REGULATORY REQUIREMENTS FOR MEDICARE

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (“MMA”); and

Except as provided herein, all other provisions of the Agreement between Plan and Ancillary Provider not inconsistent herein shall remain in full force and effect.

Definitions:

Centers for Medicare and Medicaid Services (“CMS”): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage (“MA”): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization (“MA organization”): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or

regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than \$2,500 during a contract period.

Required Provisions:

Ancillary Provider agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Plan, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]
2. Ancillary Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]
3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Ancillary Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
5. Any services or other activity performed in accordance with a contract or written agreement by Ancillary Provider are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]
6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the Plan and Ancillary Provider. [42 C.F.R. §§ 422.520(b)(1) and (2)] In accordance with 42 C.F.R. § 422.520(b), Ancillary Provider shall provide to Plan all information necessary for Plan to establish proper payment. Plan shall pay Provider for Covered Services rendered to Covered Persons in accordance with Section 2.5 of the Agreement. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by Plan at such address as may be designated by Plan, and Plan shall pay interest on any Clean Claim not paid within thirty (30) days of such receipt by Plan at the rate of interest required by law, or as otherwise set forth in the Provider Manual.
7. Ancillary Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]
8. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to

any first tier, downstream and related entity:

- (i) The delegated activities and reporting responsibilities are specified as follows:

The delegated activities are specified in the Agreement, if any.

- (ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.
- (iii) The MA organization will monitor the performance of the parties on an ongoing basis.
- (iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.
- (v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.

[42 C.F.R. §§ 422.504(i)(4) and (5)]

ATTACHMENT D
Meridian Health Plan
-Commercial-

REIMBURSEMENT FOR COMMERCIAL ENROLLEES

Ancillary Provider's total reimbursement for Covered Services shall be defined by the Plan's Commercial Fee Schedule applicable to each individual Enrollee. Prior to the introduction of any Commercial Fee Schedule applicable to any Enrollee, or any material modification to an existing Commercial Fee Schedule, Plan will provide Ancillary Provider with sixty (60) days' advance notice in writing. If Ancillary Provider objects to the Fee Schedule as proposed, Ancillary Provider retains the right to terminate participation as to the Commercial line of business only by providing Plan with written notice prior to the expiration of the sixty (60) day notice period. Silence on the part of Ancillary Provider shall be deemed as acceptance of the new or modified Fee Schedule and continued participation in the applicable product line.

ATTACHMENT E
Meridian Health Plan
-MMAI-

REIMBURSEMENT FOR MMAI ENROLLEES

Medicare and Medicaid Covered Services

For Covered Services that are both Medicare and Medicaid Covered Services, Provider shall be entitled to the lesser of: (1) Ancillary Provider's billed charges; or (2) the amount payable by Medicare, not including Medicare coinsurance and deductibles, plus the amount payable by Medicaid as a secondary coverage based on the Medicaid fee schedule in effect on the date of service.

Medicare Only Covered Services

For Covered Services that are Medicare Covered Services, but not Medicaid Covered Services, Plan shall pay Ancillary Provider the lesser of: (1) Ancillary Provider's billed charges; or 100% of the Medicare fee schedule in effect on the date of service minus any applicable copays, coinsurance or deductibles.

Medicaid Only Covered Services

For Covered Services that are Medicaid Covered Services, but not Medicare Covered Services, Plan shall pay Ancillary Provider the lesser of: (1) Ancillary Provider's billed charges; or (2) 100% of the Medicaid fee schedule in effect on the date of service.

REGULATORY REQUIREMENTS

Ancillary Provider is subject to all applicable Medicaid and Medicare Regulatory Requirements set forth above. In addition, Ancillary Provider is subject to the following:

Cultural Considerations. Services will be provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 CFR 422.112(a)(8)

APPENDIX I
Meridian Health Plan
-Organization Provider Acknowledgement-

ACKNOWLEDGMENT

of
Agreement between Meridian Health Plan of Iowa, Inc.
and

I am a physician, hospital or other health care provider employed by or under contract with the above named Organization to furnish health care services at, as a member of, or on behalf of such Organization.

I have received and reviewed a copy of the Participation Agreement between Meridian Health Plan of Iowa, Inc. (“Plan”) and the above named Organization (“Organization Master Agreement”); and, wishing to provide health care services to Enrollees of Plan encompassed by that Organization Master Agreement and to obtain the benefit of the terms of that Agreement, agree to abide by and be bound by its terms. I acknowledge and agree that the terms and conditions of Plan’s standard Primary Care Agreement and/or Specialty Agreement (each a “Participation Agreement”), whichever may be applicable, are incorporated herein by reference as material terms hereof and shall also be binding upon and apply to me except as, and only to the extent that, they are contradicted by the express terms of the Organization Master Agreement, and that in the event of any conflict between the terms and conditions of that Organization Master Agreement and the terms and conditions of the applicable Participation Agreement, the terms and conditions of that Organization Master Agreement shall supersede and govern with respect to me.

I agree to submit for review by Plan all required information necessary for my credentialing and re-credentialing in accordance with the standards established by Plan and described in Plan’s Quality Improvement Plan. I acknowledge and agree that my Participating Provider status is dependent upon my successful completion of credentialing and re-credentialing in accordance with Plan’s Quality Improvement Plan. I further agree to participate in Plan’s credentialing and re-credentialing processes and to be bound by all Plan decisions with respect thereto.

I agree to look only to Plan for compensation for services rendered to an Enrollee when such services are covered by Plan’s individual Enrollee or group contracts. I agree not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against Enrollee or persons acting on behalf of Enrollee (other than Plan), except as permitted under the Coordination of Benefits Section of the applicable Participation Agreement. I agree not to maintain any action at law or in equity against an Enrollee to collect sums that are owed by Plan to me under the terms of this Agreement, even in the event Plan fails to pay, becomes insolvent or otherwise breaches the terms and conditions of this Agreement. This provision shall survive termination of this Agreement or the Participation Agreement, regardless of the cause of termination and shall be construed to be for the benefit of Enrollees. This provision is not intended to apply to services provided after my Participation Agreement has been terminated, except as otherwise provided in the Organization Master Agreement or my Participation Agreement, or to non-covered services. I further agree that this provision supersedes any oral or written agreement, hereinafter entered into between myself and Enrollee or persons acting on Enrollee’s behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of my Participation Agreement.

I agree to be bound by all federal and state Laws and regulations and to comply with participate in and be bound by all policies, procedures and protocols set forth in Plan’s Quality Improvement Plan and Provider Manual. I further

agree to submit to requests by Plan (and authorized regulatory agencies) to review my books and records as outlined in this Agreement.

As a further condition precedent to my Participating Provider status, I hereby acknowledge the authority of the above named Organization to execute Participation Agreements and other participation-related contracts and documents with Plan on my behalf and to thereby bind me to the terms thereof.

(Signature of Organization Provider)

(Date)

Printed name, office address and phone number:

APPENDIX II
Meridian Health Plan
-Ancillary Providers-

Please list all Ancillary Providers covered under this Agreement

Provider Disclosure of Ownership and Control Interest Form



The federal regulations set forth in 42 CFR 455.104-106 require all providers who are entering into or renewing a provider agreement (“Disclosing Entities”) to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to managed care organizations that contract with the State Medicaid Agency: a) the identities of all owners with a control interest of 5% or greater, b) all agents or managing employees of the Disclosing Entity c) details of certain familial relationships between owners or owners of subcontractors owned by the Disclosing Entity, and d) the identities of any excluded individual or entity with an ownership or control interest in the Disclosing Entity. As used herein, a ‘person’ includes individuals and corporations or other business entities. **Please attach additional sheets as necessary.**

- Individuals listed in Sections 1-6 will be reviewed for inclusion on the Excluded Parties List System.
- Individuals listed in Section 7 will be reported to the HHS/Office of Inspector General (OIG) and to DHS.

| DISCLOSING ENTITY | | |
|---|------------------|----------------------|
| Check one that mostly describes you: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity | | |
| Name of Disclosing Entity: | | |
| DBA Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |
| Tax ID Number (TIN): | NPI (Individual) | NPI (Organizational) |

| SECTION 1 — Ownership and Control of Disclosing Entity | | | |
|--|---------------------------------|---|---|
| List the name, address, date of birth (DOB) and Social Security Number (or TIN for corporations) for each person with an ownership or control interest of 5% or more in the Disclosing Entity (including corporate entities, officers, directors, or partners). (42 CFR 455.104) | | | |
| Name of Individual or Entity: | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) |
| | | | |
| | | | |
| | | | |

| SECTION 2 — Ownership and Control of Disclosing Entity by Relatives | |
|---|--------------|
| Are any of the individuals listed in Section 1 related to each other? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If yes, disclose each person listed in Section 1 who are related to another person with ownership or control interest in the Disclosing Entity as a spouse, parent, child, or sibling. (42 CFR 455.104) | |
| Name of Individual | Relationship |
| | |
| | |

| SECTION 3 — Ownership And Control of Subcontractors | | | |
|--|---------------------------------|---|---|
| Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the Disclosing Entity has direct or indirect ownership of 5% or more. (42 CFR 455.104) | | | |
| Name of Individual or Entity with an Ownership Interest and Name of Subcontractor | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) of owner and SSN or TIN for subcontractor |
| | | | |
| | | | |

Continued on next page

SECTION 4 — Ownership and Control of Disclosing Entity by Relatives of Subcontractors

Are any of the individuals or entities listed in Section 3 related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling? Yes No

If yes, disclose each person listed in Section 3 who is related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling. (42 CFR 455.104)

| Name of Individual from Section 3 | Relationship |
|-----------------------------------|--------------|
| | |
| | |

SECTION 5 — Ownership and Control of any Other Disclosing Entity

Is there any Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which a person listed in Section 1 has an ownership or control interest? Yes No

If yes, list each Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which the person listed in Section 1 has an ownership or control interest.

An "Other Disclosing Entity" is usually an entity that either participates in Medicaid or is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVII (Grants for Planning Comprehensive Action to Combat Mental Retardation), or XX (Block Grants to States for Social Services) of the Social Security Act. (42 CFR 455.104)

| Name of Individual or Entity from Section 1 | Name of the other Disclosing Entity | % Interest |
|---|-------------------------------------|------------|
| | | |
| | | |

SECTION 6 — Managing Employees

List all managing employees of the Disclosing Entity along with the additional information indicated below. *A managing employee is a "general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency." (42 CFR 455.104)*

| Name of Individual or Entity: | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) |
|-------------------------------|---------------------------------|---|---|
| | | | |
| | | | |
| | | | |

SECTION 7 — Criminal Offenses

Has any person with an ownership or control interest in the Disclosing Entity, or any agent or managing employee of the Disclosing Entity ever been convicted of a crime related to that individual or entity's involvement in any program under Medicaid, Medicare, or Title XX program since the inception of those programs? Yes No (verify through HHS-OIG Website)

If yes, please list those individuals below. (42 CFR 455.106)

| Name if Individual or Entity: | Date of Birth (for individuals) | Description of Offense(s) | Social Security Number (or TIN for corporation) |
|-------------------------------|---------------------------------|---------------------------|---|
| | | | |
| | | | |

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature

Title

Printed Name

Date

Please return completed forms by faxing 313-202-0008 or by emailing providerdisclosure@mhplan.com.



Meridian

Health Plan

IOWA DELEGATED CREDENTIALING AGREEMENT

This Agreement is entered into between the Meridian Health Plan of Iowa, Inc. (Meridian) and _____ (Delegate) for the purpose of allowing the Delegate to perform delegated credentialing activities for Meridian plan providers including the establishment and maintenance of complete credentialing records at their business location in compliance with the Meridian credentialing program.

RECITALS

- A. Meridian is licensed as a Health Maintenance Organization in the State of Iowa;
- B. Delegate is a Physician Hospital or Physician Organization whose scope of operations includes providing health care services;
- C. The Parties have entered into an agreement where Delegate has agreed to provide certain healthcare services to Meridian members in accordance with the terms set forth in the Hospital , Practitioner, and/or Organization Agreement (collectively, "Provider Agreement");
- D. Both Meridian and Delegate acknowledge that approval from the appropriate regulatory bodies may be required in order to delegate the functions specified in this Agreement to Delegate;
- E. Both Meridian and Delegate recognize that regulatory bodies may rescind or limit Meridian's ability to delegate credentialing activities if such regulatory determines that Meridian or Delegate have failed to comply with the terms of this Agreement; and
- F. Meridian and Delegate desire to enter into this Agreement so that Delegate can perform credentialing services sufficient to meet the requirements of Meridian through its internal credentialing system without submitting and maintaining duplicates of all provider files to Meridian for their records and storage.

In consideration of the foregoing and other good and valuable consideration, the sufficiency of which is hereby acknowledged, the Parties agree as follows:

ARTICLE I DEFINITIONS

Unless otherwise specifically provided, the terms used in this Agreement shall have the meanings set forth below. Other defined terms applicable to this Agreement may appear in the Hospital Services Agreement.

- 1.1 CMS means the Centers for Medicare and Medicaid Services.
- 1.2 Corrective Action Plan means a plan developed by the Delegate to address any violation of Articles IV, V, VIII or X of this Agreement, as required by Meridian Health Plan.
- 1.4 Corrective Action Plan Notice means the written notification that Meridian Health Plan will provide to the Delegates regarding the necessity for a Corrective Action Plan.
- 1.5 Credentialed Provider List means a report, in a pre-approved format, provided to Meridian by Delegate of the providers credentialed during the most recent applicable reporting period as set forth in this Agreement.



- 1.6 Credentialing Committee means that committee, or equivalent peer review body, of the Delegate that will include representation from multiple practitioner specialties and will be responsible for all credentialing and recredentialing decisions of the Delegate.
- 1.7 Delegate means _____ **[Delegate name]** as set forth in the preamble to this Agreement.
- 1.8 Effective Date means that date first written above in the preamble to this Agreement, as more fully defined in Section 2.1.
- 1.9 Initial Data File means information provided to Meridian by the Delegate with respect to those practitioners that were credentialed by the Delegate prior to the Effective Date.
- 1.10 Meridian means Meridian Health Plan of Iowa, Inc.
- 1.11 NCQA means the National Committee for Quality Assurance.
- 1.12 Participating Practitioner means a physician who has executed a Participation Agreement
- 1.13 Primary Care Practitioner means a physician who is duly licensed to practice allopathic or osteopathic medicine, who has executed an Agreement to function as the physician case manager for Enrollees by providing, arranging for and coordinating the provision of Covered Services to Enrollees, and has been credentialed in accordance with Plan's requirements and procedures for credentialing and re-credentialing. A Primary Care Practitioner may be a general practitioner, internist, pediatrician, family practitioner or obstetrician/gynecologist.
- 1.14 Recredentialed Provider List means a report in a pre-approved format, provided to Meridian by Delegate of the providers re-credentialed during the most recent applicable reporting period as set forth in this Agreement.
- 1.15 Regulatory Agency(ies) means the applicable government entity(ies) that govern and/or provide oversight of Medicare, insurance or health issues for a state or the federal government, or any other interested governmental entity which has jurisdiction over Meridian Health Plan with respect to the administration of Medicaid healthcare services, including but not limited to CMS. For purposes of this definition, this will include any Regulatory Agency's representative, agent or designee.
- 1.16 Specialty Care Practitioner means a practitioner who provides specialty care services to Members who have been referred by the Member's Primary Care Practitioner.

ARTICLE II
TERM AND TERMINATION

- 2.1 Term of Agreement. The term of this Agreement will commence on the latest of the two dates specified on the signature page of this Agreement, will continue in effect for a period of twelve (12) months, and will automatically renew thereafter for one (1) year terms unless terminated in accordance with this Section 3.
- 2.2 Termination without Cause. Either Party may terminate this Agreement without cause upon sixty (60) days' prior written notice to the other Party.
- 2.3 Termination for Cause. Either Party may terminate this Agreement upon the other party's material breach if the non-breaching Party has given sixty (60) days' prior written notice specifying the material



breach to the breaching party and the breaching party has not cured the specified breach within the sixty (60) day period.

2.4 Automatic Termination. This Agreement will automatically terminate if any of the following events occur:

A. Meridian loss of Certificate of Authority as an HMO;

B. If either Party (1) applies for or consents to the appointment of a receiver, trustee, or liquidation for itself or any of its property; (2) admits in writing that it is unable to pay its debts as they become due; (3) executes an assignment for the benefit of creditors; (4) after commencement of an involuntary proceeding against it under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law, answers admitting the material allegations of the petition; or (5) has commenced against it an involuntary proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law which is not dismissed within sixty (60) days.

C. Delegate's state license (as applicable), Medicare or Medicaid certification, TJC or AOA accreditation is revoked, terminated, or suspended or Meridian reasonably believes an enrollee's health/well-being is or will be in jeopardy;

D. Suspension, termination, or exclusion of Delegate from participation for any length of time from a governmental health care program by any governmental agency;

E. Delegate is excluded from participation under Title V, Title XVIII, Title XIX, or Title XX of the Social Security Act

F. If Delegate is a Provider, Termination of the underlying Provider Agreement.

2.5 Immediate Suspension or Termination. If Meridian determines, in its sole discretion, that based on a review of Delegate's records that there are problems that could be resolved through remediation, a Corrective Action Plan will be developed and agreed upon by both Parties as set forth in Article V, to include the date for a repeat review not more than six (6) months following the unsatisfactory review. Notwithstanding the foregoing, Meridian may suspend or terminate this Agreement immediately and with no prior notice if upon review of the records maintained by Delegate, Meridian determines that the credentialing records and information is insufficient to meet Meridian's legal obligations to the state and federal entities.

2.6 Event of Termination. In the event of termination, Delegate must provide copies of files relating to the delegated services provided by Delegate under this Agreement within sixty (60) days of the termination date.

ARTICLE III OBLIGATIONS OF DELEGATE

3.1 Scope of Credentialing Services. The Delegate will perform credentialing and recredentialing for all practitioners affiliated with the Entity. Delegate will not be responsible for the credentialing and recredentialing of facility and ancillary providers. The scope of credentialing services covered under this Agreement may be modified only by an amendment signed by both parties.

3.2 General Process. The Delegate will accept for review all initial applications, recredentialing applications and attestations submitted by those practitioners electing to participate with Delegate



and be a Meridian Participating Practitioner. The Delegate will make credentialing decisions with respect to initial credentialing and recredentialing applications and will report the results of its initial credentialing and recredentialing to Meridian on a monthly basis through submission of Credentialed and Recredentialed data in a pre-approved format.

In performing its obligations under this Agreement, the Delegate will perform those functions for which it is deemed responsible in Exhibit A-3.

- 3.3 Credentialing Committee. The Delegate will develop and maintain a Credentialing Committee, or an equivalent peer review body, that will be comprised of practitioners from multiple practitioner specialties, including those types of practitioners reviewed by the Credentialing Committee. The Credentialing Committee will be responsible for all credentialing and recredentialing decisions of the Delegate. The Delegate will maintain a chairperson who will be included as a member of the Credentialing Committee and will oversee all of the Credentialing Committee's activities. The Delegate will submit copies of the Credentialing Committee meeting minutes that evidence the Credentialing Committee's review process(es) and decision making as required by Meridian. The Delegate will submit a list of the Credentialing Committee membership to Meridian upon the Effective Date and when there is a change in the composition of the Credentialing Committee
- 3.4 Policies and Procedures The Credentialing Entity, through its Credentialing Committee, will develop and maintain comprehensive credentialing and recredentialing policies and procedures, the contents of which are more fully described below, will (i) be reviewed by the Delegate, revised if necessary, and approved by the Credentialing Committee not less frequently than once per calendar year, and (ii) will, at all times, be in full compliance with the standards set forth in this Agreement, as well as the standards set forth by CMS, NCQA, any applicable Regulatory Agency and/or Meridian as now existing or as may be created or amended from time to time. Delegate agrees to create new policies and procedures as needed or required.

In the event that CMS, NCQA, any Regulatory Agency or Meridian changes its credentialing policy and procedure requirements, Meridian will notify the Delegate of such change(s) and the Delegate will, thereafter, amend its policies and procedures in order to comply with such change(s). Delegate will submit revised policies and procedures to Meridian within ninety (90) calendar days of receiving such notification from Meridian. The policies and procedures adopted and maintained by the Delegate must, at a minimum, address the following:

- A. To the extent applicable, standards for initial credentialing and recredentialing of (i) medical and osteopathic practitioners, including behavioral health practitioners, (ii) podiatrists, (iii) oral and maxillofacial surgeons, (iv) chiropractors, (v) registered nurse practitioners, (vi) physician assistants, and (vii) certified nurse midwives that will assure non-discriminatory credentialing and recredentialing decisions.
- B. In accordance with Section 3.6, a process for assuring that the offices of all Primary Care Practitioners meet CMS, Meridian, NCQA and any applicable Regulatory Agency standards.
- C. In accordance with Section 3.6, a process for identifying, tracking and reporting to Meridian instances where any Primary Care Practitioner who is a Participating Practitioner (i) relocates an existing office from one location to another, (ii) opens a new office to operate in addition to the currently existing office(s) or (iii) departs an existing practice in favor of opening a new office. Delegate shall communicate such changes to Meridian as a provider change. Delegate shall assure that the results of site visits conducted in these instances are included in the recredentialing decision for the practitioner.



Meridian

Health Plan

- D. A process for recredentialing practitioners based upon performance that considers factors including, but not limited to, (i) quality of care issues, (ii) Member complaints and (iii) practitioner sanctions. The recredentialing policy must set forth the manner in which Meridian's performance data reports for each Participating Practitioner will be incorporated into the recredentialing process.
- E. Standards for verifying credentials that include specific listings of information considered by the Delegate as primary source verification for each item required in the credentialing or recredentialing process.
- F. A quality assurance process that assures that information regarding a practitioner's education, training, certification and specialty, which the Delegate provides to Meridian for use in Meridian's provider directory, is true, complete and accurate.
- G. Processes for the acceptance of initial credentialing applications, recredentialing applications and attestations.
- H. Processes for the presentation of practitioners to the Credentialing Committee for approval.
- I. In accordance with Section 3.9, a process for the continuous and ongoing collection and evaluation of ongoing monitoring information between recredentialing cycles. Monitoring activities will include, but will not be limited to, the continuous and ongoing monitoring and reporting of actions taken against practitioners who have been sanctioned and/or have had complaints levied against them.
- J. A process to assure that practitioners are notified of the credentialing or recredentialing decision within ten (10) calendar days of the Delegate's decision.
- K. Processes for (i) notifying practitioners of their right, upon written request, to be informed of the status of their application during the credentialing or recredentialing process and (ii) drafting, completing and sending responses to such requests.
- L. Processes designed to assure the confidentiality of patient and practitioner data including, but not limited to, information obtained during the credentialing or recredentialing process.
- M. Processes regarding the release of confidential patient and practitioner information.
- N. Processes for allowing practitioners to review and correct discrepancies in information obtained during the credentialing or recredentialing process.
- O. Processes regarding the termination or alteration of conditions of a practitioner's participation in the Delegate's network to assure that practitioners receive due process in accordance with the Health Care Quality Improvement Act as set forth in 42 USC §§ 11101-11152.

The Delegate will submit its credentialing and recredentialing policies and procedures for review by Meridian not less frequently than once per calendar year and upon request. Upon any revision or modification to Delegate's credentialing or recredentialing policies or procedures, Delegate will immediately notify Meridian of such modifications or revisions by providing Meridian with a redlined version of the policy and/or procedure that identifies all changes. The Delegate will also provide Meridian with a clean copy of such modified or revised credentialing or recredentialing policy(ies) or procedure(s).



3.4.1 Compliance Policies and Procedures. Delegate agrees to maintain compliance policies and procedures that will (i) be updated by the Delegate and approved by the Credentialing Committee not less frequently than once per calendar year and (ii) will, at all times, be in full compliance with the standards set forth by CMS, Meridian, NCQA, any applicable Regulatory Agency and this Agreement. Delegate agrees to create new policies as needed or required. The compliance policies and procedures adopted and maintained by the Delegate must address, at a minimum, the following:

- A. Processes for periodically reviewing and updating Delegate's code of conduct document not less frequently than once per year.
- B. Processes by which new employees sign an attestation to the effect that the employee is not excluded from federally funded programs.
- C. Processes by which members of Delegate's Board of Directors and existing employees
 - a. sign an attestation to the effect that the Board member or employee, as applicable, is not excluded from federally funded programs at least once per calendar year.
 - b. review the Delegate's conflict of interest policy(ies) and disclose all actual or perceived conflict(s) of interest at least once per calendar year
- D. Processes by which Delegate completes training for new employees. The topics addressed in Delegate's training for new employees shall include, at a minimum, the following:
 - a. HIPAA compliance
 - b. Code of conduct
 - c. Fraud and abuse
 - d. System security components

Delegate's compliance policies and procedures shall also address the process by which Delegate demonstrates employees' comprehension of the materials presented during training for new employees.

- E. Processes by which Delegate conducts compliance training for all existing employees not less frequently than once per calendar year. The topics addressed in Delegate's compliance training for all existing employees shall include, at a minimum, the following topics:
 - a. Confidentiality
 - b. Code of conduct
 - c. Conflict of interest
 - d. Reporting of potential compliance concerns
 - e. Reporting of potential fraud, waste and/or abuse concerns
 - f. HIPAA compliance
 - g. Risks to organizations
 - h. Stark Law
 - i. Anti-Kickback Statute
 - j. False Claims Act(s)



Delegate's compliance policies and procedures shall also address the process by which Delegate demonstrates employees' comprehension of the materials presented during annual compliance training.

- F. Processes by which Delegate conducts annual compliance training for members of Credentialing Entity's Board of Directors concerning the structure and operation of the organization's compliance program.

3.5 Primary Source Verification. All data collected by Delegate for primary source verification of credentials must meet certain criteria as set forth from time to time by CMS, Meridian, applicable, Regulatory Agencies and NCQA. Pursuant to its obligations under this Agreement, Delegate's must obtain and/or verify the following information, which information must not be older than one hundred eighty (180) calendar days when a decision is made by the Credentialing Committee:

- A. Practitioner Application and Disclosure Questions: Provide written or verbal explanations for any affirmative answers regarding, but not limited to:
 - Statements from practitioners regarding inability to perform essential functions of the position, with or without accommodation
 - Lack of present illegal drug use
 - History of loss of license and/or felony convictions
 - History of loss or limitation of privileges or disciplinary activity
 - Lack of current malpractice insurance coverage
- B. Practitioner signed attestation of completeness and accuracy of the information contained in the application.
- C. Active licensure in good standing verified by the state licensing agency. For purposes of this Agreement, active licensure in good standing does not include an institutional state medical license.
- D. History of any sanctions levied against the practitioner or limitations on his or her state licensure from any state licensure board or the Federation of State Medical Boards ("FSMB").
- E. Current and valid personal Federal Drug Enforcement Agency registration number ("DEA Number") (when utilizing a source other than a copy of the DEA certificate). For purposes of this Agreement, a current and valid DEA number does not include an institutional DEA registration number.
- F. National Practitioner Data Bank ("NPDB").
- G. Review of the Department of HHS Office of the Inspector General ("OIG") List of Excluded Individuals/Entities ("LEIE").
- H. Review of the Medicare Opt Out List.
- I. Review of the System for Award Management ("SAM").
- J. Five (5) year work history including beginning and ending month and year for each work experience, accompanied by an explanation for any gaps in work history of six (6) months or greater duration.



- K. Five (5) year malpractice history, including all malpractice cases filed as well as all malpractice settlements, judgments, awards, etc. (including verification from the malpractice carrier, NPBD or an attestation in the practitioner's application).
- L. National Provider Identifier ("NPI").
- M. Medicare and State Medicaid Provider Number.
- N. Practitioner's "staff privileges" at participating Meridian hospital(s), in the appropriate specialty, that is/are current and in good standing. For purposes of this Agreement, "staff privileges" will be defined as a practitioner's ability to (i) admit patients to a hospital or (ii) establish a formal inpatient coverage arrangement with another Meridian Participating Practitioner who has admitting privileges at participating Meridian hospital(s) in the same or similar specialty.
- O. Evidence of current malpractice insurance coverage (if the source of such coverage is verification from carrier or if coverage is attested to on application).

The following information must be present but may be older than one hundred eighty (180) calendar days when a decision is made by the Credentialing Committee:

- P. Evidence of current malpractice insurance coverage (if the source of such coverage is a copy of the current malpractice insurance coverage policy that displays the date(s) and amounts of coverage). Delegate shall ensure Providers have current malpractice insurance at a minimum of \$100,000 per incident, \$300,000 annual aggregate.
- Q. All requisite or appropriate board certifications for the practitioner, if applicable.
- R. Establish credentialing and recredentialing Board Certification requirements in accordance with county designations of "urban" or "rural" as determined by Meridian and as may be amended from time to time.
- S. Practitioner's educational background and training (if not board certified).
- T. Disclosure of Ownership and Control Interest. In accordance with the federal regulations set forth in 42 CFR 455.104-106 Delegate shall require all providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to managed care organizations that contract with the State Medicaid Agency: a) the identities of all owners with a control interest of 5% or greater, b) all agents or managing employees of the Disclosing Entity c) details of certain familial relationships between each owner or each owner of a subcontractor owned by the Disclosing Entity, and d) the identities of any excluded individual or entity with an ownership or control interest in the Disclosing Entity. The term 'person' includes individuals, corporations or other business entities. Delegate agrees to collect all information contained on the Provider Disclosure of Ownership and Control Interest Form attached to this Agreement as Exhibit A-4. Provider is not required to use the specific form but must obtain all of the information requested by the form and verify through OIG and SAM that all individuals listed are not excluded from participation in state or federal health care programs. Delegate must attest to completion of this task in every initial credentialing, recredentialing file and within 35 days of changes in ownership. Delegate must monitor on a monthly basis any Person and/or Disclosing Entity to ensure absence of exclusions or debarment. Delegate shall also



immediately report to Meridian any Provider or Disclosing Entity who is found to have an exclusions, debarment or criminal convictions in accordance with 42 CFR 455.104-106.

3.6 Initial Site Visits; Identification and Reporting of Relocated Sites.

- A. Conducting Initial Site Visits. The Delegate or its sub-delegate may conduct an initial site visit of the office(s) of any Primary Care Practitioner upon completion of credentialing decision in order to assess the site(s) for compliance with standards set forth by CMS, Meridian, NCQA and any applicable Regulatory Agency including, but not limited to physical accessibility and medical record keeping practices.
- B. Identifying Relocated Offices. The Delegate will have a process for identifying, tracking and reporting to Meridian instances where any Primary Care Practitioner who is a Participating Practitioner (i) relocates an existing office from one location to another, (ii) opens a new office to operate in addition to currently existing office(s) or (iii) departs an existing practice in favor of opening a new office. Delegate shall communicate such changes to Meridian as a provider change. Delegate shall assure that the results of site visits conducted in these instances are included in the credentialing or recredentialing decision for the practitioner, as applicable.

3.7 Reporting and Performance Requirements. The Delegate will submit Reporting and Performance Requirement documents not less frequently than the interval required by CMS, Meridian, NCQA and/or any applicable Regulatory Agency. The Delegate will meet or exceed the performance standards for delegated activities as defined in Exhibit A-1.

3.8 Participating Practitioner Recredentialing. The Delegate must consider information given to the Delegate by Meridian with respect to the Delegate's recredentialing of Participating Practitioners. This may include, but will not be limited to, information concerning Member complaints and quality of care issues with respect to Participating Practitioners.

3.9 Continuous and Ongoing Monitoring of Sanctions and Complaints. The Delegate will be responsible for the continuous collection and evaluation of ongoing monitoring information concerning Participating Practitioners who are between credentialing cycles. In performing these obligations, the Delegate will, at a minimum, collect and review information from the following sources within the timeframes indicated:

- A. Medicare and Medicaid Sanctions (not less frequently than once per calendar month, or as otherwise published):
 - i. LEIE as published by the OIG of the Department of HHS.
 - ii. SAM (System for Award Management)
- B. State Licensure (not less frequently than once per calendar month, or as otherwise published):
 - i. State Board of Medicine Disciplinary Action Report.



- C. Complaints (not less frequently than once per calendar month):
 - i. Any complaints levied against Participating Practitioners from any and all sources, including Meridian.
 - a. The Delegate must conduct site visits of offices within sixty (60) calendar days of determining that the complaint threshold was met.
 - b. Delegate must institute actions to improve offices that do not meet thresholds
 - c. Evaluating the effectiveness of the actions at least every six months, until deficient offices meet the thresholds.
 - d. Documenting follow-up visits for offices that had subsequent deficiencies.
- D. Quality of Care (not less frequently than once per calendar month):
 - i. Quality of care issues identified through any and all potential sources.
 - ii. Patient safety issues identified through any and all potential sources.

Delegate agrees to incorporate the above-referenced information, as well as any other information collected and reviewed as part of the ongoing monitoring process, into the credentialing or recredentialing file(s) of Participating Practitioners, as applicable. The Delegate agrees to notify Meridian of any disciplinary action, sanction, complaint, patient safety or quality of care issue levied against a Participating Practitioner, or a practitioner in the initial credentialing process prior to being accepted by Meridian as a Participating Practitioner, as soon as possible but in no event later than fourteen (14) calendar days from the date upon which the Delegate became aware of such complaint or sanction.

- 3.10 Submission of Files. All Initial Data Files, Credentialed Provider Lists and Recredentialed Provider Lists will be electronically submitted (on a monthly basis for Credentialed Provider Lists and Recredentialed Provider Lists) and will contain all required practitioner data elements set forth on Exhibits A -2 and A-3, attached hereto and made a part hereof. If an Initial Data File, a Credentialed Provider List or a Recredentialed Provider List does not contain all of the required practitioner data elements set forth on Exhibit A-2 and A-3 for each individual practitioner, Meridian will have no obligation to accept such practitioner as a Participating Practitioner.
- 3.11 Subcontracted Entities. Upon the prior written approval of Meridian, the Delegate may subcontract responsibility for the performance of its obligations under this Agreement to one or more subcontracted agents. If the Delegate subcontracts any of its obligations under this Agreement, the Delegate will retain ultimate responsibility for the supervision and oversight of the services provided by subcontractors, and will exercise the same level of due diligence with respect to the monitoring and oversight of its subcontractors as it would if it were performing the subcontracted activity itself. The Delegate will also assure that all subcontracted entities comply with all standards required of the Delegate by CMS, Meridian, NCQA or any applicable Regulatory Agency including, but not limited to, those requirements set forth in this Agreement. Notwithstanding anything herein to the contrary, if the Delegate subcontracts any of its obligations under this Agreement, the Delegate will perform, at a minimum, an annual review of the subcontractor's performance and will report the results of such annual review to Meridian within fourteen (14) calendar days of the completion of such annual review. Delegate agrees that if, as a result of the performance of Delegate's annual review of the subcontractor's performance or if, at any other time, Delegate becomes aware that any subcontractor's performance is not in compliance with the standards required of the Delegate by CMS, Meridian, NCQA or any applicable Regulatory Agency, it will notify the subcontractor of the need for a corrective action plan within sixty (60) calendar days of the time it became aware of the subcontractor's substandard performance. Thereafter, the Delegate will ensure that the subcontractor submits a corrective action plan to Delegate for Delegate's review and approval within



a reasonable time frame. The Delegate must ensure that the subcontractor is in compliance with all performance standards within sixty (60) calendar days of the time that Delegate approved subcontractor's corrective action plan.

- 3.12 Documentation. At any time, and from time to time, Meridian may request one copy of documentation from the Delegate including, but not limited to, (i) the Delegate's current policies and procedures, (ii) specific information regarding practitioners that have been credentialed or recertified, or are in the process of being credentialed or recertified, (iii) Participating Practitioner credentialing and recertifying files, (iv) files of practitioners who have been terminated from Meridian's network of Participating Practitioners, and (v) documentation related to the Delegate's compliance with Corrective Action Plans. Delegate will comply with such request by submitting to Meridian the documentation requested within fourteen (14) calendar days of Meridian's request.
- 3.13 Quality Improvement. The Delegate will cooperate with any and all quality improvement initiatives developed by Meridian including, but not limited to, information gathering programs, studies and assessments as they specifically relate to eligible provider credentialing.
- 3.14 Performance Standards. The Delegate will at all times during the performance of this Agreement maintain compliance with the performance standards set forth in this Agreement.
- 3.15 Delegated Benefit Administrators. Delegate acknowledges that Meridian is contracted with delegated benefit administrators that are responsible for the provision of certain benefit categories to Meridian's Members, including but not limited to, dental and vision services. Delegate agrees that from time to time during the performance of delegated credentialing services under this Agreement, Delegate will be required to submit certain provider types to the delegated benefit administrators that are responsible for the provision of dental and vision services, who will credential and re-credential those providers on behalf of Meridian.

ARTICLE IV CREDENTIALING AND RE-CREDENTIALING SCHEDULES

- 4.1 Credentialing Schedule. The Delegate will maintain an average turnaround time for processing credentialing applications that does not exceed ninety (90) calendar days commencing on the date the completed application is received by the Delegate. In the event that a shorter timeframe is required by CMS, Meridian, NCQA or any applicable Regulatory Agency subsequent to the Effective Date of this Agreement, Delegate agrees to comply with any such timeframe.
- 4.2 Recertifying Schedule. The Delegate will re-credential Participating Practitioners at least every thirty-six (36) calendar months from the date of the initial credentialing decision or the most recent recertifying decision.
- 4.3 Additional Credentialing and/or Recertifying Requests. If any Credentialed Provider List or Recertified Provider List submitted to Meridian by Delegate includes a Primary Care or Specialty Care Practitioner that has previously been credentialed or recertified by another of Meridian's delegated credentialing entities, such practitioner(s) shall be excluded from the terms and conditions of this Agreement. However, if the practitioner chooses to opt out of his or her prior credentialing arrangement and all affected parties agree, Delegate will assume credentialing and recertifying responsibilities for any such practitioner and all credentialing and recertifying activities shall be governed by the terms and conditions of this Agreement.



ARTICLE V
CORRECTIVE ACTION PLAN(S)

5.1 If, during Meridian’s annual review, or at any other time, Meridian determines that a Corrective Action Plan is required based upon violation(s) of Articles III, IV, VII, or IX of this Agreement, Meridian will notify the Delegate, in writing, of the need for a Corrective Action Plan (the “Corrective Action Plan Notice”). Within sixty (60) calendar days of the receipt of the Corrective Action Plan Notice, the Delegate must have submitted a Corrective Action Plan to Meridian for review and approval. The Delegate must complete, and be in compliance with, the Corrective Action Plan within sixty (60) calendar days of that date upon which the Delegate received the Corrective Action Plan notice from Meridian.

ARTICLE VI
OBLIGATIONS OF MERIDIAN

6.1 Credentialing and Recredentialing Responsibility. Notwithstanding anything to the contrary herein, Meridian will retain ultimate accountability with respect to the credentialing and recredentialing of Participating Practitioners as defined in Exhibit A-3. Meridian retains the right to approve, suspend, or terminate from its provider network all individual practitioners and sites.

6.2 Quality Improvement (“QI”) Committee. Meridian will present Delegate’s Credentialed Provider List(s) and/or Recredentialed Provider List(s) to Meridian’s Credentialing Committee in the calendar month following the calendar month in which Meridian received Delegate’s Credentialed Provider List(s) and/or Recredentialed Provider List(s).

6.3 Acceptance. Within fourteen (14) calendar days of Meridian’s Credentialing Committee meeting, Meridian will identify and report back to Delegate those practitioners that it is willing to accept. Specialty Care Practitioners and Primary Care Practitioners who are to be reimbursed on a fee-for-service basis shall be effective on the same calendar day as Meridian’s Credentialing Committee meeting during which such practitioner was approved. Primary Care Practitioners who are to be reimbursed on a capitated basis shall be effective on the first day of the calendar month following the Meridian Credentialing Committee meeting during which such practitioner was approved.

6.4 Annual Reviews. At least annually, Meridian will:

- A. Review and approve the Delegate’s credentialing and recredentialing policies and procedures.
- B. Review credentialing and recredentialing files of the Delegate with respect to Participating Practitioners.
- C. Review (i) documentation from the Delegate’s site visits and (ii) the Delegate’s medical record keeping practices in order to assure compliance with performance and oversight standards.
- D. Review processes and documentation regarding ongoing monitoring of sanctions and complaints.
- E. Review minutes of Credentialing Committee meetings.
- F. Review and approve the Delegate’s confidentiality policies and procedures.
- G. Review and approve the Delegate’s practitioner appeal process, policies and procedures.
- H. Review Delegate’s performance against performance standards.



Following the completion of each of its annual reviews, Meridian will provide the Delegate with a written summary of such review. Should Meridian determine, as a result of any annual review, or at any other time, that the Delegate is not fulfilling its obligations under this Agreement, Meridian will inform the Delegate in writing of remedies available to the Delegate which may include, but will not be limited to, the development of a Corrective Action Plan, an additional audit of compliance of the Delegate, revision of the Delegate's policies and procedures, or termination of this Agreement.

- 6.5 Review of Delegate's Document Submissions. Meridian will (i) review those documents submitted by the Delegate, (ii) provide feedback as required to Delegate, following the submission of documents and (iii) provide information to Delegate as required for the applicable activity.
- 6.6 Member Complaints and Quality Data. At intervals determined by Meridian but not less frequently than that required by CMS, NCQA or any applicable Regulatory Agency, Meridian will submit to the Delegate a report setting forth (i) Member complaints against Participating Practitioners and (ii) quality of care data for Participating Practitioners in order for Delegate to complete its ongoing monitoring requirement(s).

ARTICLE VII
SECURITY, PRIVACY, CONFIDENTIALITY AND RELEASE OF INFORMATION

- 7.1 Confidentiality of Practitioner and Patient Information. Both the Delegate and Meridian will hold in confidence all individually identifiable practitioner and patient information, whether personal, medical or business related. All patient and practitioner information will be considered confidential without the need to identify it as confidential in any way. The Delegate and Meridian will comply with all applicable federal and state laws and any regulations or official guidance promulgated thereunder, as now effective or upon the effective dates, concerning the confidentiality and privacy of all records including, without limitation, 42 USC §§ 1396a(a)(7), 42 CFR § 431.300, and the Health Information Portability and Accountability Act of 1996 ("HIPAA") and its regulations at 45 CFR Parts 160 and 164, all as may be amended from time to time.
- 7.2 Confidentiality of Business Information. Both the Delegate and Meridian will hold in confidence all business information that either of them learns about the other including, but not limited to, fees, charges, expenses and utilization information. All such information will be considered confidential without the need to identify it as confidential in any way.
- 7.3 Compliance with Regulations. The parties will take such additional steps or negotiate such amendments to this Agreement as will be necessary to assure compliance with the statutes and regulations set forth above, or as required pursuant to the adoption of new statutory or regulatory provisions applicable to the content hereof.
- 7.4 Confidentiality Policies and Procedures; Release of Information. In accordance with Section 3.4, the Delegate will establish and maintain policies and procedures regarding patient and practitioner confidentiality and release of patient and practitioner information. Notwithstanding anything to the contrary in this Agreement, the Delegate agrees to release patient and practitioner information to Meridian and its delegated subcontractors for purposes including, but not limited to, accreditation surveys, medical record audits, patient treatment, quality of care assessment and measurement, complaint resolution and grievance resolution. In responding to any such request by Meridian or a subcontractor of Meridian, the Delegate will limit its disclosure to the amount reasonably necessary to respond to Meridian's request or the request of Meridian's subcontractor.



- 7.5 Non-Confidential Information. For purposes of this Agreement, information will be deemed to be non-confidential if (i) it is made publicly available prior to the date of this Agreement, (ii) it becomes publicly available through no wrongful act of the recipient, (iii) it is known to the recipient prior to the date of disclosure, or becomes known to recipient through a third party having an apparent bona fide right to disclose the information, (iv) it is disclosed by the recipient upon written approval of the party whose confidentiality is meant to be protected, (v) the confidential information is required to be disclosed by law or regulation; provided, however, that the recipient must promptly notify the other party and limit the scope of the amount of information disclosed to only that which is necessary or (vi) it is developed independently.
- 7.6 Release of Information to Third Parties. Except as set forth in Section 7.4, neither the Delegate nor Meridian will disclose confidential information to any person without the prior written consent of either the Member, an authorized person acting on the Member's behalf or the Participating Practitioner, except as otherwise allowed or required by law, NCQA or any applicable Regulatory Agency.
- 7.7 HIPAA Compliance. In the performance of this Agreement, Meridian and the Delegate acknowledge their respective obligations to comply with all applicable provisions of HIPAA, including all regulations promulgated thereunder, all as may be amended from time to time. The Delegate agrees that the use and disclosure of protected health information ("PHI"), as such term is defined by HIPAA, shall be limited to the purposes of, and performance under, this Agreement. In the event that the Delegate discovers improper access, use or disclosure of protected health information, the Delegate will immediately notify Meridian of such improper access, use or disclosure. The Delegate will implement safeguards to protect information from inappropriate access, use or further disclosure. Those safeguards will include (i) training of all employees on the policies and procedures for creating, accessing, using or disclosing protected health information and (ii) maintaining documentation of such training. The Delegate will also establish (i) computer security procedures, (ii) workspace security procedures and (iii) appropriate firewalls, and will identify users authorized to access protected health information. The Delegate will ensure that any subcontractor has analogous safeguards in place, or will develop and maintain such safeguards. To the extent allowed by applicable governing law, and in accordance with HIPAA, the Delegate will allow Members to have access to their own individual protected health information.
- 7.8 Destruction or Return of Protected Health Information. Within fourteen (14) calendar days of the termination or completion of this Agreement, the Delegate will return to Meridian, or will destroy, and will certify such destruction upon request by Meridian, all protected health information with respect to Members that it may have in its possession.

ARTICLE VIII

INDEMNIFICATION AND INSURANCE

- 8.1 Indemnification of the State. The Delegate agrees to indemnify and hold harmless the State of Iowa and its agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses that may in any manner accrue against the State of Iowa or its agents, officers or employees through the intentional misconduct and negligent acts or omissions of the Delegate, its agents, officers and employees or Meridian.



- 8.2 Mutual Indemnification. Each party agrees to defend, hold harmless and indemnify the other party against any and all costs, claims, liability, damages or judgments, and the like, including reasonable attorneys' fees asserted against, imposed upon or incurred by Indemnified Party that are caused by the negligent or willfully wrongful act or omission of the Indemnifying Party. The Indemnified Party agrees not to settle or compromise any claim, action or liability without the advance written approval of the Indemnifying Party.
- 8.3 Insurance. Delegate agrees to maintain an insurance policy covering any and all errors and omissions that the Delegate may make with respect to their obligations under this Agreement. Meridian will be added to any existing or purchased errors and omissions insurance policy as a loss payee.
- 8.4 Survival of Provisions. Both parties agree that (i) the indemnification, insurance and hold harmless provisions contained in this Agreement will survive the termination of this Agreement regardless of the cause giving rise to termination, and will be construed for the benefit of the party seeking to enforce the indemnification and hold harmless provisions and (ii) the indemnification and hold harmless provisions herein supersede any oral or written agreement now existing or hereafter entered into between the Delegate and Meridian that are, in any way, contrary to this Agreement.

ARTICLE IX REGULATORY COMPLIANCE

- 9.1 Delegate Books and Records. The Delegate will develop and maintain records relating to the credentialing and recredentialing of practitioners in accordance with CMS requirements, Meridian policies and procedures, and standards set forth by NCQA or any applicable Regulatory Agency.
- A. Retention of Books and Records. For a period of ten (10) years following the termination or expiration of this Agreement, or until the closure of any ongoing audit opened during such ten (10) year period, whichever is later, the Delegate will maintain books and records with respect to those Participating Practitioners that it has credentialed and recredentialed. The Delegate may keep such records in an original paper state, preserve them on micro media or keep them in an electronic format.
- B. Meridian Access to Books and Records. Meridian will have access at reasonable times, upon request, to all of the Delegate's books and records developed and maintained with respect to Participating Practitioners.
- C. Production of Books and Records. The Delegate acknowledges that (i) any applicable Regulatory Agency will, at any and all times, have access to all books and records pertaining to the credentialing and recredentialing of Participating Practitioners, and (ii) the Delegate will be responsible for the production of such books and records to any such Regulatory Agency, including any costs associated therewith.
- 9.2 Policies and Procedures. The Delegate agrees to reasonably cooperate with and participate in all quality assurance, credentialing, sanctioning, external audit and administrative policies and procedures established by Meridian. No order or requirement of a state or federal Regulatory Agency will be the subject of arbitration with Meridian unless the dispute involves Meridian's interpretation or application of such regulatory order or requirement. The Delegate will be notified thirty (30) calendar days prior to any substantial change or implementation of such policies and procedures.
- 9.3 Policies for Detecting Fraud and Abuse. The Delegate will comply with all policies and procedures that are developed and amended from time to time by Meridian and any applicable Regulatory



Meridian Health Plan

Agency for the detection and prevention of fraud and abuse committed by Participating Practitioners and employees. Such compliance may include, but will not be limited to, (i) the submission of statistical and narrative reports regarding fraud and abuse detection activities, and/or (ii) referral of information regarding suspected or confirmed fraud or abuse activity to Meridian, The Delegate acknowledges that it may be subject to sanctions for violations including, but not limited to:

- Failure to implement or maintain policies directly related to detection, prevention or referral of fraud and abuse;
- Failure to cooperate with reviews conducted by state and federal agencies or their contracted auditors, and
- Failure to adhere to applicable state and federal laws and regulations.

ARTICLE X MISCELLANEOUS

10.1 Incorporation: This Agreement may be executed contemporaneously with or subsequent to a Participating Provider or Hospital Agreement between Delegate and Meridian under which Delegate agrees to participate in one of Meridian’s provider networks (“Provider Agreement”). In the event of a conflict between the terms of any such Provider Agreement and this Agreement, the terms of this Agreement shall control.

10.2 Notices. Written notices required or permitted by this Agreement must be hand delivered or sent by certified mail or overnight delivery service having a delivery tracking and verification system with charges prepaid to the address set forth by the party to be notified. This provision will survive termination of this Agreement for any reason. Notices will be addressed as provided below, or as either party may have furnished to the other in writing. Notices of change of address will be effective only upon receipt.

If to Meridian: Meridian
Meridian Health Plan
777 Woodward Ave, Suite 600
Detroit, MI 48226
Attention: Director of Credentialing and Provider Services

With a copy to: Attention: General Counsel

If to
Credentialing Entity: _____
CREDENTIALING ENTITY

ADDRESS LINE 1

ADDRESS LINE 2



Meridian Health Plan

ADDRESS LINE 3

Attention: _____

- 10.3 **Freedom of Disclosure.** As set forth in Section 7.4 above, nothing in this Agreement will be construed to limit the authority of the Delegate to disclose to Meridian appropriate information with respect to patients or practitioners as provided for herein. The Delegate will not add any language to its employment or other contracts that will be construed to limit employees, or others, from disclosing information to Meridian as provided for herein.
- 10.4 **Authority.** Delegate represents and warrants that it has the authority to enter into this agreement on behalf of the entities listed beneath Delegate's signature below and that such signature will bind those entities as well as their successors or assigns to the terms and conditions of the Agreement. Meridian represents and warrants that the individual signing on its behalf below has the authority to legally bind Meridian.
- 10.5 **Dispute Resolution.** In the event of a dispute between the parties, either party may request a meeting of authorized representatives for each party upon written notice of dispute to the other party, for the purpose of resolving the dispute. Each party agrees to designate one (1) or more authorized representative(s) within ten (10) calendar days of receipt of the other party's written notice. Each party's authorized representative(s) shall participate in good faith negotiations with the other party at a mutually acceptable date, time and location. If the parties are unable to reach a mutually acceptable resolution to the dispute following a period of good faith negotiation of not less than thirty (30) days from the receipt of the written notice of dispute, either party may submit the dispute to non-binding arbitration pursuant to the commercial rules of the American Arbitration Association. The arbitration shall take place in Detroit, Iowa. Either party may seek judgment on the award rendered by the arbitrator in any court having competent jurisdiction.
- 10.6 **Survival.** The parties agree that the requirements of Article VIII, Article IX, and Sections 2.3, 9.3, 10.2, and 10.5 shall survive termination or expiration of the Agreement, regardless of the reason(s) for such termination or expiration.
- 10.7 **Entire Agreement.** This Agreement, along with any exhibits, schedules or attachments hereto, constitutes the entire agreement between Meridian and the Delegate with respect to the subject matter hereof. There are no understandings, written or oral, other than as set forth herein or in any attachment hereto. Notwithstanding anything to the contrary contained herein, this Agreement will in no way affect any rights, duties or obligations of either party that existed prior to the date of execution of this Agreement where such rights, duties or obligations are not contrary to this Agreement.

Meridian Health Plan of Iowa, Inc.

Delegated Entity

Signature

Signature

Name (Printed)

Name (Printed)

Title

Title

Date

Date



EXHIBIT A-1



REQUIRED PRACTITIONER REPORTING REQUIREMENTS

Delegate will submit routine quarterly reports to MHP in order to assure that Delegate activities are ongoing and current. Reports must be submitted no less than twice a year and the data provided will include all information as listed above in the minimum information requirements in a format approved by both parties. Previously approved formats include a spreadsheet or profile. Credentialing staff review the reports for completeness and timeliness of submission. The report content shall include at a minimum the information:

| Name of Delegate: | | | | |
|---|------------|---------------|-------------------|------------|
| Provider Information | PCP | OB/GYN | SPECIALIST | YTD |
| Total # of Participating Providers | | | | |
| Total # of Board Certified Providers | | | | |
| Percentage of Providers Board Certified | | | | |
| Total # of Board Eligible Providers | | | | |
| Percentage of Board Eligible Providers | | | | |
| Credentialing/Recredentialing Information | | | | |
| Total # of Providers Initially Credentialed During This Reporting Period | | | | |
| Total # of Providers Re-Credentialed During This Period | | | | |
| Total # of Providers With Re-Credentialing Past Due | | | | |
| Total # of Provider Approved | | | | |
| Total # of Provider Denials | | | | |
| Total # of Voluntary, Involuntary or Administrative Terminations | | | | |
| Total # of Providers with Newly Discovered Sanctions **(Include Committee Date) | | | | |
| Total # of Providers Terminated for Quality Reasons **(Include Committee Date) | | | | |
| PCP Site Visits (If Applicable) | | | | |
| Total # of PCP (IM, FP, GP, PEDS, OB/GYN and HIGH VOL SPEC) Site Visits | | | | |
| Total # of Office Site Visits Follow-Up Action for Initial Deficiencies | | | | |
| Total # of Medical Records Reviewed | | | | |
| Total # of Medical Records Follow-Up Action | | | | |
| Performance Improvement Activity (If Applicable) | | | | |
| Corrective Action Plan based on Pre-assessment Delegated Evaluation (if applicable) | | | | |
| Corrective Action Plan based on Annual Evaluation (if applicable) | | | | |
| Corrective Action Plan based on Quarterly Performance | | | | |



EXHIBIT A-2

REQUIRED DATA FIELDS FOR PRACTITIONER LISTS

The purpose of the following information is to specify the reporting data requirements from the delegated entity to Meridian. Delegate and Meridian will mutually agree to the format of the reports but delegated entity shall provide at a minimum the following information:

| | | |
|--|---|---|
| Original Credentialing Committee: Date mm/dd/yyyy | Primary Practice Address: (Y or N) | L= Lifetime Cert, please indicate 99999999 |
| Re-Credentialing Committee Date: mm/dd/yyyy | Group NPI | Specialty 2 |
| Last Name | Clinic/Group Name | Primary Specialty (Y or N) |
| First Name | Address 1 | Board Certification Status: |
| Middle Name | Address 2 | C= Certified |
| Name Suffix | City | E= Eligible |
| Degree | State | N=Not Certified |
| Gender | Zip | X=Not Applicable |
| National Provider Identification (NPI) | Phone | Board Certification Expiration Date (mm/dd/yyyy) |
| Date of Birth (DOB) | Fax | L= Lifetime Cert, please indicate 99999999 |
| Social Security Number (SSN) | Email | Accepting New Patients (Y or N) |
| Race | Include in Provider Directory (Y or N) | Age Limitations |
| Ethnicity | Languages Spoken in this Location | PCP/Specialist/Hospital Based |
| State Medicaid ID | Office Hours: | Tax Identification Number |
| Medicare Number | Handicap Accessible (Y or N) | Legal Business Name (TIN) |
| State License Number | Specialty 1 | Remittance Address 1 |
| State License Number Expiration Date | Primary Specialty (Y or N) | Remittance Address 2 |
| DEA Number | Board Certification Status: | City |
| DEA Number Expiration Date | C= Certified | State |
| Address Type: P = Practice C = Billing and Practice M = Mail Only D = Credentialing Only | E= Eligible | Zip |
| | N=Not Certified | Malpractice Carrier |
| | X=Not Applicable | Malpractice Insurance Coverage Limit |
| | Board Certification Expiration Date (mm/dd/yyyy) | Malpractice Insurance Coverage Expiration Date |



Exhibit A-3

Summary of Delegated Activities

The purpose of the following grid is to specify the activities delegated by Meridian to Delegate under the Delegation Agreement with respect to credentialing. All delegated activities are to be performed in accordance with currently applicable URAC, NCQA accreditation standards and CMS and State regulatory requirements, as modified from time to time. Delegate agrees to be accountable for all responsibilities delegated by Meridian and will not further delegate (sub-delegate) any such responsibilities without prior written approval by Meridian, except as outlined in the Delegation Agreement. Delegate will provide periodic reports to Meridian as described elsewhere in the Delegation Agreement. Meridian will oversee the delegation to Delegate as described elsewhere in the Delegation Agreement. In the event deficiencies are identified through this oversight, Delegate will provide a specific corrective action plan acceptable to Meridian. If Delegate does not comply with the corrective action plan within the specified time frame, Meridian may revoke the delegation to Delegate, in whole or in part.

| Specific Activities | Meridian | Delegate |
|---|----------|----------|
| Credentialing Policies | | |
| Maintain policies and procedures that specify: <ul style="list-style-type: none"> ▪ Types of practitioners to credential and recredential. ▪ Verification sources used. ▪ Criteria for credentialing and recredentialing. ▪ The process for making credentialing and recredentialing decisions. ▪ The process for managing credentialing files that meet the organization's established criteria. ▪ The process to delegate credentialing or recredentialing. ▪ The process used to ensure that credentialing and recredentialing are conducted in a nondiscriminatory manner. ▪ The process for notifying a practitioner about any information obtained during the organization's credentialing process that varies substantially from the information provided to the organization by the practitioner. ▪ The process to ensure that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision. ▪ The medical director or other designated physician's direct responsibility and participation in the credentialing program. ▪ The process used to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. ▪ The process for ensuring listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification and specialty. | | X |
| Maintain policies and procedures that include the following practitioner's rights: <ul style="list-style-type: none"> ▪ The right of practitioners to review information submitted to support their credentialing application. ▪ The right of practitioners to correct erroneous information. ▪ The right of practitioners to be informed of the status of their credentialing or recredentialing application upon request. ▪ The process to notify practitioners of these rights. | | X |
| Credentialing Committee | | |
| Maintain a Credentialing Committee that uses a peer review process to make credentialing decisions and which includes representation from a range of participating practitioners | | X |
| Ensure that the Credentialing Committee reviews the credentials of all practitioners who | | X |



| Specific Activities | Meridian | Delegate |
|---|----------|----------|
| do not meet established criteria and offer advice which the organization considers. | | |
| Implement a process for the Medical Director or designated physician's review and approval of clean files. (if applicable) | | X |
| Make decisions on credentialing and recredentialing of practitioners. | X | |
| Initial Credentialing Verification | | |
| Conduct initial primary source verification of practitioner's professional licensure using approved sources and within prescribed time limits. | | X |
| Using approved sources and within prescribed time limits, conduct primary source verification of practitioner's: <ul style="list-style-type: none"> DEA registration or CDS certificate, if applicable. Education and training, including board certification, if the practitioner states he or she is board certified. Work history. Professional liability claims history that resulted in settlements or judgments paid by or on behalf of the practitioner. | | X |
| Application and Attestation | | |
| Obtain practitioner's application including a current and signed attestation which addresses: <ul style="list-style-type: none"> Reasons for any inability to perform the essential functions of the position, with or without accommodation. Lack of present illegal drug use. History of loss of license and felony conviction. History of loss or limitation of privileges or disciplinary actions. Current malpractice insurance coverage. The correctness and completeness of the application. | | X |
| Initial Sanction Information | | |
| Using approved sources and within prescribed time limits, conduct primary source verification of practitioner's: <ul style="list-style-type: none"> State sanctions, restrictions on licensure or limitations on scope of practice. Medicare and Medicaid sanctions. | | X |
| Practitioner Office Site Quality | | |
| Set performance standards and thresholds for: <ul style="list-style-type: none"> Office-site criteria. Medical/treatment record-keeping criteria. | X | |
| Implement appropriate interventions by: <ul style="list-style-type: none"> Conducting site visits of offices about which member complaints are received. Instituting actions to improve offices that do not meet thresholds. Evaluating effectiveness of the actions at least every six months, until deficient offices meet thresholds. Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 calendar days of meeting the complaint threshold. Documenting follow-up visits for offices that have subsequent deficiencies. | X | |
| Recredentialing Verification | | |
| Conduct initial primary source verification of practitioner's professional licensure using approved sources and within prescribed time limits | | X |



| Specific Activities | Meridian | Delegate |
|---|----------|----------|
| Using approved sources and within prescribed time limits, conduct primary source verification of practitioner's: <ul style="list-style-type: none"> ▪ DEA registration or CDS certificate, if applicable. ▪ Board certification, if the practitioner states he or she is board certified. ▪ Professional liability claims history that resulted in settlements or judgments paid by or on behalf of the practitioner. | | X |
| Obtain practitioner's re-application including a current and signed attestation and which addresses: <ul style="list-style-type: none"> ▪ Reasons for any inability to perform the essential functions of the position, with or without accommodation. ▪ Lack of present illegal drug use. ▪ History of loss of license and felony convictions. ▪ History of loss or limitation of privileges or disciplinary action. ▪ Current malpractice insurance coverage. ▪ Correctness and completeness of the application. | | X |
| Recredentialing Sanction Information | | |
| Using approved sources and within prescribed time limits, conduct primary source verification of practitioner's: <ul style="list-style-type: none"> ▪ State sanctions, restrictions on licensure or limitations on scope of practice. ▪ Medicare and Medicaid sanctions. | | X |
| Recredentialing Cycle Length | | |
| Recredential practitioners at least every 36 months. | | X |
| Ongoing Monitoring | | |
| Using approved sources and within prescribed time limits, implement ongoing monitoring by collecting and reviewing: <ul style="list-style-type: none"> ▪ Medicare and Medicaid sanctions. ▪ Sanctions or limitations on licensure. ▪ Member complaints. ▪ Information from identified adverse events. | X | |
| Implement appropriate interventions when instances of poor quality are identified. | X | |
| Notification to Authorities and Practitioner Appeal Rights | | |
| Maintain policies and procedures that describe how the organization reviews participation of practitioners whose conduct could adversely affect members' health or welfare. Include in the policies and procedures: <ul style="list-style-type: none"> ▪ The range of actions that the organization may take to improve practitioner performance before termination. ▪ The process for reporting actions taken by the organization against a practitioner for quality reasons to authorities. ▪ The appeal process available to the practitioner. ▪ How the organization makes the appeal process known to practitioners. | X | |
| Report practitioner suspension or termination to the appropriate authorities. | X | |
| Inform practitioners of the appeal process when the organization alters the conditions of practitioner participation based on issues of quality or service. | X | |
| Provider Disclosure of Ownership and Control Interest | | |



| Specific Activities | Meridian | Delegate |
|--|----------|----------|
| Collect all information required by 42 CFR 455.104-106 regarding information on ownership and control, business transactions, and criminal convictions. | | X |
| Verify exclusion status of all individuals disclosed by providers. | | X |
| Report to Meridian all individuals whom (1) have an ownership or control interest in the provider, or is an agent or managing employee of the provider; and (2) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs. | | X |



Meridian Health Plan

Exhibit A-4 Provider Disclosure of Ownership and Control Interest Form

The federal regulations set forth in 42 CFR 455.104-106 require all providers who are entering into or renewing a provider agreement (“Disclosing Entities”) to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to managed care organizations that contract with the State Medicaid Agency: a) the identities of all owners with a control interest of 5% or greater, b) all agents or managing employees of the Disclosing Entity c) details of certain familial relationships between owners or owners of subcontractors owned by the Disclosing Entity, and d) the identities of any excluded individual or entity with an ownership or control interest in the Disclosing Entity. As used herein, a ‘person’ includes individuals and corporations or other business entities. **Please attach additional sheets as necessary.**

- Individuals listed in Sections 1-6 will be reviewed for inclusion on the Excluded Parties List System.
- Individuals listed in Section 7 will be reported to the HHS/Office of Inspector General (OIG) and to DHS.

| DISCLOSING ENTITY | | |
|---|------------------|----------------------|
| Check one that mostly describes you: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity | | |
| Name of Disclosing Entity: | | |
| DBA Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |
| Tax ID Number (TIN): | NPI (Individual) | NPI (Organizational) |

| SECTION 1 — Ownership and Control of Disclosing Entity | | | |
|--|---------------------------------|---|---|
| List the name, address, date of birth (DOB) and Social Security Number (or TIN for corporations) for each person with an ownership or control interest of 5% or more in the Disclosing Entity (including corporate entities, officers, directors, or partners). (42 CFR 455.104) | | | |
| Name of Individual or Entity: | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) |
| | | | |
| | | | |
| | | | |



SECTION 2 — Ownership and Control of Disclosing Entity by Relatives

Are any of the individuals listed in Section 1 related to each other? Yes No

If yes, disclose each person listed in Section 1 who are related to another person with ownership or control interest in the Disclosing Entity as a spouse, parent, child, or sibling. (42 CFR 455.104)

| Name of Individual | Relationship |
|--------------------|--------------|
| | |
| | |

SECTION 3 — Ownership And Control of Subcontractors

Are there any subcontractors that the **Disclosing Entity** has direct or indirect ownership of 5% or more? Yes No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the Disclosing Entity has direct or indirect ownership **of 5% or more**. (42 CFR 455.104)

| Name of Individual or Entity with an Ownership Interest and Name of Subcontractor | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) of owner and SSN or TIN for subcontractor |
|---|---------------------------------|--|--|
| | | | |
| | | | |

SECTION 4 — Ownership and Control of Disclosing Entity by Relatives of Subcontractors

Are any of the individuals or entities listed in Section 3 related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling? Yes No

If yes, disclose each person listed in Section 3 who is related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling. (42 CFR 455.104)

| Name of Individual from Section 3 | Relationship |
|-----------------------------------|--------------|
| | |
| | |

SECTION 5 — Ownership and Control of any Other Disclosing Entity

Is there any Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which a person listed in Section 1 has an ownership or control interest? Yes No

If yes, list each Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which the person listed in Section 1 has an ownership or control interest.

An "Other Disclosing Entity" is usually an entity that either participates in Medicaid or is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVII (Grants for Planning Comprehensive Action to Combat Mental Retardation), or XX (Block Grants to States for Social Services) of the Social Security Act. (42 CFR 455.104)

| Name of Individual or Entity from Section 1 | Name of the other Disclosing Entity | % Interest |
|---|-------------------------------------|------------|
| | | |
| | | |



SECTION 6 — Managing Employees

List all managing employees of the Disclosing Entity along with the additional information indicated below. *A managing employee is a “general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency. (42 CFR 455.104)*

| Name of Individual or Entity: | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) |
|-------------------------------|------------------------------------|--|--|
| | | | |
| | | | |
| | | | |

SECTION 7 — Criminal Offenses

Has any person with an ownership or control interest in the Disclosing Entity, or any agent or managing employee of the Disclosing Entity ever been convicted of a crime related to that individual or entity’s involvement in any program under Medicaid, Medicare, or Title XX program since the inception of those programs? Yes No (verify through HHS-OIG Website)

If yes, please list those individuals below. (42 CFR 455.106)

| Name if Individual or Entity: | Date of Birth (for individuals) | Description of Offense(s) | Social Security Number (or TIN for corporation) |
|-------------------------------|------------------------------------|---------------------------|--|
| | | | |
| | | | |

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature

Title

Printed Name

Date



**EXHIBIT B
MEDICARE REQUIRED TERMS**

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Meridian and Delegate not inconsistent herein shall remain in full force and effect. This amendment shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements. This also includes an entity that services the Medicare-Medicaid population.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.



Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than \$2,500 during a contract period.

Required Provisions:

Delegate agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Meridian through 10 years from the final date of the final contract period of the contract entered into between CMS and Meridian or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]
2. Delegate will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]
3. Enrollees will not be held liable for payment of any fees that are the legal obligation of Meridian. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
4. Any services or other activity performed in accordance with a contract or written agreement by Delegate are consistent and comply with Meridian's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]
5. Delegate and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]
6. If any of Meridian's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:
 - (i) The delegated activities and reporting responsibilities are specified as follows:

The delegated activities are specified in the Delegated Credentialing Agreement.
 - (ii) CMS and Meridian reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.
 - (iii) Meridian will monitor the performance of the parties on an ongoing basis.
 - (iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by Meridian or the credentialing process will be reviewed and approved by Meridian and Meridian must audit the credentialing process on an ongoing basis.



- (v) If Meridian delegates the selection of providers, contractors, or subcontractor, Meridian retains the right to approve, suspend, or terminate any such arrangement. [42 C.F.R. §§ 422.504(i)(4) and (5)]
7. Cultural Considerations. Services will be provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. [42 CFR 422.112(a)(8)]



IOWA HOSPITAL AGREEMENT

This Hospital Agreement (“Agreement”) shall be effective as of the ____ day of _____ 20__ between Meridian Health Plan of Iowa (“Plan”) an Iowa corporation and Health Maintenance Organization (“HMO”) under the laws of the State of Iowa, and _____, (“Hospital”) a Hospital licensed under the laws of the State of Iowa (collectively the “Parties.”)

Recitals

Whereas, Plan has a certificate of authority to operate as a Health Maintenance Organization (“HMO”) in the State of Iowa;

Whereas, Plan desires to contract with Hospital for the provision of Covered Services to Enrollees; and

Whereas, Hospital desires to provide Covered Services as specified in this Agreement to Enrollees for the consideration, and under the terms and conditions set forth in this Agreement;

Whereas, Hospital desires to provide prior authorized medically necessary services to all of Plan’s covered Enrollees for all products.

In consideration of the foregoing and other good and valuable consideration, the sufficiency of which is hereby acknowledged, the Parties agree as follows:

1. DEFINITION OF TERMS

The following definitions apply to the entire Agreement and all attachments.

1.1 Benefits Certificate means the written document approved by IID, as issued to the Enrollee, which explains the scope of benefits, limitations of coverage, and exclusions governing the Enrollee’s health care benefit coverage.

1.2 Clean Claim means a claim that:

- a) Is submitted within the time frame required under this Agreement;
- b) Identifies the name and appropriate tax identification number of the health professional or the health facility that provided treatment or service and includes a matching provider ID number assigned by Plan;
- c) Identifies the patient (Enrollee/Subscriber ID number assigned by Plan, address, and date of birth);
- d) Identifies Plan (Plan name and/or ID number);
- e) Lists the date (m/d/y) and place of service;
- f) Is for covered service (services must be described using uniform billing coding and instructions (ANSI X12 837) and ICD-9/10-CM diagnosis. Claims submitted solely for the purpose of determining if a service is covered are not considered Clean Claims);
- g) If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if prior authorization is required by Plan;
- h) Includes additional documentation based upon services rendered as reasonably required by Plan Policies;
- i) Is certified by Hospital that the claim is true, accurate, prepared with the knowledge and consent of Hospital, and does not contain untrue, misleading, or deceptive information, that
- j) identifies each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim;

- k) Is a claim for which Hospital has verified the Enrollee's eligibility and enrollment in Plan before the claim was submitted;
 - l) Is not a duplicate of a claim submitted within forty-five (45) days of the previous submission;
 - m) Is submitted in compliance with all of Plan's prior authorization and claims submission guidelines and procedures;
 - n) Is a claim for which Hospital has exhausted all known other insurance resources;
 - o) Is submitted electronically if Hospital has the ability to submit claims electronically; and
 - p) Uses the data elements of UB-04, as appropriate.
- 1.3** **CMS** means the Centers for Medicare & Medicaid Services.
- 1.4** **Commercial Enrollee** means a Subscriber in any of Plan's Commercial products.
- 1.5** **Co-Payment** means the predetermined amount an Enrollee must pay, whether stated as a percentage or a fixed dollar, to receive a specific service or benefit.
- 1.6** **Covered Services** means those Medically Necessary health care services that are properly authorized and covered under the terms of the applicable Payor Contract and rendered in accordance with the terms of this Agreement and the Provider Manual.
- 1.7** **Credentialing and Re-Credentialing** means the policy that Plan will follow in credentialing a new applicant in providing Covered Services and when appropriate, re-credentialing every two years.
- 1.8** **DHS** means the Iowa Department of Human Services and includes the Iowa Medicaid Enterprise ("IME").
- 1.9** **DHS/Plan Agreement** means the agreement between the State of Iowa and Plan pursuant to which Plan agrees to arrange for the delivery of Covered Services to Enrollees.
- 1.10** **Elective Admissions and Services** means all health services not necessary to evaluate, screen and stabilize an Emergency Medical Condition as required by the Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd ("EMTALA").
- 1.11** **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) serious jeopardy to the health of the individual or in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.
- 1.12** **Enrollee** means an individual who, pursuant to the applicable individual or group Enrollee contract with Plan, is eligible to receive Covered Services. The term Enrollee includes eligible dependents of a Subscriber, Medicaid Enrollees, Medicare Enrollees, MMAI Enrollees and Commercial Enrollees.
- 1.13** **Hospital-Based Practitioner** means a licensed physician employed by Hospital or under contract with Hospital for the provision of professional medical services to patients of Hospital, including, without limitation, radiologists, anesthesiologists, pathologists, and emergency room physicians.
- 1.14** **Hospital Services** means Covered Services customarily provided by a hospital including, without limitation, inpatient services, outpatient services and emergency services, treatment and supplies.
- 1.15** **IID** means the Iowa Insurance Division.
- 1.16** **Inpatient Services** means all Hospital Services that Hospital provides to an Enrollee who is admitted to Hospital for a period twenty-four (24) hours or more. This term shall not include any professional component of the services, or any personal, non-medical expenses incurred by Enrollee.
- 1.17** **IME** means the Iowa Medicaid Enterprise.

1.18 **Medicaid Enrollee** means an Enrollee in any of Plan's Medicaid or SCHIP products.

1.19 **Medicaid Rates** means the entire amount payable by DHS/IME to Hospitals for covered medical services provided to Medicaid beneficiaries who are not enrolled in a health plan pursuant to a Plan Agreement. It includes, without limitation, Diagnosis Related Group (DRG) payments, Per Diem payments for exempt units, outpatient fee screen payments and applicable pass-through payments. The amount payable is reduced by any other available resource such as Medicare, other insurance or a beneficiary's patient pay amount or spend down amount required to be collected by Hospital.

1.20 **Medical Director** means the individual designated by Plan to act as its Medical Director.

1.21 **Medically Necessary or Medical Necessity** means health care services which are all of the following:

- a) Appropriate and necessary for the diagnosis or treatment of a medical condition;
- b) Provided for the diagnosis or direct care and treatment of a medical condition;
- c) Within accepted medical and surgical standards; professional and technical standards;
- d) Not primarily for the convenience of the Enrollee, the Enrollee's physician or another health care provider;
- e) The most appropriate level of service which can be provided safely;
- f) In accordance with applicable federal and state laws, rules and regulations;
- g) In accordance with DHS/IME promulgated Medicaid policies for Medicaid Enrollees;
- h) In accordance with CMS promulgated policies for Medicare Enrollees; and
- i) In accordance with CMS and/or DHS/IME promulgated policies as applicable for MMAI Enrollees

1.22 **Medicare Advantage Plans** are health plan options that are part of the Medicare program and provide Medicare-covered health care (Parts A and B) through Plan. This coverage can include prescription drug coverage (Part D).

1.23 **Medicare Enrollee** means an Enrollee in any of Plan's Medicare Advantage Plans.

1.24 **Medicare Part D** is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006.

1.23 **MMAI** means the program to test new service delivery and payment methods and models for those individuals dually eligible for Medicare and Medicaid.

1.24 **MMAI Enrollee** means an individual who is eligible to receive Covered Services pursuant to Plan's agreements with DHS and CMS as a participant in the MMAI.

1.25 **Non-Covered Service** means health services that (i) are not described in Plan's Certificate of Coverage, or (ii) are services provided before an individual becomes an Enrollee or after an individual ceases to be enrolled as an Enrollee of Plan or, (iii) services not required by EMTALA for which Hospital did not secure Prior Authorization, or (iv) for Medicaid Enrollees, not covered by the Medicaid Program, or (v) for Medicare Enrollees, not covered by the Medicare Program, or (vi) not medically necessary.

1.26 **Outpatient Services** means all Covered Services other than Inpatient Services.

1.27 **Participating Practitioner** means a duly licensed physician by the State of Iowa who has individually agreed or is an employee, independent contractor or member of a professional service corporation that has agreed to provide Covered Services for Enrollees on behalf of Plan pursuant to a contract or agreement with Plan.

1.28 **Participating Provider** means a health care provider, including individuals, organizations and facilities, who/which have entered into agreements with Plan to provide Covered Services to Enrollees. A Participating Physician is also a Participating Provider.

1.29 Plan means the managed care plan, which contracts with DHS, CMS, other government sponsored programs and/or individuals and groups for commercial insurance, to provide medical assistance to Enrollees.

1.30 Plan Policies refers not only to documents so titled by Plan but also to Plan Provider Manual, Plan Formulary, procedures, and guidelines developed by Plan which address matters such as verification of eligibility, coordination of benefits, transfer policies, quality management, utilization management, peer review and Enrollee grievance procedures, standards, bulletins and subsequent additions, revisions and deletions.

1.31 Physician Services means Covered Services provided by a physician and includes primary care and specialty care services.

1.32 Primary Care Practitioner (PCP) means a physician who has the responsibility for providing initial and primary care to and for managing the total patient care of Enrollees. A Primary Care Physician may be a general practitioner, internist, pediatrician, family practitioner or obstetrician/gynecologist.

1.33 Prior Authorization or Authorized refers to Hospital securing the approval of Plan before delivery to provide non-emergency services to an Enrollee. The standards governing prior authorization and the procedure for obtaining are delineated in Plan Policies.

1.34 Special Needs Plan means a type of Medicare Advantage Coordinated Care Plan focused on individuals with special needs. Enrollees must have one or more types of Special needs as identified by Congress: 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions.

1.35 Subscriber means an individual who: (a) Has entered into contract with Plan, or on whose behalf a contract was entered into; and (b) Meets all applicable eligibility criteria; and (c) Has completed an enrollment application form which has been received by Plan; and (d) For whom Plan has received prepaid amounts of money (premiums on a monthly basis).

1.36 Utilization and Quality Management means the prospective, concurrent, and retrospective utilization management and quality management that Plan applies to Covered Services.

2. OBLIGATIONS OF HOSPITAL

2.1 Provision of Covered Services. Hospital agrees to provide Prior Authorized Medically Necessary Covered Services to Enrollees in the same manner, in accordance with the same standards, and within the same time availability, as provided to its other patients within the existing resources of Hospital, subject to Hospital's compliance with Plan's Prior Authorization policies. Hospital shall not, other than for reasons of safety, segregate Enrollees in any way or treat them in a location or manner different from any of its other patients. Hospital shall provide all services required by the Emergency Medical Treatment and Active Labor Act, ("EMTALA") and may do so without Prior Authorization. Hospital shall accept Prior Authorized Medically Necessary Elective Admissions of Enrollees that have been arranged by physicians having admitting privileges at Hospital. Hospital shall meet the applicable Medicaid accessibility standards. In the event that Plan determines, in its sole discretion, that the health or safety of Enrollees is in jeopardy, Hospital shall fully cooperate in the immediate transfer of such Enrollees to another Hospital. Hospital shall not deny Covered Services to any Enrollee who is eligible for such Covered Services due to the Enrollee's inability to pay a co-payment.

2.2 Non-Discrimination. Hospital shall not unlawfully discriminate in the acceptance or treatment of an Enrollee because of the Enrollee's religion, race, color, national origin, age, sex, income level, health status, marital status, disability or such other categories of unlawful discrimination as are or may be defined by federal or state law.

2.3 Non-Covered Services. In the event an Enrollee requests services that are Non-Covered Services, such services may be provided by Hospital at the Enrollee's sole cost and expense. Hospital shall be under no obligation to furnish Non-Covered Services to Enrollees. Plan is not responsible to pay the costs of any Non-Covered Service. Hospital must receive a signed agreement from the Enrollee prior to the provision of any Non-Covered Service in

which the Enrollee states that he/she will assume responsibility for the costs of the Non-Covered Service. Hospital agrees not to charge amounts in excess of its normal and customary charge for such services. In the event Hospital does not obtain a signed release, Hospital shall hold Plan and Enrollee harmless from any costs or obligations related to such service. Hospital agrees to cooperate with Plan in resolving any grievances related to the provision of any Non-Covered Service.

2.4 Verification of Enrollee Eligibility. Hospital shall verify the eligibility of and Plan enrollment status of Enrollees.

2.5 Hospital Admission and Services.

2.5.1 Elective Admissions and Services. All Elective Admissions and Services provided to an Enrollee must have Prior Authorization. Any Elective Admission shall be arranged by a physician with admitting privileges at Hospital. Hospital shall have the responsibility to verify Prior Authorization at the time of admission.

2.5.2 Screening and Stabilization. Hospital shall provide all services required by EMTALA, and such services do not require Prior Authorization.

2.5.3 Request for Inpatient Admission. In seeking Prior Authorization for hospitalization following stabilization of an Enrollee treated pursuant to EMTALA, Hospital shall provide Plan with requested information obtained from the medical screening examination, provided in accordance with EMTALA, and including presenting symptoms, physical findings, current medical status, and current diagnosis(es).

2.6 Government Agency Access. Hospital shall permit authorized government agencies and their subcontractors or representatives, during normal business hours, to inspect, audit, monitor, or otherwise evaluate Hospital's performance pursuant to the contract between Plan and the State of Iowa, and between Plan and CMS. Hospital shall produce relevant records requested as part of such review or audit. Hospital shall also permit authorized government agencies and their subcontractors or representative, during normal business hours to conduct on-site evaluations of Hospital's facilities, offices and records as required by state and federal laws and regulations. If Plan receives such notice, Plan shall provide reasonable notice to Hospital of any agency's plans to conduct a site visit, unless Plan is prohibited from providing such notice by law.

2.7 Plan Access. Upon reasonable notice from Plan, Hospital will allow Plan personnel to: (i) inspect Hospital's facilities, offices, and equipment during normal business hours; (ii) inspect and review the medical records of Plan Enrollees; and (iii) obtain copies of Enrollees' medical records and claims records for quality and utilization management and investigations of fraud, waste or abuse.

2.8 Maintenance of License. Hospital shall maintain in good standing all licenses required by state and federal law or regulation and shall maintain certification under Titles XVIII and XIX of the Social Security Act for all services Hospital has agreed to provide pursuant to this Agreement. Hospital shall maintain accreditation of all applicable facilities and services by the Joint Commission ("TJC") or the American Osteopathic Association ("AOA.")

2.9 Maintenance of Records. Hospital shall maintain all pertinent financial and accounting records and evidence pertaining to the provision of Covered Services to Enrollees in accordance with generally accepted accounting principles and other procedures specified by federal or state governments. Hospital shall maintain legible, comprehensive and chronological medical records documenting each episode of service to Enrollees and detailing, as appropriate, history, physical findings, diagnoses and treatment plans. Financial and medical records shall be maintained by Hospital for such times as are or may be required by state and federal law and regulations. Hospital shall comply with all medical record requirements contained within 42 CFR 456.101 through 456.145.

2.10 Insurance. Hospital shall maintain at all times policies of general liability and professional liability insurance or self-insurance with minimum limits of liability of one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in annual aggregate covering Hospital, its agents and employees against any claims for damages out of any act or omission by Hospital, its agents and employees during terms of this Agreement. Hospital shall also maintain at all times automobile insurance, unemployment compensation insurance

and workers' compensation insurance or self-insurance in accordance with the requirements of applicable federal and state laws and regulations. Upon request, Hospital shall furnish Plan with original certificates of insurance evidencing the insurance coverages and riders required.

2.11 Medical Treatment. Hospital agrees that Plan shall have no liability for the medical judgment of health care providers employed by or under contract with Hospital.

2.12 Required Disclosures. Hospital shall comply with all disclosure requirements set forth in 42 CFR 455.104 -106. In addition, Hospital shall notify Plan in writing within ten (10) days of any of the following events:

2.12.1 Suspension, termination, or cancellation of Hospital's state license, Medicaid certification or Medicare certification;

2.12.2 Failure to maintain insurance coverage or self-insurance as prescribed in Section 2.10;

2.12.3 Loss, suspension or termination of TJC or AOA accreditation;

2.12.4 Hospital becomes aware that the license or admitting privileges of a Hospital-Based Physician who is employed by it are terminated or suspended for quality reasons; or

2.12.5 Any change in assumed name(s) or taxpayer identification number(s) through which Hospital provides services and under which Hospital may submit claims under this Agreement.

2.13 Hospital Compliance with Plan Policies. Hospital agrees to be bound by the Plan Policies under the conditions set forth in section 2.2 and 2.2.1 below.

2.14 Physician Qualifications.

2.14.1 Hospital Credentialing/Re-Credentialing. Hospital shall cooperate with the credentialing and re-credentialing processes of Plan. Hospital represents that its Hospital-Based Physicians are licensed and in good standing to practice medicine in the State of Iowa. Hospital agrees to immediately notify Plan of the termination or suspension admitting privileges of any physician known to Hospital to be a Plan Participating Provider.

2.14.2 Admitting Physicians. Hospital represents that all physicians providing services at Hospital to Enrollees shall be members of the medical staff of the Hospital in accordance with the Hospital's corporate and medical staff bylaws, policies, procedures, rules and regulations. No physician shall obtain or maintain medical staff membership or clinical privileges at Hospital by virtue of being a Participating Provider with Plan. A physician shall not be denied or granted admitting privileges based solely on whether the physician is or is not a Participating Provider.

2.14.3 Hospital-Based Practitioners. Hospital represents that it has the full legal power and authority to bind its Hospital-Based Practitioners who are employees to the terms and conditions of this Agreement.

2.15 Payment Administration. Hospital will cooperate with Plan's claims payment administration as set forth in Plan Policies including, but not limited to, coordination of benefits, subrogation, verification of coverage, prior certification and record keeping.

2.16 No Unfair Labor Practices. Hospital represents and warrants that it will not engage in unfair labor practices.

2.17 Non-Discriminatory Hiring. In the performance of services pursuant to this Agreement, Hospital agrees not to discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental handicap or disability. Further, Hospital agrees to comply with the provisions of the Americans with Disabilities Act of 1990 (42 USC 12101 et seq., and 47 USC 225) and the Iowa Civil Rights Act of 1965, as amended.

2.18 Quality, Utilization and Risk Management (Q/U/RM). Hospital agrees to allow Plan to perform the review of the admission and continuation of hospitalization of Enrollees and to cooperate with Plan's policies and procedures as set forth in Plan Policies for Q/U/RM or any other program of review that may be established to promote high standards of medical care. Hospital agrees to allow a "Utilization Review Coordinator" designated by Plan to assist Hospital personnel with discharge planning and utilization review for Enrollees.

2.19 Compliance with Laws and Regulations. In performing its obligations under this Agreement, Hospital shall comply with all applicable laws, rules and regulations. Hospital represents and warrants that it does not and will not employ or contract with: (i) any individual or entity excluded from Medicaid or Medicare participation under Sections 1128 (42 U.S.C. 132a-7) or 1128A (42 U.S.C. 1320a-7a) of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services; (ii) any entity for the provision of such services (directly or indirectly) through an excluded individual or entity; or (iii) any individual or entity excluded from Medicaid participation by the DHS.

2.20 Public Health Reporting. Hospital agrees to comply with specific State of Iowa Law for reporting communicable disease and other health indicators.

2.21 Newborn Infants. Hospital shall request enrollment of a newborn at the time of birth, as set forth by the DHS or IME.

2.22 Medicare Specific Requirements. Hospital shall adhere to the provisions set forth in the Medicare Attachment for all services provided in relation to Medicare Enrollees.

2.23 Laboratory Services. Hospital shall adhere to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Public Law 100-578 and IAC 441--79.13 (249A) requirements for supplying laboratory services.

2.24 Referrals. No provider employed by a hospital or any affiliate is required or in any way obligated to refer Enrollees to providers also employed or under contract with Hospital or an affiliate.

2.25 Hospital Compliance with Plan Policies. Hospital agrees to be bound by all Plan Policies under the conditions set forth in Section 3.2 and 3.2.1 below.

2.26 Lobbying Certification. Hospital certifies to the best of Hospital's knowledge and belief, that no federally appropriated funds have been paid or will be paid by or on behalf of Hospital, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.

2.26.1 Funds. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Hospital shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such Form is to be obtained at Hospital's request from the Office of Management and Budget.

2.27 Medical Services. Hospital represents and warrants that it has complied with and is complying with all applicable statutes, orders, rules and regulations promulgated by any Federal, State, Municipal or other governmental authority relating to the conduct of Hospital's property and operations and that there are no violations of any statute, order, rule or regulation pertaining thereto now existing or threatened. Hospital further represents and warrants that it shall discharge its obligations under this Agreement in compliance with all applicable Federal and State statutes and regulations and in accordance with all policies, procedures and requirements from time to time promulgated by the U.S. Department of Health and Human Services, CMS and DHS.

3. OBLIGATIONS OF PLAN

3.1 Prior Authorization. All Hospital Services provided to Enrollees that are not mandated by EMTALA require Prior Authorization by Plan pursuant to Plan Policies. Hospital shall provide Plan with information obtained from the medical screening examination, provided in accordance with EMTALA, and presenting symptoms, physical findings, current medical status, and current diagnosis within twenty-four (24) hours or the next business day. All non-emergent services must be authorized as described in Plan Policies.

3.1.1 Documentation of Prior Authorization Process. Medical information submitted as required in Section 2.1 in support of the Prior Authorization request may be provided orally or in writing. If provided orally, the Plan Prior Authorization employee who takes the telephone request from Hospital shall write down, tape record or electronically record the information provided. Both Plan and Hospital staff will record each other's name and the time of telephone contact. If Plan gives Prior Authorization for treatment or admission, Plan shall provide Hospital with an authorization number or code.

3.1.2 Authorization Response. Failure of Plan to respond to Hospital with approval or denial of Prior Authorization within the time frame set in Section 3.1 shall be deemed as Prior Authorization for Medically Necessary treatment appropriate to the diagnosis presented when seeking Prior Authorization.

3.1.3 Effect of Prior Authorization. Prior Authorization by Plan shall not prevent Plan from a retrospective evaluation of medical services provided by Hospital pursuant to Plan Policies. Plan agrees that the grant of Prior Authorization for Covered Services shall create a rebuttable presumption that Medically Necessary services appropriate to the diagnosis presented at the time of Prior Authorization shall be paid for pursuant to this Agreement. Plan shall bear the burden to support denial of payment for Prior Authorized services through the dispute resolution process provided in this Agreement.

3.2 Plan Policies. Plan shall provide Hospital with all Plan Policies upon execution of this Agreement.

3.2.1 Amendments to Plan Policies. During the term of this Agreement, Plan may implement changes in the Plan Policies as may be required by state or federal law or regulation, Medicare and/or Medicaid policy or at its discretion. If changes in the Plan Policies are required due to changes in law, regulation, and policy beyond the control of Plan, Plan shall provide a minimum of thirty (30) days' notice to Hospital prior to implementation, unless the required changes are mandated to be implemented in less time. For changes in Plan Policies that are not required by law, regulation or policy, Plan shall provide a minimum of thirty (30) days' notice to Hospital prior to implementation of such change. If Hospital does not exercise its option to terminate the agreement, Hospital agrees to comply with the amendment(s).

3.3 Insurance. Plan shall maintain at all times managed care errors and omissions liability insurance or self-insurance with minimum coverage of one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) annual aggregate, covering Plan and its agents and employees against any claims for damage arising directly or indirectly in connection with its activities under this Agreement. Plan shall also maintain such amounts of insolvency or stop-loss insurance as may be required by the laws of the State of Iowa pertaining to HMOs. Additionally, Plan shall maintain at all times automobile insurance, unemployment compensation insurance, and workers' compensation insurance or self-insurance in accordance with the requirements of all applicable federal and state laws and regulations. Upon reasonable request, Plan shall furnish Hospital with original certificates of insurance evidencing the insurance coverages and riders required.

3.4 Plan Determinations. Plan agrees that, provided the information supplied by Hospital is accurate, Hospital shall have no liability for determinations, including without limitation, determinations regarding coverage, Prior Authorization and Medical Necessity that are made by Plan employees or contractors.

3.5 Compliance with Laws and Regulations. Plan represents that it has never been suspended, excluded or terminated as a contractor under Medicaid, Medicare, or other state or federal health care program, and that it operates and will continue to operate in conformity with the statutes and regulations applicable to Medicaid and Medicare contractors. In performing its obligations under this Agreement, Plan shall comply with all laws, rules and regulations of the United States and of the State of Iowa. All health professionals and laboratories providing

services under this Agreement shall be licensed and/or certified as required by law, including a valid Clinical Laboratory Improvement Amendments (CLIA) certificate and comply with the CLIA regulations found at 42 C.F.R. Part 493, if applicable.

3.6 Quality, Utilization and Risk Management. (Q/U/RM) Plan agrees to perform Q/U/RM services required in connection with this Agreement and Plan Policies.

3.7 Information. Plan will provide Hospital with the following documents: (i) the current Credentialing, Re-Credentialing and Hearing Policy and; (ii) the current Utilization and Quality Management programs and, within a reasonable time after adoption, any changes or amendments; and, (iii) the current grievance procedures and, within a reasonable time after adoption, any changes or amendments; and, (iv), if Hospital bears risk under this Agreement, Hospital quarterly reports measuring actual utilization against utilization targets for Hospital.

3.8 Maintenance of Records. Plan shall maintain all pertinent financial and accounting records pertaining to the operation of this Agreement in accordance with generally accepted accounting principles or other procedures specified or accepted by the state or federal government. Plan will, from time to time and upon reasonable notice from Hospital, permit Hospital to inspect during regular business hours those financial statements and enrollment records which Plan maintains and which pertain to the operation of this Agreement. Plan shall maintain financial records for such time period as is or may be required under state or federal laws or regulations.

3.9 Enrollee Disputes. Plan will notify Hospital of all Enrollee complaints involving Hospital. Hospital agrees to assist Plan in resolving disputes with Enrollees.

3.10 Enrollee Identification. Plan shall provide for distribution of identification cards to its Enrollees. Each card will include a toll-free number that Hospital may use to check eligibility and enrollment in Plan.

3.11 Lobbying Certification. Plan certifies to the best of Plan's knowledge and belief, that no federally appropriated funds have been paid or will be paid by or on behalf of Plan, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.

3.11.1 Funds. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Plan shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such Form is to be obtained at Plan's request from the Office of Management and Budget.

3.12 Monitoring. Plan shall monitor the performance of Hospital on an on-going basis to ensure that all obligations of Plan and its contract with CMS are being complied with.

4. PAYMENT FOR SERVICES

4.1 Compensation. Plan shall pay for all services required by EMTALA and for Prior Authorized Covered Services that Hospital provides to Enrollees in accordance with the payment rates or schedules set forth in the applicable attachments, all of which are incorporated into this Agreement. For Medicaid Enrollees, absent an agreement establishing different rates or schedules, Plan shall pay Hospital according to the Medicaid Rates as established and published by DHS. For Medicare Enrollees, absent an agreement establishing different rates or schedules, Plan shall pay Hospital according to the Medicare Rates as established and published by the CMS. Hospital shall not be paid for Covered Services where Prior Authorization was required under the terms of this Agreement and was not obtained in accordance with Section 3.1 or the Plan Policies.

4.2 Billing. Hospital shall exhaust all other insurance resources which could cover all or part of the costs of services delivered to an Enrollee prior to submitting any bill for services to Plan pursuant to this Agreement. Hospital shall bill Plan for Prior Authorized Covered Services and services provided pursuant to EMTALA.

4.2.1 Electronic Billing. Any electronic billing statement submitted by the Hospital to Plan shall include all information required in the UB-04/CMS-1450 form, including detailed and descriptive medical, service and patient data and identifying information. If Hospital uses a clearinghouse for electronic claims processing, the date of receipt by Plan will be the date Plan or Plan's clearinghouse receives control of the claim from the Hospital's clearinghouse. If the Hospital's clearinghouse returns the claim for incorrect or incomplete information, the billing statement will not be considered received by Plan and the time limits for payment will not begin to run until actually received. If both Hospital and Plan use the same clearinghouse, the date of receipt by Plan will be considered the date on which the clearinghouse has determined pursuant to the contract with Hospital that all ordered checks and edits are complete.

4.2.2 Billing Submission Deadline. Hospital shall present Plan with the billing statement within one hundred eighty (180) days from the date of performance of Covered Services to Enrollees. It is acknowledged that situations may necessitate the extension of the ninety (90) day submission deadline and the Parties may agree to extend this deadline on a case-by-case basis. Among the justifications for delaying submission of a claim are: changes in eligibility, coordination of benefits, other third-party payor issues or internal Hospital risk management. Absent an agreement to extend the time for submission of a bill, Plan shall have no obligation to pay any bill submitted beyond this one hundred eighty (180) day limit.

4.3 Payment. Plan shall make payment to Hospital within thirty (30) days of receipt of a Clean Claim. Hospital shall not resubmit any billing during a thirty (30) day period except in response to a Plan request for additional information pursuant to Section 4.4. Plan shall pay simple interest at a rate of twelve percent (10%) per annum on payment amount of any Clean Claim not paid within forty-five (45) days.

4.4 Rejected Claims. Plan shall provide Hospital with a written request for additional information within thirty (30) days after receipt of an inaccurate or insufficient billing statement. A corrected bill submitted by Hospital pursuant to this section shall reinitiate Section 4.3's time for processing a Clean Claim. A bill rejected after resubmission pursuant to this section shall be referred to the dispute resolution process and will not bear interest unless imposed under the dispute resolution process.

4.5 Adjusted Payments. Plan may make an adjusted payment on a submitted claim within forty-five (45) days from the date of receipt where the circumstances do not support the billing criteria for the level of service submitted on the claim. Any adjusted payment shall include a full and complete explanation and remittance advice. Hospital reserves the right to contest any adjustment and pursue any remedies through the dispute resolution processes in this Agreement.

4.6 Recoupment. Plan may recoup from, or offset against, amounts owed to Hospital under this Agreement, any payments made by Plan to Hospital that are in violation of Medicaid and/or Medicare policy, Plan Policies or this Agreement. Hospital has the right to dispute any action by Plan to recoup or offset claims pursuant to this section through resort to the Dispute Resolution Procedures of this Agreement.

4.7 Enrollee Hold Harmless. Except for applicable Enrollee deductibles, coinsurance or co-payments, Hospital shall look only to Plan for compensation for Covered Services rendered to an Enrollee and shall accept the payments set forth in this Agreement as payment in full for all Covered Services rendered to an Enrollee. In addition, consistent with 42 CFR 438.106 and 42 CFR 438.116, Enrollees shall not be held liable for any of the following: 1) Plan's debts, in case of insolvency, 2) Covered Services under the DHS Contract provided to the Enrollee for which the State did not pay Plan, c) Covered Services provided to the Enrollee for which the State or Plan did not pay Hospital due to contractual, referral, or other arrangement, or d) payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the Enrollee would owe if Plan provided the services directly. In no event, including but not limited to nonpayment by Plan, insolvency of Plan or breach of this Agreement, shall Hospital bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, seek deductibles, coinsurance or co-payments from or have any recourse against an Enrollee or persons (other than Plan) acting on his/her behalf for Covered Services

provided pursuant to this Agreement. Hospital shall give notice to Enrollees regarding any charges for Non-Covered Services. Notwithstanding the foregoing, Hospital may accept payments from third-party payors (e.g. auto insurance, etc.) or others who are legally responsible for payment of an Enrollee's medical bill. This Section shall survive termination of this Agreement, regardless of the cause of termination and shall be construed to be for the benefit of Enrollees. Hospital further agrees that this Section supersedes any oral or written agreement hereafter entered into between Hospital and Enrollee or persons acting on the Enrollee's behalf insofar as such agreement relates to payment for Covered Services provided under the terms and conditions of this contract. Except as otherwise provided in this Agreement or as required by CMS-Medicare or DHS-Medicaid policies, bulletins and federal law, this Section 4.7 is not intended to apply to services provided after this contract has been terminated or to Non-Covered Services.

4.8 Third-Party Payors and Coordination of Benefits. In the event that an Enrollee's medical expenses are eligible, in whole or in part, to be paid by any governmental program, other than by Medicaid or Medicare, or by a public or private insurance or benefit plan (collectively, "third-party payors"), Plan shall coordinate primary and secondary payment responsibility with such other third-party payors pursuant to federal and state third party liability statutes and regulations including but not limited to 42 C.F.R. 433.135-139, and the Iowa Workers' Compensation Act. Hospital shall cooperate with Plan's efforts to recover such payments or reimbursements.

4.9 Billing Disputes. At least quarterly throughout the term of this Agreement the Parties will make a good faith effort to negotiate and resolve all billing disputes. Every bill must be considered in such a quarterly billing resolution conference prior to submission to mediation or arbitration under the provisions of Section 5.2.

4.10 Financial Relationship with Plan. Plan will not prohibit Hospital from discussing Hospital's financial relationship with Enrollees.

5. TERMINATION

5.1 Term and Renewal. The term of this Agreement is for one (1) year unless terminated by either party pursuant to this Agreement. The Agreement begins at 12:01 AM on the effective date stated above. This Agreement shall automatically renew on an annual basis unless either party notifies the other in writing ninety (90) days prior to the renewal day of the Party's intention to terminate the Agreement.

5.2 Termination without Cause. After the first six (6) months, this Agreement may be terminated without cause by either party upon written notice given ninety (90) days in advance of such termination.

5.3 Termination for Cause. Either party may terminate this Agreement for a material breach of this Agreement upon written notice given forty-five (45) days in advance of such termination. The failure of Plan to make payments required under this Agreement may be deemed to be a material breach. The failure of Hospital to comply with Plan Policies may be deemed a material breach. In the event of notification of intent to terminate with cause by either party, the breaching party shall have twenty one (21) days to cure such breach. Unless the material breach is cured, the twenty one (21) day period to cure will not extend the termination date.

5.4 Automatic Termination. This Agreement will automatically terminate if any of the following events occur:

5.4.1 Suspension or termination for any reason of Plan as a Medicaid contractor;

5.4.2 Suspension or termination for any reason of Plan as a Medicare contractor;

5.4.3 Plan loss of Certificate of Authority as an HMO;

5.4.4 Hospital's state license, Medicare or Medicaid certification or TJC or AOA accreditation is revoked, terminated, or suspended; or

5.4.5 Suspension, termination or exclusion of Hospital from participation for any length of time from a governmental health care program by any governmental agency.

5.4.6 Hospital is excluded from participation under Title V, Title XVIII, Title XIX, or Title XX of the Social Security Act.

5.5 Termination due to Material Change in Plan Policies. Pursuant to section 3.2.1 above, Plan must notify Hospital of changes in Plan Policies in a timely manner prior to implementation. In the event that Plan elects to amend Plan Policies, and such amendment affects Hospital adversely, Hospital shall be entitled to terminate this Agreement. Hospital shall notify Plan immediately of its intent to terminate under this Section 5.5. Termination pursuant to this Section shall be effective on the effective date of such amendment but in no case less than fourteen (14) days following such notification of termination pursuant to this Section 5.5.

5.6 Rights upon Termination. Upon termination of this Agreement, the rights of each party hereunder shall terminate, provided however, that Hospital shall be required to treat Enrollees receiving authorized treatment at the time of termination of this Agreement until Enrollee is discharged. Plan shall be required to pay Hospital pursuant to payment terms of this Agreement for all services performed in connection with such treatment. Subject to treatment concerns of the Enrollee including continuity of care involving attending specialists and availability of alternative hospital providers, Plan shall use its best efforts to arrange for the reassignment and transfer of Enrollees as soon as possible following the termination of this Agreement.

6. DISPUTE RESOLUTION

6.1 Notice. When either party perceives the existence of a dispute, it shall give written notice to the other party describing the nature of the dispute and a proposed resolution. The Parties shall negotiate in good faith in an attempt to resolve the dispute. Section 6.2 of this Agreement shall not apply to matters relating to Plan credentialing, re-credentialing or peer review activities.

6.2 Mediation and Binding Arbitration.

5.2.1 Mediation. If the negotiations required in Section 6.1 fail to resolve the dispute, either party may request mediation under the Rules for Mediation of the Alternative Dispute Resolution Service of the American Health Lawyers Association. If the other party agrees, then both Parties shall participate in that mediation. Costs shall be apportioned in accordance with the Rules for Mediation. The legal and administrative costs of the parties shall not be considered costs of mediation subject to apportionment.

6.2.2 Binding Arbitration. If Parties do not mediate or mediation does not resolve the dispute within sixty (60) days of the request for mediation, either party may seek binding arbitration either under the Rules for Arbitration of the Alternative Dispute Resolution Service of the American Health Lawyers Association or the American Arbitration Association. Both Parties agree to binding arbitration. The Parties agree that such arbitration will take place in Des Moines, Iowa. Costs shall be apportioned pursuant to the Rules for Arbitration. The legal and administrative costs of the Parties shall in neither case be considered costs of arbitration subject to apportionment. An award entered by the arbitrator shall be final and judgment may be entered on it in accordance with applicable law. A request for binding arbitration is not valid if it is made after the date when the institution of legal or equitable proceedings on the underlying dispute would be barred by the applicable statute of limitations. The Parties exclude the following matters from the operation of this arbitration clause: (1) any counterclaim, cross-claim or third party claim for indemnity or contribution between Hospital and Plan in any Enrollee's suit against Hospital, unless a Court requires the Parties to submit the Enrollee's entire claim to arbitration; (2) any dispute concerning termination of this Agreement, which claim shall be resolved through the procedures specified for such event in Paragraph 5.1, 5.2 or 5.3, whichever may be applicable to the particular termination in dispute; and (3) any dispute for which a dispute resolution procedure or mechanism is specified in Plan's Provider Manual.

6.3 Limitation on Binding Arbitration. The binding arbitration procedures described in Section 6.2.2 above shall not apply to any claims between the Parties arising out of third-party claims asserting malpractice or professional negligence and the Parties are not precluded from asserting claims against each other based on contribution, indemnity, breach of contract, or other legal theories, by way of cross-claim or third-party complaint in

any court action commenced by a third party which alleges malpractice or professional negligence against either or both Parties to this Agreement.

7. MISCELLANEOUS PROVISIONS

7.1 Additional Products. Plan reserves the right to introduce new products in addition to the current Managed Care Products while this Agreement is in effect and to designate Hospital as a Participating or Non-Participating Provider in any such new product. To the extent that the terms for the provision of Covered Services in new products are different than those contained herein in a manner that reduces the payment terms to Hospital or would materially change Hospital's obligations hereunder, they shall be agreed to by the Parties in advance of such participation hereto if Plan offers participation in these programs to Hospital.

7.2 Relationship of Parties. The relationship of Hospital to Plan is that of an independent contractor. Neither Hospital nor any of its employees shall be considered under the provisions of this Agreement or otherwise as being an employee of Plan nor shall Plan nor any of its employees be considered under the terms of this Agreement or otherwise as being an employee of Hospital. Each party is solely responsible to meet its own financial obligations to its employees including provision of workers' compensation and unemployment insurance coverage, malpractice and other liability insurance, payment of federal state and local taxes and any other costs or expenses necessary to carry out its obligations under this Agreement. No work, act, commission or omission of any party, its agents, servants or employees, pursuant to the terms and conditions of this Agreement, shall be construed to make or render any party, its agents, servants or employees, an agent, servant, representative or employee of, or joint venturer with, the other party.

7.3 Treatment Options. Hospital shall not be prohibited from discussing treatment options with Plan Enrollees that may not reflect Plan's position or may not be covered by Plan. Hospital, when acting within the lawful scope of practice is not prohibited or otherwise restricted from advising or advocating on behalf of an Enrollee who is his/her patient for 1) the Enrollee's health status, medical care, or treatment options, including alternative treatment that may be self-administered, 2) for any information the Enrollee needs in order to decide among all relevant treatment options, 3) for the risks, benefits and consequences of treatment or non-treatment, 4) for the enrollee's right to participate in decisions regarding this or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

7.4 Advocating on Behalf of Plan Enrollees. Hospital shall not be prohibited from advocating on behalf of a Plan Enrollee in any grievance or utilization review process or individual authorization process to obtain necessary health care services.

7.5 Orderly Transfer. Hospital agrees, in the event of termination of this Agreement, to cooperate with Plan in the orderly transfer of Enrollees being treated or evaluated.

7.6 Accreditation. Both Parties agree to cooperate and facilitate the efforts of the other party to obtain and maintain appropriate accreditation from TJC, AOA, National Committee for Quality Assurance ("NCQA"), Accreditation Association for Ambulatory Health Care ("AAHC"), URAC or other appropriate accrediting body.

7.7 Confidential Information. The Parties agree that the items of information subject to confidentiality under this Agreement are: (i) medical information relating to individual Enrollees; (ii) the schedule of compensation to be paid to Hospital; (iii) all Q/U/RM documents and peer review information; and, (iv) any financial or utilization information provided by Hospital to Plan including charge masters detailing the compensation schedule (if different from Medicaid Rates) set forth in the relevant attachments to this Agreement. Otherwise, all other information, including the general manner by which Hospital is paid under this Agreement and the general terms and conditions of this Agreement may be shared with Enrollees in the reasonable and prudent judgment of the Parties to this Agreement.

7.7.1 Notwithstanding the above designation as confidential, Plan may disclose financial or utilization information to third parties as necessary: (i) to satisfy internal quality and utilization requirements; (ii) to share with employees or agents of Plan who need to know the information carry out Plan's quality and utilization obligations;

(iii) to satisfy mandatory governmental or regulatory reporting requirements; (iv) to compare cost, quality and service among providers with whom Plan has contracted or intends to contract; (v) for premium setting purposes; (vi) for HEDIS reporting; (vii) for TJC, NCQA, URAC or other reporting necessary for accreditation purposes; or (viii) to perform any of Plan's obligations under this Agreement. Any information disclosed to third parties pursuant to this subsection shall remain confidential and Plan shall require third-party recipients of such information to maintain confidentiality.

7.7.2 Plan shall be permitted to prepare and disclose to a third-party a report of Hospital's quality data provided however, that Hospital quality data shall not include any information that identifies an individual Enrollee or an individual Hospital or information that is privileged or confidential under peer review or patient confidentiality state or federal laws. For purposes of this subsection, Hospital's quality data includes, without limitation: (i) utilization data of all contracted Hospitals in the aggregate; (ii) HEDIS data production and performance evaluation; (iii) Enrollee satisfaction data; (iv) Overall compliance with TJC or other comparable quality standards (i.e., NCQA, URAC); and (v) Plan's disenrollment data.

7.8 Grievances. Plan shall notify Hospital of any and all Enrollee complaints involving Hospital. Hospital shall notify Plan of any and all Enrollee complaints received from Enrollees. Hospital and Plan shall make good faith efforts to investigate complaints and work together to resolve Enrollee complaints in a fair and equitable manner. Hospital shall participate in and cooperate with Plan's grievance procedures and comply with final determinations provided in accordance with Plan Policies. A copy of the grievance procedure shall be provided to a Enrollee at the time of enrollment and to Hospital upon execution of this Agreement. This provision shall survive termination of this Agreement.

7.9 Ownership of Medical Records. All medical records shall belong to Hospital. The release, disclosure, removal or transfer of such records shall be governed by state and federal law and the Parties established policies and procedures. Hospital agrees to make an Enrollee's medical records available to Plan for purposes of assessing quality of care, conducting medical care evaluations and audits and determining on a concurrent basis the medical necessity and appropriateness of care provided to Plan Enrollees. Hospital also agrees to make Enrollees medical records available to appropriate state and federal authorities and their agents for purposes of assessing quality of care or investigating Enrollee grievances. Hospital agrees to comply with all applicable state laws and administrative rules and federal laws and regulations related to privacy and confidentiality of medical records.

7.10 Assignment. Neither this Agreement nor any rights or obligations hereunder shall be assignable by either Hospital without the prior written consent of Plan, nor shall the duties imposed herein upon Hospital be subcontracted or delegated without the prior written approval of Plan.

7.11 Entire Agreement. This Agreement (including attachments) and the Plan Policies contain the entire agreement between the Parties with respect to the subject matter of this Agreement. If a conflict develops between this Agreement and the Plan Policies, Plan Policies shall take precedence. Neither Hospital nor Plan shall be subject to any requirements other than as set forth in this Agreement or Plan Policies. The failure of a party to insist on the strict performance of any condition, promise, agreement or undertaking set forth herein shall not be construed as a waiver or relinquishment of the right to insist upon strict performance of the same condition, promise, agreement or undertaking at a future time.

7.12 Severability. If any provision of this Agreement or portion is declared invalid or unenforceable, the remaining provisions shall nevertheless remain in full force and effect.

7.13 Notices. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be sent by first class mail, facsimile, or by certified mail, return receipt requested, postage prepaid, to the other party as follows:

| | |
|--|--|
| Meridian Health Plan 666 Grand Avenue 14th Floor Des Moines, IA 50309 | |
|--|--|

7.14 Controlling Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Iowa. This agreement shall comply with all applicable Medicare laws, regulations and CMS instructions.

7.15 Marketing. Each party to this Agreement specifically authorizes the other party to include it in any and all marketing and advertising materials. Each party will provide the other party copies of any written marketing materials referencing the other. The Parties further acknowledge that this Agreement may be terminated and agree to hold the other harmless for any continued use of marketing materials if such materials were prepared before the receipt of a notice of termination. The Parties shall hold each other harmless from reliance upon inaccurate or incomplete information provided by the other party in such materials. Except for purposes encompassed by this Section 7.15, neither party shall utilize the trademarks or service marks of the other party without the express written approval of the other party.

7.16 Limitation of Third-Party Rights. This Agreement is intended solely for the benefit of the Parties, and is not intended to create any rights or benefits, either express or implied, in any other person, including, without limitation, patients of Hospital, Hospital's successors or assigns. Plan may not subcontract or resell any rights to Hospital access or prices created by this Agreement to any third-party without the express written approval of Hospital.

7.17 Regulatory Approval. The Parties acknowledge and agree that this Agreement may be subject to approval by DHS, CMS and/or IID.

7.18 Mutual Cooperation. To the extent a conflict of interest is not created hereby each party shall cooperate with the other with respect to any action, suit or proceeding commenced against either party by a person or entity not a party hereto with respect to the subject matter thereof.

7.19 Recitals – The recitals are hereby incorporated into and made part of this Agreement.

8 SERVICES COVERED UNDER THIS AGREEMENT

Attachment B - Meridian Health Plan of Iowa Medicaid Managed Care Network

Attachment C - Meridian Advantage Plan of Iowa (HMO SNP) Medicare MA-PD Plan Network

Attachment D - Meridian Health Plan Commercial HMO Network

Attachment E - MMAI Network

Other _____

[Signature Page Follows]

IN WITNESS WHEREOF, to signify their agreement to all of the terms and conditions hereof, the Parties have executed this Agreement as of the date(s) stated below:

To be completed by Hospital:

To be completed by Meridian Health Plan:

| | |
|--|--|
| <p>Hospital Name: Hospital License Number: _____ Address: _____ _____ _____ Telephone () _____ Signature: _____ Title: _____ Date: _____</p> | <p><u>Meridian Health Plan of Iowa, Inc.</u> 666 Grand Avenue, 14th Floor Des Moines, IA 50309 (515) 802-3500</p> <p>_____ Signature: <u>Raymond Pitera</u> Printed Name: <u>President/COO</u> Title: _____ Date:</p> |
|--|--|

Attachments:

- Attachment A – Schedule of Covered Services
- Attachment B – Medicaid
- Attachment C – Medicare
- Attachment D – Commercial
- Attachment E – MMAI
- Attachment F – List of Hospital Practitioners and Providers

ATTACHMENT A
Meridian Health Plan
-Schedule of Covered Services-

1. **“REIMBURSABLE SERVICES”** are those medical and hospital services which are Covered Services and for which Hospital may submit itemized claims for Fee-For-Service payment pursuant to the respective attachments as provided in Section 8 of this Agreement.

The services to be provided are as indicated by the X mark in the appropriate blanks below:

A. Hospital Services

- Emergency Department Services – 24 hours per day, 7 days per week
- Urgent Care Services
- Outpatient Services
- Inpatient services – 24 hours per day, 7 days per week
- Birthing services such as labor and delivery rooms, birthing rooms or birthing centers
- Other: Specify

B. Physician Services

- General/Family Practice
- General Surgery
- Obstetrics/Gynecology
- Pediatrics
- Neonatology
- Internal Medicine
- Cardiology
- Anesthesiology
- Dermatology
- Neurology
- Neurosurgery
- Otolaryngology
- Ophthalmology
- Orthopedics
- Pathology
- Psychiatry
- Rehabilitative Medicine
- Thoracic Surgery
- Urology
- Vascular Surgery
- Mental Health
- Dental Services (of the type not normally provided by a dentist)
- Other: Specify

ATTACHMENT A (continued)

- C. Non-Physician Services**
- ___ Family Planning
 - ___ Laboratory
 - ___ Pharmacy
 - ___ Radiology
 - ___ Vision Care/Optomety
 - ___ Chiropractic
 - ___ Home Health Care
 - ___ Hearing Aids
 - ___ Hearing and Speech
 - ___ Podiatry
 - ___ Speech Therapy
 - ___ Physical Therapy
 - ___ Occupational Therapy
 - ___ Medical Equipment
 - ___ Medical Supplies
 - ___ Oxygen
 - ___ Orthotics
 - ___ Prosthetics
 - ___ Substance Abuse Treatment
 - ___ Transplant Services
 - ___ Other: Specify

ATTACHMENT B
Meridian Health Plan
-Medicaid -

REIMBURSEMENT SCHEDULE FOR MEDICAID ENROLLEES

Hospital's reimbursement for Covered Services (as defined in Section 1 of the Agreement) rendered to Medicaid Enrollees, except for amounts received for coordination of benefits or otherwise from third parties in accordance with this Agreement, shall be as follows:

EMERGENCY ROOM RATES: Plan shall pay 100% of current Medicaid Rates in effect on the date of service for each properly Authorized emergency room visit provided.

URGENT CARE RATES: Plan shall pay a 100% of current Medicaid Rates in effect on the date of service for each properly authorized urgent care visit provided.

OUTPATIENT HOSPITAL SERVICES: Plan shall pay Hospital at 100% of the current Medicaid Fee Screen in effect on the date of service for properly Authorized services rendered during each outpatient visit. Properly Authorized observations will be reimbursed at the current Medicaid Fee Screen, pursuant to Plan Policies.

INPATIENT HOSPITAL SERVICES: Plan shall pay Hospital the current Iowa Medicaid DRG in effect on the date of service including capital costs under the State of Iowa guidelines for properly authorized services rendered during each inpatient visit.

MAINTENANCE DAYS: When an inpatient Medicaid Enrollee is deemed medically stable for discharge from the acute care setting by both Hospital and Plan, but the Medicaid Enrollee cannot be safely discharged at the time due to the inability to locate an alternative level of care setting, a "Maintenance Bed" rate of \$350.00 per day would apply. "Maintenance Bed" shall be defined as: Minimal nursing care required, but the Medicaid Enrollee's care cannot be delivered in their current home setting, the Medicaid Enrollee cannot care for him/herself at home but does not require care in an acute care setting, or the Medicaid Enrollee could be treated in a skilled nursing facility or alternative setting if a bed was available.

MEDICAID REQUIREMENTS

In accordance with regulations, laws and official guidance applicable to Medicaid plans:

- 1. Subcontractors** - The parties agree that Hospital, in performing its duties and obligations hereunder, shall have the right, subject to the credentialing and re-credentialing requirements described in this Agreement, either to employ its own employees and agents or to utilize the services of persons, firms and other entities by means of subcontractual relationships; provided, however, that no such subcontract shall operate to relieve Hospital of its obligations hereunder and further provided that the format for all such subcontracts shall have been approved by the IID with the advice of the DHS, in the event that either agency requires such approval; and further provided that Plan's liability for reimbursement hereunder shall extend only to Hospital, and only to the sums provided for herein, and that Hospital shall be solely responsible for reimbursement and/or payment of any employee or agent of Hospital for services performed pursuant to this Agreement. All such subcontracts shall be in writing and fulfill requirements of 42 CFR 434.6 that are appropriate to the service or activity delegated under the subcontract.
- 2. Plan Obligations to DHS** - Anything herein to the contrary notwithstanding, no term or provision of this Agreement shall operate to terminate the legal responsibility of Plan to the DHS, in concurrence with the IID, with respect to Enrollees eligible for benefits under Title XIX and Title XXI of the Social Security Act (Medicaid and SCHIP). Hospital agrees that no subcontract can terminate the legal responsibility of Hospital to DHS with respect to Enrollees eligible for benefits under Title XIX and Title XXI of the Social Security Act (Medicaid and SCHIP).

Hospital will assist Plan in meeting its obligations under Plan's agreement with the DHS, in concurrence with the IID with respect to Enrollees eligible for benefits under Title XIX of the Social Security Act, and hereby agrees to the terms and conditions of such agreement as they pertain or apply to subcontractors.

3. **DHS Agreement** - Hospital will assist Plan in meeting its obligations under Plan's agreement with the DHS, in concurrence with IID with respect to Enrollees eligible for benefits under Title XIX of the Social Security Act (Medicaid), and hereby agrees to the terms and conditions of such agreement as they pertain or apply to subcontractors.

4. **Timely Access** - Hospital shall meet Iowa standards for timely access to care and services, taking into account the urgency of the need for services. Hospital shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the Hospital serves only Medicaid enrollees. Hospital shall ensure that Covered Services included in this Agreement are available 24 hours a day, 7 days a week, when medically necessary. Hospital shall cooperate with all Plan monitoring and compliance mechanisms for ensuring timely access to services under this Section 3. Plan shall take corrective action for failure to comply with this Section.

5. **Medicaid Certification** - Hospital represents that it is eligible for Medicaid Certification and warrants that it will maintain such eligibility throughout the term of this Agreement.

6. **Consumer Protection** - Hospital shall comply with and assist Plan in avoiding direct marketing to Enrollees and potential Enrollees, this limitation does not include contacting an Enrollee for the purpose of informing the Enrollee of services available or to promote health education.

7. **Utilization Review Policy Compliance** - Hospital shall follow and assist in the implementation of Plan's written utilization review policies and procedures as outlined in the Utilization Management Plan.

8. **State Held Harmless** - Hospital agrees that any dispute between Hospital and Plan shall be solely between such Hospital and Plan. The State of Iowa, Department and its officers, employees and agents and Enrollees shall not be responsible for any and all actions, claims, demands, damages, liabilities, or suits of any nature whatsoever arising out of this Agreement because of any breach by Plan or Hospital or employees, including but not limited to any negligent or wrongful acts, occurrence of omission of commission or negligence of the Plan or Hospital, their subcontractors, agents, providers, or employees.

9. **Disclosure of Excluded Persons** - Hospital is obligated to disclose the identity of any person described in 42 C.F.R. § 1001.1001(a)(1) to the Plan for disclosure to DHS. Plan must abide by any direction provided by the DHS regarding whether or not to permit Hospital for participation in the Iowa Plan for Behavioral Care. If any person who has ownership or control interest in Hospital, or who is an agent or managing employee of the Hospital, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX Services program, or if DHS or the Plan determines that the Hospital did not fully and accurately make any disclosure required pursuant to 42 C.F.R. § 1001.1001(a)(1), then Plan will abide by any direction provided by DHS on whether or not to permit the applicant to be a Hospital in the Iowa Plan for Behavioral Care.

10. **Additional Disclosures** - Hospital agrees to furnish to Plan, DHS, or Secretary request, within 35 days of the request, a full and complete listing about:

- a) The ownership of any Subcontractor with whom Hospital has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
- b) Any significant business transactions between Hospital and any wholly owned supplier, or between the Provider and any Subcontractor, during the 5-year period ending on the date of the request.

Federal Financial Participation (FFP) shall be denied for expenditures for services furnished by Hospital where Hospital fails to comply with requirements of this Section 13.

11. **Enrollee Hold Harmless** - Hospital, or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by Plan, Plan insolvency or breach of this agreement, shall Hospital, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement

from, or have any recourse against subscriber/enrollee or persons other than Plan acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on HMO's behalf made in accordance with terms of (applicable Agreement) between Plan and subscriber/enrollee.

Hospital, or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Plan subscriber/enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Hospital and subscriber/enrollee or persons acting on their behalf.

In addition, Medicaid Enrollees shall not be held liable for any of the following: a) Plan's debts, in the event of Plan insolvency; b) Covered Services provided to the Enrollee, for which either DHS does not pay the Plan or DHS or the Plan does not pay the Hospital that furnishes the services under a contractual, referral, or other arrangement; or c) Payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if the Plan provided the services directly.

ATTACHMENT C
Meridian Health Plan
-Medicare -

This Attachment C describes the payments Plan will make to Hospital pursuant to this Agreement for Covered Services to Medicare Enrollees. All such payments are subject to the terms of this Agreement.

REIMBURSEMENT SCHEDULE FOR MEDICARE ENROLLEES

Hospital's reimbursement for Covered Services (as defined in Section 1 of the Agreement) rendered to Medicare Enrollees, except for amounts received for coordination of benefits, copays, coinsurance or otherwise from third parties in accordance with this Agreement, shall be as follows:

EMERGENCY ROOM/URGENT CARE RATES: Plan shall pay 100% of current Medicare Fee Screen in effect on the date of service minus any applicable copays, coinsurance or deductibles for each visit provided.

OUTPATIENT HOSPITAL SERVICES: Plan shall pay Hospital at 100% of the current Medicare Fee Screen in effect on the date of service for properly Authorized services rendered during each outpatient visit minus any applicable copays, coinsurance or deductibles. Properly Authorized observations will be reimbursed at the current Medicare Fee Screen, pursuant to Plan Policies.

INPATIENT HOSPITAL SERVICES: Plan shall pay Hospital the current Medicare Fee Screen in effect on the date of service for properly authorized services rendered during each inpatient visit minus any applicable copays, coinsurance or deductibles.

MAINTENANCE DAYS: When an inpatient Medicare Enrollee is deemed medically stable for discharge from the acute care setting by both the Hospital and Plan, but the Medicare Enrollee cannot be safely discharged at the time due to the inability to locate an alternative level of care setting, a "Maintenance Bed" rate of \$350.00 per day would apply. "Maintenance Bed" shall be defined as; Minimal Nursing care required, but the Medicare Enrollee's care cannot be delivered in their current home setting, the Medicare Enrollee cannot care for him/herself at home but does not require care in an acute care setting, or the Medicare Enrollee could be treated in a skilled nursing facility or alternative setting if a bed was available.

REGULATORY REQUIREMENTS FOR MEDICARE

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Plan and Hospital not inconsistent herein shall remain in full force and effect.

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage (“MA”): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization (“MA organization”): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than \$2,500 during a contract period.

Required Provisions:

Hospital agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Plan, (hereinafter, “MA organization”) through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]
2. Hospital will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]
3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be

informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Hospital may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. Any services or other activity performed in accordance with a contract or written agreement by Hospital are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]
6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the Plan and Hospital. [42 C.F.R. §§ 422.520(b)(1) and (2)] In accordance with 42 C.F.R. § 422.520(b), Hospital shall provide to Plan all information necessary for Plan to establish proper payment. Plan shall pay Provider for Covered Services rendered to Covered Persons in accordance with Section 7 of the Agreement. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by Plan at such address as may be designated by Plan, and Plan shall pay interest on any Clean Claim not paid within thirty (30) days of such receipt by Plan at the rate of interest required by law, or as otherwise set forth in the Provider Manual.
7. Hospital and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]
8. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:
 - (i) The delegated activities and reporting responsibilities are specified as follows:

The delegated activities are specified in the Agreement, if any.
 - (ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.
 - (iii) The MA organization will monitor the performance of the parties on an ongoing basis.
 - (iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.
 - (v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.

[42 C.F.R. §§ 422.504(i)(4) and (5)]

ATTACHMENT D
Meridian Health Plan
-Commercial -

This Attachment D describes the payments Plan will make to Hospital pursuant to this Agreement for Covered Services to Commercial Enrollees. All such payments are subject to the terms of this Agreement.

COMMERCIAL REIMBURSEMENT TERMS

This section of Attachment D describes the payments Plan will make to Hospital pursuant to this Agreement for Covered Services to Commercial Enrollees. All such payments are subject to the terms of this Agreement.

Hospital total reimbursement for Covered Services shall be defined by the Plan's Commercial Fee Schedule applicable to each individual Enrollee. Prior to the introduction of any Commercial Fee Schedule applicable to any Enrollee, or any material modification to an existing Commercial Fee Schedule, Plan will provide Hospital with sixty (60) days' advance notice in writing. If Hospital objects to the Fee Schedule as proposed, Hospital retains the right to terminate participation as to the Commercial line of business only by providing Plan with written notice prior to the expiration of the sixty (60) day notice period. Silence on the part of Hospital shall be deemed as acceptance of the new or modified Fee Schedule and continued participation in the applicable product line.

ATTACHMENT E
Meridian Health Plan
-MMAI-

REIMBURSEMENT SCHEDULE FOR MMAI ENROLLES

Medicare and Medicaid Covered Services

For Covered Services that are both Medicare and Medicaid Covered Services, Hospital shall be entitled to the lesser of: (1) Hospital's billed charges; or (2) the amount payable by Medicare, not including Medicare coinsurance and deductibles, plus the amount payable by Medicaid as a secondary coverage based on the Medicaid fee schedule in effect on the date of service.

Medicare Only Covered Services

For Covered Services that are Medicare Covered Services, but not Medicaid Covered Services, Plan shall pay Hospital the lesser of: (1) Hospital's billed charges; or 100% of the Medicare fee schedule in effect on the date of service minus any applicable copays, coinsurance or deductibles.

Medicaid Only Covered Services

For Covered Services that are Medicaid Covered Services, but not Medicare Covered Services, Plan shall pay Hospital the lesser of: (1) Hospital's billed charges; or (2) 100% of the Medicaid fee schedule in effect on the date of service.

REGULATORY REQUIREMENTS

Hospital is subject to all applicable Medicaid and Medicare Regulatory Requirements set forth above. In addition, Hospital is subject to the following:

Cultural Considerations. Services will be provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 CFR 422.112(a)(8)

ATTACHMENT F
Meridian Health Plan
-Hospital's Practitioners and Providers-

List Hospital's employed Practitioners and Ancillary Providers.

Provider Disclosure of Ownership and Control Interest Form



The federal regulations set forth in 42 CFR 455.104-106 require all providers who are entering into or renewing a provider agreement (“Disclosing Entities”) to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to managed care organizations that contract with the State Medicaid Agency: a) the identities of all owners with a control interest of 5% or greater, b) all agents or managing employees of the Disclosing Entity c) details of certain familial relationships between owners or owners of subcontractors owned by the Disclosing Entity, and d) the identities of any excluded individual or entity with an ownership or control interest in the Disclosing Entity. As used herein, a ‘person’ includes individuals and corporations or other business entities. **Please attach additional sheets as necessary.**

- Individuals listed in Sections 1-6 will be reviewed for inclusion on the Excluded Parties List System.
- Individuals listed in Section 7 will be reported to the HHS/Office of Inspector General (OIG) and to DHS.

| DISCLOSING ENTITY | | |
|---|------------------|----------------------|
| Check one that mostly describes you: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity | | |
| Name of Disclosing Entity: | | |
| DBA Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |
| Tax ID Number (TIN): | NPI (Individual) | NPI (Organizational) |

| SECTION 1 — Ownership and Control of Disclosing Entity | | | |
|--|---------------------------------|---|---|
| List the name, address, date of birth (DOB) and Social Security Number (or TIN for corporations) for each person with an ownership or control interest of 5% or more in the Disclosing Entity (including corporate entities, officers, directors, or partners). (42 CFR 455.104) | | | |
| Name of Individual or Entity: | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) |
| | | | |
| | | | |
| | | | |

| SECTION 2 — Ownership and Control of Disclosing Entity by Relatives | |
|---|--------------|
| Are any of the individuals listed in Section 1 related to each other? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If yes, disclose each person listed in Section 1 who are related to another person with ownership or control interest in the Disclosing Entity as a spouse, parent, child, or sibling. (42 CFR 455.104) | |
| Name of Individual | Relationship |
| | |
| | |

| SECTION 3 — Ownership And Control of Subcontractors | | | |
|--|---------------------------------|---|---|
| Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the Disclosing Entity has direct or indirect ownership of 5% or more. (42 CFR 455.104) | | | |
| Name of Individual or Entity with an Ownership Interest and Name of Subcontractor | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) of owner and SSN or TIN for subcontractor |
| | | | |
| | | | |

Continued on next page

SECTION 4 — Ownership and Control of Disclosing Entity by Relatives of Subcontractors

Are any of the individuals or entities listed in Section 3 related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling? Yes No

If yes, disclose each person listed in Section 3 who is related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling. (42 CFR 455.104)

| Name of Individual from Section 3 | Relationship |
|-----------------------------------|--------------|
| | |

SECTION 5 — Ownership and Control of any Other Disclosing Entity

Is there any Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which a person listed in Section 1 has an ownership or control interest? Yes No

If yes, list each Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which the person listed in Section 1 has an ownership or control interest.

An "Other Disclosing Entity" is usually an entity that either participates in Medicaid or is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVII (Grants for Planning Comprehensive Action to Combat Mental Retardation), or XX (Block Grants to States for Social Services) of the Social Security Act. (42 CFR 455.104)

| Name of Individual or Entity from Section 1 | Name of the other Disclosing Entity | % Interest |
|---|-------------------------------------|------------|
| | | |

SECTION 6 — Managing Employees

List all managing employees of the Disclosing Entity along with the additional information indicated below. *A managing employee is a "general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency." (42 CFR 455.104)*

| Name of Individual or Entity: | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) |
|-------------------------------|---------------------------------|---|---|
| | | | |
| | | | |

SECTION 7 — Criminal Offenses

Has any person with an ownership or control interest in the Disclosing Entity, or any agent or managing employee of the Disclosing Entity ever been convicted of a crime related to that individual or entity's involvement in any program under Medicaid, Medicare, or Title XX program since the inception of those programs? Yes No (verify through HHS-OIG Website)

If yes, please list those individuals below. (42 CFR 455.106)

| Name if Individual or Entity: | Date of Birth (for individuals) | Description of Offense(s) | Social Security Number (or TIN for corporation) |
|-------------------------------|---------------------------------|---------------------------|---|
| | | | |

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature

Title

Printed Name

Date

Please return completed forms by faxing 313-202-0008 or by emailing providerdisclosure@mhplan.com.

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IOWA HOSPITAL AGREEMENT

This Hospital Agreement (“Agreement”) shall be effective as of the ____ day of _____ 20__ between Meridian Health Plan of Iowa (“Plan”) an Iowa corporation and Health Maintenance Organization (“HMO”) under the laws of the State of Iowa, and _____, (“Hospital”) a Hospital licensed under the laws of the State of Iowa (collectively the “Parties.”)

Recitals

Whereas, Plan has a certificate of authority to operate as a Health Maintenance Organization (“HMO”) in the State of Iowa;

Whereas, Plan desires to contract with Hospital for the provision of Covered Services to Enrollees; and

Whereas, Hospital desires to provide Covered Services as specified in this Agreement to Enrollees for the consideration, and under the terms and conditions set forth in this Agreement;

Whereas, Hospital desires to provide prior authorized medically necessary services to all of Plan’s covered Enrollees for all products.

In consideration of the foregoing and other good and valuable consideration, the sufficiency of which is hereby acknowledged, the Parties agree as follows:

1. DEFINITION OF TERMS

The following definitions apply to the entire Agreement and all attachments.

1.1 **Benefits Certificate** means the written document approved by IID, as issued to the Enrollee, which explains the scope of benefits, limitations of coverage, and exclusions governing the Enrollee’s health care benefit coverage.

1.2 **Clean Claim** means a claim that:

- a) Is submitted within the time frame required under this Agreement;
- b) Identifies the name and appropriate tax identification number of the health professional or the health facility that provided treatment or service and includes a matching provider ID number assigned by Plan;
- c) Identifies the patient (Enrollee/Subscriber ID number assigned by Plan, address, and date of birth);
- d) Identifies Plan (Plan name and/or ID number);
- e) Lists the date (m/d/y) and place of service;
- f) Is for covered service (services must be described using uniform billing coding and instructions (ANSI X12 837) and ICD-9/10-CM diagnosis. Claims submitted solely for the purpose of determining if a service is covered are not considered Clean Claims);
- g) If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if prior authorization is required by Plan;
- h) Includes additional documentation based upon services rendered as reasonably required by Plan Policies;
- i) Is certified by Hospital that the claim is true, accurate, prepared with the knowledge and consent of Hospital, and does not contain untrue, misleading, or deceptive information, that identifies each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim;

- j) Is a claim for which Hospital has verified the Enrollee's eligibility and enrollment in Plan before the claim was submitted;
 - k) Is not a duplicate of a claim submitted within forty-five (45) days of the previous submission;
 - l) Is submitted in compliance with all of Plan's prior authorization and claims submission guidelines and procedures;
 - m) Is a claim for which Hospital has exhausted all known other insurance resources;
 - n) Is submitted electronically if Hospital has the ability to submit claims electronically; and
 - o) Uses the data elements of UB-04, as appropriate.
- 1.3** CMS means the Centers for Medicare & Medicaid Services.
- 1.4** Commercial Enrollee means a Subscriber in any of Plan's Commercial products.
- 1.5** Co-Payment means the predetermined amount an Enrollee must pay, whether stated as a percentage or a fixed dollar, to receive a specific service or benefit.
- 1.6** Covered Services means those Medically Necessary health care services that are properly authorized and covered under the terms of the applicable Payor Contract and rendered in accordance with the terms of this Agreement and the Provider Manual.
- 1.7** Credentialing and Re-Credentialing means the policy that Plan will follow in credentialing a new applicant in providing Covered Services and when appropriate, re-credentialing every two years.
- 1.8** DHS means the Iowa Department of Human Services and includes the Iowa Medicaid Enterprise ("IME").
- 1.9** DHS/Plan Agreement means the agreement between the State of Iowa and Plan pursuant to which Plan agrees to arrange for the delivery of Covered Services to Enrollees.
- 1.10** Elective Admissions and Services means all health services not necessary to evaluate, screen and stabilize an Emergency Medical Condition as required by the Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd ("EMTALA").
- 1.11** Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) serious jeopardy to the health of the individual or in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.
- 1.12** Enrollee means an individual who, pursuant to the applicable individual or group Enrollee contract with Plan, is eligible to receive Covered Services. The term Enrollee includes eligible dependents of a Subscriber, Medicaid Enrollees, Medicare Enrollees, MMAI Enrollees and Commercial Enrollees.
- 1.13** Hospital-Based Practitioner means a licensed physician employed by Hospital or under contract with Hospital for the provision of professional medical services to patients of Hospital, including, without limitation, radiologists, anesthesiologists, pathologists, and emergency room physicians.
- 1.14** Hospital Services means Covered Services customarily provided by a hospital including, without limitation, inpatient services, outpatient services and emergency services, treatment and supplies.
- 1.15** IID means the Iowa Insurance Division.
- 1.16** Inpatient Services means all Hospital Services that Hospital provides to an Enrollee who is admitted to Hospital for a period twenty-four (24) hours or more. This term shall not include any professional component of the services, or any personal, non-medical expenses incurred by Enrollee.
- 1.17** IME means the Iowa Medicaid Enterprise.

1.18 **Medicaid Enrollee** means an Enrollee in any of Plan's Medicaid or SCHIP products.

1.19 **Medicaid Rates** means the entire amount payable by DHS/IME to Hospitals for covered medical services provided to Medicaid beneficiaries who are not enrolled in a health plan pursuant to a Plan Agreement. It includes, without limitation, Diagnosis Related Group (DRG) payments, Per Diem payments for exempt units, outpatient fee screen payments and applicable pass-through payments. The amount payable is reduced by any other available resource such as Medicare, other insurance or a beneficiary's patient pay amount or spend down amount required to be collected by Hospital.

1.20 **Medical Director** means the individual designated by Plan to act as its Medical Director.

1.21 **Medically Necessary or Medical Necessity** means health care services which are all of the following:

- a) Appropriate and necessary for the diagnosis or treatment of a medical condition;
- b) Provided for the diagnosis or direct care and treatment of a medical condition;
- c) Within accepted medical and surgical standards; professional and technical standards;
- d) Not primarily for the convenience of the Enrollee, the Enrollee's physician or another health care provider;
- e) The most appropriate level of service which can be provided safely;
- f) In accordance with applicable federal and state laws, rules and regulations;
- g) In accordance with DHS/IME promulgated Medicaid policies for Medicaid Enrollees;
- h) In accordance with CMS promulgated policies for Medicare Enrollees; and
- i) In accordance with CMS and/or DHS/IME promulgated policies as applicable for MMAI Enrollees

1.22 **Medicare Advantage Plans** are health plan options that are part of the Medicare program and provide Medicare-covered health care (Parts A and B) through Plan. This coverage can include prescription drug coverage (Part D).

1.23 **Medicare Enrollee** means an Enrollee in any of Plan's Medicare Advantage Plans.

1.24 **Medicare Part D** is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006.

1.23 **MMAI** means the program to test new service delivery and payment methods and models for those individuals dually eligible for Medicare and Medicaid.

1.24 **MMAI Enrollee** means an individual who is eligible to receive Covered Services pursuant to Plan's agreements with DHS and CMS as a participant in the MMAI.

1.25 **Non-Covered Service** means health services that (i) are not described in Plan's Certificate of Coverage, or (ii) are services provided before an individual becomes an Enrollee or after an individual ceases to be enrolled as an Enrollee of Plan or, (iii) services not required by EMTALA for which Hospital did not secure Prior Authorization, or (iv) for Medicaid Enrollees, not covered by the Medicaid Program, or (v) for Medicare Enrollees, not covered by the Medicare Program, or (vi) not medically necessary.

1.26 **Outpatient Services** means all Covered Services other than Inpatient Services.

1.27 **Participating Practitioner** means a duly licensed physician by the State of Iowa who has individually agreed or is an employee, independent contractor or member of a professional service corporation that has agreed to provide Covered Services for Enrollees on behalf of Plan pursuant to a contract or agreement with Plan.

1.28 **Participating Provider** means a health care provider, including individuals, organizations and facilities, who/which have entered into agreements with Plan to provide Covered Services to Enrollees. A Participating Physician is also a Participating Provider.

1.29 Plan means the managed care plan, which contracts with DHS, CMS, other government sponsored programs and/or individuals and groups for commercial insurance, to provide medical assistance to Enrollees.

1.30 Plan Policies refers not only to documents so titled by Plan but also to Plan Provider Manual, Plan Formulary, procedures, and guidelines developed by Plan which address matters such as verification of eligibility, coordination of benefits, transfer policies, quality management, utilization management, peer review and Enrollee grievance procedures, standards, bulletins and subsequent additions, revisions and deletions.

1.31 Physician Services means Covered Services provided by a physician and includes primary care and specialty care services.

1.32 Primary Care Practitioner (PCP) means a physician who has the responsibility for providing initial and primary care to and for managing the total patient care of Enrollees. A Primary Care Physician may be a general practitioner, internist, pediatrician, family practitioner or obstetrician/gynecologist.

1.33 Prior Authorization or Authorized refers to Hospital securing the approval of Plan before delivery to provide non-emergency services to an Enrollee. The standards governing prior authorization and the procedure for obtaining are delineated in Plan Policies.

1.34 Special Needs Plan means a type of Medicare Advantage Coordinated Care Plan focused on individuals with special needs. Enrollees must have one or more types of Special needs as identified by Congress: 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions.

1.35 Subscriber means an individual who: (a) Has entered into contract with Plan, or on whose behalf a contract was entered into; and (b) Meets all applicable eligibility criteria; and (c) Has completed an enrollment application form which has been received by Plan; and (d) For whom Plan has received prepaid amounts of money (premiums on a monthly basis).

1.36 Utilization and Quality Management means the prospective, concurrent, and retrospective utilization management and quality management that Plan applies to Covered Services.

2. OBLIGATIONS OF HOSPITAL

2.1 Provision of Covered Services. Hospital agrees to provide Prior Authorized Medically Necessary Covered Services to Enrollees in the same manner, in accordance with the same standards, and within the same time availability, as provided to its other patients within the existing resources of Hospital, subject to Hospital's compliance with Plan's Prior Authorization policies. Hospital shall not, other than for reasons of safety, segregate Enrollees in any way or treat them in a location or manner different from any of its other patients. Hospital shall provide all services required by the Emergency Medical Treatment and Active Labor Act, ("EMTALA") and may do so without Prior Authorization. Hospital shall accept Prior Authorized Medically Necessary Elective Admissions of Enrollees that have been arranged by physicians having admitting privileges at Hospital. Hospital shall meet the applicable Medicaid accessibility standards. In the event that Plan determines, in its sole discretion, that the health or safety of Enrollees is in jeopardy, Hospital shall fully cooperate in the immediate transfer of such Enrollees to another Hospital. Hospital shall not deny Covered Services to any Enrollee who is eligible for such Covered Services due to the Enrollee's inability to pay a co-payment.

2.2 Non-Discrimination. Hospital shall not unlawfully discriminate in the acceptance or treatment of an Enrollee because of the Enrollee's religion, race, color, national origin, age, sex, income level, health status, marital status, disability or such other categories of unlawful discrimination as are or may be defined by federal or state law.

2.3 Non-Covered Services. In the event an Enrollee requests services that are Non-Covered Services, such services may be provided by Hospital at the Enrollee's sole cost and expense. Hospital shall be under no obligation to furnish Non-Covered Services to Enrollees. Plan is not responsible to pay the costs of any Non-Covered Service. Hospital must receive a signed agreement from the Enrollee prior to the provision of any Non-Covered Service in

which the Enrollee states that he/she will assume responsibility for the costs of the Non-Covered Service. Hospital agrees not to charge amounts in excess of its normal and customary charge for such services. In the event Hospital does not obtain a signed release, Hospital shall hold Plan and Enrollee harmless from any costs or obligations related to such service. Hospital agrees to cooperate with Plan in resolving any grievances related to the provision of any Non-Covered Service.

2.4 Verification of Enrollee Eligibility. Hospital shall verify the eligibility of and Plan enrollment status of Enrollees.

2.5 Hospital Admission and Services.

2.5.1 Elective Admissions and Services. All Elective Admissions and Services provided to an Enrollee must have Prior Authorization. Any Elective Admission shall be arranged by a physician with admitting privileges at Hospital. Hospital shall have the responsibility to verify Prior Authorization at the time of admission.

2.5.2 Screening and Stabilization. Hospital shall provide all services required by EMTALA, and such services do not require Prior Authorization.

2.5.3 Request for Inpatient Admission. In seeking Prior Authorization for hospitalization following stabilization of an Enrollee treated pursuant to EMTALA, Hospital shall provide Plan with requested information obtained from the medical screening examination, provided in accordance with EMTALA, and including presenting symptoms, physical findings, current medical status, and current diagnosis(es).

2.6 Government Agency Access. Hospital shall permit authorized government agencies and their subcontractors or representatives, during normal business hours, to inspect, audit, monitor, or otherwise evaluate Hospital's performance pursuant to the contract between Plan and the State of Iowa, and between Plan and CMS. Hospital shall produce relevant records requested as part of such review or audit. Hospital shall also permit authorized government agencies and their subcontractors or representative, during normal business hours to conduct on-site evaluations of Hospital's facilities, offices and records as required by state and federal laws and regulations. If Plan receives such notice, Plan shall provide reasonable notice to Hospital of any agency's plans to conduct a site visit, unless Plan is prohibited from providing such notice by law.

2.7 Plan Access. Upon reasonable notice from Plan, Hospital will allow Plan personnel to: (i) inspect Hospital's facilities, offices, and equipment during normal business hours; (ii) inspect and review the medical records of Plan Enrollees; and (iii) obtain copies of Enrollees' medical records and claims records for quality and utilization management and investigations of fraud, waste or abuse.

2.8 Maintenance of License. Hospital shall maintain in good standing all licenses required by state and federal law or regulation and shall maintain certification under Titles XVIII and XIX of the Social Security Act for all services Hospital has agreed to provide pursuant to this Agreement. Hospital shall maintain accreditation of all applicable facilities and services by the Joint Commission ("TJC") or the American Osteopathic Association ("AOA.")

2.9 Maintenance of Records. Hospital shall maintain all pertinent financial and accounting records and evidence pertaining to the provision of Covered Services to Enrollees in accordance with generally accepted accounting principles and other procedures specified by federal or state governments. Hospital shall maintain legible, comprehensive and chronological medical records documenting each episode of service to Enrollees and detailing, as appropriate, history, physical findings, diagnoses and treatment plans. Financial and medical records shall be maintained by Hospital for such times as are or may be required by state and federal law and regulations. Hospital shall comply with all medical record requirements contained within 42 CFR 456.101 through 456.145.

2.10 Insurance. Hospital shall maintain at all times policies of general liability and professional liability insurance or self-insurance with minimum limits of liability of one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in annual aggregate covering Hospital, its agents and employees against any claims for damages out of any act or omission by Hospital, its agents and employees during terms of this Agreement. Hospital shall also maintain at all times automobile insurance, unemployment compensation insurance

and workers' compensation insurance or self-insurance in accordance with the requirements of applicable federal and state laws and regulations. Upon request, Hospital shall furnish Plan with original certificates of insurance evidencing the insurance coverages and riders required.

2.11 Medical Treatment. Hospital agrees that Plan shall have no liability for the medical judgment of health care providers employed by or under contract with Hospital.

2.12 Required Disclosures. Hospital shall comply with all disclosure requirements set forth in 42 CFR 455.104 -106. In addition, Hospital shall notify Plan in writing within ten (10) days of any of the following events:

2.12.1 Suspension, termination, or cancellation of Hospital's state license, Medicaid certification or Medicare certification;

2.12.2 Failure to maintain insurance coverage or self-insurance as prescribed in Section 2.10;

2.12.3 Loss, suspension or termination of TJC or AOA accreditation;

2.12.4 Hospital becomes aware that the license or admitting privileges of a Hospital-Based Physician who is employed by it are terminated or suspended for quality reasons; or

2.12.5 Any change in assumed name(s) or taxpayer identification number(s) through which Hospital provides services and under which Hospital may submit claims under this Agreement.

2.13 Hospital Compliance with Plan Policies. Hospital agrees to be bound by the Plan Policies under the conditions set forth in section 2.2 and 2.2.1 below.

2.14 Physician Qualifications.

2.14.1 Hospital Credentialing/Re-Credentialing. Hospital shall cooperate with the credentialing and re-credentialing processes of Plan. Hospital represents that its Hospital-Based Physicians are licensed and in good standing to practice medicine in the State of Iowa. Hospital agrees to immediately notify Plan of the termination or suspension admitting privileges of any physician known to Hospital to be a Plan Participating Provider.

2.14.2 Admitting Physicians. Hospital represents that all physicians providing services at Hospital to Enrollees shall be members of the medical staff of the Hospital in accordance with the Hospital's corporate and medical staff bylaws, policies, procedures, rules and regulations. No physician shall obtain or maintain medical staff membership or clinical privileges at Hospital by virtue of being a Participating Provider with Plan. A physician shall not be denied or granted admitting privileges based solely on whether the physician is or is not a Participating Provider.

2.14.3 Hospital-Based Practitioners. Hospital represents that it has the full legal power and authority to bind its Hospital-Based Practitioners who are employees to the terms and conditions of this Agreement.

2.15 Payment Administration. Hospital will cooperate with Plan's claims payment administration as set forth in Plan Policies including, but not limited to, coordination of benefits, subrogation, verification of coverage, prior certification and record keeping.

2.16 No Unfair Labor Practices. Hospital represents and warrants that it will not engage in unfair labor practices.

2.17 Non-Discriminatory Hiring. In the performance of services pursuant to this Agreement, Hospital agrees not to discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental handicap or disability. Further, Hospital agrees to comply with the provisions of the Americans with Disabilities Act of 1990 (42 USC 12101 et seq., and 47 USC 225) and the Iowa Civil Rights Act of 1965, as amended.

2.18 Quality, Utilization and Risk Management (Q/U/RM). Hospital agrees to allow Plan to perform the review of the admission and continuation of hospitalization of Enrollees and to cooperate with Plan's policies and procedures as set forth in Plan Policies for Q/U/RM or any other program of review that may be established to promote high standards of medical care. Hospital agrees to allow a "Utilization Review Coordinator" designated by Plan to assist Hospital personnel with discharge planning and utilization review for Enrollees.

2.19 Compliance with Laws and Regulations. In performing its obligations under this Agreement, Hospital shall comply with all applicable laws, rules and regulations. Hospital represents and warrants that it does not and will not employ or contract with: (i) any individual or entity excluded from Medicaid or Medicare participation under Sections 1128 (42 U.S.C. 132a-7) or 1128A (42 U.S.C. 1320a-7a) of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services; (ii) any entity for the provision of such services (directly or indirectly) through an excluded individual or entity; or (iii) any individual or entity excluded from Medicaid participation by the DHS.

2.20 Public Health Reporting. Hospital agrees to comply with specific State of Iowa Law for reporting communicable disease and other health indicators.

2.21 Newborn Infants. Hospital shall request enrollment of a newborn at the time of birth, as set forth by the DHS or IME.

2.22 Medicare Specific Requirements. Hospital shall adhere to the provisions set forth in the Medicare Attachment for all services provided in relation to Medicare Enrollees.

2.23 Laboratory Services. Hospital shall adhere to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Public Law 100-578 and IAC 441--79.13 (249A) requirements for supplying laboratory services.

2.24 Referrals. No provider employed by a hospital or any affiliate is required or in any way obligated to refer Enrollees to providers also employed or under contract with Hospital or an affiliate.

2.25 Hospital Compliance with Plan Policies. Hospital agrees to be bound by all Plan Policies under the conditions set forth in Section 3.2 and 3.2.1 below.

2.26 Lobbying Certification. Hospital certifies to the best of Hospital's knowledge and belief, that no federally appropriated funds have been paid or will be paid by or on behalf of Hospital, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.

2.26.1 Funds. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Hospital shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such Form is to be obtained at Hospital's request from the Office of Management and Budget.

2.27 Medical Services. Hospital represents and warrants that it has complied with and is complying with all applicable statutes, orders, rules and regulations promulgated by any Federal, State, Municipal or other governmental authority relating to the conduct of Hospital's property and operations and that there are no violations of any statute, order, rule or regulation pertaining thereto now existing or threatened. Hospital further represents and warrants that it shall discharge its obligations under this Agreement in compliance with all applicable Federal and State statutes and regulations and in accordance with all policies, procedures and requirements from time to time promulgated by the U.S. Department of Health and Human Services, CMS and DHS.

3. OBLIGATIONS OF PLAN

3.1 Prior Authorization. All Hospital Services provided to Enrollees that are not mandated by EMTALA require Prior Authorization by Plan pursuant to Plan Policies. Hospital shall provide Plan with information obtained from the medical screening examination, provided in accordance with EMTALA, and presenting symptoms, physical findings, current medical status, and current diagnosis within twenty-four (24) hours or the next business day. All non-emergent services must be authorized as described in Plan Policies.

3.1.1 Documentation of Prior Authorization Process. Medical information submitted as required in Section 2.1 in support of the Prior Authorization request may be provided orally or in writing. If provided orally, the Plan Prior Authorization employee who takes the telephone request from Hospital shall write down, tape record or electronically record the information provided. Both Plan and Hospital staff will record each other's name and the time of telephone contact. If Plan gives Prior Authorization for treatment or admission, Plan shall provide Hospital with an authorization number or code.

3.1.2 Authorization Response. Failure of Plan to respond to Hospital with approval or denial of Prior Authorization within the time frame set in Section 3.1 shall be deemed as Prior Authorization for Medically Necessary treatment appropriate to the diagnosis presented when seeking Prior Authorization.

3.1.3 Effect of Prior Authorization. Prior Authorization by Plan shall not prevent Plan from a retrospective evaluation of medical services provided by Hospital pursuant to Plan Policies. Plan agrees that the grant of Prior Authorization for Covered Services shall create a rebuttable presumption that Medically Necessary services appropriate to the diagnosis presented at the time of Prior Authorization shall be paid for pursuant to this Agreement. Plan shall bear the burden to support denial of payment for Prior Authorized services through the dispute resolution process provided in this Agreement.

3.2 Plan Policies. Plan shall provide Hospital with all Plan Policies upon execution of this Agreement.

3.2.1 Amendments to Plan Policies. During the term of this Agreement, Plan may implement changes in the Plan Policies as may be required by state or federal law or regulation, Medicare and/or Medicaid policy or at its discretion. If changes in the Plan Policies are required due to changes in law, regulation, and policy beyond the control of Plan, Plan shall provide a minimum of thirty (30) days' notice to Hospital prior to implementation, unless the required changes are mandated to be implemented in less time. For changes in Plan Policies that are not required by law, regulation or policy, Plan shall provide a minimum of thirty (30) days' notice to Hospital prior to implementation of such change. If Hospital does not exercise its option to terminate the agreement, Hospital agrees to comply with the amendment(s).

3.3 Insurance. Plan shall maintain at all times managed care errors and omissions liability insurance or self-insurance with minimum coverage of one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) annual aggregate, covering Plan and its agents and employees against any claims for damage arising directly or indirectly in connection with its activities under this Agreement. Plan shall also maintain such amounts of insolvency or stop-loss insurance as may be required by the laws of the State of Iowa pertaining to HMOs. Additionally, Plan shall maintain at all times automobile insurance, unemployment compensation insurance, and workers' compensation insurance or self-insurance in accordance with the requirements of all applicable federal and state laws and regulations. Upon reasonable request, Plan shall furnish Hospital with original certificates of insurance evidencing the insurance coverages and riders required.

3.4 Plan Determinations. Plan agrees that, provided the information supplied by Hospital is accurate, Hospital shall have no liability for determinations, including without limitation, determinations regarding coverage, Prior Authorization and Medical Necessity that are made by Plan employees or contractors.

3.5 Compliance with Laws and Regulations. Plan represents that it has never been suspended, excluded or terminated as a contractor under Medicaid, Medicare, or other state or federal health care program, and that it operates and will continue to operate in conformity with the statutes and regulations applicable to Medicaid and Medicare contractors. In performing its obligations under this Agreement, Plan shall comply with all laws, rules and regulations of the United States and of the State of Iowa. All health professionals and laboratories providing

services under this Agreement shall be licensed and/or certified as required by law, including a valid Clinical Laboratory Improvement Amendments (CLIA) certificate and comply with the CLIA regulations found at 42 C.F.R. Part 493, if applicable.

3.6 Quality, Utilization and Risk Management. (Q/U/RM) Plan agrees to perform Q/U/RM services required in connection with this Agreement and Plan Policies.

3.7 Information. Plan will provide Hospital with the following documents: (i) the current Credentialing, Re-Credentialing and Hearing Policy and; (ii) the current Utilization and Quality Management programs and, within a reasonable time after adoption, any changes or amendments; and, (iii) the current grievance procedures and, within a reasonable time after adoption, any changes or amendments; and, (iv), if Hospital bears risk under this Agreement, Hospital quarterly reports measuring actual utilization against utilization targets for Hospital.

3.8 Maintenance of Records. Plan shall maintain all pertinent financial and accounting records pertaining to the operation of this Agreement in accordance with generally accepted accounting principles or other procedures specified or accepted by the state or federal government. Plan will, from time to time and upon reasonable notice from Hospital, permit Hospital to inspect during regular business hours those financial statements and enrollment records which Plan maintains and which pertain to the operation of this Agreement. Plan shall maintain financial records for such time period as is or may be required under state or federal laws or regulations.

3.9 Enrollee Disputes. Plan will notify Hospital of all Enrollee complaints involving Hospital. Hospital agrees to assist Plan in resolving disputes with Enrollees.

3.10 Enrollee Identification. Plan shall provide for distribution of identification cards to its Enrollees. Each card will include a toll-free number that Hospital may use to check eligibility and enrollment in Plan.

3.11 Lobbying Certification. Plan certifies to the best of Plan's knowledge and belief, that no federally appropriated funds have been paid or will be paid by or on behalf of Plan, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.

3.11.1 Funds. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Plan shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such Form is to be obtained at Plan's request from the Office of Management and Budget.

3.12 Monitoring. Plan shall monitor the performance of Hospital on an on-going basis to ensure that all obligations of Plan and its contract with CMS are being complied with.

4. PAYMENT FOR SERVICES

4.1 Compensation. Plan shall pay for all services required by EMTALA and for Prior Authorized Covered Services that Hospital provides to Enrollees in accordance with the payment rates or schedules set forth in the applicable attachments, all of which are incorporated into this Agreement. For Medicaid Enrollees, absent an agreement establishing different rates or schedules, Plan shall pay Hospital according to the Medicaid Rates as established and published by DHS. For Medicare Enrollees, absent an agreement establishing different rates or schedules, Plan shall pay Hospital according to the Medicare Rates as established and published by the CMS. Hospital shall not be paid for Covered Services where Prior Authorization was required under the terms of this Agreement and was not obtained in accordance with Section 3.1 or the Plan Policies.

4.2 Billing. Hospital shall exhaust all other insurance resources which could cover all or part of the costs of services delivered to an Enrollee prior to submitting any bill for services to Plan pursuant to this Agreement. Hospital shall bill Plan for Prior Authorized Covered Services and services provided pursuant to EMTALA.

4.2.1 Electronic Billing. Any electronic billing statement submitted by the Hospital to Plan shall include all information required in the UB-04/CMS-1450 form, including detailed and descriptive medical, service and patient data and identifying information. If Hospital uses a clearinghouse for electronic claims processing, the date of receipt by Plan will be the date Plan or Plan's clearinghouse receives control of the claim from the Hospital's clearinghouse. If the Hospital's clearinghouse returns the claim for incorrect or incomplete information, the billing statement will not be considered received by Plan and the time limits for payment will not begin to run until actually received. If both Hospital and Plan use the same clearinghouse, the date of receipt by Plan will be considered the date on which the clearinghouse has determined pursuant to the contract with Hospital that all ordered checks and edits are complete.

4.2.2 Billing Submission Deadline. Hospital shall present Plan with the billing statement within one hundred eighty (180) days from the date of performance of Covered Services to Enrollees. It is acknowledged that situations may necessitate the extension of the ninety (90) day submission deadline and the Parties may agree to extend this deadline on a case-by-case basis. Among the justifications for delaying submission of a claim are: changes in eligibility, coordination of benefits, other third-party payor issues or internal Hospital risk management. Absent an agreement to extend the time for submission of a bill, Plan shall have no obligation to pay any bill submitted beyond this one hundred eighty (180) day limit.

4.3 Payment. Plan shall make payment to Hospital within thirty (30) days of receipt of a Clean Claim. Hospital shall not resubmit any billing during a thirty (30) day period except in response to a Plan request for additional information pursuant to Section 4.4. Plan shall pay simple interest at a rate of twelve percent (10%) per annum on payment amount of any Clean Claim not paid within forty-five (45) days.

4.4 Rejected Claims. Plan shall provide Hospital with a written request for additional information within thirty (30) days after receipt of an inaccurate or insufficient billing statement. A corrected bill submitted by Hospital pursuant to this section shall reinitiate Section 4.3's time for processing a Clean Claim. A bill rejected after resubmission pursuant to this section shall be referred to the dispute resolution process and will not bear interest unless imposed under the dispute resolution process.

4.5 Adjusted Payments. Plan may make an adjusted payment on a submitted claim within forty-five (45) days from the date of receipt where the circumstances do not support the billing criteria for the level of service submitted on the claim. Any adjusted payment shall include a full and complete explanation and remittance advice. Hospital reserves the right to contest any adjustment and pursue any remedies through the dispute resolution processes in this Agreement.

4.6 Recoupment. Plan may recoup from, or offset against, amounts owed to Hospital under this Agreement, any payments made by Plan to Hospital that are in violation of Medicaid and/or Medicare policy, Plan Policies or this Agreement. Hospital has the right to dispute any action by Plan to recoup or offset claims pursuant to this section through resort to the Dispute Resolution Procedures of this Agreement.

4.7 Enrollee Hold Harmless. Except for applicable Enrollee deductibles, coinsurance or co-payments, Hospital shall look only to Plan for compensation for Covered Services rendered to an Enrollee and shall accept the payments set forth in this Agreement as payment in full for all Covered Services rendered to an Enrollee. In addition, consistent with 42 CFR 438.106 and 42 CFR 438.116, Enrollees shall not be held liable for any of the following: 1) Plan's debts, in case of insolvency, 2) Covered Services under the DHS Contract provided to the Enrollee for which the State did not pay Plan, c) Covered Services provided to the Enrollee for which the State or Plan did not pay Hospital due to contractual, referral, or other arrangement, or d) payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the Enrollee would owe if Plan provided the services directly. In no event, including but not limited to nonpayment by Plan, insolvency of Plan or breach of this Agreement, shall Hospital bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, seek deductibles, coinsurance or co-payments from or have any recourse against an Enrollee or persons (other than Plan) acting on his/her behalf for Covered Services

provided pursuant to this Agreement. Hospital shall give notice to Enrollees regarding any charges for Non-Covered Services. Notwithstanding the foregoing, Hospital may accept payments from third-party payors (e.g. auto insurance, etc.) or others who are legally responsible for payment of an Enrollee's medical bill. This Section shall survive termination of this Agreement, regardless of the cause of termination and shall be construed to be for the benefit of Enrollees. Hospital further agrees that this Section supersedes any oral or written agreement hereafter entered into between Hospital and Enrollee or persons acting on the Enrollee's behalf insofar as such agreement relates to payment for Covered Services provided under the terms and conditions of this contract. Except as otherwise provided in this Agreement or as required by CMS-Medicare or DHS-Medicaid policies, bulletins and federal law, this Section 4.7 is not intended to apply to services provided after this contract has been terminated or to Non-Covered Services.

4.8 Third-Party Payors and Coordination of Benefits. In the event that an Enrollee's medical expenses are eligible, in whole or in part, to be paid by any governmental program, other than by Medicaid or Medicare, or by a public or private insurance or benefit plan (collectively, "third-party payors"), Plan shall coordinate primary and secondary payment responsibility with such other third-party payors pursuant to federal and state third party liability statutes and regulations including but not limited to 42 C.F.R. 433.135-139, and the Iowa Workers' Compensation Act. Hospital shall cooperate with Plan's efforts to recover such payments or reimbursements.

4.9 Billing Disputes. At least quarterly throughout the term of this Agreement the Parties will make a good faith effort to negotiate and resolve all billing disputes. Every bill must be considered in such a quarterly billing resolution conference prior to submission to mediation or arbitration under the provisions of Section 5.2.

4.10 Financial Relationship with Plan. Plan will not prohibit Hospital from discussing Hospital's financial relationship with Enrollees.

5. TERMINATION

5.1 Term and Renewal. The term of this Agreement is for one (1) year unless terminated by either party pursuant to this Agreement. The Agreement begins at 12:01 AM on the effective date stated above. This Agreement shall automatically renew on an annual basis unless either party notifies the other in writing ninety (90) days prior to the renewal day of the Party's intention to terminate the Agreement.

5.2 Termination without Cause. After the first six (6) months, this Agreement may be terminated without cause by either party upon written notice given ninety (90) days in advance of such termination.

5.3 Termination for Cause. Either party may terminate this Agreement for a material breach of this Agreement upon written notice given forty-five (45) days in advance of such termination. The failure of Plan to make payments required under this Agreement may be deemed to be a material breach. The failure of Hospital to comply with Plan Policies may be deemed a material breach. In the event of notification of intent to terminate with cause by either party, the breaching party shall have twenty one (21) days to cure such breach. Unless the material breach is cured, the twenty one (21) day period to cure will not extend the termination date.

5.4 Automatic Termination. This Agreement will automatically terminate if any of the following events occur:

5.4.1 Suspension or termination for any reason of Plan as a Medicaid contractor;

5.4.2 Suspension or termination for any reason of Plan as a Medicare contractor;

5.4.3 Plan loss of Certificate of Authority as an HMO;

5.4.4 Hospital's state license, Medicare or Medicaid certification or TJC or AOA accreditation is revoked, terminated, or suspended; or

5.4.5 Suspension, termination or exclusion of Hospital from participation for any length of time from a governmental health care program by any governmental agency.

5.4.6 Hospital is excluded from participation under Title V, Title XVIII, Title XIX, or Title XX of the Social Security Act.

5.5 Termination due to Material Change in Plan Policies. Pursuant to section 3.2.1 above, Plan must notify Hospital of changes in Plan Policies in a timely manner prior to implementation. In the event that Plan elects to amend Plan Policies, and such amendment affects Hospital adversely, Hospital shall be entitled to terminate this Agreement. Hospital shall notify Plan immediately of its intent to terminate under this Section 5.5. Termination pursuant to this Section shall be effective on the effective date of such amendment but in no case less than fourteen (14) days following such notification of termination pursuant to this Section 5.5.

5.6 Rights upon Termination. Upon termination of this Agreement, the rights of each party hereunder shall terminate, provided however, that Hospital shall be required to treat Enrollees receiving authorized treatment at the time of termination of this Agreement until Enrollee is discharged. Plan shall be required to pay Hospital pursuant to payment terms of this Agreement for all services performed in connection with such treatment. Subject to treatment concerns of the Enrollee including continuity of care involving attending specialists and availability of alternative hospital providers, Plan shall use its best efforts to arrange for the reassignment and transfer of Enrollees as soon as possible following the termination of this Agreement.

6. DISPUTE RESOLUTION

6.1 Notice. When either party perceives the existence of a dispute, it shall give written notice to the other party describing the nature of the dispute and a proposed resolution. The Parties shall negotiate in good faith in an attempt to resolve the dispute. Section 6.2 of this Agreement shall not apply to matters relating to Plan credentialing, re-credentialing or peer review activities.

6.2 Mediation and Binding Arbitration.

5.2.1 Mediation. If the negotiations required in Section 6.1 fail to resolve the dispute, either party may request mediation under the Rules for Mediation of the Alternative Dispute Resolution Service of the American Health Lawyers Association. If the other party agrees, then both Parties shall participate in that mediation. Costs shall be apportioned in accordance with the Rules for Mediation. The legal and administrative costs of the parties shall not be considered costs of mediation subject to apportionment.

6.2.2 Binding Arbitration. If Parties do not mediate or mediation does not resolve the dispute within sixty (60) days of the request for mediation, either party may seek binding arbitration either under the Rules for Arbitration of the Alternative Dispute Resolution Service of the American Health Lawyers Association or the American Arbitration Association. Both Parties agree to binding arbitration. The Parties agree that such arbitration will take place in Des Moines, Iowa. Costs shall be apportioned pursuant to the Rules for Arbitration. The legal and administrative costs of the Parties shall in neither case be considered costs of arbitration subject to apportionment. An award entered by the arbitrator shall be final and judgment may be entered on it in accordance with applicable law. A request for binding arbitration is not valid if it is made after the date when the institution of legal or equitable proceedings on the underlying dispute would be barred by the applicable statute of limitations. The Parties exclude the following matters from the operation of this arbitration clause: (1) any counterclaim, cross-claim or third party claim for indemnity or contribution between Hospital and Plan in any Enrollee's suit against Hospital, unless a Court requires the Parties to submit the Enrollee's entire claim to arbitration; (2) any dispute concerning termination of this Agreement, which claim shall be resolved through the procedures specified for such event in Paragraph 5.1, 5.2 or 5.3, whichever may be applicable to the particular termination in dispute; and (3) any dispute for which a dispute resolution procedure or mechanism is specified in Plan's Provider Manual.

6.3 Limitation on Binding Arbitration. The binding arbitration procedures described in Section 6.2.2 above shall not apply to any claims between the Parties arising out of third-party claims asserting malpractice or professional negligence and the Parties are not precluded from asserting claims against each other based on contribution, indemnity, breach of contract, or other legal theories, by way of cross-claim or third-party complaint in

any court action commenced by a third party which alleges malpractice or professional negligence against either or both Parties to this Agreement.

7. MISCELLANEOUS PROVISIONS

7.1 Additional Products. Plan reserves the right to introduce new products in addition to the current Managed Care Products while this Agreement is in effect and to designate Hospital as a Participating or Non-Participating Provider in any such new product. To the extent that the terms for the provision of Covered Services in new products are different than those contained herein in a manner that reduces the payment terms to Hospital or would materially change Hospital's obligations hereunder, they shall be agreed to by the Parties in advance of such participation hereto if Plan offers participation in these programs to Hospital.

7.2 Relationship of Parties. The relationship of Hospital to Plan is that of an independent contractor. Neither Hospital nor any of its employees shall be considered under the provisions of this Agreement or otherwise as being an employee of Plan nor shall Plan nor any of its employees be considered under the terms of this Agreement or otherwise as being an employee of Hospital. Each party is solely responsible to meet its own financial obligations to its employees including provision of workers' compensation and unemployment insurance coverage, malpractice and other liability insurance, payment of federal state and local taxes and any other costs or expenses necessary to carry out its obligations under this Agreement. No work, act, commission or omission of any party, its agents, servants or employees, pursuant to the terms and conditions of this Agreement, shall be construed to make or render any party, its agents, servants or employees, an agent, servant, representative or employee of, or joint venturer with, the other party.

7.3 Treatment Options. Hospital shall not be prohibited from discussing treatment options with Plan Enrollees that may not reflect Plan's position or may not be covered by Plan. Hospital, when acting within the lawful scope of practice is not prohibited or otherwise restricted from advising or advocating on behalf of an Enrollee who is his/her patient for 1) the Enrollee's health status, medical care, or treatment options, including alternative treatment that may be self-administered, 2) for any information the Enrollee needs in order to decide among all relevant treatment options, 3) for the risks, benefits and consequences of treatment or non-treatment, 4) for the enrollee's right to participate in decisions regarding this or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

7.4 Advocating on Behalf of Plan Enrollees. Hospital shall not be prohibited from advocating on behalf of a Plan Enrollee in any grievance or utilization review process or individual authorization process to obtain necessary health care services.

7.5 Orderly Transfer. Hospital agrees, in the event of termination of this Agreement, to cooperate with Plan in the orderly transfer of Enrollees being treated or evaluated.

7.6 Accreditation. Both Parties agree to cooperate and facilitate the efforts of the other party to obtain and maintain appropriate accreditation from TJC, AOA, National Committee for Quality Assurance ("NCQA"), Accreditation Association for Ambulatory Health Care ("AAHC"), URAC or other appropriate accrediting body.

7.7 Confidential Information. The Parties agree that the items of information subject to confidentiality under this Agreement are: (i) medical information relating to individual Enrollees; (ii) the schedule of compensation to be paid to Hospital; (iii) all Q/U/RM documents and peer review information; and, (iv) any financial or utilization information provided by Hospital to Plan including charge masters detailing the compensation schedule (if different from Medicaid Rates) set forth in the relevant attachments to this Agreement. Otherwise, all other information, including the general manner by which Hospital is paid under this Agreement and the general terms and conditions of this Agreement may be shared with Enrollees in the reasonable and prudent judgment of the Parties to this Agreement.

7.7.1 Notwithstanding the above designation as confidential, Plan may disclose financial or utilization information to third parties as necessary: (i) to satisfy internal quality and utilization requirements; (ii) to share with employees or agents of Plan who need to know the information carry out Plan's quality and utilization obligations;

(iii) to satisfy mandatory governmental or regulatory reporting requirements; (iv) to compare cost, quality and service among providers with whom Plan has contracted or intends to contract; (v) for premium setting purposes; (vi) for HEDIS reporting; (vii) for TJC, NCQA, URAC or other reporting necessary for accreditation purposes; or (viii) to perform any of Plan's obligations under this Agreement. Any information disclosed to third parties pursuant to this subsection shall remain confidential and Plan shall require third-party recipients of such information to maintain confidentiality.

7.7.2 Plan shall be permitted to prepare and disclose to a third-party a report of Hospital's quality data provided however, that Hospital quality data shall not include any information that identifies an individual Enrollee or an individual Hospital or information that is privileged or confidential under peer review or patient confidentiality state or federal laws. For purposes of this subsection, Hospital's quality data includes, without limitation: (i) utilization data of all contracted Hospitals in the aggregate; (ii) HEDIS data production and performance evaluation; (iii) Enrollee satisfaction data; (iv) Overall compliance with TJC or other comparable quality standards (i.e., NCQA, URAC); and (v) Plan's disenrollment data.

7.8 Grievances. Plan shall notify Hospital of any and all Enrollee complaints involving Hospital. Hospital shall notify Plan of any and all Enrollee complaints received from Enrollees. Hospital and Plan shall make good faith efforts to investigate complaints and work together to resolve Enrollee complaints in a fair and equitable manner. Hospital shall participate in and cooperate with Plan's grievance procedures and comply with final determinations provided in accordance with Plan Policies. A copy of the grievance procedure shall be provided to a Enrollee at the time of enrollment and to Hospital upon execution of this Agreement. This provision shall survive termination of this Agreement.

7.9 Ownership of Medical Records. All medical records shall belong to Hospital. The release, disclosure, removal or transfer of such records shall be governed by state and federal law and the Parties established policies and procedures. Hospital agrees to make an Enrollee's medical records available to Plan for purposes of assessing quality of care, conducting medical care evaluations and audits and determining on a concurrent basis the medical necessity and appropriateness of care provided to Plan Enrollees. Hospital also agrees to make Enrollees medical records available to appropriate state and federal authorities and their agents for purposes of assessing quality of care or investigating Enrollee grievances. Hospital agrees to comply with all applicable state laws and administrative rules and federal laws and regulations related to privacy and confidentiality of medical records.

7.10 Assignment. Neither this Agreement nor any rights or obligations hereunder shall be assignable by either Hospital without the prior written consent of Plan, nor shall the duties imposed herein upon Hospital be subcontracted or delegated without the prior written approval of Plan.

7.11 Entire Agreement. This Agreement (including attachments) and the Plan Policies contain the entire agreement between the Parties with respect to the subject matter of this Agreement. If a conflict develops between this Agreement and the Plan Policies, Plan Policies shall take precedence. Neither Hospital nor Plan shall be subject to any requirements other than as set forth in this Agreement or Plan Policies. The failure of a party to insist on the strict performance of any condition, promise, agreement or undertaking set forth herein shall not be construed as a waiver or relinquishment of the right to insist upon strict performance of the same condition, promise, agreement or undertaking at a future time.

7.12 Severability. If any provision of this Agreement or portion is declared invalid or unenforceable, the remaining provisions shall nevertheless remain in full force and effect.

7.13 Notices. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be sent by first class mail, facsimile, or by certified mail, return receipt requested, postage prepaid, to the other party as follows:

| | |
|--|--|
| Meridian Health Plan 666 Grand Avenue 14th Floor Des Moines, IA 50309 | |
|--|--|

7.14 Controlling Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Iowa. This agreement shall comply with all applicable Medicare laws, regulations and CMS instructions.

7.15 Marketing. Each party to this Agreement specifically authorizes the other party to include it in any and all marketing and advertising materials. Each party will provide the other party copies of any written marketing materials referencing the other. The Parties further acknowledge that this Agreement may be terminated and agree to hold the other harmless for any continued use of marketing materials if such materials were prepared before the receipt of a notice of termination. The Parties shall hold each other harmless from reliance upon inaccurate or incomplete information provided by the other party in such materials. Except for purposes encompassed by this Section 7.15, neither party shall utilize the trademarks or service marks of the other party without the express written approval of the other party.

7.16 Limitation of Third-Party Rights. This Agreement is intended solely for the benefit of the Parties, and is not intended to create any rights or benefits, either express or implied, in any other person, including, without limitation, patients of Hospital, Hospital's successors or assigns. Plan may not subcontract or resell any rights to Hospital access or prices created by this Agreement to any third-party without the express written approval of Hospital.

7.17 Regulatory Approval. The Parties acknowledge and agree that this Agreement may be subject to approval by DHS, CMS and/or IID.

7.18 Mutual Cooperation. To the extent a conflict of interest is not created hereby each party shall cooperate with the other with respect to any action, suit or proceeding commenced against either party by a person or entity not a party hereto with respect to the subject matter thereof.

7.19 Recitals – The recitals are hereby incorporated into and made part of this Agreement.

8 SERVICES COVERED UNDER THIS AGREEMENT

Attachment B - Meridian Health Plan of Iowa Medicaid Managed Care Network

Attachment C - Meridian Advantage Plan of Iowa (HMO SNP) Medicare MA-PD Plan Network

Attachment D - Meridian Health Plan Commercial HMO Network

Attachment E - MMAI Network

Other _____

[Signature Page Follows]

IN WITNESS WHEREOF, to signify their agreement to all of the terms and conditions hereof, the Parties have executed this Agreement as of the date(s) stated below:

To be completed by Hospital:

To be completed by Meridian Health Plan:

| | |
|---|--|
| <p>Hospital Name: Hospital License Number: _____ Address: _____ _____ _____ Telephone () _____ Signature: _____ Title: _____ Date:</p> | <p style="text-align: center;"><u>Meridian Health Plan of Iowa, Inc.</u> 666 Grand Avenue, 14th Floor Des Moines, IA 50309 (515) 802-3500</p> <p>_____ Signature: <u>Raymond Pitera</u> Printed Name: <u>President/COO</u> Title: _____ Date:</p> |
|---|--|

Attachments:

- Attachment A – Schedule of Covered Services
- Attachment B – Medicaid
- Attachment C – Medicare
- Attachment D – Commercial
- Attachment E – MMAI
- Attachment F – List of Hospital Practitioners and Providers

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|--|
| <p>ATTACHMENT A Meridian Health Plan -Schedule of Covered Services-</p> |
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1. **“REIMBURSABLE SERVICES”** are those medical and hospital services which are Covered Services and for which Hospital may submit itemized claims for Fee-For-Service payment pursuant to the respective attachments as provided in Section 8 of this Agreement.

The services to be provided are as indicated by the X mark in the appropriate blanks below:

A. Hospital Services

- Emergency Department Services – 24 hours per day, 7 days per week
- Urgent Care Services
- Outpatient Services
- Inpatient services – 24 hours per day, 7 days per week
- Birthing services such as labor and delivery rooms, birthing rooms or birthing centers
- Other: Specify

B. Physician Services

- General/Family Practice
- General Surgery
- Obstetrics/Gynecology
- Pediatrics
- Neonatology
- Internal Medicine
- Cardiology
- Anesthesiology
- Dermatology
- Neurology
- Neurosurgery
- Otolaryngology
- Ophthalmology
- Orthopedics
- Pathology
- Psychiatry
- Rehabilitative Medicine
- Thoracic Surgery
- Urology
- Vascular Surgery
- Mental Health
- Dental Services (of the type not normally provided by a dentist)
- Other: Specify

ATTACHMENT A (continued)

- C. Non-Physician Services**
- ___ Family Planning
 - ___ Laboratory
 - ___ Pharmacy
 - ___ Radiology
 - ___ Vision Care/Optomety
 - ___ Chiropractic
 - ___ Home Health Care
 - ___ Hearing Aids
 - ___ Hearing and Speech
 - ___ Podiatry
 - ___ Speech Therapy
 - ___ Physical Therapy
 - ___ Occupational Therapy
 - ___ Medical Equipment
 - ___ Medical Supplies
 - ___ Oxygen
 - ___ Orthotics
 - ___ Prosthetics
 - ___ Substance Abuse Treatment
 - ___ Transplant Services
 - ___ Other: Specify

ATTACHMENT B
Meridian Health Plan
-Medicaid -

REIMBURSEMENT SCHEDULE FOR MEDICAID ENROLLEES

Hospital's reimbursement for Covered Services (as defined in Section 1 of the Agreement) rendered to Medicaid Enrollees, except for amounts received for coordination of benefits or otherwise from third parties in accordance with this Agreement, shall be as follows:

EMERGENCY ROOM RATES: Health Plan shall pay 100% of current Medicaid rates in effect on the date of service for each properly authorized emergency room visit provided.

URGENT CARE RATES: Health Plan shall pay a 100% of current Medicaid rates in effect on the date of service for each properly authorized urgent care visit provided.

OUTPATIENT HOSPITAL SERVICES: Health Plan shall pay Hospital at 100% of the current Medicaid Fee Screen in effect on the date of service for properly authorized services rendered during each outpatient visit. Properly Authorized observations will be reimbursed at the current Medicaid Fee Screen, pursuant to Plan Policies.

INPATIENT HOSPITAL SERVICES: Health Plan shall pay Hospital the current Iowa Medicaid DRG in effect on the date of service including capital costs under the State of Iowa guidelines for properly authorized services rendered during each inpatient visit.

MAINTENANCE DAYS: When an inpatient member is deemed medically stable for discharge from the acute care setting by both the Hospital and Health Plan, but the patient cannot be safely discharged at the time due to the inability to locate an alternative level of care setting, a "Maintenance Bed" rate of \$350.00 per day would apply. "Maintenance Bed" shall be defined as: Minimal nursing care required, but the member's care cannot be delivered in their current home setting, the member cannot care for him/herself at home but does not require care in an acute care setting, or the member could be treated in a skilled nursing facility or alternative setting if a bed was available.

RATE CHANGES

Within thirty (30) days of each release of the tentative annual cost settlement determination applicable to Hospital by the State of Iowa, Hospital shall provide Plan with sufficient data as directed by Plan for the most recent three years so that Plan can verify the information upon which the State of Iowa determined the tentative annual cost settlement amount. Plan will have fifteen (15) days to examine the data provided (the "Plan review period") at which point, Plan and Hospital agree to negotiate in good faith regarding a new reimbursement rate. If Plan and Hospital do not agree upon a new reimbursement rate within thirty (30) days of the expiration of the fifteen day Plan review period, or if Hospital does not provide Plan with sufficient data within fifteen days of each release of the annual cost settlement determination applicable to Hospital by the State of Iowa, the reimbursement rate will be deemed to be 100% of then-current Medicaid fee screen for properly authorized Basic Health Services until the next release of the annual cost settlement applicable to Hospital by the State of Iowa. At no time during this Agreement shall Plan pay Hospital any interim payments or retrospective adjustments. During the pendency of the rate change process, no changes shall be made to the then current rates paid by Plan to Hospital for properly authorized Basic Health Services. New rates shall be effective upon the later of: (1) the date the new reimbursement rate is agreed upon in writing; (2) the 31st day following the Plan review period; or (3) If Plan and Hospital do not agree upon a new reimbursement rate within thirty (30) days of the expiration of the fifteen day Plan review period, or if Hospital does not provide Plan with sufficient data within fifteen days of each release of the annual cost settlement determination applicable to Hospital by the State of Iowa, the reimbursement rate will be deemed to be 100% of then-current Medicaid fee screen for properly authorized Basic Health Services until the next release of the annual cost settlement applicable to Hospital by the State of Iowa.

Within fifteen (15) days of each release of the final cost settlement determination applicable to Hospital by the State of Iowa, Hospital shall provide Plan with sufficient data as directed by Plan for the most recent three years so that Plan can verify the information upon which the State of Iowa determined the final cost settlement amount. Plan reserves the right to look at final cost settlement data and to adjust the reimbursement rate in its sole discretion. In no event will Plan reduce the reimbursement rate to lower than 100% of the then-current Medicaid fee screen.

MEDICAID REQUIREMENTS

In accordance with regulations, laws and official guidance applicable to Medicaid plans:

1. **Subcontractors** - The parties agree that Hospital, in performing its duties and obligations hereunder, shall have the right, subject to the credentialing and re-credentialing requirements described in this Agreement, either to employ its own employees and agents or to utilize the services of persons, firms and other entities by means of subcontractual relationships; provided, however, that no such subcontract shall operate to relieve Hospital of its obligations hereunder and further provided that the format for all such subcontracts shall have been approved by the IID with the advice of the DHS, in the event that either agency requires such approval; and further provided that Plan's liability for reimbursement hereunder shall extend only to Hospital, and only to the sums provided for herein, and that Hospital shall be solely responsible for reimbursement and/or payment of any employee or agent of Hospital for services performed pursuant to this Agreement. All such subcontracts shall be in writing and fulfill requirements of 42 CFR 434.6 that are appropriate to the service or activity delegated under the subcontract.
2. **Plan Obligations to DHS** - Anything herein to the contrary notwithstanding, no term or provision of this Agreement shall operate to terminate the legal responsibility of Plan to the DHS, in concurrence with the IID, with respect to Enrollees eligible for benefits under Title XIX and Title XXI of the Social Security Act (Medicaid and SCHIP). Hospital agrees that no subcontract can terminate the legal responsibility of Hospital to DHS with respect to Enrollees eligible for benefits under Title XIX and Title XXI of the Social Security Act (Medicaid and SCHIP). Hospital will assist Plan in meeting its obligations under Plan's agreement with the DHS, in concurrence with the IID with respect to Enrollees eligible for benefits under Title XIX of the Social Security Act, and hereby agrees to the terms and conditions of such agreement as they pertain or apply to subcontractors.
3. **DHS Agreement** - Hospital will assist Plan in meeting its obligations under Plan's agreement with the DHS, in concurrence with IID with respect to Enrollees eligible for benefits under Title XIX of the Social Security Act (Medicaid), and hereby agrees to the terms and conditions of such agreement as they pertain or apply to subcontractors.
4. **Timely Access** - Hospital shall meet Iowa standards for timely access to care and services, taking into account the urgency of the need for services. Hospital shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the Hospital serves only Medicaid enrollees. Hospital shall ensure that Covered Services included in this Agreement are available 24 hours a day, 7 days a week, when medically necessary. Hospital shall cooperate with all Plan monitoring and compliance mechanisms for ensuring timely access to services under this Section 3. Plan shall take corrective action for failure to comply with this Section.
5. **Medicaid Certification** - Hospital represents that it is eligible for Medicaid Certification and warrants that it will maintain such eligibility throughout the term of this Agreement.
6. **Consumer Protection** - Hospital shall comply with and assist Plan in avoiding direct marketing to Enrollees and potential Enrollees, this limitation does not include contacting an Enrollee for the purpose of informing the Enrollee of services available or to promote health education.
7. **Utilization Review Policy Compliance** - Hospital shall follow and assist in the implementation of Plan's written utilization review policies and procedures as outlined in the Utilization Management Plan.
8. **State Held Harmless** - Hospital agrees that any dispute between Hospital and Plan shall be solely between such Hospital and Plan. The State of Iowa, Department and its officers, employees and agents and Enrollees shall

not be responsible for any and all actions, claims, demands, damages, liabilities, or suits of any nature whatsoever arising out of this Agreement because of any breach by Plan or Hospital or employees, including but not limited to any negligent or wrongful acts, occurrence of omission of commission or negligence of the Plan or Hospital, their subcontractors, agents, providers, or employees.

9. Disclosure of Excluded Persons - Hospital is obligated to disclose the identity of any person described in 42 C.F.R. § 1001.1001(a)(1) to the Plan for disclosure to DHS. Plan must abide by any direction provided by the DHS regarding whether or not to permit Hospital for participation in the Iowa Plan for Behavioral Care. If any person who has ownership or control interest in Hospital, or who is an agent or managing employee of the Hospital, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX Services program, or if DHS or the Plan determines that the Hospital did not fully and accurately make any disclosure required pursuant to 42 C.F.R. § 1001.1001(a)(1), then Plan will abide by any direction provided by DHS on whether or not to permit the applicant to be a Hospital in the Iowa Plan for Behavioral Care.

10. Additional Disclosures - Hospital agrees to furnish to Plan, DHS, or Secretary on request, within 35 days of the request, a full and complete listing about:

- a) The ownership of any Subcontractor with whom Hospital has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
- b) Any significant business transactions between Hospital and any wholly owned supplier, or between the Provider and any Subcontractor, during the 5-year period ending on the date of the request.

Federal Financial Participation (FFP) shall be denied for expenditures for services furnished by Hospital where Hospital fails to comply with requirements of this Section 13.

11. Enrollee Hold Harmless - Hospital, or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by Plan, Plan insolvency or breach of this agreement, shall Hospital, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than Plan acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on HMO's behalf made in accordance with terms of (applicable Agreement) between Plan and subscriber/enrollee.

Hospital, or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Plan subscriber/enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Hospital and subscriber/enrollee or persons acting on their behalf.

In addition, Medicaid Enrollees shall not be held liable for any of the following: a) Plan's debts, in the event of Plan insolvency; b) Covered Services provided to the Enrollee, for which either DHS does not pay the Plan or DHS or the Plan does not pay the Hospital that furnishes the services under a contractual, referral, or other arrangement; or c) Payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if the Plan provided the services directly.

ATTACHMENT C
Meridian Health Plan
-Medicare -

This Attachment C describes the payments Plan will make to Hospital pursuant to this Agreement for Covered Services to Medicare Enrollees. All such payments are subject to the terms of this Agreement.

REIMBURSEMENT SCHEDULE FOR MEDICARE ENROLLEES

Hospital's reimbursement for Covered Services (as defined in Section 1 of the Agreement) rendered to Medicare Enrollees, except for amounts received for coordination of benefits, copays, coinsurance or otherwise from third parties in accordance with this Agreement, shall be as follows:

EMERGENCY ROOM/URGENT CARE RATES: Plan shall pay 100% of current Medicare Fee Screen in effect on the date of service minus any applicable copays, coinsurance or deductibles for each visit provided.

OUTPATIENT HOSPITAL SERVICES: Plan shall pay Hospital at 100% of the current Medicare Fee Screen in effect on the date of service for properly Authorized services rendered during each outpatient visit minus any applicable copays, coinsurance or deductibles. Properly Authorized observations will be reimbursed at the current Medicare Fee Screen, pursuant to Plan Policies.

INPATIENT HOSPITAL SERVICES: Plan shall pay Hospital the current Medicare Fee Screen in effect on the date of service for properly authorized services rendered during each inpatient visit minus any applicable copays, coinsurance or deductibles.

MAINTENANCE DAYS: When an inpatient Medicare Enrollee is deemed medically stable for discharge from the acute care setting by both the Hospital and Plan, but the Medicare Enrollee cannot be safely discharged at the time due to the inability to locate an alternative level of care setting, a "Maintenance Bed" rate of \$350.00 per day would apply. "Maintenance Bed" shall be defined as; Minimal Nursing care required, but the Medicare Enrollee's care cannot be delivered in their current home setting, the Medicare Enrollee cannot care for him/herself at home but does not require care in an acute care setting, or the Medicare Enrollee could be treated in a skilled nursing facility or alternative setting if a bed was available.

REGULATORY REQUIREMENTS FOR MEDICARE

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Plan and Hospital not inconsistent herein shall remain in full force and effect.

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a

first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage (“MA”): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization (“MA organization”): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than \$2,500 during a contract period.

Required Provisions:

Hospital agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Plan, (hereinafter, “MA organization”) through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]
2. Hospital will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]
3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Hospital may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with

respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. Any services or other activity performed in accordance with a contract or written agreement by Hospital are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]
6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the Plan and Hospital. [42 C.F.R. §§ 422.520(b)(1) and (2)] In accordance with 42 C.F.R. § 422.520(b), Hospital shall provide to Plan all information necessary for Plan to establish proper payment. Plan shall pay Provider for Covered Services rendered to Covered Persons in accordance with Section 7 of the Agreement. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by Plan at such address as may be designated by Plan, and Plan shall pay interest on any Clean Claim not paid within thirty (30) days of such receipt by Plan at the rate of interest required by law, or as otherwise set forth in the Provider Manual.
7. Hospital and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]
8. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:
 - (i) The delegated activities and reporting responsibilities are specified as follows:

The delegated activities are specified in the Agreement, if any.
 - (ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.
 - (iii) The MA organization will monitor the performance of the parties on an ongoing basis.
 - (iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.
 - (v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.

[42 C.F.R. §§ 422.504(i)(4) and (5)]

ATTACHMENT D
Meridian Health Plan
-Commercial -

This Attachment D describes the payments Plan will make to Hospital pursuant to this Agreement for Covered Services to Commercial Enrollees. All such payments are subject to the terms of this Agreement.

COMMERCIAL REIMBURSEMENT TERMS

This section of Attachment D describes the payments Plan will make to Hospital pursuant to this Agreement for Covered Services to Commercial Enrollees. All such payments are subject to the terms of this Agreement.

Hospital's total reimbursement for Covered Services shall be defined by the Plan's Commercial Fee Schedule applicable to each individual Enrollee. Prior to the introduction of any Commercial Fee Schedule applicable to any Enrollee, or any material modification to an existing Commercial Fee Schedule, Plan will provide Hospital with sixty (60) days' advance notice in writing. If Hospital objects to the Fee Schedule as proposed, Hospital retains the right to terminate participation as to the Commercial line of business only by providing Plan with written notice prior to the expiration of the sixty (60) day notice period. Silence on the part of Hospital shall be deemed as acceptance of the new or modified Fee Schedule and continued participation in the applicable product line.

ATTACHMENT E
Meridian Health Plan
-MMAI-

REIMBURSEMENT SCHEDULE FOR MMAI ENROLLES

Medicare and Medicaid Covered Services

For Covered Services that are both Medicare and Medicaid Covered Services, Hospital shall be entitled to the lesser of: (1) Hospital's billed charges; or (2) the amount payable by Medicare, not including Medicare coinsurance and deductibles, plus the amount payable by Medicaid as a secondary coverage based on the Medicaid fee schedule in effect on the date of service.

Medicare Only Covered Services

For Covered Services that are Medicare Covered Services, but not Medicaid Covered Services, Plan shall pay Hospital the lesser of: (1) Hospital's billed charges; or 100% of the Medicare fee schedule in effect on the date of service minus any applicable copays, coinsurance or deductibles.

Medicaid Only Covered Services

For Covered Services that are Medicaid Covered Services, but not Medicare Covered Services, Plan shall pay Hospital the lesser of: (1) Hospital's billed charges; or (2) 100% of the Medicaid fee schedule in effect on the date of service.

REGULATORY REQUIREMENTS

Hospital is subject to all applicable Medicaid and Medicare Regulatory Requirements set forth above. In addition, Hospital is subject to the following:

Cultural Considerations. Services will be provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 CFR 422.112(a)(8)

ATTACHMENT F
Meridian Health Plan
-Hospital's Practitioners and Providers-

List Hospital's employed Practitioners and Ancillary Providers.

Provider Disclosure of Ownership and Control Interest Form



The federal regulations set forth in 42 CFR 455.104-106 require all providers who are entering into or renewing a provider agreement (“Disclosing Entities”) to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to managed care organizations that contract with the State Medicaid Agency: a) the identities of all owners with a control interest of 5% or greater, b) all agents or managing employees of the Disclosing Entity c) details of certain familial relationships between owners or owners of subcontractors owned by the Disclosing Entity, and d) the identities of any excluded individual or entity with an ownership or control interest in the Disclosing Entity. As used herein, a ‘person’ includes individuals and corporations or other business entities. **Please attach additional sheets as necessary.**

- Individuals listed in Sections 1-6 will be reviewed for inclusion on the Excluded Parties List System.
- Individuals listed in Section 7 will be reported to the HHS/Office of Inspector General (OIG) and to DHS.

| DISCLOSING ENTITY | | |
|---|------------------|----------------------|
| Check one that mostly describes you: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity | | |
| Name of Disclosing Entity: | | |
| DBA Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |
| Tax ID Number (TIN): | NPI (Individual) | NPI (Organizational) |

| SECTION 1 — Ownership and Control of Disclosing Entity | | | |
|--|---------------------------------|--|---|
| List the name, address, date of birth (DOB) and Social Security Number (or TIN for corporations) for each person with an ownership or control interest of 5% or more in the Disclosing Entity (including corporate entities, officers, directors, or partners). (42 CFR 455.104) | | | |
| Name of Individual or Entity: | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) |
| | | | |
| | | | |
| | | | |

| SECTION 2 — Ownership and Control of Disclosing Entity by Relatives | |
|---|--------------|
| Are any of the individuals listed in Section 1 related to each other? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If yes, disclose each person listed in Section 1 who are related to another person with ownership or control interest in the Disclosing Entity as a spouse, parent, child, or sibling. (42 CFR 455.104) | |
| Name of Individual | Relationship |
| | |
| | |

| SECTION 3 — Ownership And Control of Subcontractors | | | |
|--|---------------------------------|--|---|
| Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the Disclosing Entity has direct or indirect ownership of 5% or more. (42 CFR 455.104) | | | |
| Name of Individual or Entity with an Ownership Interest and Name of Subcontractor | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) of owner and SSN or TIN for subcontractor |
| | | | |
| | | | |

Continued on next page

SECTION 4 — Ownership and Control of Disclosing Entity by Relatives of Subcontractors

Are any of the individuals or entities listed in Section 3 related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling? Yes No

If yes, disclose each person listed in Section 3 who is related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling. (42 CFR 455.104)

| Name of Individual from Section 3 | Relationship |
|-----------------------------------|--------------|
| | |
| | |

SECTION 5 — Ownership and Control of any Other Disclosing Entity

Is there any Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which a person listed in Section 1 has an ownership or control interest? Yes No

If yes, list each Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which the person listed in Section 1 has an ownership or control interest.

An "Other Disclosing Entity" is usually an entity that either participates in Medicaid or is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVII (Grants for Planning Comprehensive Action to Combat Mental Retardation), or XX (Block Grants to States for Social Services) of the Social Security Act. (42 CFR 455.104)

| Name of Individual or Entity from Section 1 | Name of the other Disclosing Entity | % Interest |
|---|-------------------------------------|------------|
| | | |
| | | |

SECTION 6 — Managing Employees

List all managing employees of the Disclosing Entity along with the additional information indicated below. *A managing employee is a "general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency." (42 CFR 455.104)*

| Name of Individual or Entity: | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) |
|-------------------------------|---------------------------------|---|---|
| | | | |
| | | | |
| | | | |

SECTION 7 — Criminal Offenses

Has any person with an ownership or control interest in the Disclosing Entity, or any agent or managing employee of the Disclosing Entity ever been convicted of a crime related to that individual or entity's involvement in any program under Medicaid, Medicare, or Title XX program since the inception of those programs? Yes No (verify through HHS-OIG Website)

If yes, please list those individuals below. (42 CFR 455.106)

| Name if Individual or Entity: | Date of Birth (for individuals) | Description of Offense(s) | Social Security Number (or TIN for corporation) |
|-------------------------------|---------------------------------|---------------------------|---|
| | | | |
| | | | |

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ Title _____

Printed Name _____ Date _____

Please return completed forms by faxing 313-202-0008 or by emailing providerdisclosure@mhplan.com.

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Hospital and Ancillary Provider Credentialing Application

Please answer the questions below. If a question is not applicable, indicate by documenting "N/A" in the space provided.

1. Legal Name _____

2. Main Location _____
(street)

(city)

(state)

(zip)

3. Phone Number _____ Fax _____ Email _____

4. Website _____

5. Office Hours _____

6. Location Information (check all that apply)

| | |
|----------------------------|--|
| Handicap Access | |
| 24 Hour Phone Coverage | |
| Electronic Medical Records | |
| Radiology Services | |
| Perform Mammograms | |
| Lab Services | |
| Surgical Suite | |
| Child Care | |

| | |
|---|--|
| Public Transportation | |
| Weekend Late Hours | |
| Level III Perinatal Facility | |
| OB/GYN Services (OB, GYN or both?) _____. | |
| TDD Service | |
| TDD Phone # _____ - _____ - _____. | |
| Other - | |
| Other - | |

7. Language(s) spoken _____

Language(s) written _____

If there are additional locations that will be participating, please attach a list with names, addresses, contact information, services performed and languages. Thank you!

8. Primary Contact Name _____

9. Phone Number _____ Fax _____ Email _____

10. Name of Chief Executive Officer _____

11. Name of Chief Medical Officer _____

12. State Licensure Number(s) _____ (Attach a copy of the license certificate(s))

13. Medicare ID Number _____ Medicaid ID Number _____

14. National Provider Identifier (NPI) _____

15. Accredited? YES [] NO [] Name (TJC, AOHA, etc.) _____ Expiration Date _____

If yes, attach copy of certificate. If no, submit copy of latest CMS or State site visit report.

16. Medicare Certification YES [] NO [] Date _____

17. Tax Identification Number _____ (Attach copy of SS-4 or W-9)

18. Reporting name and address as they appear on your IRS W-9 form

19. Complete the following information for the most recent fiscal year

Time Period _____ (month/year) to _____ (month/year)

| Service | Licensed Beds | Staffed Beds | Occupancy Rate |
|--------------------------|---------------|--------------|----------------|
| General Acute Care | | | |
| Hospice | | | |
| Inpatient Psych | | | |
| Inpatient Rehab | | | |
| Skilled Nursing Facility | | | |
| Other - | | | |
| Other - | | | |
| Total | | | |

20. Has the institution been sanctioned, placed on probation, or lost accreditation, licensure, or certification status during the last five years by any of the following?

| Organization | Yes | No |
|---------------------------|-----|----|
| The Joint Commission/AOHA | | |
| State Licensure | | |
| Medicaid/Medicare | | |
| P.R.O. | | |
| Other - | | |

If you answered yes to any of the above, describe the nature of the sanction, reason and date below

21. List all individuals* with ownership or controlling interest of 5% or more of the organization (if applicable and optional for Meridian Health Plan of Illinois applicants)

Name _____

Address _____

*Individuals listed will be reviewed for inclusion on the Excluded Parties List System

22. List all Managing employees* along with their social security number below (**optional for Meridian Health Plan of Illinois applicants**)

A managing employee is a “general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency

Name _____

*Individuals listed will be reviewed for inclusion on the Excluded Parties List System

Social Security Number _____

23. Has any person who has ownership or controlling interest in the provider ever been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of the programs? No [] Yes []

24. Has any agent or managing employee for the provider ever been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of the programs? No [] Yes []

25. If yes to either of the two previous questions, list their names and social security numbers below

Name _____

Social Security Number _____

26. Are you aware of any pending investigations by Medicare, Medicaid, state or federal agency or are you aware of any situation which may result in a claim or suit?

If yes, explain (attach additional explanation if necessary) _____

27. Provide the following information on medical staff (**if applicable**)

| Provider Name (including Degree) | Hospital Staff Privileges | Board Certification Status/Licensure | Office Location and Phone |
|-------------------------------------|---------------------------|---|------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

28. Participation Statement

I fully understand that any misrepresentation in, or omission from this application that has bearing on qualifications constitutes cause for denial of credentialing or summary dismissal from participation with Meridian Health Plan. All information submitted in this application is warranted to be true and correct.

In making this application to Meridian Health Plan, I agree to abide by all rules, regulations and policies that may be promulgated from time to time. I am also familiar with the principles and standards which govern my specialty and profession, and agree to be bound by those as well.

I understand and agree that as an applicant for Meridian Health Plan, I have the burden of producing adequate information for proper evaluation of credentials, including professional competence, character, ethics and other qualifications, and I am responsible for resolving any questions about qualifications.

Signature _____

Title _____

Printed Name _____

Date _____

Thank you for completing your application for participation! Did you attach the following?

- a. Copy of SS-4 or W-9 form
- b. Copy of state license certificate(s)
- c. Medicare certification documentation
- d. Accreditation documentation
- e. CMS or State site visit report (if no accreditation)
- f. Copy of your malpractice insurance policy cover sheet
- g. Copy of your program brochures (optional)



IOWA PRACTITIONER AGREEMENT

This Practitioner Agreement (“Agreement”) shall be effective as of the ____ day of _____ 20__ between Meridian Health Plan of Iowa (“Plan”) an Iowa corporation and Health Maintenance Organization (“HMO”) under the laws of the State of Iowa, and _____, a Participating Practitioner (“PP”) or Participating Practitioner Group (“PPG”) (may be a Primary Care Practitioner or Specialty Care Practitioner) (collectively the “Parties.”)

Recitals

Whereas, Plan has a certificate of authority to operate as a HMO in the State of Iowa;

Whereas, Plan desires to contract with PP/PPG for the provision of Covered Services to Enrollees; and

Whereas, PP/PPG desires to provide Covered Services as specified in this Agreement to Enrollees for the consideration, and under the terms and conditions set forth in this Agreement;

In consideration of the foregoing and other good and valuable consideration, the sufficiency of which is hereby acknowledged, the Parties agree as follows:

1 DEFINITION OF TERMS

As used in this Agreement, the following terms have the following meaning:

1.1 Anniversary Date means the date one year from the date on which this Agreement was first signed by both Parties.

1.2 Certificate of Coverage means the contract between Plan and the employer or group or government entity, as it applies to the Enrollee for the provision of benefits, limitations, and exclusions of services.

1.3 Clean Claim means a claim as defined as follows:

- a) Is submitted within the time frame required under this Agreement;
- b) Identifies the name and appropriate tax identification number of the health professional or the health facility that provided treatment or service and includes a matching provider ID number assigned by Plan;
- c) Identifies the Enrollee (Enrollee ID number assigned by Plan, address, and date of birth);
- d) Identifies Plan (Plan name and/or ID number);
- e) Lists the date (m/d/y) and place of service;
- f) Is for covered service (Services must be described using uniform billing coding and instructions (ANSI X12 837) and ICD-9-CM diagnosis. Claims submitted solely for the purpose of determining if a service is covered are not considered clean claims);
- g) If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if prior authorization is required by Plan;
- h) Includes additional documentation based upon services rendered as reasonably required by Plan Policies;
- i) Is certified by PP/PPG that the claim is true, accurate, prepared with the knowledge and consent of PP/PPG, and does not contain untrue, misleading, or deceptive information, that identifies each

attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim;

- j) Is a claim for which PP/PPG has verified the Enrollee's eligibility and enrollment in Plan before the claim was submitted;
- k) Is not a duplicate of a claim submitted within 45 days of the previous submission;
- l) Is submitted in compliance with all of Plan's prior authorization and claims submission guidelines and procedures;
- m) Is a claim for which PP/PPG has exhausted all known other insurance resources;
- n) Is submitted electronically if PP/PPG has the ability to submit claims electronically; and
- o) Uses the data elements of UB-04, as appropriate.

1.4 **CMS** means the Centers for Medicare & Medicaid Services.

1.5 **Commercial Enrollee** means a Subscriber in any of Plan's commercial products.

1.6 **Covered Services** means those Medically Necessary health care services covered under the terms of the applicable Payor Contract and rendered in accordance with the terms of this Agreement and the Provider Manual.

1.7 **DHS** means the Iowa Department of Human Services.

1.8 **Emergency Services** means those Medically Necessary Covered Services provided in connection with an "Emergency" which the Enrollee receives after the onset of such Emergency (or as soon thereafter as care can be made available but not more than twenty-four (24) hours after onset). Emergency shall have that meaning as defined in the Medicaid program. An "Emergency" is usually defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention, in the judgment of a reasonably prudent layperson prior to an initial medical screening, could be expected to result in the Enrollee's death or permanent impairment of the Enrollee's health.

1.9 **Enrollee** means an individual who, pursuant to the applicable individual or group Enrollee contract with Plan, is eligible to receive Basic Health Services. The term Enrollee includes eligible dependents, Medicaid Enrollees, Medicare Enrollees, MMAI Enrollees and Commercial Enrollees.

1.10 **Fee-For-Service Health Care Services** means those Covered Services which are not Capitated Health Care Services and for which PP/PPG may submit itemized claims for fee-for-service payment.

1.11 **Health Maintenance Organization** means any person or entity which directly or through contracts with providers furnishes at least basic comprehensive health services on a prepaid basis to Enrollees in a designated geographic area pursuant to Title XIII of the Public Health Services Act and Iowa Code Chapter 514B, as amended, and the applicable regulations promulgated thereunder.

1.12 **IID** means the Iowa Insurance Division.

1.13 **Inpatient Services** means those Health Care Services that a Participating Hospital provides or arranges to provide to Enrollees admitted to the Participating Hospital for a period of twenty-four (24) hours or more.

1.14 **Medically Necessary or Medical Necessity** means health care services which are all of the following:

- a) Appropriate and necessary for the diagnosis or treatment of a medical condition;
- b) Provided for the diagnosis or direct care and treatment of a medical condition;
- c) Within accepted medical and surgical standards; professional and technical standards;
- d) Not primarily for the convenience of the Enrollee, the Enrollee's physician or another health care provider;
- e) The most appropriate level of service which can be provided safely; or
- f) Applicable federal and state laws, rules and regulations, and DHS promulgated Medicaid policies.

1.15 **Medicaid Enrollee** means an Enrollee in any of Plan's Medicaid or SCHIP products.

1.16 **Medicare Enrollee** means an Enrollee in any of Plan's Medicare Advantage products.

1.17 **MMAI** means the program to test new service delivery and payment methods and models for those individuals dually eligible for Medicare and Medicaid.

1.18 **MMAI Enrollee** means an individual who is eligible to receive Covered Services pursuant to Plan's agreements with HFS and CMS as a participant in the MMAI.

1.19 **Participating Primary Care Practitioner (PCP)** shall mean a Physician who is duly licensed to practice allopathic or osteopathic medicine in the State of Iowa, who has executed a Participation Agreement to function as the Physician case manager for Enrollees by providing, arranging for and coordinating the provision of Covered Services to Enrollees, and has been credentialed in accordance with Plan's requirements and procedures for credentialing and re-credentialing. A Primary Care Physician may be a general practitioner, internist, pediatrician, family practitioner or obstetrician/gynecologist.

1.20 **Participating Practitioner (PP)** means a physician who has executed a Participation Agreement.

1.21 **Participating Practitioner Group (PPG)** means a physician group who has executed a Participation Agreement.

1.22 **Participating Skilled Nursing Facility** means an institution, primarily engaged in providing to residents skilled nursing care and related services or rehabilitation services and which is not primarily engaged in the care and treatment of mental disease, which has executed a Participation Agreement.

1.23 **Participating Specialty Care Practitioner (SCP)** means a Physician duly licensed to practice medicine or osteopathy in the State of Iowa who is Board certified or Board eligible in his/her area of specialty and has executed a Practitioner Agreement for the provision of Specialty Care Services to Enrollees, and who has been credentialed in accordance with Plan's requirements and procedures for credentialing and re-credentialing.

1.24 **Plan's License** means a certificate issued by the Commissioner of Health, authorizing the establishment and operation of a health maintenance organization pursuant to Iowa Code Chapter 514B *et. seq.*, as amended, and the applicable regulations promulgated thereunder.

1.25 **Primary Health Care Services** shall be deemed to include those medical and hospital services and benefits provided by a Primary Care Practitioner, to which Enrollees are entitled.

1.26 **Quality Improvement Plan** means an on-going program for systematic monitoring of the various aspects of Plan, its systems, services, PP/PPGs and providers to identify and act upon events or occasions where standards are not met, and to continuously improve Plan's ability to meet the needs and expectations of Enrollees.

1.27 **Quality Plan Incentive Shared Risk Fund** means a program administered by Plan whereby both Plan and PP/PPG will be at risk to control utilization and increase quality as described in the Reimbursement Schedule.

1.28 **Specialty Health Care Services** shall be deemed to include those medical and hospital services and benefits provided by a Specialty Care Practitioner, to which Enrollees are entitled on referral from a Primary Care Practitioner.

1.29 **Subscriber** means an Enrollee who, pursuant to the applicable individual or group Enrollee contract with Plan, is responsible for making payments for Basic Health Services to Plan or on whose behalf such payments are made to Plan.

1.30 **Subscriber Group** shall mean a group of eligible Enrollees with which Plan has agreed, via a Subscriber Group Agreement, to provide a defined set of Basic Health Services for a specified premium.

1.31 **Utilization Management Plan** means a program for evaluating and determining the appropriateness of the use of health care services provided to Enrollees.

2 PP/PPG PATIENT RELATIONSHIP

2.1 At the time of enrollment, an Enrollee shall be entitled to select any Primary Care PP/PPG to provide Primary Care Services, and PP/PPG agrees to provide Covered Services to Enrollees who select PP/PPG for the provision of those Covered Services in accordance with the terms of Plan's Provider Manual.

2.2 In the event that Plan determines that the health or safety of an Enrollee is in jeopardy, Plan may at its sole discretion, immediately transfer Enrollee to another PP/PPG. PP/PPG shall fully cooperate in the immediate transfer of such Enrollees to another PP/PPG.

2.3 PP/PPG acknowledges that Plan does not practice medicine and that each PP/PPG shall be solely responsible for all clinical decisions regarding the admission, treatment, and discharge of Enrollees under PP/PPG's care, notwithstanding the receipt by PP/PPG, whether in writing or otherwise, of any information, recommendation, authorization, or denial of authorization regarding such admission, treatment, or discharge that may be issued by Plan. PP/PPG further acknowledges that the policies and procedures, recommendations, authorizations and/or denials of authorization of and by Plan shall be recommendations to PP/PPG and that nothing contained in this Agreement shall interfere with or in any way alter the physician-patient relationship between PP/PPG and any Enrollee, and that PP/PPG shall have the sole responsibility for the care and treatment of Enrollees under the care of such PP/PPG. Plan encourages PP/PPG to freely communicate with its patients regarding treatment regimens including medication treatment options, regardless of benefit coverage limitations (including non-covered benefits) or advocating on behalf of Enrollee for grievances/appeals to obtain necessary health services.

2.4 Plan shall not prohibit PP/PPG from advocating on behalf of an Enrollee with written permission in any grievance/appeal or utilization review process, individual authorization process to obtain necessary health care services or regarding Plan quality assurance programs.

2.5 Plan will not prohibit PP/PPG from discussing PP/PPG's financial relationship with Enrollees.

3 RESPONSIBILITIES OF PP/PPG

3.1 **PP/PPG Representation** – PP represents and warrants that he/she is a licensed physician or other health care professional. PPG represents and warrants that PPG is a Medical Group as defined by federal regulation pursuant to the Public Health Service Act, 42 U.S.C. 300e, *et seq.*, as amended, and is composed of health professionals licensed to practice allopathic or osteopathic medicine in the State of Iowa and of such other licensed health professionals (including dentists, optometrists, and podiatrists, if any) as are necessary for the provision of health services for which PPG is responsible hereunder.

3.2 **Licenses; Board Certification; Participation** – PP/PPG represents and warrants that each PP/PPG covered by this Agreement will maintain in good standing all licenses and other certificates required to practice medicine in Iowa and all board certificates, if any, required by Plan for any specialty practiced by PP/PPG. PP/PPG also represents and warrants that PP/PPG is not excluded from participation in the Medicaid and Medicare Programs.

3.3 **Hospital Privileges** – PP/PPG represents and warrants that each PP/PPG covered by this Agreement will either maintain admitting privileges to at least one hospital and notify Plan of any changes in hospital privileges or have made arrangements with a physician or physicians for PP/PPG's Enrollees to be admitted and cared for at a local hospital.

3.4 **Credentials** – PP/PPG agrees to submit for review all information required by Plan to credential and re-credential each PP/PPG covered by this Agreement in accordance with the standards established by Plan and described in the Quality Improvement Plan. PP/PPG agrees that the Participating Provider status of each PP/PPG covered by this Agreement is dependent upon his/her successful completion of credentialing and re-credentialing in accordance with the Quality Improvement Plan. PP/PPG agrees to notify Plan of any changes to the information submitted to Plan during credentialing and re-credentialing. Any physician joining the PPG after the effective date hereof must be credentialed by Plan, agree to the terms of this Agreement and execute a PP acknowledgement prior

to rendering Covered Services to Enrollees. PP/PPG agrees to notify Plan thirty (30) days in advance of any change of fifty percent (50%) or more, of the ownership or control of PPG.

3.4.1 Practitioners have the following rights during the credentialing process: All information received during the credentialing process that is not peer protected can be forwarded to the applicant upon written request to the credentialing department. If there are any substantial discrepancies noted during the credentialing process the applicant will be notified in writing or verbally by the credentialing department within 30 days and will have 30 days to respond in writing regarding the discrepancies and correct any erroneous information. Plan is not required to reveal the source of the information if the information is not obtained to meet the credentialing verification requirements or if disclosure is prohibited by law. Upon written request to the credentialing department, any practitioner has the right to be informed in writing or verbally of their credentialing status.

3.5 Medical Services – PP/PPG agrees to provide those Covered Services for Enrollees which are set forth in the applicable attachment to this Agreement and are within the limits of his or her designated specialty, and to perform such health care services with the same standard of care, skill and diligence that is customarily used by fellow physicians located in the community in which such services are rendered. Excluded services are also outlined in Attachment C. PP/PPG agrees to provide health care services to Enrollees in the same manner, in accordance with the same standards, and with the same time availability as offered to other PP/PPG patients. PP/PPG shall provide for twenty-four (24) hour, seven (7) days per week medical coverage to Enrollees in accordance with the medical standards as outlined in the Provider Manual; comply with the appointment standards provided in the Provider Manual; to notify Plan immediately of significant changes affecting provision of services or PP/PPG’s performance under this Agreement, such as relocation of practice or alternative coverage arrangements during times of non-availability. PP/PPG represents and warrants that it has complied with and is complying with all applicable statutes, orders, rules and regulations promulgated by any Federal, State, Municipal or other governmental authority relating to the conduct of PP/PPG’s property and operations and that there are no violations of any statute, order, rule or regulation pertaining thereto now existing or threatened. PP/PPG further represents and warrants that it shall discharge its obligations under this Agreement in compliance with all applicable federal and state statutes and regulations and in accordance with all policies, procedures and requirements from time to time promulgated by the U.S. Department of Health and Human Services, DHS and/or CMS.

3.6 Utilization Management and Quality Improvement – PP/PPG agrees to follow and be bound by all federal and state laws and regulations and to comply with, participate in, and be bound by all policies, procedures, and protocols as set forth in Plan’s Quality Improvement Plan and Provider Manual, both as may be amended from time to time, and such other policies, procedures and protocols established from time to time by Plan and by any State or Federal agency with respect to quality assurance, Covered Services, claims processing and review, utilization control, patient confidentiality and peer review. PP/PPG hereby acknowledges, understands and agrees that Plan will periodically modify or amend policies, procedures, and protocols governing Utilization Management and Quality Improvement and Plan agrees to notify PP/PPG of such changes thirty (30) days prior to implementation of such changes. PP/PPG further represents and warrants that it shall discharge its obligations under this Agreement in compliance with all applicable federal and state statutes and regulations and in accordance with all policies, procedures and requirements from time to time promulgated by the U.S. Department of Health and Human Services, DHS and/or CMS.

3.7 Reimbursement – PP/PPG agrees to comply with the provisions of Section 7 for payment administration and to accept payments as described in the applicable attachment(s) as provided in Section 9 of this Agreement as payment in full for Covered Services rendered to Enrollees by PP/PPG, except amounts received for coordination of benefits or otherwise from third parties.

3.8 Enrollee Hold Harmless – PP/PPG agrees that in no event, including but not limited to nonpayment by Plan because of insolvency, bankruptcy, or breach of this Agreement, shall PP/PPG bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from; maintain any action at law or in equity against or have any recourse against an Enrollee or person (other than Plan) acting on behalf of an Enrollee for services provided pursuant to this Agreement. The provisions of this Section 3.8 shall not prohibit the collection of sums that are owed to PP/PPG for services provided after this Agreement has terminated, except as otherwise provided in this Agreement, or to services that are not Primary Care Services. PP/PPG further agrees that (1) the provisions of this Section 3.8 shall survive the termination of this Agreement, regardless of the cause giving rise to the termination, for

Primary Care Services rendered prior to termination of this Agreement, and shall be construed to be for the benefit of Plan's Enrollees and that (2) the provisions of this Section 3.8 supersede any and all oral and written contrary Agreements now existing or hereafter entered into between PP/PPG and any Enrollee or person acting on behalf of any Enrollee.

3.9 Physician Listing – PP/PPG authorizes Plan to publish PP/PPG's name, address, area of practice, and other relevant information in connection with the promotion of Plan and Plan's products, plans and programs.

3.10 Inspection – PP/PPG shall permit authorized representatives of Plan and of any State or Federal supervisory authority or agency to conduct medical audits relating to standard medical practice and quality care, to inspect PP/PPG's facility during regular business hours, and to review records of services provided to Enrollees.

3.11 Confidentiality – PP/PPG shall comply with Plan confidentiality policies as set forth in the Provider Manual with respect to Enrollee information and Plan trade and operations information. All Enrollee information, including all records, electronic or written, and all forms of communication whereby an Enrollee's identity, diagnosis, condition or treatment are identifiable are to be treated as confidential. Individual office staff may access Enrollee information only when it is necessary to perform their Plan responsibilities. Except where required by law, Enrollee information may be transmitted only to those individuals who need to know the information to carry out their responsibilities within the office or to deliver clinical services to Enrollees of Plan. Transmission of Enrollee information will occur in a manner that safeguards confidentiality, (e.g. "Confidential" coversheet on all faxed information). Printed patient information shall be kept secure via double lock. PP/PPG shall keep the terms of this Agreement confidential. Except as expressly provided herein, neither party may disclose the compensation rates or other relevant terms of this Agreement to any third party, except upon written consent of the other, or if required by law.

3.12 Non-Discrimination – PP/PPG shall not unlawfully discriminate in the acceptance or treatment of an Enrollee because of the Enrollee's religion, race, color, national origin, age sex, income level, health status, marital status, disability or such other categories of unlawful discrimination as are or may be defined by federal or state law.

3.13 Grievance Procedures – PP/PPG shall comply with Plan's grievance procedures as set forth in the Provider Manual.

3.14 Public Health Reporting – PP/PPG agrees to comply with specific State of Iowa law for reporting communicable disease and other health indicators.

3.15 Access to Premises – PP/PPG shall allow duly authorized agents or representatives of the state and federal government, during normal business hours, access to its premises inspect, audit, monitor or otherwise evaluate PP/PPG's performance pursuant to the contract between Plan and DHS/CMS, and PP/PPG shall produce relevant records requested as part of such review or audit.

3.16 Laboratory Services – PP/PPG shall adhere to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Public Law 100-578 and IAC 441--79.13 (249A) requirements for supplying laboratory services.

3.17 Appointment Standards – PP/PPG shall adhere to the access and appointment standards as set forth in the Provider Manual.

3.18 Non-Discriminatory Hiring and Contracting. In the performance of services pursuant to this Agreement, PP/PPG agrees not to discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental handicap or disability or such other categories of unlawful discrimination as are or may be defined by federal or state law. Further, PP/PPG agrees to comply with the provisions of the Americans with Disabilities Act of 1990 (42 USC 12101 et seq., and 47 USC 225) and all Iowa non-discrimination laws. PP/PPG shall not discriminate against minority owned and women owned businesses and businesses owned by person with

disabilities in subcontracting. Discrimination by PP/PPG in violation of this Section 3.18 is a material breach of this Agreement.

3.19 Compliance with Laws. PP/PPG represents and warrants that it does not and will not employ or contract with: (i) any individual or entity excluded from Medicaid or Medicare participation under Sections 1128 (42 U.S.C. 132a-7) or 1128A (42 U.S.C. 1320a-7a) of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services; (ii) any entity for the provision of such services (directly or indirectly) through an excluded individual or entity; or (iii) any individual or entity excluded from Medicaid participation by the DHS.

4 RESPONSIBILITIES OF PLAN

4.1 Financial – Plan agrees to comply with the provisions of Section 7 and compensate PP/PPG, in accordance with the respective reimbursement set forth in applicable attachments as provided in Section 9 of this Agreement rendered to the respective Enrollees and billed in accordance with Plan’s policies and the terms hereof. Payment in accordance with the respective Reimbursement Schedule (as set forth in applicable attachments) shall constitute payment in full for Covered Services rendered to Enrollees by PP/PPG, except for amounts received for coordination of benefits or otherwise from third parties in accordance with this Agreement. All payments required by Plan hereunder shall be made by Plan to PP/PPG or its payee designee listed on the signature page of this Agreement.

4.2 Federal and State Law – Plan agrees to carry out its obligations as herein provided in accordance with applicable Federal and State statutes and regulations and with the policies, procedures and requirements as may from time to time be promulgated by HHS and DHS.

5 GENERAL PROVISIONS

5.1 Additional Products. Plan reserves the right to introduce new products in addition to the current Managed Care Products while this Agreement is in effect and to designate PP/PPG as a participating or nonparticipating provider in any such new product. To the extent that the terms for the provision of Covered Services in new products are different than those contained herein in a manner that reduces the payment terms to Provider or would materially change PP/PPG’s obligations hereunder, they shall be agreed to by the Parties in advance of such participation hereto if Plan offers participation in these programs to PP/PPG.

5.2 Assignment – This Agreement, including the rights, benefits and duties hereunder, shall not be assignable by PP/PPG without the prior written consent of Plan. Any attempted assignment in violation of this Section 5.2 shall be void *ab initio*. The Parties agree that the terms and conditions of this Agreement are binding upon the Parties (including each PP/PPG) and their respective heirs, successors, and permitted assigns.

5.3 Governing Law – This Agreement shall be governed and construed in accordance with the laws of the State of Iowa.

5.4 Insurance – PP/PPG will maintain current professional liability insurance to insure against any claim or claims for damages due to personal injury or death arising out of or in any way connected with the acts or omissions to act of PP/PPG, and/or PP/PPG’s agents or employees, in the performance of PP/PPG’s obligations hereunder. Such insurance will have limits of at least one-hundred thousand dollars (\$100,000) per occurrence and three-hundred thousand dollars (\$300,000) aggregate for a year, or such other limits as may from time to time be specified in the Quality Improvement Plan. As long as this Agreement is in effect, PP/PPG shall, upon the anniversary date of this Agreement, provide Plan with updated Certificates of Insurance consistent with the terms herein. PP/PPG will notify Plan at least thirty (30) days prior to the termination, cancellation, lapse or reduction of such insurance. Within seven (7) days of request by Plan, PP/PPG will provide Plan with policies or other documents acceptable to Plan evidencing such insurance(s).

5.5 Physical Records – PP/PPG shall maintain records in accordance with Plan’s Provider Manual and Quality Improvement Plan and as required by applicable statutes and regulations.

5.6 Other Contracts – Nothing contained in this Agreement shall be construed to prevent PP/PPG from entering into agreements with other comprehensive health care plans or providing health care services to persons other than Enrollees. Nothing in this Agreement shall be construed to prevent Plan from contracting with other providers in the same or other areas.

5.7 Entire Agreement – This Agreement, including all of the Attachments, Appendices and other written documents referenced herein (Plan Policies, Provider Manual), constitutes the entire Agreement of the Parties with respect to the subject matter hereof and supersedes all prior agreements, representations, negotiations, and undertakings not expressly set forth or incorporated herein. If a conflict develops between this Agreement and the Plan Policies, the Plan Policies shall take precedence. The terms of this Agreement shall prevail notwithstanding any variances with the terms and conditions of any written or verbal communication subsequently occurring, except as provided elsewhere in this Agreement. Any written amendment hereto complying with Section 7.2 hereof constitutes a material part of this Agreement as though it was fully set out herein.

5.8 Severability – If any clause or provision of this Agreement is rendered invalid or unenforceable because of any state or federal statute or regulation or ruling by any tribunal of competent jurisdiction, that clause or provision shall be null and void, and any such invalidity or unenforceability shall not affect the validity or enforceability of the remainder of this Agreement.

5.9 Violation of Laws – Notwithstanding any provision contained in this Agreement to the contrary, neither of the Parties, nor any of their respective employees, agents, representatives, consultants or subcontractors shall be required to perform any act which would violate any federal or state statute, law, regulatory agency rule or regulation, code, or canon of professional ethics. PP/PPG shall be solely responsible for the provision of quality medical care to each Enrollee in accordance with PP/PPG's professional judgment.

5.10 Independent Contractors – It is understood that both Parties to this Agreement are independent contractors engaged in the operation of their own respective businesses. Neither party is, or is to be considered as, the agent or employee of the other party for any purpose whatsoever. Nothing in this Agreement shall be construed to establish a relationship of co-partners or joint ventures between the Parties. Neither party has authority to enter into contracts or to assume any obligations for the other party or to make any warranties or representations on behalf of the other party; provided, however, that Plan is expressly authorized and empowered to enter into individual Enrollee and group contracts providing for the receipt by Enrollees of Basic Health Services pursuant to this Agreement and to enter into Participation Agreements with other Participating Providers.

5.11 Compliance with Disclosure Law – In accordance with Section 952 of the Omnibus Reconciliation Act of 1980, the Parties agree that, until the expiration of four (4) years after the furnishing of Primary Care Services pursuant to this Agreement, they shall, upon written request, make available to the Secretary of HHS or the Secretary's duly authorized representatives, this Agreement and such books, documents and records that are necessary to certify the nature and extent of costs under this Agreement. This provision shall apply only if the value or cost of this Agreement equals ten thousand dollars (\$10,000) or more over a twelve (12) month period. The availability of each party's books, documents and records shall be subjected at all times to such criteria and procedures for seeking or obtaining access as may be promulgated by the Secretary of HHS in regulations and other applicable laws.

5.12 Dispute Resolution – In the event the Parties cannot satisfactorily resolve a dispute concerning this Agreement (other than a dispute expressly specified herein as being excluded from operation of this Section 5.12), the Parties will settle the dispute by arbitration in Des Moines, Iowa, in accordance with the commercial arbitration rules of the American Arbitration Association then in effect. Either party may initiate such arbitration by making a written demand for arbitration on the other party within thirty (30) days of the time the dispute arises. Within ten (10) business days of that demand, Plan and PP/PPG will jointly select a single mutually agreed upon arbitrator, or, if the Parties cannot agree to such a single arbitrator within such period, then Plan and PP/PPG will, at their own expense, each designate an arbitrator and give written notice of such designation to the other. The two (2) arbitrators selected by this process will select a third arbitrator whose costs shall be shared equally by Plan and PP/PPG and give notice of the selection to Plan and PP/PPG. The arbitrator or arbitrators, as the case may be, will hold a hearing and decide the matter within thirty (30) days after selection. The results of the arbitration will be final and binding on both Parties. Any court that has jurisdiction may enter judgment upon an arbitration award rendered pursuant to

this Section. The arbitrator(s) may award the prevailing party its expenses of the arbitration (including attorney fees) as part of his/her/their award. The Parties exclude the following matters from the operation of this arbitration clause: (1) any counterclaim, cross-claim or third party claim for indemnity or contribution between PP/PPG and Plan in any Enrollee's suit against PP/PPG, another Participating Provider or Plan, unless a court requires the Parties to submit the Enrollee's entire claim to arbitration; (2) any dispute concerning termination of this Agreement, which claim shall be resolved through the procedures specified for such event in Section 6.1, 6.2 or 6.3, whichever may be applicable to the particular termination in dispute; and (3) any dispute for which a dispute resolution procedure or mechanism is specified in Plan's Provider Manual.

5.13 Recitals – The recitals are hereby incorporated into and made part of this Agreement.

5.14 Confidentiality – All Enrollee information, including all records, electronic or written, and all forms of communication whereby an Enrollee's identity, diagnosis, condition or treatment are identifiable are to be treated as confidential by PP/PPG. Individual office staff may access Enrollee information only when it is necessary to perform their Plan responsibilities.

Except where otherwise required by law, Enrollee information may be transmitted only to those individuals who need to know the information to carry out their responsibilities within the office or to deliver clinical services to Enrollees of Plan. PP/PPG's transmission of Enrollee information will occur in a manner that safeguards confidentiality, i.e. "Confidential" coversheet on all faxed information. Printed patient information shall be kept secure via double lock.

6 TERMINATION OF AGREEMENT

6.1 Immediate Termination –

a) Either party may terminate this Agreement immediately upon written notice to the other party if such other party: (1) applies for or consents to the appointment of a receiver, trustee, or liquidation for itself or any of its property; (2) admits in writing that it is unable to pay its debts as they become due; (3) executes an assignment for the benefit of creditors; (4) after commencement of an involuntary proceeding against it under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law, answers admitting the material allegations of the petition; or (5) has commenced against it an involuntary proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law which is not dismissed within sixty (60) days; or (6) if Plan permanently loses its state HMO license or dissolves.

b) Plan may terminate this Agreement immediately if PP/PPG temporarily or permanently loses licensure to deliver health care services; or Plan reasonably believes enrollees health/well-being will be in jeopardy.

c) Plan may immediately terminate this Agreement in the event of any change of fifty percent (50%) or more of the ownership or control of PP/PPG.

d) Plan may terminate this Agreement immediately if PP/PPG is suspended, terminated or excluded from participation for any length of time from a governmental health care program by any governmental agency.

6.2 Termination Without Cause – Either party may terminate this Agreement without cause upon sixty (60) days' prior written notice to the other party.

6.3 Termination For Cause – Either party may terminate this Agreement upon the other party's material breach if the non-breaching party has given sixty (60) days' prior written notice specifying the material breach to the breaching party and the breaching party has not cured the specified breach within the sixty (60) day period. In the event that Plan terminates this Agreement for cause pursuant to this Section 6.3, PP/PPG shall have the appeal and/or hearing rights specified for such circumstances in Plan's Provider Manual.

6.4 Obligation to Enrollee on Termination – PP/PPG will continue to provide Covered Services to Enrollees that PP/PPG is actively treating at the time of termination in accordance with dictates of medical prudence until PP/PPG completes such treatment or for up to ninety (90) calendar days, whichever is less, until Plan makes

arrangements to have another Participating Provider provide such services. Care must be continued through the postpartum period for Enrollees in their second or third trimester of pregnancy, if applicable. The provisions of this Agreement, including those pertaining to PP/PPG's compensation for Primary Care Services or Specialty Care Services, shall continue to apply after termination of this Agreement to all Covered Services provided by PP/PPG prior to termination of this Agreement and to all post-termination Covered Services provided by PP/PPG pursuant to this Section 6.4.

6.5 Notification of Termination – In the event that this Agreement is terminated or is not renewed for any reason, Plan shall be responsible for notifying all Enrollees covered under this Agreement of the date of such termination or expiration, at least thirty (30) calendar days prior to the effective date for any Primary Care Physician (General, Family, Internal Medicine or Pediatrics) termination. To the extent possible, for any termination or non-renewal of a Specialist PP/PPG, PP/PPG agrees to inform affected Enrollees seeking medical care ninety (90) days prior to the date of such termination that PP/PPG will no longer be a Participating Provider.

7. PAYMENT ADMINISTRATION

7.1 PP/PPG Obligations –

a) PP/PPG shall submit itemized claims for Fee-For-Service Covered Services (as defined in Section 1) and encounter information for Covered Services (as defined in Section 1) using the CMS-1500 billing form or such other form(s) as may be specified as permissible in the Provider Manual. PP/PPG shall submit claims for Fee-For-Service Covered Services within one hundred eighty (180) days from the date of service, or, in those instances in which Plan is the secondary payor, forty-five (45) days from the date that PP/PPG receives a notice of payment decision from the primary payor. PP/PPG shall submit encounter information for Covered Services within forty-five (45) days from the date of service or, in those instances in which Plan is the secondary payor, forty-five (45) days from the date that PP/PPG receives a notice of payment decision from the primary payor. In the event that PP/PPG does not submit claims or encounters within the forty-five (45) day period, Plan may elect to reduce or deny payment.

b) If Plan pays PP/PPG more than is provided by this Agreement for the applicable service, PP/PPG agrees to return the overpayment to Plan within forty-five (45) days after receipt, discovery or notice of the overpayment.

c) In instances in which Plan is the secondary payor and services are reimbursed on a Fee-For-Service basis, Plan will reimburse PP/PPG the amount calculated in accordance with Attachment G, minus the amount paid by the primary payor. When the primary and secondary benefits are coordinated, determination of liability will be in accordance with the usual procedures employed by the DHS and/or IID and applicable Iowa laws and regulations. PP/PPG agrees to coordinate with Plan for proper determination of coordination of benefits and to bill and collect from other payors charges for which the other payor is responsible. Such collections, including all collections from workers' compensation and all sums payable under the terms of any court judgment, may be retained by PP/PPG as compensation in addition to the sums paid by Plan.

d) PP/PPG will verify with Plan the Enrollee's eligibility for Covered Services before providing such services. Verification of eligibility and any required pre-authorization shall be requested by PP/PPG as specified in the Provider Manual.

e) For Medicare, PP/PPG agrees to provide Plan with its updated FI Rate letter within thirty (30) days of receipt from CMS. Provider's payment rates will be adjusted only in accordance with the updated FI Rate letter, the first of the following month, after thirty (30) days of its receipt by Plan.

f) Plan may recoup from, or offset against, amounts owed to PP/PPG under this Agreement, any payments made by Plan to PP/PPG that are in violation of Medicare or Medicaid policy, Plan Policies or this Agreement. PP/PPG has the right to dispute any action by Plan to recoup or offset claims, or capitation.

7.2 Covered Services –

a) PP/PPG's reimbursement for Covered Services (as provided in applicable attachments) rendered to Enrollees, except for amounts received for coordination of benefits or otherwise from third parties in accordance

with this Agreement, shall be set forth in the applicable attachments.

b) As provided in, and subject to, the Agreement, Plan will pay the reimbursement calculated in accordance with Section 7.2(a) above to PP/PPG within thirty (30) days after Plan's receipt of a Clean Claim as defined in Section 1.

c) PP/PPG claims for reimbursement for Primary Care Services shall be deemed received only upon actual receipt by Plan, and shall be deemed paid by Plan only upon actual receipt of funds by PP/PPG. If, in compliance with this Agreement, additional information is required to pay a claim, Plan will request the information as soon as is practicable after Plan's receipt of the claim.

d) In the event that CMS, DHS or a commercial payer adjusts the rate(s) paid to Plan or adjusts benefits covered by Plan, Plan may at its sole discretion adjust reimbursement, and or Covered Services.

e) Plan will follow any applicable federal and state laws, rules and regulations outlining prompt payment provisions.

8 EFFECTIVE TERM, AMENDMENT AND NOTICE

8.1 Term of Agreement – The term of this Agreement will commence on the latest of the two dates specified on the Signature Page hereof, will continue in effect for a period of twelve (12) months, and will automatically renew thereafter for successive terms of one year each, unless sooner terminated pursuant to the terms and conditions hereof.

8.2 Amendments – Plan may amend this Agreement or any other documents, plans or policies (i.e. Quality Improvement Plan, Provider Manual, Utilization Review Plan) immediately if such amendment is necessary in order to comply with applicable governmental statutes and/or regulations, provided that Plan shall provide PP/PPG with prompt written notice of such amendment. Further, Plan may amend this Agreement or any other documents, plans or policies, upon thirty (30) days' written notice.

8.3 Notices – Notices to the Parties as to any matter hereunder will be sufficient only if given in writing and sent by facsimile, certified mail, postage prepaid, or recognized overnight delivery service or delivered by hand (provided that the sender maintains written evidence of receipt) to the Parties' addresses specified on the Signature Page hereof.

9 SERVICES COVERED UNDER THIS AGREEMENT

Attachment A - Meridian Health Plan of Iowa Medicaid Managed Care Network

Attachment B - Meridian Advantage Plan of Iowa (HMO SNP) Medicare MA-PD Plan Network

Attachment C - Meridian Health Plan Commercial HMO Network

Attachment D - Meridian MMAI Network

Other _____

[Signature Page Follows]

IN WITNESS WHEREOF, to signify their agreement to all of the terms and conditions hereof, the Parties have executed this Agreement as of the date(s) stated below:

To be completed by PP/PPG:

To be completed by Meridian Health Plan of Iowa, Inc.

| | |
|--|--|
| <p>Practitioner or Group Name: _____</p> <p>Specialty: _____</p> <p>Contract Type:</p> <p><input type="checkbox"/> Primary Care - Non Pediatric</p> <p><input type="checkbox"/> Primary care - Pediatric</p> <p><input type="checkbox"/> Primary Care - OBGYN</p> <p><input type="checkbox"/> Specialty Care</p> <p>Address: _____ _____ _____</p> <p>Telephone () _____</p> <p>_____ Signature</p> <p>_____ Printed Name</p> <p>_____ Title</p> <p>_____ Date</p> <p>Member of the following Contracting Organization having a Master Agreement with Plan: _____</p> | <p style="text-align: center;">Meridian Health Plan of Iowa, Inc. 666 Grand Avenue, Floor 14 Des Moines, Iowa 50309 (888) 773-2647</p> <p>_____ Signature</p> <p><u>Raymond Pitera</u> Printed Name</p> <p><u>President/COO</u> Title</p> <p>_____ Date</p> |
|--|--|

Attachments

- Attachment A - Medicaid
- Attachment B - Medicare
- Attachment C - Commercial
- Attachment D - MMAI
- Appendix I - Primary Care Provider Acknowledgement Appendix II - Physician Group Providers

ATTACHMENT A
Meridian Health Plan
-Medicaid-

Covered Services for Medicaid Enrollees

PP/PPG shall provide Covered Services that are within the scope of practice which have been authorized in the contract between Plan and DHS. A detailed list of Covered Services will be provided in the Medicaid Provider Manual. Such Covered Services may be amended as dictated by DHS.

Specialty Health Care Services are those Services within the Specialty Care Practitioner's scope of practice which have been authorized and approved according to Plan's referral and authorization policy and for which the Specialty Care Practitioner may submit itemized claims for payment pursuant to Attachment D.

Non-Covered Services/Prohibited for Medicaid Enrollees

The following services are excluded from coverage under the DHS Agreement for Medicaid Enrollees:

1. Medical Transportation by common carrier or private motor vehicle as outlined in 441 Iowa Administrative Code--78.13;
2. Services by nursing facilities as outlined in 441 Iowa Administrative Code Chapters 81 and 82;
3. Home and Community Based Waiver Services as outlined in 441 Iowa Administrative Code Chapter 83;
4. Services in Psychiatric Institutions as outlined in 441 Iowa Administrative Code Chapter 85;
5. Services by Area Educational Agencies as outlined in 441 Iowa Administrative Code -- 78.32;
6. Rehabilitative Treatment Services as outlined in 441 Iowa Administrative Code --78.42;
 - a. Family Preservation
 - b. Family Foster Care
 - c. Family Centered
 - d. Group Care
7. Dental Services as outlined in 441 Iowa Administrative Code--78.4;
8. Mental Health Services covered by the Iowa Plan as outlined in 441 Iowa Administrative Code 88, Division IV;
9. Substance Abuse Services covered by the Iowa Plan as outlined in 441 Iowa Administrative Code Chapter 88, Division IV.

REIMBURSEMENT FOR MEDICAID ENROLLEES

Reimbursement Plan:

PRIMARY CARE PRACTITIONER

Plan 1 – Fee-For-Service – The lesser of 100% of the current Medicaid Fee Schedule on the date of service or PP/PPG's billed charges, minus any applicable copays, coinsurance or deductibles.

SPECIALTY CARE PRACTITIONER

Specialty Care Practitioner – The lesser of 100% of the current Medicaid Fee Schedule on the date of service or PP/PPG's billed charges, minus any applicable copays, coinsurance or deductibles.

MEDICAID REQUIREMENTS

For Medicaid, in accordance with state and federal regulations and official Medicaid guidance as well as DHS guidelines, and notwithstanding any other provision in this Agreement to the contrary, PP/PPG is subject to the following requirements:

1. **Subcontractors** – The Parties agree that PP/PPG, in performing PP/PPG's duties and obligations hereunder, shall have the right, subject to the credentialing and re-credentialing requirements described in this

Agreement, either to employ its own employees and agents or to utilize the services of persons, firms and other entities by means of subcontractual relationships; provided, however, that no such subcontract shall operate to relieve PP/PPG of its obligations hereunder and further provided that the format for all such subcontracts shall have been approved by the DHS or IID in the event that either agency requires such approval; and further provided that Plan's liability for reimbursement hereunder shall extend only to PP/PPG, and only to the sums provided for herein, and that PP/PPG shall be solely responsible for reimbursement and/or payment of any employee or agent of PP/PPG for services performed pursuant to this Agreement. All such subcontracts shall be in writing and fulfill requirements of 42 CFR 434.6 that are appropriate to the service or activity delegated under the subcontract.

2. **Plan Obligations to DHS** – Anything herein to the contrary notwithstanding, no term or provision of this Agreement shall operate to terminate the legal responsibility of Plan to the DHS, in concurrence with the IID, with respect to Enrollees eligible for benefits under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act. PP/PPG agrees that no subcontract can terminate the legal responsibility of PP/PPG to DHS with respect to Enrollees eligible for benefits under Title XIX and Title XXI of the Social Security Act.

3. **DHS Agreement** – PP/PPG will assist Plan in meeting its obligations under Plan's agreement with the DHS, in concurrence with IID with respect to Enrollees eligible for benefits under Title XIX of the Social Security Act (Medicaid), and hereby agrees to the terms and conditions of such agreement as they pertain or apply to subcontractors.

4. **Timely Access** – PP/PPG shall meet Iowa standards for timely access to care and services, taking into account the urgency of the need for services. PP/PPG shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the PP/PPG serves only Medicaid enrollees. PP/PPG shall ensure that Covered Services included in this Agreement are available 24 hours a day, 7 days a week, when medically necessary. PP/PPG shall cooperate with all Plan monitoring and compliance mechanisms for ensuring timely access to services under this Section 3. Plan shall take corrective action for failure to comply with this Section.

5. **Primary Care Provider Responsibilities** – PP/PPG that is also a PCP must at a minimum:

- a) Work with Plan to maintain continuity of each Enrollee's health care,
- b) Make referrals for specialty care and other Medically Necessary services to both participating and non-participating providers,
- c) Maintain a comprehensive current medical record for each Enrollee, including documentation of all services provided to the Enrollee by the PCP, as well as any specialty or referral services, diagnostic reports, physical and mental health screens, etc.,
- d) Participate in Plan's monitoring programs related to PCP services and Plan Policies,
- e) Be responsible for ensuring access to care

6. **Medicaid Certification** – PP/PPG represents that it is eligible for Medicaid Certification and warrants that it will maintain such eligibility throughout the term of this Agreement.

7. **Consumer Protection** – PP/PPG shall comply with and assist Plan in avoiding direct marketing to Enrollees and potential Enrollees, this limitation does not include contacting an Enrollee for the purpose of informing the Enrollee of services available or to promote health education.

8. **Utilization Review Policy Compliance** – PP/PPG shall follow and assist in the implementation of Plan's written utilization review policies and procedures as outlined in the Utilization Management Plan and Plan Policies.

9. **Primary Care Appointments** – PP/PPG shall ensure that the average length of time for Enrollee appointments with PCPs shall not exceed one (1) hour from scheduled appointment time. This includes time spent both in the waiting room and in the examination room prior to being seen by PCP. PCPs may be delayed when they "work in" urgent cases, when a serious problem is found, or when the Enrollee had an unknown need that requires more services or education than was described at the time the appointment was made.

10. State Held Harmless – PP/PPG agrees that any dispute between PP/PPG and Plan shall be solely between such PP/PPG and Plan. The State of Iowa, Department and its officers, employees and agents and Enrollees shall not be responsible for any and all actions, claims, demands, damages, liabilities, or suits of any nature whatsoever arising out of this Agreement because of any breach by Plan or PP/PPG or employees, including but not limited to any negligent or wrongful acts, occurrence of omission of commission or negligence of the Plan or PP/PPG, their subcontractors, agents, providers, or employees.

11. Disclosure of Excluded Persons – PP/PPG is obligated to disclose the identity of any person described in 42 C.F.R. § 1001.1001(a)(1) to the Plan for disclosure to DHS. Plan must abide by any direction provided by the DHS regarding whether or not to permit PP/PPG for participation in the Iowa Plan for Behavioral Care. If any person who has ownership or control interest in PP/PPG, or who is an agent or managing employee of the PP/PPG, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX Services program, or if DHS or the Plan determines that the PP/PPG did not fully and accurately make any disclosure required pursuant to 42 C.F.R. § 1001.1001(a)(1), then Plan will abide by any direction provided by DHS on whether or not to permit the applicant to be a PP/PPG in the Iowa Plan for Behavioral Care.

12. Additional Disclosures – PP/PPG agrees to furnish to Plan, DHS, or Secretary on request, within 35 days of the request, a full and complete listing about:

- a) The ownership of any Subcontractor with whom PP/PPG has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
- b) Any significant business transactions between PP/PPG and any wholly owned supplier, or between the Provider and any Subcontractor, during the 5-year period ending on the date of the request.

Federal Financial Participation (FFP) shall be denied for expenditures for services furnished by PP/PPG where PP/PPG fails to comply with requirements of this Section 12.

13. Enrollee Hold Harmless – PP/PPG, or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by Plan, Plan insolvency or breach of this agreement, shall PP/PPG, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than Plan acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on HMO's behalf made in accordance with terms of (applicable Agreement) between Plan and subscriber/enrollee. PP/PPG, or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Plan subscriber/enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between PP/PPG and subscriber/enrollee or persons acting on their behalf.

In addition, Medicaid Enrollees shall not be held liable for any of the following: a) Plan's debts, in the event of Plan insolvency; b) Covered Services provided to the Enrollee, for which either DHS does not pay the Plan or DHS or the Plan does not pay the PP/PPG that furnishes the services under a contractual, referral, or other arrangement; or c) Payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if the Plan provided the services directly.

ATTACHMENT B
Meridian Health Plan
-Medicare-

Covered Services for Medicare Enrollees

PP/PPG shall provide Covered Services that are within the scope of practice which have been authorized in the contract between Plan and CMS. A detailed list of Covered Services will be provided in the Medicare Provider Manual. Such Covered Services may be amended as dictated by CMS.

Specialty Health Care Services are those Services within the Specialty Care Practitioner's scope of practice which have been authorized and approved according to Plan's referral and authorization policy and for which the Specialty Care Practitioner may submit itemized claims for fee-for-service payment pursuant to this Attachment B.

Non-Covered Services/Prohibited for Medicare Enrollees

The following services are excluded from coverage to Medicare Enrollees pursuant to CMS:

Experimental services, private duty nurses, convenience items, full-time in-home nursing care, homemaker services, elective or voluntary enhancement procedures, cosmetic surgery, routine chiropractic, dental, and foot care, routine eye exams/glasses, RK & LASIK surgery, and vision therapy.

Reversal of sterilization procedures, aqua therapy, sex change operations, non-prescription contraceptive supplies, acupuncture, naturopath (natural or alternative treatment) services, and services provided to veterans in Veterans Affairs (VA) facilities.

REIMBURSEMENT FOR MEDICARE ENROLLEES

Reimbursement Plan:

PRIMARY CARE PRACTITIONER

Plan 1 – Fee-For-Service –100% of then current Medicare Rates minus any applicable copays, coinsurance or deductibles.

SPECIALTY CARE PRACTITIONER

Specialty Care Practitioner – 100% of the then current Medicare Rates, Minus any applicable copays, coinsurance or deductibles.

REGULATORY REQUIREMENTS FOR MEDICARE

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (“MMA”); and

Except as provided herein, all other provisions of the Agreement between Plan and PP/PPG not inconsistent herein shall remain in full force and effect.

Definitions:

Centers for Medicare and Medicaid Services (“CMS”): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage (“MA”): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization (“MA organization”): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than \$2,500 during a contract period.

Required Provisions:

PP/PPG agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Plan, (hereinafter, “MA organization”) through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]
2. PP/PPG will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]
3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare

Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. PP/PPG may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. Any services or other activity performed in accordance with a contract or written agreement by PP/PPG are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]
6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the Plan and PP/PPG. [42 C.F.R. §§ 422.520(b)(1) and (2)] In accordance with 42 C.F.R. § 422.520(b), PP/PPG shall provide to Plan all information necessary for Plan to establish proper payment. Plan shall pay Provider for Covered Services rendered to Covered Persons in accordance with Section 7 of the Agreement. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by Plan at such address as may be designated by Plan, and Plan shall pay interest on any Clean Claim not paid within thirty (30) days of such receipt by Plan at the rate of interest required by law, or as otherwise set forth in the Provider Manual.
7. PP/PPG and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]
8. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

The delegated activities and reporting responsibilities are specified as follows:

- (i) The delegated activities are specified in the Agreement, if any.
- (ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.
- (iii) The MA organization will monitor the performance of the parties on an ongoing basis.
- (iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.
- (v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement. [42 C.F.R. §§ 422.504(i)(4) and (5)]

ATTACHMENT C
Meridian Health Plan
-Commercial-

Commercial Enrollees

PP/PPG shall provide Covered Services that are within the scope of practice which have been authorized in the contract between Plan and its commercial contracts. A detailed list of Covered Services will be provided in the Medicare Provider Manual. Such Covered Services may be amended as dictated by the Certificate of Coverage.

Specialty Health Care Services are those Services within the Specialty Care Practitioner's scope of practice which have been authorized and approved according to the Plan's referral and authorization policy and for which the Specialty Care Practitioner may submit itemized claims for fee-for-service payment pursuant to this Attachment C.

COMMERCIAL

Excluded services shall be those services which Plan does not contract to provide to a Commercial Enrollee pursuant to the respective Commercial Enrollee's Certificate of Coverage.

REIMBURSEMENT FOR COMMERCIAL ENROLLEES

PP/PPG total reimbursement for Covered Services shall be defined by the Plan's Commercial Fee Schedule applicable to each individual Enrollee. Prior to the introduction of any Commercial Fee Schedule applicable to any Enrollee, or any material modification to an existing Commercial Fee Schedule, Plan will provide PP/PPG with sixty (60) days' advance notice in writing. If PP/PPG objects to the Fee Schedule as proposed, PP/PPG retains the right to terminate participation as to the Commercial line of business only by providing Plan with written notice prior to the expiration of the sixty (60) day notice period. Silence on the part of PP/PPG shall be deemed as acceptance of the new or modified Fee Schedule and continued participation in the applicable product line.

ATTACHMENT D
Meridian Health Plan
-MMAI-

COVERED SERVICES

PP/PPG shall provide Covered Services that are within the scope of practice which have been authorized in the contracts between Plan and CMS and DHS. A detailed list of Covered Services will be provided. Such Covered Services may be amended as dictated by DHS and/or CMS.

EXCLUDED/NON-COVERED SERVICES

Excluded services shall be those Medicaid services excluded under Medicaid and those Medicare services excluded under Medicare as provided above.

REIMBURSEMENT FOR MMAI ENROLLEES

PP/PPG's total reimbursement for Covered Services for MMAI Enrollees shall be:

Medicare and Medicaid Covered Services

For Covered Services that are both Medicare and Medicaid Covered Services, Provider shall be entitled to the lesser of: (1) PP/PPG's billed charges; or (2) the amount payable by Medicare, not including Medicare coinsurance and deductibles, plus the amount payable by Medicaid as a secondary coverage based on the Medicaid fee schedule in effect on the date of service.

Medicare Only Covered Services

For Covered Services that are Medicare Covered Services, but not Medicaid Covered Services, Plan shall pay PP/PPG the lesser of: (1) PP/PPG's billed charges; or 100% of the Medicare fee schedule in effect on the date of service minus any applicable copays, coinsurance or deductibles.

Medicaid Only Covered Services

For Covered Services that are Medicaid Covered Services, but not Medicare Covered Services, Plan shall pay PP/PPG the lesser of: (1) PP/PPG's billed charges; or (2) 100% of the Medicaid fee schedule in effect on the date of service.

REGULATORY REQUIREMENTS

PP/PPG is subject to all applicable Medicaid and Medicare Regulatory Requirements set forth above. In addition, PP/PPG is subject to the following:

Cultural Considerations. Services will be provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 CFR 422.112(a)(8)

APPENDIX I
Meridian Health Plan
-Organization Provider Acknowledgement-

ACKNOWLEDGMENT
of
Agreement between Meridian Health Plan
and

I am a physician, hospital or other health care provider employed by or under contract with the above named Organization to furnish health care services at, as a member of, or on behalf of such Organization.

I have received and reviewed a copy of the Participation Agreement between Meridian Health Plan (the "Plan") and the above named Organization ("Organization Master Agreement"); and, wishing to provide health care services to Enrollees of Plan encompassed by that Organization Master Agreement and to obtain the benefit of the terms of that Agreement, agree to abide by and be bound by its terms. I acknowledge and agree that the terms and conditions of Plan's standard Primary Care Agreement and/or Specialty Agreement (each a "Participation Agreement"), whichever may be applicable, are incorporated herein by reference as material terms hereof and shall also be binding upon and apply to me except as, and only to the extent that, they are contradicted by the express terms of the Organization Master Agreement, and that in the event of any conflict between the terms and conditions of that Organization Master Agreement and the terms and conditions of the applicable Participation Agreement, the terms and conditions of that Organization Master Agreement shall supersede and govern with respect to me.

I agree to submit for review by Plan all required information necessary for my credentialing and re-credentialing in accordance with the standards established by Plan and described in Plan's Quality Improvement Plan. I acknowledge and agree that my Participating Provider status is dependent upon my successful completion of credentialing and re-credentialing in accordance with Plan's Quality Improvement Plan. I further agree to participate in Plan's credentialing and re-credentialing processes and to be bound by all Plan decisions with respect thereto.

I agree to look only to Plan for compensation for services rendered to an Enrollee when such services are covered by Plan's individual Enrollee or group contracts. I agree not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against Enrollee or persons acting on behalf of Enrollee (other than Plan), except as permitted under the Coordination of Benefits Section of the applicable Participation Agreement. I agree not to maintain any action at law or in equity against an Enrollee to collect sums that are owed by Plan to me under the terms of this Agreement, even in the event Plan fails to pay, becomes insolvent or otherwise breaches the terms and conditions of this Agreement. This provision shall survive termination of this Agreement or the Participation Agreement, regardless of the cause of termination and shall be construed to be for the benefit of Enrollees. This provision is not intended to apply to services provided after my Participation Agreement has been terminated, except as otherwise provided in the Organization Master Agreement or my Participation Agreement, or to non-covered services. I further agree that this provision supersedes any oral or written agreement, hereinafter entered into between myself and Enrollee or persons acting on Enrollee's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of my Participation Agreement.

I agree to be bound by all federal and state laws and regulations and to comply with, participate in and be bound by all policies, procedures and protocols set forth in Plan's Quality Improvement Plan and Provider Manual. I further agree to submit to requests by Plan (and authorized regulatory agencies) to review my books and records as outlined in this agreement.

As a further condition precedent to my Participating Provider status, I hereby acknowledge the authority of the above named Organization to execute participation agreements and other participation-related contracts and documents with Plan on my behalf and to thereby bind me to the terms thereof.

(Signature of Organization Provider)

(Date)

Printed name, Office address and Phone:

APPENDIX II
Meridian Health Plan
-Physician Group Providers-

Please list all Physician Members of Physician Group and CAQH #'s if applicable.

Provider Disclosure of Ownership and Control Interest Form



The federal regulations set forth in 42 CFR 455.104-106 require all providers who are entering into or renewing a provider agreement (“Disclosing Entities”) to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to managed care organizations that contract with the State Medicaid Agency: a) the identities of all owners with a control interest of 5% or greater, b) all agents or managing employees of the Disclosing Entity c) details of certain familial relationships between owners or owners of subcontractors owned by the Disclosing Entity, and d) the identities of any excluded individual or entity with an ownership or control interest in the Disclosing Entity. As used herein, a ‘person’ includes individuals and corporations or other business entities. **Please attach additional sheets as necessary.**

- Individuals listed in Sections 1-6 will be reviewed for inclusion on the Excluded Parties List System.
- Individuals listed in Section 7 will be reported to the HHS/Office of Inspector General (OIG) and to DHS.

| DISCLOSING ENTITY | | |
|---|------------------|----------------------|
| Check one that mostly describes you: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity | | |
| Name of Disclosing Entity: | | |
| DBA Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |
| Tax ID Number (TIN): | NPI (Individual) | NPI (Organizational) |

| SECTION 1 — Ownership and Control of Disclosing Entity | | | |
|--|---------------------------------|---|---|
| List the name, address, date of birth (DOB) and Social Security Number (or TIN for corporations) for each person with an ownership or control interest of 5% or more in the Disclosing Entity (including corporate entities, officers, directors, or partners). (42 CFR 455.104) | | | |
| Name of Individual or Entity: | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) |
| | | | |
| | | | |
| | | | |

| SECTION 2 — Ownership and Control of Disclosing Entity by Relatives | |
|---|--------------|
| Are any of the individuals listed in Section 1 related to each other? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If yes, disclose each person listed in Section 1 who are related to another person with ownership or control interest in the Disclosing Entity as a spouse, parent, child, or sibling. (42 CFR 455.104) | |
| Name of Individual | Relationship |
| | |
| | |

| SECTION 3 — Ownership And Control of Subcontractors | | | |
|--|---------------------------------|---|---|
| Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the Disclosing Entity has direct or indirect ownership of 5% or more. (42 CFR 455.104) | | | |
| Name of Individual or Entity with an Ownership Interest and Name of Subcontractor | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) of owner and SSN or TIN for subcontractor |
| | | | |
| | | | |

Continued on next page

SECTION 4 — Ownership and Control of Disclosing Entity by Relatives of Subcontractors

Are any of the individuals or entities listed in Section 3 related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling? Yes No
 If yes, disclose each person listed in Section 3 who is related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling. (42 CFR 455.104)

| Name of Individual from Section 3 | Relationship |
|-----------------------------------|--------------|
| | |
| | |

SECTION 5 — Ownership and Control of any Other Disclosing Entity

Is there any Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which a person listed in Section 1 has an ownership or control interest? Yes No
 If yes, list each Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which the person listed in Section 1 has an ownership or control interest.
An "Other Disclosing Entity" is usually an entity that either participates in Medicaid or is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVII (Grants for Planning Comprehensive Action to Combat Mental Retardation), or XX (Block Grants to States for Social Services) of the Social Security Act. (42 CFR 455.104)

| Name of Individual or Entity from Section 1 | Name of the other Disclosing Entity | % Interest |
|---|-------------------------------------|------------|
| | | |
| | | |

SECTION 6 — Managing Employees

List all managing employees of the Disclosing Entity along with the additional information indicated below. *A managing employee is a "general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency." (42 CFR 455.104)*

| Name of Individual or Entity: | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) |
|-------------------------------|---------------------------------|---|---|
| | | | |
| | | | |
| | | | |

SECTION 7 — Criminal Offenses

Has any person with an ownership or control interest in the Disclosing Entity, or any agent or managing employee of the Disclosing Entity ever been convicted of a crime related to that individual or entity's involvement in any program under Medicaid, Medicare, or Title XX program since the inception of those programs? Yes No (verify through HHS-OIG Website)
 If yes, please list those individuals below. (42 CFR 455.106)

| Name if Individual or Entity: | Date of Birth (for individuals) | Description of Offense(s) | Social Security Number (or TIN for corporation) |
|-------------------------------|---------------------------------|---------------------------|---|
| | | | |
| | | | |

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ Title _____

Printed Name _____ Date _____

Please return completed forms by faxing 313-202-0008 or by emailing providerdisclosure@mhplan.com.

Provider Disclosure of Ownership and Control Interest Form



The federal regulations set forth in 42 CFR 455.104-106 require all providers who are entering into or renewing a provider agreement (“Disclosing Entities”) to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to managed care organizations that contract with the State Medicaid Agency: a) the identities of all owners with a control interest of 5% or greater, b) all agents or managing employees of the Disclosing Entity c) details of certain familial relationships between owners or owners of subcontractors owned by the Disclosing Entity, and d) the identities of any excluded individual or entity with an ownership or control interest in the Disclosing Entity. As used herein, a ‘person’ includes individuals and corporations or other business entities. **Please attach additional sheets as necessary.**

- Individuals listed in Sections 1-6 will be reviewed for inclusion on the Excluded Parties List System.
- Individuals listed in Section 7 will be reported to the HHS/Office of Inspector General (OIG) and to DHS.

| DISCLOSING ENTITY | | |
|---|------------------|----------------------|
| Check one that mostly describes you: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity | | |
| Name of Disclosing Entity: | | |
| DBA Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |
| Tax ID Number (TIN): | NPI (Individual) | NPI (Organizational) |

| SECTION 1 — Ownership and Control of Disclosing Entity | | | |
|--|---------------------------------|---|---|
| List the name, address, date of birth (DOB) and Social Security Number (or TIN for corporations) for each person with an ownership or control interest of 5% or more in the Disclosing Entity (including corporate entities, officers, directors, or partners). (42 CFR 455.104) | | | |
| Name of Individual or Entity: | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) |
| | | | |
| | | | |
| | | | |

| SECTION 2 — Ownership and Control of Disclosing Entity by Relatives | |
|---|--------------|
| Are any of the individuals listed in Section 1 related to each other? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If yes, disclose each person listed in Section 1 who are related to another person with ownership or control interest in the Disclosing Entity as a spouse, parent, child, or sibling. (42 CFR 455.104) | |
| Name of Individual | Relationship |
| | |
| | |

| SECTION 3 — Ownership And Control of Subcontractors | | | |
|--|---------------------------------|---|---|
| Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the Disclosing Entity has direct or indirect ownership of 5% or more. (42 CFR 455.104) | | | |
| Name of Individual or Entity with an Ownership Interest and Name of Subcontractor | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) of owner and SSN or TIN for subcontractor |
| | | | |
| | | | |

Continued on next page

SECTION 4 — Ownership and Control of Disclosing Entity by Relatives of Subcontractors

Are any of the individuals or entities listed in Section 3 related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling? Yes No

If yes, disclose each person listed in Section 3 who is related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling. (42 CFR 455.104)

| Name of Individual from Section 3 | Relationship |
|-----------------------------------|--------------|
| | |
| | |

SECTION 5 — Ownership and Control of any Other Disclosing Entity

Is there any Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which a person listed in Section 1 has an ownership or control interest? Yes No

If yes, list each Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which the person listed in Section 1 has an ownership or control interest.

An "Other Disclosing Entity" is usually an entity that either participates in Medicaid or is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVII (Grants for Planning Comprehensive Action to Combat Mental Retardation), or XX (Block Grants to States for Social Services) of the Social Security Act. (42 CFR 455.104)

| Name of Individual or Entity from Section 1 | Name of the other Disclosing Entity | % Interest |
|---|-------------------------------------|------------|
| | | |
| | | |

SECTION 6 — Managing Employees

List all managing employees of the Disclosing Entity along with the additional information indicated below. A managing employee is a "general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency." (42 CFR 455.104)

| Name of Individual or Entity: | Date of Birth (for individuals) | Address(es) (for corporations, include primary business address, every business location, and P.O. Box address) | Social Security Number (or TIN for corporation) |
|-------------------------------|---------------------------------|---|---|
| | | | |
| | | | |
| | | | |

SECTION 7 — Criminal Offenses

Has any person with an ownership or control interest in the Disclosing Entity, or any agent or managing employee of the Disclosing Entity ever been convicted of a crime related to that individual or entity's involvement in any program under Medicaid, Medicare, or Title XX program since the inception of those programs? Yes No (verify through HHS-OIG Website)

If yes, please list those individuals below. (42 CFR 455.106)

| Name if Individual or Entity: | Date of Birth (for individuals) | Description of Offense(s) | Social Security Number (or TIN for corporation) |
|-------------------------------|---------------------------------|---------------------------|---|
| | | | |
| | | | |

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature

Title

Printed Name

Date

Please return completed forms by faxing 313-202-0008 or by emailing providerdisclosure@mhplan.com.



PARTICIPATING PHARMACY PROVIDER AGREEMENT

This PARTICIPATING PHARMACY PROVIDER AGREEMENT, together with all schedules, attachments, exhibits, Pharmacy Operations Manuals, (the “Agreement”) is entered into by and between MeridianRx, LLC, a Michigan limited liability company (“PBM”), and the undersigned pharmacy (“Pharmacy”). This Agreement shall become effective as of the date set forth on the signature page hereto.

WHEREAS, PBM provides administrative services to, or manages prescription benefits for, certain groups, including, but not limited to, Meridian Health Plan, employers, insurance carriers, health care service plans, third party administrators, and other health related entities and/or payors;

WHEREAS, PBM provides networks of participating pharmacies as part of its prescription benefit administrative and management services;

WHEREAS, Pharmacy desires and is willing to participate in PBM's networks of participating pharmacy providers and to provide pharmacy services under the terms and conditions set forth in this Agreement; and

WHEREAS, PBM and Pharmacy recognize as a mutual objective continuing efforts toward the goal of access, cost containment, and the delivery of quality pharmacy services.

NOW, THEREFORE, in consideration of the premises and the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

ARTICLE 1 DEFINITIONS

1.1 Affiliate.

The term “Affiliate” shall mean any entity which owns or controls or is owned or controlled by, PBM, directly or indirectly, and any entity which is under common ownership with PBM directly or indirectly.

1.2 Average Wholesale Price or AWP.

The terms “Average Wholesale Price” or “AWP” shall mean the average wholesale price of a Covered Service as established and reported by Medispan. AWP shall be updated at least weekly or in accordance with reasonable industry standards with data received from the pricing source; provided, however, PBM receives usable and acceptable data from such pricing source, which if not received timely could result in delays. AWP does not represent a true wholesale price, but rather is a fluctuating benchmark provided by third party pricing sources. In the event that the AWP pricing benchmark used by PBM hereunder is replaced with another benchmark calculation (such as ABP – average benchmark price), PBM may switch to such new pricing benchmark upon written notice to Pharmacy, and such notice will identify any new pricing terms, if any, required to maintain comparable pricing under the new benchmark.

1.3 Claim.

The term “Claim” shall mean the Pharmacy request for payment in the format prescribed by PBM of amounts due Pharmacy under this Agreement for providing Covered Services to Covered Individuals.

1.4 Co-payment or Co-pay.

The terms “Co-payment” or “Co-pay” shall mean the payment due from a Covered Individual to the Pharmacy at the time the Covered Service is provided, according to the Covered Individual's Plan or as otherwise required by a Payor, which shall be deducted from Pharmacy's reimbursement hereunder. Co-payments may include, but are not limited to, flat or percentage dollar amounts, coinsurance, deductible, and preferred or formulary incentives. At no time shall the Participating Pharmacy charge a covered Individual more than the Co-payment or Copay for a covered service.

1.5 Cognitive Services.

The term “Cognitive Services” shall mean certain services, agreed upon between PBM and Pharmacy that are not required by Law when providing Covered Services, but may be rendered by a Pharmacy.

1.6 Compound Prescriptions.

The term “Compound Prescriptions” shall mean a mixture of two or more ingredients when at least one of the ingredients in the preparation is a federal legend drug or state restricted drug in a therapeutic amount. It excludes the addition of only water or flavoring to any preparation. Further, “Compound Prescriptions” shall refer to a compound preparation not administered by infusion.

1.7 Covered Individual.

The term “Covered Individual” shall mean an individual who is eligible, as determined by Payors, to receive Covered Services under a Plan on the date the service is rendered.

1.8 Covered Quantity.

The term “Covered Quantity” shall mean a quantity of a Covered Service as allowed by Law and the Plan and authorized by a prescriber.

1.9 Covered Refill.

The term “Covered Refill” shall mean refills of a Covered Quantity of a Covered Service as allowed by Law and the Plan and authorized by a prescriber and Covered Individual.

1.10 Covered Service or Covered Prescriptions.

The terms “Covered Service” or “Covered Prescriptions” shall mean any medically necessary drugs, devices, supplies, equipment, and other items (which may include insulin, disposable insulin syringes, and other diabetic supplies) dispensed to a Covered Individual for which such Covered Individual is entitled to receive in accordance with and subject to the terms and conditions (including any Covered Quantity, Covered Refill, or other limiting provisions) of the applicable Plan, including all services usually and customarily rendered by a pharmacy in the normal course of business, including but not limited to dispensing, counseling, product consultation and other cognitive services.

1.11 Dispense As Written or DAW Code.

The terms “Dispense As Written” or “DAW Code” shall mean the code promulgated by NCPDP to indicate the reason for dispensing a medication, not limited to multi-source brand-named medication and provided by the participating pharmacy on a claim.

1.12 Dispensing Fee.

The term “Dispensing Fee” shall mean the amount paid to Pharmacy for professional services rendered by a licensed pharmacist for providing Covered Services to a Covered Individual.

1.13 Federal Upper Limit or FUL.

“Federal Upper Limit” or “FUL” shall have the meaning as established by the Centers for Medicare and Medicaid Services (CMS) in 42 CFR 447.332.

1.14 Formulary.

The term “Formulary” shall mean a list of preferred covered drugs and medical supplies developed, published, and periodically revised by PBM and/or Payors. Formularies may be available to Pharmacy upon request or by electronic messaging via the online system.

1.15 HIPAA.

The term “HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any subsequent amendments or regulations promulgated thereunder.

1.16 Law.

The term “Law” shall mean any federal, state, local or other constitution, charter, act, statute, law, ordinance, code, rule, regulation, order, specified standards, instructions, or objective criteria contained in any applicable permit or approval, or other legislative or administrative action of the United States of America, or any state or local government or any agency, department, authority, political subdivision or other instrumentality thereof or a decree or judgment or order of a court.

1.17 Maximum Allowable Cost or MAC.

The terms "Maximum Allowable Cost" or "MAC" shall mean the highest ingredient cost amount at which Pharmacy will be reimbursed for a Covered Service, which lists and pricing may be established and amended by PBM and/or Payor in its sole discretion.

1.18 NCPDP.

The term "NCPDP" shall mean the National Council for Prescription Drug Programs, which is a pharmaceutical-industry trade association.

1.19 NDC.

The term "NDC" shall mean the national drug code, which is an identifier published by Drug Labeling Branch of the Food & Drug Administration (FDA) for an approved prescription drug.

1.20 Network.

The term "Network" shall mean a group of pharmacies that have agreed to participate in a national, state, Payor, or other network under this Agreement or obtained by acquisition or otherwise.

1.21 Payor.

The term "Payor" shall mean the entity for which PBM provides prescription benefit administrative and/or management services, which may include, among others, Affiliates, employers, insurance carriers, health care service plans, third party administrators, self-administered or self-insured programs providing health care benefits, insurers, pharmacy benefit management companies, and other health related entities and/or other payors.

1.22 Pharmacy Operations Manual.

The term "Pharmacy Operations Manual" shall mean collectively the pharmacy operations manuals or provider manuals published by either PBM and/or its designees, as amended and/or supplemented by PBM or its designees from time to time, which are provided or made available to Pharmacy in written or electronic format to explain policies and procedures and other requirements to be followed by Pharmacy in connection with this Agreement.

1.23 Pharmacy Services Administration Organization or Affiliation or PSAO.

The terms "Pharmacy Services Administration Organization or Affiliation" or "PSAO" shall mean an entity that provides administrative services to pharmacies, including arranging for such pharmacies' participation in various pharmacy networks.

1.24 Plan.

The term "Plan" shall mean a contract, endorsement, or other agreement or program and any changes or additions thereto as may be made or amended from time to time which, by its terms, provides coverage for health care or pharmacy services and/or supplies or otherwise provides access to health care or pharmacy services and/or supplies pursuant to agreed upon terms, which may include but is not limited to document(s) describing the partially or wholly insured, underwritten and/or administered healthcare benefits or services program between a PBM and Payor or an employer or other entity or individual; in the case of a self-funded arrangement, the plan document, which describes the Covered Services for a Covered Individual(s).

1.25 Prescription Charge.

The term "Prescription Charge" shall mean the total compensation payable to Pharmacy for providing Covered Services to a Covered Individual. Such compensation shall be messaged to Pharmacy via PBM's electronic Claims submission system, and as the submission is more fully described in the applicable Pharmacy Operations Manual. The Prescription Charge is limited to the quantity of the Covered Service as prescribed, up to, and including, a thirty (30) day supply, unless a Covered Individual's Plan and Program Conditions and/or Requirements permits a different supply. The Prescription Charge is based on the actual bottle size, package size, or container from which the applicable Covered Service was dispensed from Pharmacy's stock.

1.26 Prior Authorization.

The term "Prior Authorization" shall mean certain Covered Services, identified by PBM's online system, that are not payable unless certain criteria are first satisfied.

1.27 Usual and Customary Charge or U&C.

The terms "Usual and Customary Charge" or "U&C" shall mean the lowest price the Pharmacy would charge to a cash-paying similar customer with no insurance for an identical pharmaceutical good or service on the date and at the location that the prescription is dispensed.

1.28 Wholesale Acquisition Cost or WAC.

The terms "Wholesale Acquisition Cost" or "WAC" shall mean the wholesale acquisition cost of a Covered Service as established and reported by First DataBank. WAC shall be updated at least weekly or in accordance with reasonable industry standards with data received from the pricing source; provided, however, PBM receives usable and acceptable data from such pricing source, which if not received timely could result in delays. WAC may not represent a true wholesale price, but rather is a published benchmark provided by third party pricing sources. In the event that the WAC pricing benchmark used by PBM hereunder is replaced with another benchmark calculation (such as ABP – average benchmark price), PBM may switch to such new pricing benchmark upon written notice to Pharmacy, and such notice will identify any new pricing terms, if any, required to maintain comparable pricing under the new benchmark.

**ARTICLE 2
RELATIONSHIP OF THE PARTIES**

2.1 Independent Entities.

PBM and Pharmacy are independent entities, and nothing in this Agreement shall be interpreted to create any relationship other than that of independent parties contracting with each other for the sole purpose of carrying out the provisions of this Agreement. In the performance of the obligations of this Agreement, regarding any services rendered under this Agreement, by either party or its agents, servants, or employees, each party is at all times acting and performing as an independent contractor with respect to the other party, and no party shall have or exercise any control or direction over the method by which the other party shall perform such work or render or perform such services and functions. It is further expressly agreed that no work, act, commission or omission of any party, its agents, servants or employees, pursuant to the terms and conditions of this Agreement, shall be construed to make or render any party, its agents, servants or employees, an agent, servant, representative, or employee of, or joint venture with, or fiduciary of, the other party. No provision of this Agreement or any part of any Plan shall be construed to require any pharmacist to dispense any medication or specific type of medication to any Covered Individual if, in the pharmacist's reasonable professional judgment, such medication should not be dispensed to such person.

2.2 Relationship Between Pharmacy And Covered Individuals.

The relationship between Pharmacy and Covered Individuals is that of pharmaceutical provider and patient. Pharmacy shall perform all professional and other services required to be provided under this Agreement and shall be free to exercise its own judgment on all questions of professional practice.

2.3 Non-Exclusivity.

The Agreement is non-exclusive, and Pharmacy may contract with other third party entities so long as its ability to perform its obligations under this Agreement is not impaired. Nothing in this Agreement shall in any way restrict the ability of PBM or Pharmacy to enter into any agreement of any kind relating to the subject matter of this Agreement.

2.4 No Third Party Beneficiaries.

This is an Agreement between PBM and Pharmacy only. It shall not be interpreted to create any rights or remedies in favor of any person or entity who is not a party to the Agreement, and no such person or entity shall have any right or cause of action under this Agreement, including any Covered Individual, except as otherwise provided herein.

**ARTICLE 3
PARTICIPATION**

3.1 General.

Pharmacy agrees that it will participate in all PBM pharmacy networks in which: (a) Pharmacy participates in as of the date of the acceptance of this Agreement by PBM; (b) Pharmacy executes a Network Participation Addendum accepted by PBM for such pharmacy network(s); and/or (c) Pharmacy agrees to participate as evidenced by its provision of Prescription Drug Benefits to an Eligible Person of a Payor utilizing such pharmacy network(s). All such pharmacy network(s) in which Pharmacy participates are referred to as the "Networks".

3.2 Other Pharmacy Programs.

Pharmacy may be included in additional Networks for Pharmacy Program(s), including but not limited to, insured programs, consumer discount card programs, and worker's compensation programs, upon thirty (30) calendar days advance written notice from PBM. In such event, Pharmacy may decline to participate in such additional Pharmacy Program(s) Networks by giving PBM written notification of its intent not to participate prior to the effective date of such Pharmacy Program(s) Network. Failure by the Pharmacy to provide written notification to PBM of its non-participation in the referenced additional Pharmacy Program(s) prior to the effective date of such Program(s) shall be deemed acceptance by the Pharmacy to participate in such additional Pharmacy Program(s).

3.3 Other Pharmacy Networks.

PBM reserves the right to establish other pharmacy networks or other pharmacy referral panels (hereinafter "Other Networks"), which have their own set of selection criteria. If Pharmacy does not meet the selection criteria, Pharmacy understands and agrees that it will cooperate in the transfer of the Covered Individual pharmacy information to a pharmacy within the Other Network. In the event Pharmacy renders Covered Services to the Covered Individual that should have been rendered by an Other Network pharmacy, then Pharmacy agrees that it will be deemed an out-of-network provider under the Covered Individual's Plan for the rendition of said services. PBM will give Pharmacy at least sixty (60) calendar days advance notice of the implementation of an Other Network.

3.4 Participation Exclusions/Restrictions.

To the extent not prohibited by Law, Pharmacy acknowledges and agrees that: (a) Payors may not utilize all pharmacies in a Network for their respective Plan networks or Pharmacy Programs; and (b) Payors may restrict or limit access to certain Covered Services (including, but not limited to, specialty medications, high cost medications, injectibles, medications with limited availability, etc.) to specified providers, which may or may not include Pharmacy.

ARTICLE 4 RESPONSIBILITIES AND OBLIGATIONS OF PHARMACY

4.1 Licensure and Other Requirements.

Pharmacy warrants and represents that Pharmacy and each pharmacist is in and shall maintain in good standing with all federal, state, and local regulatory bodies and has and shall maintain all federal, state and local approvals, licenses, and permits required to operate as a pharmacy at each location and to provide services under this Agreement. Pharmacy will notify PBM immediately of any revocation, suspension, limitation or other action, which could materially impair performance of its obligations under this Agreement. Pharmacy shall immediately notify PBM in writing if Pharmacy loses or voluntarily surrenders such licensure, accreditation, permits, authorizations or approvals, or no longer meets the PBM's standards, during the term of this Agreement.

4.2 Ineligibility To Participate.

Pharmacies or pharmacists providing covered services sanctioned by the General Services Administration, Office of Inspector General, or other applicable regulatory body, who are not eligible to participate in Medicare, Medicaid, or other Federal health care programs are not eligible to participate in any Network. Pharmacy warrants and represents that at the time of execution of this Agreement, neither it nor any of its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of Parties Excluded from Federal Programs and the HHS/OIG List of Excluded Individuals/Entities. In the event Pharmacy or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose ineligible person status, Pharmacy shall have an obligation to: (i) immediately notify PBM in writing of such ineligible person status, and (ii) within ten (10) calendar days of such notice, remove such individual, entity, or location that is responsible for, or involved with, Pharmacy's business operations related to this Agreement.

4.3 Other Pharmacy Qualifications.

Pharmacy acknowledges and agrees that Pharmacy: (i) has registered with the National Association of Boards of Pharmacy to dispense pharmaceuticals; and (ii) does not act as or provide services under this Agreement as a mail order pharmacy, internet pharmacy, long term care pharmacy, institutional pharmacy, 340B, or specialty pharmacy as identified by either the National Council of Prescription Drug Programs ("NCPDP") or PBM, unless specifically agreed to by PBM in writing.

4.4 Service Availability.

Pharmacy shall provide Covered Services to all Covered Individuals pursuant to the terms of this Agreement during regular hours of operation of Pharmacy and in the same manner, in accordance with the same standards,

and with the same availability as that offered to other persons. Pharmacy shall use best efforts to maintain a supply of drugs, devices, supplies, equipment, and other items to provide Covered Services.

4.5 Eligibility Verification.

Pharmacy agrees to determine, as a condition precedent to providing Covered Services, the eligibility of each Covered Individual by requesting a current PBM or Payor identification card or by requesting Covered Individual's identification number and verifying eligibility using the on-line electronic network. Pharmacy may not be paid for Covered Services provided to an individual whose eligibility was not correctly submitted to and verified by PBM prior to providing the Covered Service.

4.6 Providing Covered Services.

Pharmacy will provide Covered Services to Covered Individuals subject to and in accordance with this Agreement, including but not limited to the Pharmacy Operations Manual, the prescriber's directions, the Plan, Formulary, applicable Law, and the standard of practice of the community in which Pharmacy provides Covered Services and in a manner so as to assure the quality of such services in a culturally competent manner. Pharmacy agrees that all Covered Services provided to Covered Individuals under this Agreement shall be provided by a pharmacist or by a qualified person under a pharmacist's direction. Pharmacy shall have a licensed pharmacist or other designated licensed professional available during all business hours for patient consultations, which will be provided to Covered Individuals at no additional charge unless such charge specifically agreed to between the PBM and Pharmacy. Pharmacy shall not refuse to provide any Covered Service to a Covered Individual due to dissatisfaction with reimbursement under this Agreement for a particular Covered Service.

4.7 Collection From Covered Individuals.

Upon Covered Individual's receipt of each Covered Service, Pharmacy shall collect and retain from the Covered Individual the Co-payment for the Covered Service. Pharmacy shall have full responsibility for the collection of such Co-payment, as well as the collection of any other charge(s) designated as a Covered Individual's financial responsibility in accordance with the terms of the applicable Plan, and shall not seek to collect any Co-payment from PBM or Payors. Pharmacy shall not discount, or facilitate a discount, waive, reduce, or defer Covered Individual's Co-payment in whole or in part. Pharmacy shall not: (a) balance-bill a Covered Individual; (b) charge Covered Individuals any charges other than the Co-Payment related to the Covered Service; and/or (c) charge a fee to Covered Individuals as a condition to be part of Pharmacy's panel of patients.

4.8 Claims Submission.

In each instance when a Covered Service is provided to a Covered Individual, Pharmacy must submit a Claim to PBM or its designee. Each Claim submitted by Pharmacy will constitute a representation and certification by Pharmacy to PBM that the Covered Services were provided to the Covered Individual and that the information transmitted is accurate and complete. Pharmacy shall require a Covered Individual to sign a log when the service is delivered to the Covered Individual and maintain this signature log in proper order for a minimum of ten (10) years from the date of service. This log will be available to PBM upon request.

Electronic Format. All Claims (including Compounds) for Covered Services must be submitted electronically to PBM or its designee via the electronic claims system in NCPDP format (then most current version) or in such other manner and format as directed by PBM or its designee. Failure to submit the Claim electronically when the electronic claims system is operational may be considered a material breach and grounds for termination of this Agreement and/or PBM may impose a reasonable handling fee per Claim in those situations in which Pharmacy submits Claims non-electronically. Pharmacy shall provide and maintain at its expense the equipment, software, and communications network transmission capabilities necessary to submit Claims and receive processing messages via the electronic claims system. Pharmacy shall be responsible to pay for its own electronic communication and/or switch charges incurred in the online delivery and receipt of Claims and processing messages.

Required Information. Claims must be submitted in accordance with Law, the Pharmacy Operations Manual and as otherwise set forth in this Agreement, including attachments to this Agreement. Pharmacy must submit all required information for the Claim via the electronic claims system, which may include but not be limited to the following: Covered Individual's identification number; quantity of the medication dispensed; days supply dispensed; Pharmacy's NCPDP, Provider, or NPI number; the eleven (11) digit NDC of the item dispensed based

on the bottle size from which the item was dispensed; the correct DAW Code; the prescriber's identification number; and the Pharmacy's U&C.

U&C. Pharmacy acknowledges and agrees that accurate submission of U&C is a material requirement of this Agreement and failure to electronically submit an accurate U&C with each Claim (including but not limited to Compounds) may be considered a material breach and grounds for termination of this Agreement.

DAW Codes. Pharmacy further acknowledges and agrees that Pharmacy must submit an accurate DAW Code in accordance with NCPDP specifications and that DAW Code submission may change the calculation of the Claim and/or Co-payment depending on Payor specifications. Pharmacy will be liable for any miscalculations and/or adjustments resulting from incorrect submission of a DAW Code. A Covered Individual's or Pharmacy's selection of a brand name multi-source product does not constitute medical necessity.

Prescriber Identification Number. Unless prohibited by Law, and in accordance with the other provisions of this Agreement, PBM has the right to terminate this Agreement for cause if PBM determines in its sole discretion that Pharmacy has submitted an unreasonable number of Claims with invalid prescriber identification and/or provider numbers ("Prescriber Number"). Prescriber Numbers shall be considered invalid when: (i) the Prescriber Number submitted by Pharmacy with the Claim is not the Prescriber Number listed on the prescription by the Prescriber; or (ii) no Prescriber Number is provided on the prescription, and the Prescriber Number submitted by the Pharmacy with the prescription Claim is not the "default" identification number provided by PBM; or (iii) the Prescriber Number submitted by the Pharmacy with the prescription Claim does not correspond to the actual prescriber of the prescription. This provision of the Agreement does not prohibit Pharmacy from submitting valid Prescriber Numbers that may be available to the Pharmacy through its prescription claims processing system but the Pharmacy is responsible for the validity of these Prescriber numbers.

Time for Submission. All Claims shall be submitted promptly after providing the Covered Service, and in no event later than thirty (30) calendar days after the date that Covered Service is rendered (or such longer period required by applicable Law). Failure to timely submit a Claim may result in non-payment of such Claim. If a claim is rejected from coverage or adjusted by the PBM, the pharmacy has a period of time not to exceed 90 days to pursue further adjustments to such claims, but in no case will a claim be payable by the PBM after 120 days from the date of the covered service.

4.9 Claim Reversals.

All Covered Services not received by a Covered Individual must be reversed through the electronic claims system. Unless otherwise notified in writing by PBM, Pharmacy shall submit Claim reversals within ten (10) calendar days following the date the Claim was originally submitted. This includes (but is not limited to) reversals and resubmittals for partial fills, where the Covered Service is partially filled and the remainder is not retrieved by the Covered Individual in a reasonable period of time, in which case Pharmacy must electronically reverse and resubmit the actual quantity of a Covered Service received by a Covered Individual. In addition, this provision prohibits Pharmacy from submitting separate Claims for a Covered Service which should have been dispensed and covered as one Claim but due to inadequate supplies or other issues is dispensed and covered on different dates or at different times as multiple Claims.

4.10 Clinical, Quality, and Cost Containment Efforts.

In providing Covered Services to Covered Individuals, Pharmacy shall use its best efforts in supporting PBM and Payors in managing the cost and quality of Covered Services. Pharmacy shall use best efforts to cooperate with cost containment efforts such as Formularies, prior authorization programs, step therapy programs and drug utilization reviews which promote prescribing and dispensing of appropriate and cost-effective therapeutic alternatives, including but not limited to the following:

4.10.1 Lowest Cost Drugs.

Pharmacy agrees to dispense the lowest cost drug that Pharmacy then has in stock, consistent with the orders of the prescriber, the requirements of Law, and the professional judgment of Pharmacy.

4.10.2 Generic Substitution.

Pharmacy agrees to promote generic utilization, consistent with the requirements of Law, and will provide Covered Services using generic medications in compliance with the applicable Plan and Formulary. Pharmacy shall maintain a record on the original prescription order of its attempt at achieving a less expensive generic dispensing.

4.10.3 Mandatory Generic Programs.

Pharmacy shall use its best efforts to support PBM and Payor mandatory generic programs, including but not limited to, contacting the prescriber to encourage a change to a generic substitute when the prescription for the Covered Service contains a Dispense As Written signature for a multi-source brand medication. Pharmacy shall use best efforts to maintain a supply of generic drugs.

4.10.4 Formulary Compliance.

Pharmacy shall dispense items on the Covered Individual's Formulary to the maximum extent permitted by Law. Pharmacy shall use best efforts to contact the prescriber to encourage Formulary compliance and request authorization to change to a therapeutic alternative Formulary drug. Pharmacy shall maintain a record on the original prescription order of its attempt at achieving Formulary compliance.

4.10.5 Prior Authorization.

Unless otherwise instructed in writing by PBM, if Pharmacy receives a system message that states "Prior Authorization Required" (or such other language to that affect) when submitting a Claim for a Covered Service, Pharmacy shall use best efforts to contact the prescriber and inform the prescriber of the Prior Authorization requirement or, where appropriate and permitted by the Plan, obtain additional information and contact the PBM or Payor (as applicable) prior authorization help desk to determine if the Plan Prior Authorization requirements have been satisfied. In those situations where Pharmacy must contact the prescriber and the prescriber is not available, Pharmacy shall notify Covered Individual and shall contact the PBM or Payor (as applicable) prior authorization help desk to obtain a one-time emergency authorization. If the applicable Payor's or PBM's prior authorization help desk is closed, to the extent required by Law, Pharmacy must provide an emergency supply, or, if not so required by Law, as otherwise instructed by PBM.

4.10.6 DUR.

Drug Utilization Review ("DUR") messages may appear in the online claim response. Pharmacy shall act upon all such messages subject to the professional judgment of the pharmacist. To the extent that PBM or its designee provides DUR information or messages to Pharmacy, Pharmacy acknowledges and agrees that: (a) information contained in DUR messages is derived from third party sources and is not independently developed by PBM; (b) the usefulness of DUR and other Formulary information is necessarily limited by the amount of patient information input into the online system as a result of Claims processing, the amount of information provided by Payors, and the thoroughness and accuracy of industry information and information provided by third parties; (c) DUR messages and Formulary information are intended as an aid to, and not a substitute for, the knowledge, expertise, skill, and judgment of prescribers, Pharmacy, pharmacists, and other healthcare professionals; (d) Pharmacy, prescribers, pharmacists, and other healthcare professionals are responsible for acting or not acting upon information generated and transmitted by PBM or its designee; (e) PBM does not control the healthcare decisions made or actions taken by Pharmacy, prescribers, pharmacists, other healthcare professionals, Payors, or Covered Individuals; (f) the DUR messages and Formulary information do not contain all currently available information on healthcare or pharmaceutical practices; (g) PBM and its designee are not responsible for failing to include information in a DUR message or in Formulary detail, for the actions or omissions of contributors of information to PBM or its designee, or for misstatements or inaccuracies in industry materials utilized by PBM or its designee; and (h) all warranty disclaimers and exclusions made by contributors of information or data to PBM or its designee shall apply to PBM hereunder.

4.11 PBM and Payor Programs and Initiatives.

Pharmacy agrees to provide Covered Services in accordance with any PBM and Payor programs and initiatives. This includes, but is not limited to, cooperating in good faith with, and participating in and complying with, any credentialing, utilization review, cognitive services, and quality assurance initiatives of PBM and/or Payors, as communicated to Pharmacy, as may be amended from time to time. Pharmacy practices that impact Covered Individuals that do not follow Formulary and other programs and initiatives are strictly prohibited.

4.12 Professional Judgment.

Nothing in this Agreement is intended to limit a pharmacist's professional judgment or violate applicable Law. Accordingly, notwithstanding anything to the contrary in this Agreement, Pharmacy and its pharmacists must exercise sound professional judgment at all times when providing Covered Services to Covered Individuals. Pharmacy or pharmacist may refuse to provide Covered Services to a Covered Individual based on that professional judgment, which must be documented. Pharmacy shall be solely responsible for its professional services rendered.

4.13 Covered Service Products.

All drug products utilized in providing Covered Services to Covered Individuals must be in compliance with applicable federal and state requirements including those of the Federal Food and Drug Administration (“FDA”).

4.14 Rebates.

PBM, Payors, and/or their designees have and retain the right to submit all Claims for Covered Services for Covered Individuals to pharmaceutical companies in connection with rebate or other similar programs. Unless otherwise agreed to in writing, Pharmacy shall not submit any of the Claims for Covered Services for Covered Individuals to any pharmaceutical company for the purpose of receiving any rebates or discounts.

4.15 Grievance/Complaint Procedures.

Pharmacy agrees to cooperate fully with any applicable Covered Individual grievance, complaint, or similar procedure, including but not limited to, informing Covered Individuals of applicable grievance and/or complaint rights. Further, Pharmacy agrees to fully cooperate with, and provide information requested by PBM, to enable PBM and or Payors to conduct and resolve grievances that may be raised by Covered Individuals, Payors, or other providers regarding the provision of Covered Services by Pharmacy. Disputes of malpractice are outside the scope of this Agreement. This provision shall survive termination of this Agreement.

4.16 Appeals Procedures.

Pharmacy agrees to comply with any applicable Covered Individual appeal(s) procedures, including but not limited to, informing Covered Individuals of applicable Appeal rights. This provision shall survive termination of this Agreement.

4.17 Diversion of Covered Prescriptions to Non-Participating Pharmacy.

Pharmacy shall not undermine Usual and Customary Charges or compound pricing or otherwise undermine the intent of this Agreement, including but not limited to encouraging the use of, or diverting a Covered Prescription to, a non-participating pharmacy that is owned, operated by, or affiliated with Pharmacy. In the event PBM, at its sole discretion, determines that Pharmacy has taken actions to undermine Usual and Customary Charges or compound pricing or otherwise undermine the intent of this Agreement, PBM shall have the right to initiate termination process to remove the Pharmacy from all PBM networks upon written notice to Pharmacy.

4.18 Non-discrimination.

Pharmacy shall not discriminate or differentiate against any Covered Individual as a result of his or her enrollment in a particular plan, or because of race, color, creed, national origin, ancestry, religion, sex, sexual orientation, marital status, age, disability, payment source, state of health, need for health services, status such as a Medicare or Medicaid beneficiary, or any other basis prohibited by Law.

4.19 Notification of Legal Action.

Pharmacy shall notify PBM or its designated agent of any legal or administrative claim made or action filed against Pharmacy arising from this Agreement, by a Covered Individual, or otherwise which could affect the ability of Pharmacy to carry out of this Agreement within ten (10) calendar days of receipt of such claim or action.

4.20 Coordination of Benefits.

Pharmacy agrees to cooperate in good faith with PBM regarding coordination of benefits and to notify PBM promptly after receipt of information regarding any Covered Individual who may have a Claim involving coordination of benefits. When Payor has been determined to be other than the primary payer, payment hereunder shall be based upon the Prescription Charge, reduced by the amount paid for the Covered Service by the primary and other tertiary plans. Pharmacy agrees to accept such amount as payment in full for the Covered Service. Notwithstanding the foregoing, this Section shall not be construed to require Pharmacy to waive coinsurance, indemnity balances and deductibles in contravention of any Medicare rule or regulation, nor shall this Section be construed to supersede any other Medicare Law.

4.21 Subrogation.

Pharmacy agrees to cooperate with PBM regarding subrogation and to notify PBM promptly after receipt of information regarding any Covered Individual who may have a Claim involving subrogation.

4.22 Compliance with Law.

Pharmacy shall comply with, and operate its pharmacy in compliance with, all Laws, including HIPAA. Pharmacy acknowledges and agrees that various state and federal mandates may apply with respect to the Agreement and the Covered Services and/or Covered Individuals hereunder. Such mandates may provide specific, different, and/or additional contractual provisions applicable to some of the Covered Services, Covered Individuals, Plan,

and/or Payors, and are set forth in the Regulatory Requirements Manual, which is incorporated herein by this reference as if fully set forth herein. The provisions in the Regulatory Requirements Manual only apply if they are required and then only as those provisions relate to Covered Individuals whose Plan, Pharmacy Program, or Payor is governed by the applicable provision.

4.23 Pharmacy Credentialing Application.

Pharmacy acknowledges it has completed and reviewed the Pharmacy Credentialing Application attached hereto as Exhibit A and incorporated herein. Pharmacy shall update the Pharmacy Credentialing Application promptly upon any material changes in the information contained therein, and otherwise upon request of PBM.

ARTICLE 5 COMPENSATION AND PAYMENT

5.1 Payment in Full.

Payors have agreed with PBM to pay sufficient funds for claims submitted by Pharmacy. Provided that sufficient payment has been received by PBM from Payor and provided the applicable Copayment has been collected by Pharmacy, Pharmacy will accept as payment in full for Covered Services rendered to Covered Individuals in accordance with the amounts provided for in the payment schedules attached as Exhibit B to this Agreement, less the applicable Copayment. Such payments will be made within 30 days of receipt of such a clean claim. Any overpayments made to Pharmacy or amounts owed by Pharmacy to PBM (including but not limited to POS charges, administrative charges, claim overpayments and reversals) may be deducted from amounts otherwise payable to Pharmacy. In no case shall reimbursement to Pharmacy exceed Pharmacy's Usual and Customary Charge.

Pharmacy acknowledges, understands, and agrees that claim payment amounts are the sole and absolute responsibility of the Payor. Pharmacy further acknowledges, understands, and agrees that PBM is not obligated to pay Pharmacy for claims of a Payor if a Payor fails to provide PBM with sufficient funds for such payment, and PBM has no liability to Pharmacy for nonpayment or for any delay in payment from a Payor. Accordingly, Pharmacy agrees to recover any unpaid balances from Payor only and that Pharmacy shall have no claim against PBM, and shall not seek payment from PBM, above or beyond the amount of payments made to PBM by the applicable Payor regardless of the cause of any non-payment or delay in payment by Payor. Pharmacy acknowledges, understands, and agrees that PBM is not the Payor and that except as otherwise set forth in this Agreement, there are no third party beneficiaries under this Agreement.

In the event that a Payor makes an assignment for the benefit of creditors, files a voluntary or involuntary petition in bankruptcy, is adjudicated insolvent or bankrupt, or a receiver or trustee is appointed, PBM shall have the right, but not the obligation, to participate in such proceedings on behalf of Pharmacy. PBM has the right to deduct from amounts otherwise payable to Pharmacy the Pharmacy's pro rata share of any reasonable costs and fees (including attorneys' fees) incurred by PBM in any such proceedings. All such amounts shall become immediately due and owing by Pharmacy upon notification by PBM.

5.2 Payment Processing Cycles.

PBM shall process or arrange to process all Claims submitted for payment which are accurate, complete, and otherwise in compliance with this Agreement within thirty (30) calendar days of receipt. PBM shall issue or arrange to issue or require Payors to issue checks, or pay Pharmacy electronically, for payment of Claims no fewer than twice per month. Pharmacy acknowledges and agrees that PBM operates only as an intermediary between Payors and Pharmacy with respect to payment under this Agreement and that Claim payment amounts due hereunder are the sole and exclusive responsibility of the Payor. In no event shall PBM be obligated to pay Pharmacy for Covered Services unless and until payment for such Covered Services is received from the Payor responsible for such payment. PBM has no liability to Pharmacy for nonpayment or for any delay in payment from a Payor. Pharmacy shall look solely to the Payor for payment.

5.3 Overpayments and Authorized Deductions.

Any amounts owed by Pharmacy to PBM (including but not limited to transmission fees and overpayments from Claim reversals, errors, inaccurate submissions, or otherwise) shall become immediately due and owing and shall be paid by Pharmacy to PBM upon request. Pharmacy agrees not to attempt to affect any accord or satisfaction through a payment instrument or accompanying written communication and not to conditionally or restrictively endorse any payment instrument; and PBM shall not be bound by any such attempt or endorsement. In the event of non-payment by Pharmacy or as otherwise authorized by this Agreement or at PBM's discretion, PBM may

deduct or offset any overpayments or other amounts owed by Pharmacy to PBM from any amounts otherwise payable to Pharmacy. PBM further reserves the right, in its sole discretion, to require pharmacy to assign to PBM any collection rights Pharmacy may have against any person.

5.4 Payment for Cognitive and/or Other Services.

PBM may, at its discretion and if Pharmacy agrees, make payments to Pharmacy with respect to Cognitive and/or other services provided to Covered Individuals. Such payments may result in different amounts payable to Pharmacy hereunder.

5.5 Taxes.

If any taxes, assessments, and/or similar fees (“taxes”) are imposed on Pharmacy by a governmental authority for the provision of Covered Services to Covered Individuals, Pharmacy shall be responsible for such taxes and shall not pass such taxes on to Covered Individuals, Payors or PBM unless specifically required to do so under applicable Laws. In no event shall PBM be liable for any taxes or the determination of the amount of taxes.

5.6 Objection To Payment.

Pharmacy must promptly notify PBM in writing of any alleged error, miscalculation, discrepancy or basis for disputing the correctness or accuracy of any Claim (whether paid, denied, rejected, reversed, or otherwise) within one hundred eighty (180) calendar days after payment is due. Otherwise, Pharmacy will be deemed to have confirmed the correctness and accuracy of the Claims processed and/or paid during that financial cycle. In no event will PBM have liability above or beyond the aggregate amount of Claims during such one hundred eighty (180) calendar day period. To request an adjustment to a Claim payment, Pharmacy must timely submit to PBM sufficient documentation to evidence that the Claim was paid incorrectly. This objection and time limitation does not apply with respect to any overpayments that may be made to Pharmacy.

5.7 Covered Individual Held Harmless.

Pharmacy agrees that in no event, including but not limited to, nonpayment, insolvency, or bankruptcy of PBM or Payor, or breach of this Agreement, shall Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Individual for Covered Services. This does not prohibit collection of Co-payments in accordance with the terms of this Agreement. In the event Pharmacy violates this provision, Pharmacy shall promptly refund the amount collected in violation of this Agreement to Covered Individual, Payor, and/or PBM, as directed by PBM in writing. Pharmacy further agrees that: (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Covered Individuals, and that (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Pharmacy and Covered Individual(s).

**ARTICLE 6
RECORD MAINTENANCE AND ACCESS**

6.1 Maintenance of Records.

Pharmacy agrees to maintain records as is required by PBM, by Law, or by appropriate regulatory authorities as such relate to Covered Services to be provided in accordance with this Agreement for a period of no less than ten (10) years (or such longer period required by Law) following the termination of this Agreement. Without limiting the generality of the foregoing, Pharmacy shall maintain all pharmacy records and data relating to the provisions of Covered Services to Covered Individuals and its responsibilities under this Agreement in a manner consistent with appropriate pharmacy standards and Laws, including, without limitation, maintaining original prescription orders, patient signature logs, pharmaceutical purchase records, prescriber information, patient profiles, billing records, and payments received from, or on behalf of, Covered Individuals. With respect to re-written prescription, re-written prescriptions for Covered Services must contain all appropriate documentation which was on the original prescription, including but not limited to DAW Code designations. PBM may withhold, deny, or chargeback payments where records and logs are not maintained as required hereunder.

6.2 Access to Records.

PBM, and any and all applicable governmental authorities, shall have access at all reasonable times to Pharmacy’s books, records and other papers which relate to this Agreement and/or Covered Services, including, without limitation, original prescription orders, patient signature logs, pharmaceutical purchase records, prescriber information, patient profiles, billing records, and payments received from, or on behalf of, Covered Individuals.

6.3 Survival of Termination.

The provision of this Article 6 shall survive the termination of this Agreement.

**ARTICLE 7
AUDITS**

7.1 Audit Procedures.

PBM, the Comptroller General of the United States (“Comptroller”), the Department of Health and Human Services (“DHHS”), the Centers for Medicare and Medicaid Services (“CMS”), and their respective duly authorized representatives or designees shall have the right, for the term of this Agreement and for three (3) years thereafter (or such longer period required by Law) to review, audit, examine, and reproduce any of Pharmacy’s books, records, prescription files, and other documentation pertaining to Covered Services for Covered Individuals and/or Pharmacy’s compliance with this Agreement. Except in instances where PBM suspects fraud, waste or abuse by the Pharmacy, PBM will provide Pharmacy with fifteen (15) calendar days prior notice, or such lesser or greater time as is required by Law, of any onsite audit. In addition, where no fraud, waste or abuse is suspected PBM, Pharmacy shall provide records or copies of records requested by PBM, Comptroller, DHHS, CMS, or their third party authorized representatives or designees within ten (10) calendar days from the date of such written request or such shorter time required by Law. Where fraud, waste or abuse is suspected by PBM, in PBM’s sole and absolute discretion, Pharmacy agrees to allow PBM to conduct an immediate audit in any form desired by PBM. Pharmacy agrees to fully cooperate in good faith with such audits, regardless of the form of such audit, including but not limited to, onsite audits and audits by mail, in-house desk audits, drug utilization reviews and detection of Claim submission errors. In connection with such audits, Pharmacy agrees to allow PBM or its subcontractor to copy, photocopy, photograph, or use digital camera photography, for all prescriptions, profiles and other records relating to the dispensing of Covered Services to Covered Individuals. In addition, where based on a sampling of audited Claims, PBM determines that Pharmacy has engaged in fraud or abuse or has made common errors in the submission of Claims, PBM has the right to extrapolate for purposes of determining the amount due and owing to PBM for noncompliant Claims to the extent not prohibited by Law.

7.2 Audit Discrepancies.

Audits of the Pharmacies will be conducted to determine non-compliant or discrepant Claims, which include, but are not limited to, the following: Pharmacy billed for brand, but dispensed generic; days’ supply or quantity dispensed does not reflect the prescription order, ethical use, exceeds or is not in accordance with the Covered Individual’s Plan; missing (or not timely produced) hard copy prescriptions; inaccurate Usual and Customary Charge submission; inaccurate DAW Code designations, including but not limited to prescriber Dispensed as Written (“DAW-1”) not designated on prescription when billed as such and patient requests brand instead of generic drug (“DAW-2”) is not documented on the prescription; reason not specified on prescription when refill too early message is over-ridden; inaccurate Prescriber Numbers submitted; Formulary non-compliance; NDC number billed not in accordance with NDC number dispensed; NDC number of product or number of units billed does not reflect Covered Service; Claim billed as a compound or is not written and designated as a compound preparation; non-compliance with quality, clinical, and cost containment programs.

7.3 Audit Recovery.

If it is determined by PBM or its designee that overpayments were made to Pharmacy, any such overpayment shall become immediately due and owing and shall be paid by Pharmacy to PBM upon notice to Pharmacy. PBM may, at its sole discretion, deduct or offset such amount of any overpayments made to Pharmacy from any amounts otherwise payable to Pharmacy.

7.4 Pharmacy Non-Compliance.

If Pharmacy is deemed non-compliant with the Agreement, certain penalties may apply, including, but not limited to, fees, interest, penalties, damages, or other charges imposed upon PBM by governmental entities, regulatory agencies, and/or Payors. PBM has the right to deduct any such amounts from any amounts payable to Pharmacy. PBM may report its audit findings to Payors, appropriate governmental entities, and/or regulatory agencies.

7.5 Survival of Termination.

The provisions of this Article 7 shall survive the termination of this Agreement.

**ARTICLE 8
INSURANCE, INDEMNIFICATION AND ACCOUNTABILITY**

8.1 Insurance.

Pharmacy, at its sole cost and expense, shall procure and maintain policies of general and professional liability insurance and such other insurance as shall be necessary to insure it and its employees against any claim or claims for damages arising out of, or related to, alleged personal injuries or death occasioned directly or indirectly in connection with the performance of Covered Services and activities of Pharmacy, and/or the use of any facilities, equipment or supplies provided by Pharmacy. Each of such policies shall be amounts of at least one million dollars (\$1,000,000.00) per occurrence and three million dollars (\$3,000,000.00) annual aggregate, or such greater amount required by Law; or Pharmacy shall provide such other evidence of financial responsibility as may be acceptable to PBM. Pharmacy shall name as an additional insured PBM, its successors and assignees. Pharmacy shall immediately notify PBM in writing of any suspension, cancellation, or material change of insurance coverage. Pharmacy shall furnish PBM reasonable proof of such insurance as may be requested upon execution of this Agreement and/or at any reasonable time thereafter. Pharmacy acknowledges and agrees that failure to maintain the appropriate insurance policies may result in immediate termination of this Agreement at PBM's sole discretion. This provision shall survive the termination of this Agreement.

8.2 Indemnification.

All liability arising from the provision of Covered Services and any other services rendered by Pharmacy will be the sole responsibility of Pharmacy. Pharmacy will indemnify, defend, and hold harmless PBM, its designees, Payors, and their respective shareholders, directors, employees, agents, and representatives from and against any and all liabilities, losses, settlements, claims, injuries, damages, expenses, demands, penalties, or judgments of any kind (including reasonable costs, expenses, and attorneys' fees) that may result or arise out of: (a) any actual or alleged malpractice, negligence, misconduct, or breach by Pharmacy in the performance or omission of any act or responsibility assumed by Pharmacy; (b) the provision of pharmacy services for the sale, compounding, dispensing, manufacturing, or use of a drug or device dispensed by Pharmacy; or (c) the breach or alleged breach by Pharmacy of any representation, warranty, or covenant of Pharmacy as set forth in this Agreement.

8.3 Data Processing Limitations.

Pharmacy acknowledges that PBM or its designee will provide electronic claims/data processing services (hereinafter the "Data Processor"). PBM MAKES NO EXPRESS WARRANTIES AS TO SUCH DATA PROCESSING SERVICES, AND NO WARRANTIES ARE TO BE IMPLIED, INCLUDING, BUT NOT LIMITED TO, IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE. IN NO EVENT SHALL PBM, ITS SUBSIDIARIES OR AFFILIATES, OR ITS SUBCONTRACTORS, HAVE ANY LIABILITY WHATSOEVER TO PHARMACY ARISING OUT OF OR IN CONNECTION WITH SUPPLYING OR FAILING TO SUPPLY THE DATA PROCESSING SERVICES. Pharmacy acknowledges that Data Processor has expended substantial sums in creating and obtaining rights in the applications software programs used in the Pharmacy Program(s) (the "System") and has substantial proprietary interest and valuable trade secrets therein. At no time during the term of this Agreement or thereafter may Pharmacy assign, sell, license, let, duplicate, transfer, pledge or hypothecate the System or any portion thereof. Pharmacy shall utilize reasonable security controls to protect the System which are no less stringent than those Pharmacy uses to protect its own proprietary rights. Pharmacy agrees that all data submitted to the Data Processor for processing and all output provided by the Data Processor shall be delivered and transported to and from Pharmacy at its sole risk, cost and expense. Ownership rights to all data and information submitted to Data Processor or PBM in connection with this Agreement shall vest in the PBM.

8.4 Limitation of Liability.

Notwithstanding any other term of this Agreement, in no event shall PBM be liable to Pharmacy for special, indirect, incidental, exemplary, consequential (including but not limited to loss of profits) or punitive damages arising from the relationship of the parties or the conduct of business under this Agreement (even if PBM has been advised of or has foreseen the possibility of such damages).

ARTICLE 9 CONFIDENTIAL AND PROPRIETARY RIGHTS

9.1 Covered Individual Records.

Pharmacy and PBM agree that all Covered Individual records shall be treated as confidential so as to comply with all Laws regarding the confidentiality of Covered Individual records and/or is prudent in accordance with applicable industry standards. Pharmacy agrees never to provide Covered Individuals' information to others for Pharmacy's pecuniary gain. Nothing herein is meant, however, or shall be construed, to limit the rights of PBM, or the rights of governmental authorities, to inspect and copy any accounting, administrative, or Covered Individual records maintained by Pharmacy pursuant to Article 7 of this Agreement.

9.2 Confidential and Proprietary Information.

Pharmacy agrees that all terms contained herein and within any other Agreement between PBM and Pharmacy, and all pricing, programs, services, business practices, and procedures of PBM are confidential and/or proprietary. Pharmacy agrees to maintain the confidential nature of such materials and not to disclose the terms and conditions contained herein or contained in any other Agreement with PBM or any pricing, programs, services, business practices, or procedures of PBM, without the express written consent of PBM, unless such information is already publicly available due to no fault of Pharmacy.

9.3 Remedies.

Pharmacy shall promptly notify PBM if it becomes aware of any use of confidential information or data that is not authorized by PBM. Pharmacy acknowledges and agrees that any unauthorized disclosure or use of confidential and/or proprietary information or data obtained from or provided by PBM would cause PBM immediate and irreparable injury or loss that cannot be fully remedied by monetary damages. Accordingly, if Pharmacy fails to comply with this Article 9, PBM is entitled to seek and obtain injunctive relief, monetary remedies, and/or such other damages as available by Law against Pharmacy.

**ARTICLE 10
MARKETING, ADVERTISING, AND PUBLICITY**

10.1 Publish Pharmacy Information.

Pharmacy agrees to provide to PBM, and agrees that PBM may publish, Pharmacy's name, tax identification number or other provider identification number, address, telephone number, hours of operation and other similar descriptive information or information reasonably required for any advertisement, literature or publication produced for the marketing, administration and/or operation of a Pharmacy Program or Network. Pharmacy's use of the name or a symbol, trademark or service mark of PBM or its Affiliates or subsidiaries in any advertisement, literature, publication, pamphlet or sign Pharmacy uses, whether or not such use relates to Pharmacy's participation in the Pharmacy Program(s) or Network(s), shall be subject to the prior written consent of PBM. Notwithstanding such consent, nothing herein shall be deemed to grant Pharmacy any rights in such names, symbols, trademarks or service marks. Upon termination of this Agreement, Pharmacy agrees to immediately cease all such use.

10.2 Direct Marketing.

Pharmacy shall not directly market to or solicit Covered Individuals without written authorization from PBM and the applicable Payor. Such marketing and soliciting activities to Covered Individuals shall include without limitation direct marketing campaigns and solicitations via mail, telephone, internet or any other means available.

10.3 Public Comments.

PBM and Pharmacy agree that, in the event of conflict involving the terms of this Agreement or termination of this Agreement, both PBM and Pharmacy will refrain from publicly disparaging the other.

**ARTICLE 11
GOVERNING LAW AND DISPUTE RESOLUTION**

11.1 Choice of Law.

This Agreement shall be construed, interpreted, and governed by the Laws of the State of Michigan. The operation of a pharmacy or the professional practice of pharmacy shall in all respects be governed by the Laws of the State of Michigan.

11.2 Dispute Resolution.

In the event that any dispute, claim or controversy relating to this Agreement arises between Pharmacy and PBM, except for disputes deemed by PBM to be related to termination without cause of this Agreement, both agree to meet and make a good faith effort to resolve the dispute. If such efforts are unsuccessful, either party may commence arbitration by filing an arbitration demand with the American Arbitration Association ("AAA") or American Health Lawyers Association ("AHLA") within thirty (30) calendar days of the meeting. The dispute will be resolved through arbitration to be conducted in Wayne County, Michigan.

Any dispute subject to arbitration shall be settled by binding arbitration, strictly in accordance with this Agreement, except to the extent the dispute is required by Law to be resolved by a state or federal authority. The parties shall not have the right to participate as a member of any class of claimants pertaining to any dispute subject to arbitration hereunder, nor shall there be any authority for disputes arising hereunder to be arbitrated on a class

action basis. Arbitration shall be limited only to disputes arising between Pharmacy and PBM and cannot be consolidated or joined with claims of other persons who may have similar claims.

The Commercial Arbitration Rules of the AAA or AHLA, as applicable, shall be employed, using a three (3) member panel of arbitrators. Any dispute under \$500,000 shall be handled by expedited procedures under the AAA or AHLA. The panel shall consist of one (1) arbitrator selected by Pharmacy, one (1) arbitrator selected by PBM, and the third independent arbitrator shall be selected and agreed upon by the first two arbitrators. The parties may also use a single arbitrator, provided they mutually agree to do so and mutually agree on the choice of arbitrator. The decision of the arbitrator, if a single arbitrator is used, or the majority decision of the arbitrators, if a panel is used, shall be binding. The cost of any arbitration proceeding under this Section shall be shared equally by the parties to such dispute unless otherwise ordered by the arbitrator(s). Judgment upon the award rendered by the arbitrator(s) may be entered and enforced in any court of competent jurisdiction. In the event the dispute is required by Law to be resolved by a state or federal authority, PBM and Pharmacy agree to be bound by the findings of such state or federal authority.

11.3 Survival of Termination.

This Article 11 shall survive termination of this Agreement.

ARTICLE 12 TERM AND TERMINATION

12.1 Term.

This Agreement shall be effective as of the Effective Date appearing on the signature page hereof and shall continue in effect for a one (1) year term, and shall automatically renew for successive one-year terms unless either party provides written notice of non-renewal to the other party at least sixty (60) calendar days' prior to the end of the initial term or any renewal term.

12.2 Termination.

This entire Agreement may be terminated as follows:

(a) Automatic Termination.

This Agreement will terminate automatically without notice with respect to any individual pharmacy location operated by Pharmacy as of the date on which such individual pharmacy location fails to maintain appropriate licensure, registration, certification, good standing, or insurance, as required under this Agreement and/or Law.

(b) Immediate Termination Rights.

PBM may terminate this Agreement immediately upon written notice to Pharmacy in the event of:

- (i) Breach of any representation, warranty or covenant of Pharmacy in this Agreement;
- (ii) The transfer of ownership of any of Pharmacy's pharmacy locations to a new owner, or if the right to control any aspect of Pharmacy's operations is transferred to another person or entity;
- (iii) Pharmacy becomes insolvent, admits it is unable to pay its debts, an action is filed by or against Pharmacy under the Federal Bankruptcy Act or any other Law or act regarding insolvency, reorganization, arrangement, or extension for the relief of debtors, including any assignment for the benefit of creditors, the appointment of a receiver or trustee for transfer or sale of a material portion of Pharmacy's assets, or PBM's receipt of a writ of attachment, execution or garnishment;
- (iv) Pharmacy or Pharmacy's employees act in an illegal, unethical, unscrupulous or immoral manner which adversely impacts the reputation of PBM, its Affiliates, or Payors;
- (v) PBM has reason to believe in its sole discretion that the health or safety of a Covered Individual(s) may be in jeopardy; or
- (vi) Pharmacy engages in any fraudulent activity related to the terms of the Agreement.

(c) Event of Default.

Either Party may terminate this Agreement at any time for material breach by the other party by giving at least thirty (30) days' written notice to the other party, or such longer period as required by Law, which termination shall become effective at the end of such notice period if such breach is not cured to the satisfaction of the non-breaching party by such date.

(d) Pharmacy Termination Right.

Pharmacy may terminate this Agreement in accordance with Section 13.2 in the event Pharmacy objects to any amendment made under Section 13.2 of this Agreement.

(e) Pharmacy Program and/or Network Termination.

PBM may terminate Pharmacy from participating in any specific Network or Pharmacy Program, including but not limited to any Network or Pharmacy Program as it relates to a specific Plan or Payor, without cause upon a sixty (60) day written notice to Pharmacy (or such longer period as required by Law).

(f) Mutual Right of Termination Without Cause.

Either party may terminate this Agreement, without cause, provided one terminating party sends the other party written notice at least sixty (60) days prior to the effective date of termination.

12.3 Rights and Remedies in the Event of Termination or Breach.

In the event of termination or breach of this Agreement, in addition to all other rights and remedies PBM may have at Law, equity, or under this Agreement, PBM shall have the right, upon notice to Pharmacy, to: (i) deduct from any amounts owing to Pharmacy any amounts which Pharmacy owes PBM; (ii) impose reasonable investigation, collection, audit, and/or similar fees with respect to any breach of this Agreement; (iii) suspend performance of any and/or all of PBM's obligations under or in connection with this Agreement, including, without limitation, PBM's obligation to process claims; and/or (iv) suspend Pharmacy's performance of any and/or all of Pharmacy's obligations under or in connection with this Agreement.

In the event this Agreement is terminated, Pharmacy shall submit all Claims for Covered Services dispensed before the date of termination within five (5) calendar days after the date of termination. Any rights to payment for any Claim submitted after such time, whether or not the same would qualify as a Claim, shall be deemed forfeited, and Pharmacy agrees to hold PBM, Affiliates, their subsidiaries, subcontractors, Payors, and each of their respective employees, shareholders, members, officers and directors and the Covered Individual receiving the Covered Service harmless for any expense associated therewith.

Upon termination of this Agreement, Pharmacy shall return, at its expense, any Pharmacy Operations Manuals, decals, participation identification materials and other documents or materials supplied to Pharmacy by PBM in connection with this Agreement and/or any Pharmacy Program or Network, including all confidential and proprietary information of PBM.

Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. The termination rights hereunder are in addition to any and all other rights and remedies that may be available to PBM under this Agreement.

ARTICLE 13 GENERAL PROVISIONS

13.1 Entire Agreement.

This Agreement together with all attachments hereto or incorporated herein, contains the entire Agreement between PBM and Pharmacy, all of which are incorporated by referenced as if fully set forth herein and referred to collectively as the "Agreement". Any prior oral or written agreements, promises, negotiations, or representations concerning the subject matter covered by this Agreement are terminated and of no force and effect except that all existing pricing schedules, Pharmacy Program Conditions and/or Requirements, and addenda shall be incorporated into this Agreement, unless otherwise provided for in any attached Schedule to this Agreement. This Agreement will be effective and binding on the parties only if the duly authorized signatures of the parties are affixed hereto where indicated on the signature page.

13.2 Amendments/Modifications.

The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the parties to comply with State and Federal Law, and CMS, MDCH or OFIR Regulations.

13.3 Replacement Agreement.

From time to time, PBM may issue a replacement agreement which restates the provisions of this Agreement, together with any amendments, addenda, attachments, appendices, exhibits, and schedules. The replacement agreement shall not contain any new provisions. Pharmacy agrees to execute the replacement agreement without re-opening negotiations.

13.4 Assignment.

No part of this Agreement may be assigned by Pharmacy without PBM's prior written consent. Pharmacy acknowledges and agrees that PBM, without consent of the Pharmacy, may assign all or any part of this

Agreement and/or PBM's rights, privileges or duties under this Agreement to any direct or indirect parent, subsidiary, or Affiliate or to a successor company.

13.5 Third Party Agreements/Subcontractors.

PBM may subcontract all or any part of its obligations under this Agreement to a third party provided that such subcontractor agrees to perform the services as set forth herein. Pharmacy will be advised of such subcontracting relationships when necessary to enable Pharmacy to perform its duties under this Agreement.

13.6 Lawful Interpretation.

This Agreement will be interpreted and performed in compliance with all Laws. If this Agreement or any part hereof is found not to be in compliance with any Law, then the parties shall renegotiate the Agreement for the sole purpose of correcting the non-compliance.

13.7 Force Majeure.

The parties shall be excused, discharged, and released from performance under this Agreement to the extent that all or part of the Agreement cannot be performed due to causes which are outside the control of PBM and Pharmacy, and could not be avoided by the exercise of due care, including but not limited to acts of God, acts of a public enemy, acts of a sovereign nation or any state or political subdivision or any department or regulatory agency thereof or entity created thereby, acts of any person engaged in a subversive activity or sabotage, terrorist activity, fires, floods, earthquakes, explosions, strikes, slow-downs, lockouts or labor stoppage, freight embargoes, or by any enforceable Law. The foregoing shall not be considered to be a waiver of any continuing obligations under this Agreement, and as soon as conditions cease, the party affected thereby shall fulfill its obligations as set forth under this Agreement.

13.8 Severability.

In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

13.9 Waiver.

Neither the waiver by either of the parties of a breach or a default of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasions, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach or default of any of the provisions of this Agreement. A waiver by either party of strict compliance with the terms of this Agreement shall only be effective if in writing and signed by both parties hereto, and shall not be effective with respect to any prior or subsequent failure by either party to comply with any term of this Agreement.

13.10 Binding Effect.

Except as otherwise provided herein, this Agreement shall be binding upon and inure to the benefit of the parties, their agents, successors and permitted assigns unless otherwise set forth herein or agreed to in writing by the parties.

13.11 Notices.

Any notice required to be given pursuant to this Agreement shall be in writing, postage prepaid, and shall be sent via facsimile transmission or by United States first class mail or by certified or registered mail to the parties at the addresses indicated on the signature page of this Agreement (or such other addresses that the parties may hereafter designate); provided however that any notice of dispute or termination by Pharmacy must be sent by certified or registered mail to PBM at the address indicated on the signature page of this Agreement, with a copy sent by certified or registered mail to the following (or such other address designated by written notice of PBM):

MeridianRx, LLC
777 Woodward Avenue, Suite 600
Detroit, MI 48226
Attn: General Counsel

The notice shall be effective on the third business day after deposit in the U.S. Mail if sent by certified mail or on the date of electronic confirmation of facsimile receipt if sent by facsimile.

13.12 Headings.

The paragraph headings herein are for convenience purposes only and are not to be utilized in construction of the provisions of the Agreement.

13.13 Subcontractors.

The parties agree that the pharmacy, in performing pharmacy's duties and obligations hereunder, shall have the right, subject to the credentialing and re-credentialing requirements described in this Agreement, either to employ its own employees and agents or to utilize the services of persons, firms and other entities by means of sub-contractual relationships; provided, however, that no such subcontract shall operate to relieve pharmacy of its obligations hereunder.

13.14 Violation of Laws.

Notwithstanding any provision contained in this Agreement to the contrary, neither of the parties, nor any of their respective employees, agents, representatives, consultants or subcontractors shall be required to perform any act which would violate any Federal or State statute, law, regulatory agency rule or regulation, code, or canon of professional ethics.

**ARTICLE 14
PHARMACY SERVICES ADMINISTRATION ORGANIZATION OR AFFILIATION**

14.1 Applicability.

This Article 14 shall apply only when the entity executing this Agreement is a PSAO entering into this Agreement on behalf of one or more pharmacies.

14.2 PSAO Exhibit.

PSAO and Pharmacy agree to comply with and be bound by the provisions contained in Exhibit C attached hereto and incorporated herein by this reference.

In Witness Whereof, the parties hereto have executed and delivered this Agreement, the day and year first written below.

[NAME OF PHARMACY]

MERIDIANRX, LLC

By: _____
Signature

By: _____
Signature

Name

Name

Title

Title

Pharmacy Name

Effective Date

Pharmacy Address

City, State, Zip Code

Phone Number

Fax Number

Email Address

Date

EXHIBIT A

Credentialing Survey Application For Pharmacies

1.) General Information:

| | | | |
|---|---------------------|---------------|--|
| Legal Business Name | | | |
| Name | | | |
| Contact Last Name | | | |
| Contact First Name | | | |
| Pharmacist In Charge (PIC) | | PIC License # | |
| NCPDP Provider ID | | | |
| National Provider ID (NPI) | | | |
| Federal Tax ID Number | | | |
| DEA Registration ID | | Exp. Date | |
| State License Number | | Exp. Date | |
| Medicaid # (if applicable) | | | |
| Medicare Provider (Supplier) ID | | | |
| Pharmacy Insurance \$1M/\$3M gen liability & gen aggregate per occurrence | Amount of coverage: | Exp. Date | |
| Insurance Company Name | | Account # | |
| Last State Board Inspection | Date: | Grade: | |

2.) Payment Information (if different from NCPDP info):

| | |
|---------------------------------------|--|
| Remittance Contact Name | |
| Remittance Address 1 | |
| Remittance City, State Code, Zip Code | |
| Remittance Phone Number | |
| Remittance Fax Number | |
| Remittance Email Address | |

3.) Patient Services

a. Pharmacy Type – Please indicate the approximate amount of business you do in each of the following:

| Dispenser Type | Percent of Business | State Licensed | |
|----------------|---------------------|----------------|----|
| | | Yes | No |
| Retail | % | | |
| Mail Service | % | | |
| Long Term Care | % | | |
| Specialty | % | | |
| Compounding | % | | |
| IV Infusion | % | | |
| Internet | % | | |

b. Physical Location Provider Hours (if different from NCPDP info):

M-F _____ Sat. _____ Sun. _____

| Yes | No | |
|-----|----|--|
| | | Patient counseling? |
| | | Written literature about the prescription being dispensed? |
| | | Physical location compounding service? |
| | | Physical location delivery service? |
| | | Separate charge for delivery service? |
| | | Physical location language? |
| | | Physical location? |

c. Other Services Provided:

EXHIBIT B

Retail Pharmacy Services Compensation

Plan shall pay pharmacy the following reimbursement rate for each covered drug or covered service provided to a Member, less the Member out-of-pocket or copayment paid to pharmacy, if any, for the covered drug or service at the time of service:

Wholesale Acquisition Cost (WAC), Average Wholesale Price (AWP), and Federal Upper Limit (FUL) will be defined as being the price in the M-PBM data file as published by First Databank and/or Medispan database on the date of service.

Open Network

1-83 Day Supply Open Network

For each Brand or Generic pharmaceutical product dispensed at a retail pharmacy location for **1-83** days' supply, PBM will pay Pharmacy at the lesser of: the dispensing pharmacy's Usual and Customary Charge; FUL plus dispensing fee of \$X; AWP-X% plus a dispensing fee of \$X; MAC plus a dispensing fee of \$X; WAC +X% plus a dispensing fee of \$X; or the rates set forth in this section, reduced by any applicable Co-Payment fee receive.

84+ Day Supply Network

For each Brand or Generic pharmaceutical product dispensed at a mail order or retail pharmacy location for an **84** days' or more supply, PBM will pay Pharmacy at the lesser of: the dispensing pharmacy's Usual and Customary Charge; Federal Upper Limit (FUL) plus dispensing fee of \$X; AWP-X% plus dispensing fee of \$X; WAC -X% plus dispensing fee of \$X, MAC plus dispensing fee of \$X, or the rates set forth in this section, reduced by any applicable Co-Payment fee received.

Preferred Network (Minus one large national retail chain or PSAO with 2,500+ locations)

1-83 Day Supply Preferred Network

For each Brand or Generic pharmaceutical product dispensed at a retail pharmacy location for **1-83** days' supply, PBM will pay Pharmacy at the lesser of: the dispensing pharmacy's Usual and Customary Charge; FUL plus dispensing fee of \$X; AWP-X% plus dispensing fee of \$X; WAC -X% plus dispensing fee of \$X, MAC plus dispensing fee of \$X or (iii) the rates set forth in this section, reduced by any applicable Co-Payment fee received.

84+ Day Supply Preferred Network

For each Brand or Generic pharmaceutical product dispensed at a mail order or retail pharmacy location for an **84** days' or more supply, PBM will pay Pharmacy at the lesser of: the dispensing pharmacy's Usual and Customary Charge; Federal Upper Limit (FUL); AWP-X%; MAC or the rates set forth in this section, reduced by any applicable Co-Payment fee received.

MEDICARE PART D VACCINES ADMINISTRATION FEE:

Pharmacy will be reimbursed \$X for the administration of vaccines.

EXHIBIT C

PHARMACY SERVICES ADMINISTRATION ORGANIZATION OR AFFILIATION AGREEMENT

By executing the Agreement, PSAO agrees as follows:

1. Requirements for participation as a Pharmacy Services Administrative Organization.

PSAO must have a chain headquarters established.

Chain headquarters must handle all communications to the pharmacy from the PBM.

Chain headquarters must have a help desk for pharmacies to call for assistance with on-line claims processing.

Chain headquarters must be able to assist pharmacy with payment issues.

Chain headquarters must have a signed contract with the pharmacy enrolled with their PSAO that confirms the pharmacy agrees to the terms and conditions of the PBM contract..

All pharmacies enrolled with the chain must agree to participate in all applicable PBM Networks.

Pharmacy must agree to remain with current PSAO for no less than one month in our database.

Updates will be done only once a month in accordance with the affiliation reported by NCPDP.

All pharmacies must accept the PSAO rate.

2. PSAO Representation of Pharmacies.

By signing the Agreement, PSAO is entering into the Agreement on its own behalf and on behalf of the Pharmacies. PSAO represents and warrants that it has authority to enter into the Agreement on its own behalf and on behalf of the Pharmacies and, for the term of the Agreement and any renewals thereof, shall continue to possess the authority to individually bind each Pharmacy to the terms of the Agreement and any addenda or amendments thereto. Pharmacies shall be deemed to have accepted all terms and conditions of the Agreement. PSAO shall promptly provide to PBM upon PBM's written request evidence of such authority.

3. PSAO Payments (Please check one).

Check the appropriate box below:

By checking this box, PSAO instructs PBM to send all amounts due and owing to Pharmacies under the Agreement to PSAO. PSAO represents and warrants that it has authority to collect any payments due under the Agreement on behalf of the Pharmacies and, for the term of the Agreement and any renewals thereof, shall continue to possess the authority to collect such payments on behalf of the Pharmacies. Based upon such representation, warranty, and instruction, PBM shall send one check to PSAO for all amounts due and owing to all Pharmacies under the Agreement, less any deductions or setoffs authorized under the Agreement.

By checking this box, PSAO instructs PBM to send all amounts due and owing under the Agreement directly to the Participating Pharmacy, less any deductions or setoffs authorized under the Agreement.

If PSAO fails to check either box above or checks both boxes above, Box 1 will be deemed checked, and Pharmacy payments due under the Agreement will be sent to PSAO.

4. Pharmacy Notification.

PSAO shall develop, implement and maintain efficient and accurate procedures for notifying Pharmacies of the Pharmacies' obligations under the Agreement and any amendments or addenda thereto.

5. Indemnification.

PSAO shall indemnify PBM, Affiliates, Payors, and their respective shareholders, officers, directors, employees, and agents, and their successors, representatives, and assigns thereof, and hold them harmless for, from, and against, any and all liability, loss, damage, settlement, claim, injury, demand, judgment, and expense, including attorneys' fees, arising directly or indirectly from: (a) PBM's response to subpoenas or other requests for PSAO or Pharmacy information, (b) failure of PSAO to act in accordance with its agreement with Pharmacy(ies), (c) any dispute between PSAO and Pharmacy(ies), and/or (d) any delay or failure by PSAO to pay Pharmacy(ies) upon receipt of payment from PBM.

**Medicare Part D Addendum
To Pharmacy Network Agreement**

This Medicare Part D Addendum (“Addendum”), by and between MeridianRx, LLC (“PBM”) and the undersigned _____ (“Member Pharmacy”) is effective as of the date below, when signed and executed by both parties.

Whereas, PBM and Member Pharmacy have entered into that certain Pharmacy Agreement, under which PBM maintains networks of pharmacies in which Member Pharmacy participates and provides pharmacy services (the “Agreement”);

Whereas, PBM provides pharmaceutical benefit management services to certain Part D plan sponsors that have or become approved by the Centers for Medicare and Medicaid Services (“CMS”) as a Part D plan sponsor authorized to offer a Medicare Part D plan in connection with the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the “Act”);

Whereas, certain provisions are required to be included in provider agreements with respect to Medicare Part D plans; and

Whereas, PBM and Member Pharmacy desire to amend the Agreement as set forth in this Addendum with respect to Medicare Part D plans.

Now, therefore, PBM and Member Pharmacy agree as follows:

1. **Defined Terms.** The capitalized terms used in this Addendum shall have the meanings stated herein or in the Agreement. Otherwise terms used in this Addendum shall have the meanings stated in the Medicare Prescription Drug Benefit Plan Final Rules contained in 42 CFR Parts 422 and 423 (“PDP Final Rules”).
2. **Network Participation.** Member Pharmacy desires to participate in the Medicare Part D network and provide pharmacy services to Medicare Part D plans’ members in accordance with the terms and conditions of the Agreement and this Addendum.
3. **Regulatory Provisions.** The Medicare Part D Regulatory Provisions Appendix, attached hereto as Appendix 1, is incorporated into this Addendum by reference and sets forth the regulatory requirements applicable to PBM, Member Pharmacy, and Part D plan sponsors in connection with providing services to Medicare Part D plans under the Agreement. The parties shall comply with all provisions set forth in Appendix 1. It is the understanding of the parties that each provision in Appendix 1 is required by CMS to be included herein. The parties agree that any provision not required by CMS to be included herein shall not be binding on PBM. To the extent that the provisions of Appendix 1 conflict with any other provisions of the Agreement, the provisions of Appendix 1 shall supersede the conflicting provisions of the Agreement. All references to Addendum shall include the Addendum and Appendix 1.
4. **90 Day Supply.** Eligible Persons are permitted to receive benefits, which may include up to a ninety (90) day supply of covered Part D drugs, at any network pharmacies that have agreed to a ninety (90) day supply rate, when the Part D plan sponsor allows for up to a ninety (90) day supply at mail order. Retail pharmacies may dispense the 90-day supply at the ninety (90) day supply rates contracted with Member Pharmacy.

PHARMACY COMPLIANCE CERTIFICATION: By signing below, Member Pharmacy certifies that: (1) during the past twelve (12) months Member Pharmacy has reviewed the OIG and GSA exclusion lists and no Member Pharmacy or Covered Individual has been or is excluded from participation in government funded health care programs; (2) during the past twelve (12) months, all Covered Individuals have participated in fraud, waste, and abuse training as required by CMS in connection with 42 CFR Section 423.504(b)(vi); and (3) all managers, officers, and directors of Member Pharmacy who are responsible for the administration or delivery of Part D benefits are free from any conflict of interest in administering or delivering Part D benefits. Member Pharmacy acknowledges that this is a continuing certification and agrees to promptly notify PBM in writing if the foregoing certification becomes inaccurate.

This Addendum and the Agreement contain the entire agreement between Member Pharmacy and PBM relating to the subject matter hereof. Any prior agreements, promises, negotiations, or representations concerning the subject matter of this Addendum are of no force and effect. This Addendum and the Agreement are referred to

collectively as the "Agreement". Except as specifically amended hereby, all provisions of the Agreement shall remain in full force and effect. From time to time, PBM may amend the Agreement by giving thirty (30) days advance written notice to Member Pharmacy of the terms of the amendment. Member Pharmacy may object to such amendment by notifying PBM in writing of its objection within thirty (30) days of receiving the notice of amendment. In the event Member Pharmacy objects to any such amendment, PBM may terminate Member Pharmacy's Agreement or participation with respect to the applicable network or plan sponsor.

No alterations to this Addendum shall be binding on PBM unless initialed by duly authorized representatives of PBM. Member Pharmacy and PBM have caused this Addendum to be executed by their respective officers or representatives duly authorized to do so.

By checking the appropriate box(es) below, Member Pharmacy attests that is participating under this Addendum as one or more of the following (as designated):

- Retail Pharmacy
- Mail Order Pharmacy
- Home Infusion Pharmacy
- Long-Term Care Pharmacy
- Indian Health Services (IHS) and any pharmacy or dispensary operated by IHS
- Indian Tribe that operates a health program, including one or more pharmacies or dispensaries, under a contract or compact with IHS issued pursuant to the Indian Self-Determination and Education Assistance Act, 25 USC 450 *et seq.*
- Tribal Organization authorized by one or more Indian tribes to operates a health program, including one or more pharmacies or dispensaries, under a contract or compact with IHS issued pursuant to the Indian Self-Determination and Education Assistance Act, 25 USC 450 *et seq.*
- Urban Indian Organization that operates a health program, including one or more pharmacies or dispensaries, under a grant from IHS issued pursuant to Title V of the Indian Health Care Improvement Act

In Witness Whereof, the parties hereto have executed and delivered this Addendum, the day and year first written below.

[NAME OF PHARMACY]

MERIDIANRX, LLC

By: _____
Signature

By: _____
Signature

Name

Name

Title

Title

Date

Effective Date

APPENDIX 1
MEDICARE PART D REGULATORY PROVISIONS

Notwithstanding any other provision of the Agreement or the Addendum, Member Pharmacy agrees, and will require any of its downstream and related entities to agree substantially in the form hereto, to the following provisions:

1. Member Pharmacy acknowledges and agrees that claims data and information provided in connection with this Addendum is used for purposes of obtaining Federal funds. Member Pharmacy agrees that it is bound by 2 CFR Part 376 (previously 45 CFR Part 76). Member Pharmacy represents and warrants that it has not been excluded from participation in federal or state health care programs, is not the subject of any pending exclusion proceeding, and has not been adjudicated or determined to have committed any action that could subject Member Pharmacy to exclusion from a government program. Member Pharmacy shall notify PBM promptly upon receipt of notice of (a) exclusion or proposed exclusion from a state or federal health care program, or (b) adjudication or other determination that Member Pharmacy has committed any action which could lead to exclusion from a government program. Member Pharmacy shall review the OIG and GSA exclusion lists upon hire of any employee, contractor, or agent that will be providing services to PBM directly or indirectly ("Covered Individual"), and periodically thereafter (in all events no less than annually), to ensure that all Covered Individuals are not excluded from government funded health care programs. Member Pharmacy shall provide PBM with a certification or attestation by an officer or director of Member Pharmacy of compliance with this section upon PBM's request. Member Pharmacy shall notify PBM immediately upon receipt of any information indicating that Member Pharmacy or a Covered Individual has been charged with a crime relating to healthcare or is facing a proposed debarment, exclusion, or other adverse action, in which case, Member Pharmacy shall immediately remove any such Covered Individual(s) from direct responsibility for, or involvement in, services provided to PBM related to government health care programs, and will take appropriate corrective actions. This Section shall refer to and include members of Member Pharmacy's board of directors and any key management, executive staff, or any major stockholder.
2. In accordance with 42 CFR 423.505(k)(3), Member Pharmacy agrees to certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the claims data related to payment. Member Pharmacy shall not submit to PBM Medicare Part B claims under this Medicare Part D Addendum.
3. In accordance with 42 CFR 423.505(i)(1), 42 CFR 423.562(a)(4), and 42 CFR 422.504(i)(1), notwithstanding anything to the contrary agreed to by the parties, Part D plan sponsor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Part D contract with CMS and for ensuring that Member Pharmacy satisfies its obligations under Part D plan sponsor's Medicare Part D plan.
4. In accordance with 42 CFR 423.505(e)(2), 42 CFR 423.505(i)(2), 42 CFR 422.504(e)(2), 42 CFR 422.504(i)(2)(ii), HHS, the Comptroller General, or their designees have direct access to (e.g., on site access) and the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records, including medical records, of Member Pharmacy involving transactions related to Part D plan sponsor's contract with CMS or that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Part D plan sponsor's contract with CMS. HHS, the Comptroller General, and their designees shall have direct access (e.g., on site access) to Member Pharmacy, and Member Pharmacy will make such books and records directly available to HHS, the Comptroller General or their designee for such inspection, evaluation, and audit. This right exists through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. If Member Pharmacy receives a court order, subpoena, or governmental request relating to PBM and/or the services provided hereunder, Member Pharmacy shall provide PBM with prompt written notice of such order, subpoena, or request, and upon PBM's request shall provide PBM with copies of any pertinent contracts, books, documents, papers, and records, related to PBM and/or the services provided hereunder that are provided in response to such order, subpoena, or request.
5. In accordance with 42 CFR 423.505(g)(1), 42 CFR 423.505(i)(3)(i), and 42 CFR 422.504(g)(1)(i), Member Pharmacy shall not hold any Eligible Person liable for payment of any fees that are the legal obligation of Part D plan sponsor.
6. In accordance with 42 CFR 423.505(i)(3)(ii) and (i)(4)(ii) and 42 CFR 422.504(i)(3)(ii) and (i)(4)(ii), in the event CMS or Part D plan sponsor determines that a Member Pharmacy has not performed satisfactorily under this Addendum, the delegated activities and reporting responsibilities of the Member Pharmacy may be revoked.

7. In accordance with 42 CFR 423.505(i)(3)(ii) and (i)(4)(iii) and 42 CFR 422.504(i)(3)(ii) and (i)(4)(iii), Part D plan sponsor will establish and maintain ongoing monitoring and oversight of all aspects of Member Pharmacy's performance of its obligations in connection with Part D plan sponsor's Medicare Part D plan. Member Pharmacy agrees to cooperate with any such monitoring oversight by Part D plan sponsors.

8. In accordance with 42 CFR 423.505(i)(3)(ii) and (i)(4)(iv) and 42 CFR 422.504(i)(3)(ii) and (i)(4)(v), Member Pharmacy shall comply with all applicable Federal and State laws, regulations, and CMS instructions.

9. Member Pharmacy agrees to participate in Part D plan sponsor's Medicare Part D plan under the terms and conditions agreed to by the parties in the Agreement and this Addendum. Any such services or other activity performed by Member Pharmacy in connection with Part D plan sponsor's Medicare Part D plan shall be consistent and comply with Part D plan sponsor's contract with CMS as required by 42 CFR 423.505(i)(3)(iii) and 42 CFR 422.504(i)(3)(iii).

10. In accordance with 42 CFR 423.159 and 42 CFR 423.505(b)(6), Member Pharmacy will support and comply with electronic prescription standards developed by CMS once final standards are effective with respect to Eligible Persons. In addition, Member Pharmacy will utilize NCPDP 5.1 Field 419 DJ – Prescription Origin Code so that the source of origin for prescriptions filled can be identified and reported.

11. In accordance with 42 CFR 423.505(d) and 42 CFR 422.504(d), Member Pharmacy agrees to maintain for ten (10) years, books, records, and documents related to the performance of its obligations with respect to Part D plan sponsor's Medicare Part D plan.

12. Member Pharmacy agrees to comply with all applicable State and Federal privacy and security requirements, including the requirements of 42 CFR 423.136, 42 CFR 423.505(b)(14), 42 CFR 422.504(a)(13), and 42 CFR 422.118, which require that for any medical records or other health and enrollment information Member Pharmacy maintains with respect to Eligible Persons, Member Pharmacy will do the following:

a. Abide by all applicable Federal and State laws regarding confidentiality and disclosure of medical records or other health and enrollment information of Eligible Persons. With respect to information that identifies a particular Eligible Person, Member Pharmacy will have procedures that specify: (1) for what purpose the information is used within the organization; and (2) to whom and for what purposes it discloses the information outside the organization;

b. Ensure that medical information is released only in accordance with applicable Federal or State law or under court orders or subpoenas;

c. Maintain the records and information in an accurate and timely manner; and

d. Ensure timely access by Eligible Persons to the records and information that pertain to them.

13. Member Pharmacy must submit claims in real time by means of point of service claims adjudication systems in compliance with CMS standards (except when necessary to provide access in underserved areas, I/T/U pharmacies and long-term care pharmacies). 42 CFR 423.505(b)(17).

14. Member Pharmacy may not distribute printed information comparing the benefits of different Part D plans unless Member Pharmacy accepts and displays materials from all Part D plan sponsors. 42 CFR 423.50(f)(1)(v).

15. Member Pharmacy must provide the negotiated prices to Eligible Person even if no benefits are payable to the Eligible Person for covered Part D drugs because of the application of any deductible or 100 percent coinsurance requirement following satisfaction of any initial coverage limit. 42 CFR 423.104(g)(1).

16. Member Pharmacy must inform an Eligible Person of any differential between the price of the dispensed drug and the price of the lowest priced generic version of that drug that is therapeutically equivalent and bioequivalent and available at the pharmacy, unless the particular drug being purchased is the lowest-priced therapeutically equivalent and bioequivalent version of that drug available at the pharmacy. Member Pharmacy must provide this notice after the drug is dispensed at the point of sale or, in the case of dispensing by mail order, at the time of delivery of the drug. Long-term care pharmacies must provide this notice by providing such information to Part D plan sponsor for inclusion in written explanation of benefits provided to Eligible Persons. The notice requirement in this Section does not apply to I/T/U pharmacies or pharmacies located in any of the U.S. territories. 42 CFR 423.132(a) and (b).

17. Member Pharmacy must charge/apply the correct cost-sharing amount to the Eligible Person as indicated via the on-line claims adjudication system, including that which applies to Eligible Persons qualifying for the low-income subsidy.
18. Member Pharmacy must comply with minimum standards for pharmacy practice as established by the states. 42 CFR 423.153(c)(1).
19. Member Pharmacy must review DUR messages as they are received via the online claims adjudication system and use professional judgment as to whether action is required. 42 CFR 423.153(c)(2).
20. Member Pharmacy must implement a method for maintaining up-to-date Eligible Person information, such as, but not limited to, Eligible Person demographic information and Eligible Person allergy information (drug and food).
21. Member Pharmacy must post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist as required by CMS. 42 CFR 423.562(a)(3).
22. Member Pharmacy agrees that Part D plan sponsor has the right to approve, suspend, or terminate any arrangement with a pharmacy. 42 CFR 423.505(i)(5).
23. Member Pharmacy must offer patient counseling to Eligible Persons when appropriate and must provide information regarding treatment options in a culturally-competent manner, including the option of no treatment. Member Pharmacy must ensure that Eligible Persons with disabilities have effective communications in making decisions regarding treatment options. 42 CFR 206(a)(2).
24. Notwithstanding anything to the contrary herein, Member Pharmacy does not indemnify Part D plan sponsor against any civil liability for damage caused to an Eligible Person as a result of Part D plan sponsor's denial of medically necessary care. 42 CFR 422.212.
25. In no event does Part D plan sponsor or PBM prohibit or otherwise restrict Member Pharmacy, acting within the lawful scope of practice, from advising or advocating on behalf of an Eligible Person about the Eligible Person's health status, medical care, treatment options, risks, benefits, consequences of treatment or non-treatment, or the opportunity to refuse treatment. 42 CFR 422.206.
26. With respect to Medicare Advantage Part D plans, PBM will pay clean claims submitted by Member Pharmacy on behalf of Eligible Persons within 14 days for electronic claims and within 30 days for claims submitted otherwise. If Member Pharmacy is a mail-order pharmacy, Member Pharmacy agrees as follows:
 - a. Member Pharmacy's mail order processing will meet three (3) business days turnaround time from the point of receipt of prescription for in-stock items with no intervention to the point of shipment.
 - b. Member Pharmacy's mail order processing will meet five (5) business days turnaround time from the point of receipt of prescription for in-stock items with intervention to the point of shipment.
27. If Member Pharmacy is a long-term care ("LTC") pharmacy, Member Pharmacy agrees as follows:
 - a. Comprehensive Inventory and Inventory Capacity: Member Pharmacy will provide a comprehensive inventory of plan formulary drugs commonly used in the long term care setting. In addition, Member Pharmacy will provide a secured area for physical storage of drugs, with necessary added security as required by Federal and State law for controlled substances.
 - b. Pharmacy Operations and Prescription Orders: Member Pharmacy will provide services of a dispensing pharmacist to meet the requirements of pharmacy practice for dispensing prescription drugs to LTC residents, including but not limited to the performance of drug utilization review. In addition, Member Pharmacy pharmacists will conduct DUR to routinely screen for allergies and drug interactions, to identify potential adverse drug reactions, to identify inappropriate drug usage in the LTC population, and to promote cost effective therapy in the LTC setting. Member Pharmacy also will be equipped with, and utilize, pharmacy software and systems sufficient to meet the needs of prescription drug ordering and distribution to an LTC facility. Further, Member Pharmacy will provide written copies of Member Pharmacy's procedures manual to PBM upon request and Member Pharmacy will make such manuals available at each LTC facility nurses' unit. Member Pharmacy will provide ongoing in-service training to assure that LTC facility staff is proficient in Member Pharmacy's processes for ordering and

receiving of medications. Member Pharmacy is responsible for return and/or disposal of unused medications following discontinuance, transfer, discharge, or death as permitted by applicable State Boards of Pharmacy. Member Pharmacy will dispose of controlled substances and out of date substances in accordance with State and Federal guidelines.

c. Special Packaging: Member Pharmacy will have the capacity to provide specific drugs in unit of use packaging, bingo cards, cassettes, unit dose, or other special packaging commonly required by LTC facilities. Member Pharmacy agrees to have access to, or arrangements with, a vendor to furnish supplies and equipment including but not limited to labels, auxiliary labels, and packing machines for furnishing drugs in such special packaging required by the LTC setting.

d. IV Medications: Member Pharmacy will have the capacity to provide IV medications to the LTC resident Eligible Member as ordered by a qualified medical professional. Member Pharmacy agrees to have access to specialized facilities for the preparation of IV prescriptions (clean room). Additionally, Member Pharmacy agrees to have access to or arrangements with a vendor to furnish special equipment and supplies as well as IV trained pharmacists and technicians as required to safely provide IV medications to Eligible Members.

e. Compounding/Alternative Forms of Drug Composition: Member Pharmacy will be capable of providing specialized drug delivery formulations as required for some LTC resident Eligible Members. Specifically, Eligible Member residents unable to swallow or ingest medications through normal routes may require tablets split or crushed or provided in suspensions or gel forms, to facilitate effective drug delivery by Member Pharmacy.

f. Pharmacist On-Call Service: Member Pharmacy will provide on-call, 24 hours a day, 7 days a week service with a qualified pharmacist available for handling calls after hours and to provide medication dispensing available for emergencies, holidays, and after hours of normal operations.

g. Delivery Service: Member Pharmacy will provide for delivery of medications to the LTC facility up to seven (7) days each week (up to three (3) times per day) and in-between regularly scheduled visits. Member Pharmacy agrees emergency delivery service will be available 24 hours a day, 7 days a week. Specific delivery arrangements will be determined through an agreement between the Member Pharmacy and the LTC facility. Member Pharmacy will provide safe and secure exchange systems for delivery of medication to the LTC facility. In addition, Member Pharmacy will provide medication cassettes, or other standard delivery systems, that may be exchanged on a routine basis for automatic restocking. Member Pharmacy agrees that the delivery of medication to carts is a part of routine "dispensing".

h. Emergency Boxes: Member Pharmacy will provide "emergency" supply of medications as required by the LTC facility in compliance with State requirements.

i. Emergency Log Books: Member Pharmacy will provide a system for logging and charging medications used from emergency/first dose stock. Further, Member Pharmacy will maintain a comprehensive record of a resident's medication order and drug administration.

j. Miscellaneous Reports, Forms, and Prescription Ordering Supplies: Member Pharmacy will provide reports, forms, and prescription ordering supplies necessary for the delivery of quality pharmacy care in the LTC setting. Such reports, forms, and prescription ordering supplies may including, but will not necessarily be limited to, provider order forms, monthly management reports to assist the LTC facility in managing orders, medication administration records, treatment administration records, interim order forms for new prescription orders, and boxes/folders for order storage and reconciliation in the LTC facility.

k. Rebate Reporting: Member Pharmacy shall fully and accurately report to PBM, any and all discounts and rebate arrangements with or any other direct or indirect remuneration from, drug manufacturers or other parties when such remuneration is designed to or likely to directly or indirectly influence or impact utilization of Part D drugs. This disclosure must identify the source of the funds, the purpose, the specific dollar amounts paid to Member Pharmacy from the manufacturer for these purposes, and any other information required by CMS, or reasonably required by PBM. Member Pharmacy shall indemnify, defend and hold harmless PBM and each Part D Plan Sponsor for any failure to make the disclosure required in this Section. Member Pharmacy acknowledges and agrees that this information will be reported by PBM to the Part D Plan Sponsor and may be reported by the Part D Plan Sponsor to CMS or as otherwise required by CMS. Member Pharmacy agrees to make the required reporting to PBM at least thirty (30) days prior to the date such information is due to CMS for the current contract year. Member Pharmacy shall comply with all rules, regulations, and guidance issued by CMS or other entity with authority over the Medicare Part D Program, as such may be amended from time to time, regarding the

availability, treatment, and reporting of remuneration identified in this Section, including but not limited to CMS Call Letters, the Medicare Part D Reporting Requirements, and the NCPDP Long-Term Care (LTC) Rebate Reporting Guide for Medicare Part which can be found at http://ncpdp.org/frame_news_feds.htm. Member Pharmacy further agrees to comply with all applicable laws, rules, and CMS guidance regarding the contracting for and collection of these amounts from pharmaceutical manufacturers and/or long term care pharmacies. Member Pharmacy acknowledges and agrees that PBM may withhold any amounts otherwise owed to Member Pharmacy, including claim reimbursement amounts, in the event Member Pharmacy fails to make any required reporting or disclosure, or provides incorrect or insufficient reporting or disclosures.

28. For the Indian Health Service (IHS) and all pharmacies and dispensaries operated by the IHS, Indian tribes, tribal organizations, and urban Indian organizations which operate one or more pharmacies or dispensaries, the parties agree to be bound by the provisions contained in the Indian Health Addendum attached hereto as Appendix 1-A (Revised), which is incorporated herein by this reference. To the extent that any provision of the Agreement or the Addendum or any other addendum thereto is inconsistent with any provision of Appendix 1-A (Revised), the provisions of Appendix 1-A shall supersede all such other provisions.

29. Member Pharmacy is not required to accept insurance risk as a condition of participation under this Addendum.

30. Member Pharmacy shall track medication errors, take corrective action with respect to such errors, and provide a report of such to PBM or the applicable Medicare Part D plan sponsor with respect to Eligible Persons under this Addendum. 42 CFR 423.153(c)(4).

31. Member Pharmacy shall comply with Medicare Coordination of Benefits (COB) on-line process consistent with industry standards.

32. If Member Pharmacy is a home infusion therapy ("HIT") pharmacy, Member Pharmacy agrees as follows:

a. Member Pharmacy agrees that it will deliver home infused drugs in a form that can be administered in a clinically appropriate fashion in the Eligible Person's place of residence.

b. Member Pharmacy agrees that it is capable of providing infusible Part D drugs for both short term acute care (e.g. IV antibiotics) and long term chronic care (e.g. alpha protease inhibitor) therapies.

c. Member Pharmacy agrees that it will ensure that the professional services and ancillary supplies necessary for home infusion are in place before dispensing home infusion drugs to the Eligible Person in his/her place of residence.

d. Member Pharmacy agrees to provide delivery of home infusion drugs within 24 hours of discharge from an acute setting, or later if so prescribed.

33. No Zero Balance Logic. Notwithstanding anything in the Agreement, the Part D Addendum, or an Authorization to Participate Form to the contrary, effective January 1, 2009, zero balance logic shall not apply, and Eligible Persons shall be charged the lesser of the contract rate (i.e., lesser of U&C or AWP/MAC plus dispensing fee) or the applicable copayment.

34. Compliance Program/Code of Conduct. PBM encourages Member Pharmacy to have its own compliance program that satisfies CMS' requirements (see Medicare Part D Prescription Drug Benefit Manual, Chapter 9). PBM expects and requires Member Pharmacy and its Covered Individuals to act in an ethical and compliant manner, including compliance with PBM's Code of Conduct and any applicable fraud, waste and abuse policies. Member Pharmacy acknowledges and agrees that PBM has provided or made available to Member Pharmacy a copy of PBM's Code of Conduct and applicable fraud, waste and abuse policies, which may be updated by PBM in its sole discretion from time to time, with such updates shall either be provided to or made available to Member Pharmacy by PBM. Member Pharmacy shall promptly report to PBM's Compliance Officer, compliance hot line, or other PBM designated compliance reporting mechanism compliance concerns and suspected or actual violations of law or policy related to the services provided to PBM.

35. Training. On an annual basis, Member Pharmacy shall have all Covered Individuals participate in fraud, waste, and abuse training in connection with 42 C.F.R. Section 423.504(b)(vi). Member Pharmacy shall institute its own training or attend other training that satisfies CMS' requirements. Member Pharmacy shall provide PBM

with a certification or attestation by an officer or director of Member Pharmacy of compliance with this section upon PBM's request.

36. **Effective Lines of Communication.** Member Pharmacy shall have effective lines of communication with PBM related to detecting, correcting, and preventing fraud, waste, and abuse in accordance with 42 C.F.R. Section 423.504(b)(vi) and 422.503(b)(4)(vi).

37. **Conflicts of Interest.** Member Pharmacy shall require its managers, officers, and directors responsible for the administration or delivery of Part D benefits to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer, or director is free from any conflict of interest in administering or delivering Part D benefits. Member Pharmacy shall provide PBM with a certification or attestation by an officer or director of Member Pharmacy of compliance with this section upon PBM's request.

38. **Termination.** In addition to the termination rights in the Agreement, this Medicare Part D Addendum may be terminated by PBM immediately upon notice in the event: (a) Member Pharmacy has been excluded from participation in a state or federal health care program or has been adjudicated or determined to have committed an action which could subject it to mandatory exclusion; (b) Member Pharmacy fails to report pending government action or related information as required hereunder; (c) Member Pharmacy violates the Code of Conduct, applicable fraud, waste, and abuse policies, and/or applicable statutory or regulatory requirements; (d) Member Pharmacy fails to obtain or maintain required training hereunder; or (e) Member Pharmacy fails to provide the required certifications specified herein or otherwise required by law.

39. **Presentation of ID Card; Claim Submission.** Pursuant to 42 C.F.R. § 120(c)(3), Member Pharmacy must submit a claim to the PBM whenever the Enrollee's Membership ID card is presented to or on file with the Member Pharmacy unless the Enrollee expressly requests that a particular claim not be submitted.

40. **Appropriate Dispensing of Prescription Drugs in Long-Term Care Facilities.**

If the Member Pharmacy is a long-term care pharmacy or services long-term care facilities, Member Pharmacy agrees to comply with the provisions of 42 C.F.R. § 423.154, including the updated version effective 1/1/2013. Member Pharmacy must:

1. Dispense solid oral doses of brand-name drugs, as defined in 42 C.F.R. § 423.4, to enrollees in long-term care facilities in no greater than 14-day increments at a time;
2. Collect and report information, in a form and manner specified by CMS, on the dispensing methodology used for each dispensing event described by Subsection 1, above, and on the nature and quantity of unused brand and generic drugs, as defined in 42 C.F.R. § 423.4, dispensed by the pharmacy to enrollees residing in a long-term care facility.
3. Member Pharmacy shall not have to comply with the above sections if the drugs are solid oral doses of antibiotics, or solid oral doses that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist patients with compliance (for example, oral contraceptives).
4. The requirements of Sections 1 and 2 are waived if the Member Pharmacy services intermediate care facilities for the mentally retarded (ICFs/MR) and institutes for mental disease (IMDs) as defined in 42 C.F.R. § 435.1010, and for I/T/U pharmacies as defined in 42 C.F.R. § 423.100.

Regardless of the number of incremental dispensing events, the total cost sharing for a Part D drug to which the dispensing requirements of this Section apply must be no greater than the total cost sharing that would be imposed for such Part D drug if the requirements of this Section did not apply.

41. **Time for Claim Submission, Long-Term Care.** Pursuant to 42 C.F.R. § 423.505(b)(20), pharmacies servicing long-term care facilities shall have not less than 30 days, nor more than 90 days, to submit to the PBM claims for reimbursement under the plan.

42. **MAC prices** will be made available through the MeridianRx website to provide notice to pharmacies of updated drug prices as those changes take place, in accordance with 42 C.F.R. § 423.505(b)(21)(iii) and 42 CFR §423.505(i)(3)(viii).

MEDICARE PART D VACCINES ADMINISTRATION FEE PROGRAM

Recitals

A. The Parties previously entered into a Participating Pharmacy Provider Agreement (“Agreement”) and hereby intend to modify the Agreement to incorporate the administration of certain vaccines as a Medicare Part D benefit; and

B. Pharmacy intends to administer certain vaccines that qualify as Medicare Part D drugs to MeridianRx members.

NOW WHEREFORE, in consideration of the foregoing and other good and valuable consideration, the sufficiency of which is hereby acknowledged, the Parties agree as follows:

1. MeridianRx will pay to Pharmacy \$7.00 for the administration of all commercially available vaccines, except the Influenza, Pneumococcal and Hepatitis B vaccines.

2. Pharmacy shall submit the Professional Service Code of “MA” (Medical Administration) in the NCPDP fields 440-E5 and enter the administration fee in field 438-E3 in order to receive reimbursement for dispensing and administering a Medicare Part D Vaccine to a Member.

3. Pharmacy warrants and represents that its pharmacists and/or other staff members who administer vaccines are trained and able to provide administer vaccines as required by federal and/or state laws.

4. Pharmacy shall abide by federal and state laws and regulations and local ordinances governing the administration of vaccines. If applicable, Pharmacy shall comply with the requirements of the Vaccine Injury Compensation Program.

5. Pharmacy warrants and represents that its pharmacists or other qualified staff are qualified to administer vaccines as permitted by state and/or federal law and that Pharmacy shall not administer Medicare Part D Vaccines when prohibited from doing so by federal or state law or regulation or local ordinance.

*Michigan Department
of Community Health*



**Rick Snyder, Governor
Nick Lyon, Director**

**2013–2014 EXTERNAL QUALITY REVIEW
TECHNICAL REPORT**

for

Medicaid Health Plans

With Findings for

Meridian Health Plan of Michigan

February 2015



3133 East Camelback Road, Suite 100 • Phoenix, AZ 85016-4545
Phone 602.801.6600 • Fax 602.801.6051

| | |
|--|------------|
| 1. Executive Summary | 1-1 |
| Purpose of Report | 1-1 |
| Scope of External Quality Review (EQR) Activities Conducted..... | 1-2 |
| Summary of Findings..... | 1-3 |
| 2. External Quality Review Activities..... | 2-1 |
| Introduction | 2-1 |
| Compliance Monitoring..... | 2-1 |
| Validation of Performance Measures | 2-4 |
| Validation of Performance Improvement Projects (PIPs) | 2-7 |
| 3. Statewide Findings | 3-1 |
| Annual Compliance Review | 3-1 |
| Performance Measures | 3-3 |
| Performance Improvement Projects (PIPs)..... | 3-11 |
| Conclusions/Summary..... | 3-12 |
| 4. Appendices Introduction..... | 4-1 |
| Overview | 4-1 |
| Michigan Medicaid Health Plan Names | 4-1 |

CAHPS[®] refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS[®] refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

NCQA HEDIS Compliance Audit[™] is a trademark of the NCQA.

Purpose of Report

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with the Code of Federal Regulations (CFR), 42 CFR 438.358, were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the states' managed care organizations, called Medicaid Health Plans (MHPs) in Michigan. The report of results must also contain an assessment of the strengths and weaknesses of the plans regarding health care quality, timeliness, and access, and must make recommendations for improvement. Finally, the report must assess the degree to which the MHPs addressed any previous recommendations. To meet this requirement, the State of Michigan Department of Community Health (MDCH) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to aggregate and analyze MHP data and prepare the annual technical report.

The State of Michigan contracted with the following MHPs represented in this report:

- ◆ **Blue Cross Complete of Michigan (BCC)**
- ◆ **CoventryCares of Michigan, Inc. (COV)**
- ◆ **Harbor Health Plan (HAR)¹**
- ◆ **HealthPlus Partners (HPP)**
- ◆ **McLaren Health Plan (MCL)**
- ◆ **Meridian Health Plan of Michigan (MER)**
- ◆ **HAP Midwest Health Plan, Inc. (MID)²**
- ◆ **Molina Healthcare of Michigan (MOL)**
- ◆ **Physicians Health Plan—FamilyCare (PHP)**
- ◆ **Priority Health Choice, Inc. (PRI)³**
- ◆ **Total Health Care, Inc. (THC)**
- ◆ **UnitedHealthcare Community Plan (UNI)**
- ◆ **Upper Peninsula Health Plan (UPP)**

¹ ProCare Health Plan became Harbor Health Plan effective January 1, 2014.

² Midwest Health Plan changed its name to HAP Midwest Health Plan, Inc. effective July 1, 2014.

³ Priority Health Government Programs, Inc. changed its name to Priority Health Choice, Inc. effective December 1, 2013.

Scope of External Quality Review (EQR) Activities Conducted

This EQR technical report analyzes and aggregates data from three mandatory EQR activities:

- ◆ **Compliance Monitoring:** MDCH evaluated the MHPs' compliance with federal Medicaid managed care regulations using a compliance review process. HSAG examined, compiled, and analyzed the results as presented in the MHP compliance review documentation provided by MDCH.
- ◆ **Validation of Performance Measures:** Each MHP underwent a National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audit™ conducted by an NCQA-licensed audit organization. HSAG performed an independent audit of the audit findings to determine the validity of each performance measure.
- ◆ **Validation of Performance Improvement Projects (PIPs):** HSAG reviewed one PIP for each MHP to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported improvements.

Summary of Findings

The following is a statewide summary of the conclusions drawn regarding the MHPs’ general performance in 2013–2014. Appendices A–M contain detailed, MHP-specific findings, while Section 3 presents detailed statewide findings with year-to-year comparisons.

Compliance Review

MDCH completed its assessment of the MHPs’ compliance with the requirements in the six standards shown in the table below through the 2013–2014 annual compliance review process. Table 1-1 shows the statewide results for each standard.

| Table 1-1—Summary of Data From the Annual Compliance Reviews | | | |
|--|---------------------|--|-------------------------|
| Standard | Range of MHP Scores | Number of MHPs With 100 Percent Compliance | Statewide Average Score |
| Standard 1— <i>Administrative</i> | 88%–100% | 10 | 97% |
| Standard 2— <i>Providers</i> | 89%–100% | 8 | 97% |
| Standard 3— <i>Members</i> | 92%–100% | 7 | 96% |
| Standard 4— <i>Quality</i> | 83%–94% | 0 | 93% |
| Standard 5— <i>MIS</i> | 67%–100% | 10 | 95% |
| Standard 6— <i>Program Integrity</i> | 100%–100% | 13 | 100% |
| Overall Score | 94%–99% | 0 | 97% |

The statewide average across all standards and all 13 MHPs was 97 percent, reflecting continued strong performance. The *Administrative* standard was a statewide strength with an average score of 97 percent and ten of the 13 MHPs achieving 100 percent compliance. All MHPs had organizational charts that met contractual requirements as well as final, approved policies for the election of Board members that included the required provisions for vacancies, election procedures, and Board composition. Performance on the *Providers* and *Members* standards was also strong, with statewide average scores of 97 percent and 96 percent, respectively, but with fewer MHPs in full compliance with all requirements. All MHPs met the requirements for standard provider contract provisions, pharmacy contracts, agreements with the community mental health centers, and provider directories. On the *Members* standard, all MHPs demonstrated compliance with the requirements for the member handbook, member newsletter, and the resolution of member grievances and appeals. Ten MHPs had compliance scores of 100 percent on the *MIS* (Management Information System) standard, resulting in a statewide average score of 95 percent. None of the three criteria of this standard was met by all MHPs. The *Quality* standard continued to represent the largest opportunity for improvement with a statewide average score of 93 percent and none of the MHPs meeting all requirements. Twelve of the 13 MHPs failed to demonstrate full compliance with one criterion on this standard, which addressed meeting contractually required minimum standards for key performance measures. Statewide strengths on the *Quality* standard included HEDIS submissions and final audit reports as well as policies and procedures for practice guidelines,

quality improvement, and utilization management. Performance on the *Program Integrity* standard—while resulting in the highest statewide score of 100 percent—was not comparable to the other standards due to a modified review process as described in Section 2 of this report. Overall, the MHPs showed continued strong performance on the compliance monitoring reviews, demonstrating compliance with most of the contractual requirements across the standards.

Validation of Performance Measures

Table 1-2 displays the 2014 Michigan Medicaid statewide HEDIS averages and performance levels. The performance levels are a comparison of the 2014 Michigan Medicaid statewide average to the NCQA national HEDIS 2013 Medicaid percentiles. For all measures except those under *Utilization*, the Michigan Medicaid weighted average rate was used to represent Michigan Medicaid statewide performance. For measures in the *Utilization* dimension, an unweighted average rate was calculated for the statewide rate. For most measures, a display of ★★★★★ indicates performance at or above the 90th percentile. Performance levels displayed as ★★★★ represent performance at or above the 75th percentile but below the 90th percentile. A ★★★ performance level indicates performance at or above the 50th percentile but below the 75th percentile. Performance levels displayed as ★★ represent performance at or above the 25th percentile but below the 50th percentile. Finally, performance levels displayed as a ★ indicate that the statewide performance was below the 25th percentile.

For inverse measures, such as *Comprehensive Diabetes Care—Poor HbA1c Control*, the 10th percentile (rather than the 90th percentile) represents excellent performance and the 75th percentile (rather than the 25th percentile) represents below-average performance. For *Ambulatory Care* measures, since high/low visit counts did not take into account the demographic and clinical conditions of an eligible population, higher or lower rates do not necessarily denote better or worse performance.

Statewide and plan-specific rate changes between HEDIS 2013 and HEDIS 2014 for two measures may not accurately reflect actual performance improvement or decline. For the *Breast Cancer Screening* measure, continuous enrollment requirement, age range requirement, and numerator time frame were revised in the HEDIS 2014 specifications. These revisions were likely to increase rates. Consequently, rate changes from HEDIS 2013 may reflect both the impact of these revisions and MHPs' improvement efforts. For the *Cervical Cancer Screening* measure, additional tests with a longer look-back period were included in the HEDIS 2014 specification as evidence of screening for women between 30 and 64 years of age. Although a performance star was displayed for this measure, please use caution when interpreting the star due to the significant differences in the measure specification between HEDIS 2013 and HEDIS 2014.

All 13 MHPs were fully compliant with the information system (IS) standards related to Medical Service Data (IS 1.0), Medical Record Review Process (IS 4.0), and Supplemental Data (IS 5.0). Although one MHP was not fully compliant with at least one of the remaining standards—Enrollment Data (IS 2.0), Practitioner Data (IS 3.0), and Data Integration (IS 7.0)—the issues identified by their auditors either did not apply to Medicaid reporting or would not pose a significant impact to their HEDIS reporting. The IS standard related to Member Call Center Data (IS 6.0) was not applicable to the measures required to be reported by the MHPs.

Table 1-2—Overall Statewide Averages for Performance Measures

| Performance Measure | 2014 MI Medicaid | Performance Level for 2014 |
|--|------------------|----------------------------|
| Child and Adolescent Care | | |
| <i>Childhood Immunization—Combination 2</i> | 80.90% | ★★★★ |
| <i>Childhood Immunization—Combination 3</i> | 77.21% | ★★★★ |
| <i>Childhood Immunization—Combination 4</i> | 70.61% | ★★★★ |
| <i>Childhood Immunization—Combination 5</i> | 61.42% | ★★★★ |
| <i>Childhood Immunization—Combination 6</i> | 42.17% | ★★★★ |
| <i>Childhood Immunization—Combination 7</i> | 57.33% | ★★★★ |
| <i>Childhood Immunization—Combination 8</i> | 40.22% | ★★★★ |
| <i>Childhood Immunization—Combination 9</i> | 35.18% | ★★★★ |
| <i>Childhood Immunization—Combination 10</i> | 33.87% | ★★★★ |
| <i>Immunizations for Adolescents—Combination 1</i> | 88.43% | ★★★★★ |
| <i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i> | 73.09% | ★★★★ |
| <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i> | 77.05% | ★★★★ |
| <i>Adolescent Well-Care Visits</i> | 57.80% | ★★★★ |
| <i>Lead Screening in Children</i> | 80.43% | ★★★★ |
| <i>Appropriate Treatment for Children With Upper Respiratory Infection (URI)</i> | 86.53% | ★★★★ |
| <i>Appropriate Testing for Children With Pharyngitis</i> | 59.19% | ★ |
| <i>Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase</i> | 40.24% | ★★★★ |
| <i>Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase</i> | 47.04% | ★★★★ |
| Women—Adult Care | | |
| <i>Breast Cancer Screening¹</i> | 62.56% | ★★★★ |
| <i>Cervical Cancer Screening²</i> | 71.34% | ★★★★ |
| <i>Chlamydia Screening in Women—16 to 20 Years</i> | 60.15% | ★★★★ |
| <i>Chlamydia Screening in Women—21 to 24 Years</i> | 69.44% | ★★★★ |
| <i>Chlamydia Screening in Women—Total</i> | 63.40% | ★★★★ |
| ¹ Changes made in the HEDIS 2014 specifications for this measure may have the potential to increase the HEDIS 2014 rates and consequently result in a higher percentile ranking when compared to the national HEDIS 2013 percentiles. ² Due to significant changes in the measure specification, NCQA indicates that the <i>Cervical Cancer Screening</i> rate is not publicly reported. Please also use caution when comparing the HEDIS 2014 rate with the HEDIS 2013 Medicaid percentile values. | | |
| ★★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile | | |

Table 1-2—Overall Statewide Averages for Performance Measures

| Performance Measure | 2014 MI Medicaid | Performance Level for 2014 |
|---|------------------|----------------------------|
| Access to Care | | |
| <i>Children’s Access to Primary Care Practitioners—12 to 24 Months</i> | 96.73% | ☆☆ |
| <i>Children’s Access to Primary Care Practitioners—25 Months to 6 Years</i> | 88.91% | ☆☆ |
| <i>Children’s Access to Primary Care Practitioners—7 to 11 Years</i> | 91.68% | ★★★ |
| <i>Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i> | 90.48% | ★★★ |
| <i>Adults’ Access to Preventive/Ambulatory Health Services—20 to 44 Years</i> | 84.30% | ★★★ |
| <i>Adults’ Access to Preventive/Ambulatory Health Services—45 to 64 Years</i> | 90.93% | ★★★★ |
| <i>Adults’ Access to Preventive/Ambulatory Health Services—65+ Years</i> | 90.29% | ★★★ |
| <i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i> | 86.75% | ★★★★ |
| Obesity | | |
| <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, BMI Percentile—Ages 3 to 11 Years</i> | 68.76% | ★★★ |
| <i>Weight Assessment and Counseling, BMI Percentile—Ages 12 to 17 Years</i> | 72.49% | ★★★★ |
| <i>Weight Assessment and Counseling, BMI Percentile—Total</i> | 70.07% | ★★★★ |
| <i>Weight Assessment and Counseling for Nutrition—Ages 3 to 11 Years</i> | 66.15% | ★★★ |
| <i>Weight Assessment and Counseling for Nutrition—Ages 12 to 17 Years</i> | 62.09% | ★★★ |
| <i>Weight Assessment and Counseling for Nutrition—Total</i> | 64.72% | ★★★ |
| <i>Weight Assessment and Counseling for Physical Activity—Ages 3 to 11 Years</i> | 50.27% | ★★★ |
| <i>Weight Assessment and Counseling for Physical Activity—Ages 12 to 17 Years</i> | 58.17% | ★★★ |
| <i>Weight Assessment and Counseling for Physical Activity—Total</i> | 52.99% | ★★★ |
| <i>Adult BMI Assessment</i> | 86.05% | ★★★★★ |
| Pregnancy Care | | |
| <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> | 88.92% | ★★★ |
| <i>Prenatal and Postpartum Care—Postpartum Care</i> | 70.84% | ★★★★ |
| <i>Weeks of Pregnancy at Time of Enrollment—≤ 0 Weeks</i> | 29.72% | — |
| <i>Weeks of Pregnancy at Time of Enrollment—1 to 12 Weeks</i> | 9.27% | — |
| <i>Weeks of Pregnancy at Time of Enrollment—13 to 27 Weeks</i> | 40.51% | — |
| <i>Weeks of Pregnancy at Time of Enrollment—28 or More Weeks</i> | 17.12% | — |
| <i>Weeks of Pregnancy at Time of Enrollment—Unknown</i> | 3.38% | — |
| — = The national HEDIS 2013 Medicaid percentiles are not available. | | |
| ★★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile | | |

Table 1-2—Overall Statewide Averages for Performance Measures

| Performance Measure | 2014 MI Medicaid | Performance Level for 2014 |
|--|------------------|----------------------------|
| Pregnancy Care (continued) | | |
| <i>Frequency of Ongoing Prenatal Care—< 21 Percent*</i> | 6.59% | NC |
| <i>Frequency of Ongoing Prenatal Care—21 to 40 Percent</i> | 6.28% | NC |
| <i>Frequency of Ongoing Prenatal Care—41 to 60 Percent</i> | 7.29% | NC |
| <i>Frequency of Ongoing Prenatal Care—61 to 80 Percent</i> | 13.49% | NC |
| <i>Frequency of Ongoing Prenatal Care—≥ 81 Percent</i> | 66.36% | ★★★★ |
| Living With Illness | | |
| <i>Comprehensive Diabetes Care—HbA1c Testing</i> | 85.45% | ★★★★ |
| <i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*</i> | 37.23% | ★★★★ |
| <i>Comprehensive Diabetes Care—HbA1c Control (<8.0%)</i> | 53.74% | ★★★★ |
| <i>Comprehensive Diabetes Care—Eye Exam</i> | 63.01% | ★★★★ |
| <i>Comprehensive Diabetes Care—LDL-C Screening</i> | 78.67% | ★★★★ |
| <i>Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)</i> | 40.83% | ★★★★ |
| <i>Comprehensive Diabetes Care—Nephropathy</i> | 82.00% | ★★★★ |
| <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/80 mm Hg)</i> | 41.41% | ★★★★ |
| <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> | 63.56% | ★★★★ |
| <i>Use of Appropriate Medications for People With Asthma—5 to 11 Years</i> | 89.18% | ★★ |
| <i>Use of Appropriate Medications for People With Asthma—12 to 18 Years</i> | 84.94% | ★★ |
| <i>Use of Appropriate Medications for People With Asthma—19 to 50 Years</i> | 73.24% | ★★ |
| <i>Use of Appropriate Medications for People With Asthma—51 to 64 Years</i> | 64.40% | ★ |
| <i>Use of Appropriate Medications for People With Asthma—Total</i> | 81.19% | ★★ |
| <i>Controlling High Blood Pressure</i> | 63.58% | ★★★★ |
| <i>Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers to Quit</i> | 80.35% | — |
| <i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications</i> | 53.75% | — |
| <i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies</i> | 46.12% | — |
| <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i> | 83.54% | ★★★★ |
| <p>* For this indicator, a lower rate indicates better performance. — = The national HEDIS 2013 Medicaid percentiles are not available. NC = Not Comparable (i.e., measure not comparable to national percentiles)</p> <p>★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile</p> | | |

Table 1-2—Overall Statewide Averages for Performance Measures

| Performance Measure | 2014 MI Medicaid | Performance Level for 2014 |
|--|------------------|----------------------------|
| Living With Illness (continued) | | |
| <i>Diabetes Monitoring for People With Diabetes and Schizophrenia</i> | 72.60% | ★★★★ |
| <i>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</i> | 60.14% | ★ |
| <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i> | 60.49% | ★★ |
| Health Plan Diversity | | |
| <i>Race/Ethnicity Diversity of Membership—White</i> | 52.18% | NC |
| <i>Race/Ethnicity Diversity of Membership—Black or African-American</i> | 29.18% | NC |
| <i>Race/Ethnicity Diversity of Membership—American-Indian and Alaska Native</i> | 0.18% | NC |
| <i>Race/Ethnicity Diversity of Membership—Asian</i> | 0.89% | NC |
| <i>Race/Ethnicity Diversity of Membership—Native Hawaiian and Other Pacific Islanders</i> | 0.05% | NC |
| <i>Race/Ethnicity Diversity of Membership—Some Other Race</i> | 0.44% | NC |
| <i>Race/Ethnicity Diversity of Membership—Two or More Races</i> | <0.01% | NC |
| <i>Race/Ethnicity Diversity of Membership—Unknown</i> | 15.54% | NC |
| <i>Race/Ethnicity Diversity of Membership—Declined</i> | 1.55% | NC |
| <i>Race/Ethnicity Diversity of Membership—Hispanic[£]</i> | 5.52% | — |
| <i>Language Diversity of Membership: Spoken Language—English</i> | 90.43% | NC |
| <i>Language Diversity of Membership: Spoken Language—Non-English</i> | 1.55% | NC |
| <i>Language Diversity of Membership: Spoken Language—Unknown</i> | 8.01% | NC |
| <i>Language Diversity of Membership: Spoken Language—Declined</i> | <0.01% | NC |
| <i>Language Diversity of Membership: Written Language—English</i> | 55.36% | NC |
| <i>Language Diversity of Membership: Written Language—Non-English</i> | 0.77% | NC |
| <i>Language Diversity of Membership: Written Language—Unknown</i> | 43.87% | NC |
| <i>Language Diversity of Membership: Written Language—Declined</i> | 0.00% | NC |
| <i>Language Diversity of Membership: Other Language Needs—English</i> | 45.84% | NC |
| <i>Language Diversity of Membership: Other Language Needs—Non-English</i> | 0.75% | NC |
| <i>Language Diversity of Membership: Other Language Needs—Unknown</i> | 53.40% | NC |
| <i>Language Diversity of Membership: Other Language Needs—Declined</i> | 0.00% | NC |
| [£] The rate was calculated by HSAG; national benchmarks are not comparable. — = The national HEDIS 2013 Medicaid percentiles are not available. NC = Not Comparable (i.e., measure not comparable to national percentiles) | | |
| ★★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile | | |

Table 1-2—Overall Statewide Averages for Performance Measures

| Performance Measure | 2014 MI Medicaid | Performance Level for 2014 |
|--|------------------|----------------------------|
| Utilization | | |
| <i>Ambulatory Care—Total (Visits per 1,000 Member Months): Outpatient—Total</i> | 325.25 | ★★ |
| <i>Ambulatory Care—Total (Visits per 1,000 Member Months): ED—Total*</i> | 73.41 | ★★ |
| <i>Inpatient Utilization—General Hospital/Acute Care: Total (Visits per 1,000 Member Months): Total Inpatient—Total</i> | 8.38 | NC |
| <i>Inpatient Utilization—General Hospital/Acute Care: Discharges, Medicine—Total</i> | 4.03 | NC |
| <i>Inpatient Utilization—General Hospital/Acute Care: Discharges, Surgery—Total</i> | 1.45 | NC |
| <i>Inpatient Utilization—General Hospital/Acute Care: Discharges, Maternity—Total</i> | 4.80 | NC |
| <i>Inpatient Utilization—General Hospital/Acute Care: Total (Average Length of Stay), Total Inpatient—Total</i> | 3.89 | NC |
| <i>Inpatient Utilization—General Hospital/Acute Care: Total (Average Length of Stay), Medicine—Total</i> | 3.87 | NC |
| <i>Inpatient Utilization—General Hospital/Acute Care: Total (Average Length of Stay), Surgery—Total</i> | 6.51 | NC |
| <i>Inpatient Utilization—General Hospital/Acute Care: Total (Average Length of Stay), Maternity—Total</i> | 2.57 | NC |
| * For this indicator, a lower rate indicates better performance. | | |
| NC = Not Comparable (i.e., measure not comparable to national percentiles) | | |
| ★★★★★ = 90th percentile and above ★★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile | | |

Of the 65 performance measures that had national results available and were appropriate for comparison, two rates (*Immunizations for Adolescents—Combination 1* and *Adult BMI Assessment*) indicated statewide strength by ranking at or above the national HEDIS 2013 Medicaid 90th percentile. Fourteen rates (21.5 percent) fell between the 75th and 89th percentile and an additional 37 rates (56.9 percent) were at or above the 50th percentile but below the 75th percentile. Twelve measures (18.5 percent) had rates that fell below the 50th percentile, three of which were below the 25th percentile. These three indicators (*Appropriate Testing for Children With Pharyngitis*, *Use of Appropriate Medications for People With Asthma—51 to 64 Years*, and *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*) presented opportunities for improvement.

Performance Improvement Projects (PIPs)

For the 2013–2014 validation cycle, MDCH directed the MHPs to select a new study topic that focused on a special group or unique subpopulation of enrollees. All 13 MHPs received a validation status of *Met* for their PIPs, as shown in Table 1-3.

| Validation Status | Number of MHPs |
|----------------------|----------------|
| <i>Met</i> | 13 |
| <i>Partially Met</i> | 0 |
| <i>Not Met</i> | 0 |

Table 1-4 presents a summary of the statewide 2013–2014 results for the activities of the protocol for validating PIPs.

| Review Activities | | Number of PIPs Meeting All Evaluation Elements/ Number Reviewed | Number of PIPs Meeting All Critical Elements/ Number Reviewed |
|-------------------|---|--|--|
| I. | Select the Study Topic | 13/13 | 13/13 |
| II. | Define the Study Question(s) | 13/13 | 13/13 |
| III. | Use a Representative and Generalizable Study Population | 13/13 | 13/13 |
| IV. | Select the Study Indicator(s) | 13/13 | 13/13 |
| V. | Use Sound Sampling Techniques* | 13/13 | 13/13 |
| VI. | Reliably Collect Data | 11/13 | 13/13 |
| VII. | Analyze Data and Interpret Study Results | 13/13 | 13/13 |
| VIII. | Implement Interventions and Improvement Strategies | 5/7 | 7/7 |
| IX. | Assess for Real Improvement | Not Assessed | |
| X. | Assess for Sustained Improvement | Not Assessed | |

* This activity is assessed only for PIPs that conduct sampling.

The MHPs demonstrated both strong performance related to the quality of their PIPs and a thorough application of the requirements for Activities I through VIII of the Centers for Medicare & Medicaid Services (CMS) protocol for conducting PIPs.

HSAG validated all 13 PIPs for Activities I through VII. All 13 PIPs completed the design phase of the study, and 11 PIPs demonstrated compliance with all evaluation elements, including critical elements, for Activities I–VI. All 13 PIPs advanced to the implementation and evaluation phase of the study and completed Activity VII, demonstrating compliance with all evaluation elements. Seven MHPs progressed to Activity VIII—Implement Interventions and Improvement Strategies, and HSAG identified opportunities for improvement for two of the PIPs. All 13 MHPs reported

baseline data, but only seven of them progressed to the point of developing and implementing interventions.

The PIPs submitted for the 2013–2014 validation were a statewide strength. Each MHP selected an appropriate topic and designed a scientifically sound project supported by the use of key research principles. The technical design of the PIPs was sufficient to measure outcomes and advance to the subsequent stages of the studies. As the PIPs progress, the MHPs should evaluate the effectiveness of each implemented intervention to make decisions regarding continuing, revising, or abandoning interventions; use quality improvement tools (e.g., key driver diagrams or Failure Mode Analysis) to determine barriers and weaknesses in processes that may prevent the MHP from achieving its desired outcomes; and use quality improvement science techniques such as the plan-do-study-act (PDSA) cycle as part of their improvement strategies.

Quality, Timeliness, and Access

The annual compliance review of the MHPs showed strong performance across the domains of **quality, timeliness, and access**. Combined, the areas with the highest level of compliance—the *Providers, Administrative, and MIS* standards—addressed the **quality** and **timeliness** of, as well as **access** to, services provided to beneficiaries. The compliance reviews identified opportunities for improvement primarily the **quality** and **access** domains.

Results for the validated performance measures reflected statewide strengths across the domains of **quality, timeliness, and access**. Statewide rates for 65 of the 107 performance indicators were compared with the available national HEDIS 2013 Medicaid percentiles. Fifty-three indicators demonstrated average to above-average performance and ranked above the 50th percentile, with 16 of these indicators ranking above the 75th percentile. The 12 indicators with rates below the 50th percentile represented opportunities for improvement.

The validation of the MHPs' PIPs reflected strong performance in the studies that addressed the **quality, timeliness, and access** domains. All projects were designed in a methodologically sound manner with a foundation on which to progress to subsequent PIP stages.

Table 1-5 shows HSAG’s assignment of the compliance review standards, performance measures, and PIPs into the domains of **quality**, **timeliness**, and **access**.

| Table 1-5—Assignment of Activities to Performance Domains | | | |
|---|---------|------------|--------|
| Compliance Review Standards | Quality | Timeliness | Access |
| Standard 1—Administrative | ✓ | | |
| Standard 2—Providers | ✓ | ✓ | ✓ |
| Standard 3—Members | ✓ | ✓ | ✓ |
| Standard 4—Quality | ✓ | | ✓ |
| Standard 5—MIS | ✓ | ✓ | |
| Standard 6—Program Integrity | ✓ | ✓ | ✓ |
| Performance Measures | Quality | Timeliness | Access |
| Childhood Immunization Status | ✓ | ✓ | |
| Immunizations for Adolescents | ✓ | ✓ | |
| Well-Child Visits in the First 15 Months of Life—Six or More Visits | ✓ | | |
| Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life | ✓ | | |
| Adolescent Well-Care Visits | ✓ | | |
| Lead Screening in Children | ✓ | ✓ | |
| Appropriate Treatment for Children With Upper Respiratory Infection (URI) | ✓ | | |
| Appropriate Testing for Children With Pharyngitis | ✓ | | |
| Follow-Up Care for Children Prescribed ADHD Medication | ✓ | ✓ | ✓ |
| Breast Cancer Screening | ✓ | | |
| Cervical Cancer Screening | ✓ | | |
| Chlamydia Screening in Women | ✓ | | |
| Children and Adolescents’ Access to Primary Care Practitioners | | | ✓ |
| Adults’ Access to Preventive/Ambulatory Health Services | | | ✓ |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents | ✓ | | |
| Adult BMI Assessment | ✓ | | |
| Prenatal and Postpartum Care | | ✓ | ✓ |
| Frequency of Ongoing Prenatal Care | ✓ | | ✓ |
| Comprehensive Diabetes Care | ✓ | | |
| Use of Appropriate Medications for People With Asthma | ✓ | | |
| Controlling High Blood Pressure | ✓ | | |
| Medical Assistance With Smoking and Tobacco Use Cessation | ✓ | | |

Table 1-5—Assignment of Activities to Performance Domains

| Performance Measures (continued) ¹⁻⁴ | Quality | Timeliness | Access |
|---|----------------|-------------------|---------------|
| <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i> | ✓ | | |
| <i>Diabetes Monitoring for People With Diabetes and Schizophrenia</i> | ✓ | | |
| <i>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</i> | ✓ | | |
| <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i> | ✓ | | |
| <i>Ambulatory Care</i> | | | ✓ |
| PIPs | Quality | Timeliness | Access |
| One PIP for each MHP | ✓ | ✓ | ✓ |

¹⁻⁴ *Race/Ethnicity Diversity of Membership, Language Diversity of Membership, Weeks of Pregnancy at Time of Enrollment, and Inpatient Utilization* were not included in Table 1-5 since they cannot be categorized into either domain. Please see Section 2 of this report for additional information.

2. External Quality Review Activities

Introduction

This section of the report describes the manner in which data from the activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed.

Compliance Monitoring

Objectives

According to 42 CFR 438.358, a state or its EQRO must conduct a review within a three-year period to determine the Medicaid managed care organizations' compliance with standards established by the state for access to care, structure and operations, and quality measurement and improvement. To meet this requirement, MDCH performed compliance reviews of its MHPs.

The objectives of evaluating contractual compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing corrective actions to achieve compliance with the contractual requirements.

Technical Methods of Data Collection

MDCH was responsible for the activities that assessed MHP compliance with federal Medicaid managed care regulations. This technical report presents the results of the 2013–2014 compliance reviews. MDCH completed a review of all criteria in the six standards listed below:

1. *Administrative* (4 criteria)
2. *Providers* (9 criteria)
3. *Members* (6 criteria)
4. *Quality* (9 criteria)
5. *MIS* (3 criteria)
6. *Program Integrity* (16 criteria)

Description of Data Obtained

To assess the MHPs' compliance with federal and State requirements, MDCH obtained information from a wide range of written documents produced by the MHPs, including the following:

- ◆ Policies and procedures
- ◆ Current quality assessment and performance improvement (QAPI) programs

- ◆ Minutes of meetings of the governing body, quality improvement (QI) committee, compliance committee, utilization management (UM) committee, credentialing committee, and peer review committee
- ◆ QI work plans, utilization reports, provider and member profiling reports, QI effectiveness reports
- ◆ Internal auditing/monitoring plans, auditing/monitoring findings
- ◆ Claims review reports, prior-authorization reports, complaint logs, grievance logs, telephone contact logs, disenrollment logs, MDCH hearing requests, medical record review reports
- ◆ Provider service and delegation agreements and contracts
- ◆ Provider files, disclosure statements, current sanctioned/suspended provider lists
- ◆ Organizational charts
- ◆ Program integrity forms and reports
- ◆ Employee handbooks, fliers, employee newsletters, provider manuals, provider newsletters, Web sites, educational/training materials, and sign-in sheets
- ◆ Member materials, including welcome letters, member handbooks, member newsletters, provider directories, and certificates of coverage
- ◆ Provider manuals

For the 2013–2014 compliance reviews, MDCH continued to use the review tool and process from the previous review cycle. Standards, criteria, and number of MHPs remained unchanged from the 2012–2013 review cycle. Due to the MHPs experiencing continued difficulties with submissions of documentation for Standard 6—*Program Integrity*, MDCH provided technical assistance through conference calls with MHP representatives, updated the submission template, and created a guidance document and list of frequently asked questions to assist the MHPs in properly completing the submission template. Throughout the fiscal year, MHPs submitted documentation of their compliance with a specified subset of the criteria in the review tool. The assessment of compliance with each standard was spread over multiple months or repeated at multiple points during the fiscal year. Following each month’s submissions, MDCH determined the MHPs’ levels of compliance with the criteria assessed and provided feedback to the MHPs about their performance. For criteria with less than complete compliance, MDCH also specified its findings and requirements for a corrective action plan. MHPs then detailed the proposed corrective action, which was reviewed and—when acceptable—approved by MDCH prior to implementation. MDCH conducted an annual site visit with each MHP to perform a detailed review of the 2013–2014 focus study topic—Children’s Special Health Care Services (CSHCS).

Data Aggregation, Analysis, and How Conclusions Were Drawn

MDCH reviewers used the compliance review tool for each MHP to document their findings and to identify, when applicable, specific action(s) required of the plan to address any areas of noncompliance with contractual requirements.

For each criterion reviewed, MDCH assigned one of the following scores:

- ◆ *Pass*—The MHP demonstrated full compliance with the requirement(s).
- ◆ *Incomplete*—The MHP demonstrated partial compliance with the requirement(s).
- ◆ *Fail*—The MHP failed to demonstrate compliance with the requirement(s).
- ◆ *Not Applicable (N/A)*—The requirement was not applicable to the MHP

HSAG calculated a total compliance score for each standard, reflecting the degree of compliance with contractual requirements related to that area, and an overall score for each MHP across all six standards. The total compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), *Fail* (0 points), or *N/A* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

This report presents some comparisons to prior-year performance. Results of the 2013–2014 compliance reviews for Standard 6—*Program Integrity* and the overall compliance scores across all standards are not fully comparable to previous review cycles because of changes in the review methodology. Due to continued difficulties with submissions of required documentation for Standard 6—*Program Integrity*, MDCH allowed MHPs to provide additional or corrected documentation to support compliance with any requirements that received a score of less than “Pass” before assigning a percentage score to the standard. Scores of less than 100 percent on this standard would not necessarily reflect lack of compliance with the requirements but rather indicate a lack of understanding of how to submit the expected information. Final corrective action plan submissions reflected full compliance with the requirements of Standard 6—*Program Integrity*¹. For all other standards, the scores reflect the MHPs’ performance on the original submission per MDCH’s established practice.

To draw conclusions and make overall assessments about the **quality** and **timeliness** of and **access** to care provided by the MHPs using findings from the compliance reviews, the standards were categorized to evaluate each of these three domains. Using this framework, Table 1-5 (page 1-12) shows HSAG’s assignment of standards to the three domains of performance.

¹ At the time of this report, one final corrective action plan was still pending.

Validation of Performance Measures

Objectives

As set forth in 42 CFR 438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process are to:

- ◆ Evaluate the accuracy of the performance measure data collected by the MHP.
- ◆ Determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure.

To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess each MHP's support system available to report accurate HEDIS measures.

Technical Methods of Data Collection and Analysis

MDCH required each MHP to collect and report a set of Medicaid HEDIS measures. Developed and maintained by NCQA, HEDIS is a set of performance measures broadly accepted in the managed care environment as an industry standard.

Each MHP underwent an NCQA HEDIS Compliance Audit conducted by an NCQA-licensed audit organization. The NCQA HEDIS Compliance Audit followed NCQA audit methodology as set out in NCQA's 2014 *HEDIS Compliance Audit: Standards, Policies, and Procedures*. The NCQA HEDIS Compliance Audit encompasses an in-depth examination of the health plans' processes consistent with CMS' protocols for validation of performance measures. To complete the validation of performance measures process according to the CMS protocols, HSAG performed an independent evaluation of the audit results and findings to determine the validity of each performance measure.

Each HEDIS Compliance Audit was conducted by a licensed audit organization and included the following activities:

Pre-review Activities: Each MHP was required to complete the NCQA Record of Administration, Data Management, and Processes (Roadmap), which is comparable to the Information Systems Capabilities Assessment Tool, Appendix V of the CMS protocols. Pre-on-site conference calls were held to follow up on any outstanding questions. The audit team conducted a thorough review of the Roadmap and supporting documentation, including an evaluation of processes used for collecting, storing, validating, and reporting the performance measure data.

On-site Review: The on-site reviews, which typically lasted one to two day(s), included:

- ◆ An evaluation of system compliance, focusing on the processing of claims and encounters.
- ◆ An overview of data integration and control procedures, including discussion and observation.
- ◆ A review of how all data sources were combined and the method used to produce the performance measures.

- ◆ Interviews with MHP staff members involved with any aspect of performance measure reporting.
- ◆ A closing conference at which the audit team summarized preliminary findings and recommendations.

Post-on-site Review Activities: For each performance measure calculated and reported by the MHPs, the audit teams aggregated the findings from the pre-on-site and on-site activities to determine whether the reported measures were valid, based on an allowable bias. The audit teams assigned each measure one of four audit findings: (1) *Report* (the rate was valid and below the allowable threshold for bias), (2) *Not Applicable* (the MHP followed the specifications but the denominator was too small to report a valid rate), (3) *No Benefit* (the MHP did not offer the health benefits required by the measure), or (4) *Not Report* (the measure was significantly biased or the plan chose not to report the measure).

Description of Data Obtained

As identified in the CMS protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures. Table 2-1 shows the data sources used in the validation of performance measures and the time period to which the data applied.

| Table 2-1—Description of Data Sources | |
|---|---------------------------------------|
| Data Obtained | Time Period to Which the Data Applied |
| HEDIS Compliance Audit reports were obtained for each MHP, which included a description of the audit process, the results of the information systems findings, and the final audit designations for each performance measure. | Calendar Year (CY) 2013 (HEDIS 2014) |
| Performance measure reports, submitted by the MHPs using NCQA’s Interactive Data Submission System (IDSS), were analyzed and subsequently validated by the HSAG validation team. | CY 2013 (HEDIS 2014) |
| Previous performance measure reports were reviewed to assess trending patterns and the reasonability of rates. | CY 2012 (HEDIS 2013) |

Data Aggregation, Analysis, and How Conclusions Were Drawn

HSAG performed a comprehensive review and analysis of the MHPs’ IDSS results, data submission tools, and MHP-specific HEDIS Compliance Audit reports and performance measure reports.

HSAG ensured that the following criteria were met prior to accepting any validation results:

- ◆ An NCQA-licensed audit organization completed the audit.
- ◆ An NCQA-certified HEDIS compliance auditor led the audit.
- ◆ The audit scope included all MDCH-selected HEDIS measures.
- ◆ The audit scope focused on the Medicaid product line.
- ◆ Data were submitted via an auditor-locked NCQA IDSS.

- ◆ A final audit opinion, signed by the lead auditor and responsible officer within the licensed organization, was produced.

While national benchmarks were available for the following measures, they were not included in the report as it was not appropriate to use them for benchmarking the MHPs' performance: *Frequency of Ongoing Prenatal Care* (for the <21 Percent, 21 to 40 Percent, 41 to 60 Percent, and 61 to 80 Percent indicators), *Race/Ethnicity Diversity of Membership*, *Language Diversity of Membership*, and *Inpatient Utilization*. However, for *Frequency of Ongoing Prenatal Care*, benchmarking is appropriate for the ≥ 81 Percent category (i.e., higher rates suggesting better performance). The *Diversity* indicators are demographic descriptors only and do not reflect health plan performance. The *Inpatient Utilization* measures without the context of the MHP's population characteristics are not reflective of the quality of the health plan's performance. HEDIS benchmarks were not available for the *Medical Assistance With Smoking and Tobacco Use Cessation* and *Weeks of Pregnancy at Time of Enrollment* measures.

To draw conclusions and make overall assessments about the **quality** and **timeliness** of and **access** to care provided by the MHPs using findings from the validation of performance measures, measures were categorized to evaluate one or more of the three domains. Table 1-5 (page 1-12) shows HSAG's assignment of performance measures to these domains of performance.

Several measures do not fit into these domains since they are collected and reported as health plan descriptive measures or because the measure results cannot be tied to any of the domains. These measures include *Race/Ethnicity Diversity of Membership*, *Language Diversity of Membership*, *Weeks of Pregnancy at Time of Enrollment*, and *Inpatient Utilization*. The first three measures are considered health plan descriptive measures. These measures do not have associated benchmarks, and performance cannot be directly impacted by improvement efforts. The last measure does not fit into the domains due to the inability to directly correlate performance to **quality**, **timeliness**, or **access** to care. For these reasons, these measures were not included in Table 1-5.

Validation of Performance Improvement Projects (PIPs)

Objectives

As part of its QAPI program, each MHP is required by MDCH to conduct PIPs in accordance with 42 CFR 438.240. The purpose of the PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. As one of the mandatory EQR activities under the BBA, a state is required to validate the PIPs conducted by its contracted Medicaid managed care organizations. To meet this validation requirement for the MHPs, MDCH contracted with HSAG.

The primary objective of PIP validation was to determine each MHP's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- ◆ Measurement of performance using objective quality indicators.
- ◆ Implementation of systematic interventions to achieve improvement in quality.
- ◆ Evaluation of the effectiveness of the interventions.
- ◆ Planning and initiation of activities for increasing or sustaining improvement.

MDCH required that each MHP conduct one PIP subject to validation by HSAG. For the 2013–2014 validation cycle, MDCH directed the MHPs to select a new study topic that focused on a special group or unique subpopulation of enrollees.

Technical Methods of Data Collection and Analysis

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. The methodology used to validate PIPs was based on guidelines outlined in the CMS guidelines as outlined in *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.²⁻² Using this protocol, HSAG, in collaboration with MDCH, developed the PIP Summary Form. Each MHP completed this form and submitted it to HSAG for review. The PIP Summary Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

HSAG, with MDCH's input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The CMS protocols identify ten activities that should be validated for each PIP, although in some cases the PIP may not have progressed to the point at which all of the activities can be validated.

²⁻² Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: Feb 19, 2013.

These activities are:

- ◆ Activity I. Select the Study Topic(s)
- ◆ Activity II. Define the Study Question(s)
- ◆ Activity III. Use a Representative and Generalizable Study Population
- ◆ Activity IV. Select the Study Indicator(s)
- ◆ Activity V. Use Sound Sampling Techniques
- ◆ Activity VI. Reliably Collect Data
- ◆ Activity VII. Analyze Data and Interpret Study Results
- ◆ Activity VIII. Implement Intervention and Improvement Strategies
- ◆ Activity IX. Assess for Real Improvement
- ◆ Activity X. Assess for Sustained Improvement

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validations from the MHPs' PIP Summary Form. This form provided detailed information about each MHP's PIP as it related to the ten activities reviewed and evaluated for the 2013–2014 validation cycle.

Data Aggregation, Analysis, and How Conclusions Were Drawn

HSAG used the following methodology to evaluate PIPs conducted by the MHPs to determine if a PIP is valid and to rate the percentage of compliance with CMS' protocol for conducting PIPs.

Each PIP activity consisted of critical and noncritical evaluation elements necessary for successful completion of a valid PIP. Each evaluation element was scored as *Met (M)*, *Partially Met (PM)*, *Not Met (NM)*, *Not Applicable (NA)*, or *Not Assessed*.

The percentage score for all evaluation elements was calculated by dividing the number of elements (including critical elements) *Met* by the sum of evaluation elements *Met*, *Partially Met*, and *Not Met*. The percentage score for critical elements *Met* was calculated by dividing the number of critical elements *Met* by the sum of critical elements *Met*, *Partially Met*, and *Not Met*. The scoring methodology also included the *Not Applicable* designation for situations in which the evaluation element did not apply to the PIP. For example, in Activity V, if the PIP did not use sampling techniques, HSAG would score the evaluation elements in Activity V as *Not Applicable*. HSAG used the *Not Assessed* scoring designation when the PIP had not progressed to the remaining activities in the CMS protocol. HSAG used a *Point of Clarification* when documentation for an evaluation element included the basic components to meet requirements for the evaluation element (as described in the narrative of the PIP), but enhanced documentation would demonstrate a stronger understanding of CMS protocols.

The validation status score was based on the percentage score and whether or not critical elements were *Met*, *Partially Met*, or *Not Met*. Due to the importance of critical elements, any critical element scored as *Not Met* would invalidate a PIP. Critical elements that were *Partially Met* and noncritical elements that were *Partially Met* or *Not Met* would not invalidate the PIP, but they would affect the

overall percentage score (which indicates the percentage of the PIP's compliance with CMS' protocol for conducting PIPs).

HSAG assessed the implications of the study's findings on the likely validity and reliability of the results as follows:

- ◆ *Met*: Confidence/high confidence in the reported PIP results.
- ◆ *Partially Met*: Low confidence in the reported PIP results.
- ◆ *Not Met*: Reported PIP results that were not credible.

The MHPs had an opportunity to resubmit revised PIP Summary Forms and additional information in response to any *Partially Met* or *Not Met* evaluation scores, regardless of whether the evaluation element was critical or noncritical. HSAG re-reviewed the resubmitted documents and rescored the PIPs before determining a final validation score and status. With MDCH's approval, HSAG offered technical guidance to any MHP that requested an opportunity to review the scoring of the evaluation elements prior to a resubmission. Four of the 13 MHPs requested and received technical assistance from HSAG. HSAG conducted conference calls or responded to e-mails to answer questions regarding the plans' PIPs or to discuss areas of deficiency. HSAG encouraged the MHPs to use the PIP Summary Form Completion Instructions as they completed their PIPs. These instructions outlined each evaluation element and provided documentation resources to support CMS PIP protocol requirements.

HSAG followed the above methodology for validating the PIPs for all MHPs to assess the degree to which the MHPs designed, conducted, and reported their projects in a methodologically sound manner.

After completing the validation review, HSAG prepared a report of its findings and recommendations for each validated PIP. These reports, which complied with 42 CFR 438.364, were forwarded to MDCH and the appropriate MHP.

The EQR activities related to PIPs were designed to evaluate the validity and reliability of the MHP's processes in conducting the PIPs and to draw conclusions about the MHP's performance in the domains of quality, timeliness, and access to care and services. With the new MDCH requirement that each MHP's new PIP topic be targeted to a special group or unique subpopulation of enrollees, the topics varied across the MHPs, covering all three domains of **quality** and **timeliness** of—and **access** to—care, as illustrated in Table 1-5 (page 1-12).

3. Statewide Findings

The following section presents findings from the annual compliance reviews and the EQR activities of validation of performance measures and validation of PIPs for the two reporting periods of 2012–2013 and 2013–2014. Appendices A–M present additional details about the 2013–2014 plan-specific results of the activities.

Annual Compliance Review

MDCH conducted annual compliance reviews of the MHPs, assessing their compliance with contractual requirements on six standards: *Administrative*, *Providers*, *Members*, *Quality*, *MIS*, and *Program Integrity*. MDCH completed the full review of all standards over the course of the 2013–2014 State fiscal year. Due to a modified compliance monitoring process as described in Section 2 of this report, results from the 2013–2014 review cycle are not fully comparable to previous results.

In addition to the range of compliance scores and the statewide averages for each of the six standards and overall, Table 3-1 presents the number of corrective actions required and the number and percentage of MHPs that achieved 100 percent compliance for each standard, including a total across all standards.

| | | Compliance Scores | | | | Number of Corrective Actions Required | | MHPs in Full Compliance (Number/Percent) | |
|----------------------------|--------------------------|-------------------|----------------|-------------------|------------|---------------------------------------|-----------|--|-------------|
| | | Range | | Statewide Average | | P | C | P | C |
| | | P | C | P | C | | | | |
| 1 | <i>Administrative</i> | 75%–100% | 88%–100% | 96% | 97% | 4 | 3 | 10/77% | 10/77% |
| 2 | <i>Providers</i> | 89%–100% | 89%–100% | 97% | 97% | 7 | 6 | 8/62% | 8/62% |
| 3 | <i>Members</i> | 75%–100% | 92%–100% | 95% | 96% | 8 | 6 | 8/62% | 7/54% |
| 4 | <i>Quality</i> | 83%–100% | 83%–94% | 93% | 93% | 17 | 17 | 1/8% | 0/0% |
| 5 | <i>MIS</i> | 83%–100% | 67%–100% | 96% | 95% | 3 | 4 | 10/77% | 10/77% |
| 6 | <i>Program Integrity</i> | 100%–100% | 100%–100% | 100% | 100% | 0 | 0 | 13/100% | 13/100% |
| Overall Score/Total | | 93%–100% | 94%–99% | 97% | 97% | 39 | 36 | 0/0% | 0/0% |

Overall, the MHPs demonstrated continued strong performance related to their compliance with contractual requirements assessed in the compliance reviews. The statewide overall compliance score across all standards and MHPs remained at 97 percent. The number of corrective actions required decreased for the *Administrative*, *Providers*, and *Members* standards as well as overall, but increased for the *MIS* standard. The number of MHPs with a compliance score of 100 percent decreased for the *Members* and *Quality* standards.

Performance on the *Administrative* standard remained strong, with ten of the 13 MHPs demonstrating full compliance with all requirements in this area.

The *Providers* and *Members* standards continued to represent statewide strengths, with average scores of 97 percent and 96 percent, respectively. For the *Providers* standard, the number of MHPs in full compliance with all requirements remained at eight, while the *Members* standard had a slight decrease from eight MHPs in 2012–2013 to seven MHPs in the current review cycle. On the *Members* standard, several MHPs received recommendations related to timely mailing of member materials. Recommendations on the *Providers* standard addressed various requirements, including provider subcontract requirements and accessibility of covered services. Performance on the *MIS* standard was lower than in the previous cycle, as the number of corrective actions increased and the statewide average score declined. The number of MHPs in full compliance with all MIS requirements remained unchanged at ten.

For the *Quality* standard, the statewide average score remained unchanged at 93 percent. The number of MHPs that demonstrated full compliance on this standard remained the lowest among all standards, with no MHP achieving a score of 100 percent. The criterion for which all but one of the MHPs failed to demonstrate full compliance addressed performance monitoring measures. Compliance with MDCH-specified minimum performance standards remains the only statewide opportunity for improvement.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process were to evaluate the accuracy of the performance measure data collected by the MHPs and determine the extent to which the specific performance measures calculated by the MHPs (or on behalf of the MHPs) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a thorough information system evaluation was performed to assess the ability of each MHP's support system to report accurate HEDIS measures, as well as a measure-specific review of all reported measures.

Results from the validation of performance measures activities showed that all 13 MHPs received a finding of *Report* (i.e., appropriate processes, procedures, and corresponding documentation) for all assessed performance measures. The performance measure data were collected accurately from a wide variety of sources statewide. All of the MHPs demonstrated the ability to calculate and accurately report performance measures that complied with HEDIS specifications. This finding suggested that the information systems for reporting HEDIS measures were a statewide strength.

Table 3-2 displays the Michigan Medicaid 2014 HEDIS weighted averages and performance levels. The performance levels are a comparison of the 2014 Michigan Medicaid weighted average and the NCQA national HEDIS 2013 Medicaid percentiles. For most measures, a display of ★★★★★ indicates performance at or above the 90th percentile. Performance levels displayed as ★★★★ represent performance at or above the 75th percentile but below the 90th percentile. A ★★★ performance level indicates performance at or above the 50th percentile but below the 75th percentile. Performance levels displayed as ★★ represent performance at or above the 25th percentile but below the 50th percentile. Finally, performance levels displayed as a ★ indicate that the weighted average performance was below the 25th percentile.

For inverse measures, such as *Comprehensive Diabetes Care—Poor HbA1c Control*, the 10th percentile (rather than the 90th percentile) represents excellent performance and the 75th percentile (rather than the 25th percentile) represents below-average performance.

For *Ambulatory Care* measures, since high/low visit counts reported did not take into account the demographic and clinical conditions of an eligible population, performance levels do not necessarily denote better or worse performance. Nonetheless, percentile ranking is provided for information only.

Table 3-2—Overall Statewide Averages for Performance Measures

| Performance Measure | 2013 MI Medicaid | 2014 MI Medicaid | Performance Level for 2014 | 2013–2014 Comparison |
|--|------------------|------------------|----------------------------|----------------------|
| Child and Adolescent Care | | | | |
| <i>Childhood Immunization—Combination 2</i> | 81.48% | 80.90% | ★★★★ | -0.58 |
| <i>Childhood Immunization—Combination 3</i> | 77.16% | 77.21% | ★★★★ | +0.05 |
| <i>Childhood Immunization—Combination 4</i> | 56.14% | 70.61% | ★★★★ | +14.47 |
| <i>Childhood Immunization—Combination 5</i> | 57.57% | 61.42% | ★★★★ | +3.85 |
| <i>Childhood Immunization—Combination 6</i> | 37.77% | 42.17% | ★★★★ | +4.40 |
| <i>Childhood Immunization—Combination 7</i> | 42.85% | 57.33% | ★★★★ | +14.48 |
| <i>Childhood Immunization—Combination 8</i> | 30.16% | 40.22% | ★★★★ | +10.06 |
| <i>Childhood Immunization—Combination 9</i> | 30.61% | 35.18% | ★★★★ | +4.57 |
| <i>Childhood Immunization—Combination 10</i> | 24.79% | 33.87% | ★★★★ | +9.08 |
| <i>Immunizations for Adolescents—Combination 1</i> | 88.85% | 88.43% | ★★★★★ | -0.42 |
| <i>Well-Child Visits, First 15 Months—6 or More Visits</i> | 77.83% | 73.09% | ★★★★ | -4.74 |
| <i>Well-Child Visits, Third Through Sixth Years of Life</i> | 78.03% | 77.05% | ★★★★ | -0.98 |
| <i>Adolescent Well-Care Visits</i> | 61.46% | 57.80% | ★★★★ | -3.66 |
| <i>Lead Screening in Children</i> | 82.40% | 80.43% | ★★★★ | -1.97 |
| <i>Appropriate Treatment for Children With URI</i> | 85.53% | 86.53% | ★★★★ | +1.00 |
| <i>Appropriate Testing for Children With Pharyngitis</i> | 61.28% | 59.19% | ★ | -2.09 |
| <i>Follow-Up Care for Children Prescribed ADHD Meds—Initiation Phase</i> | 39.09% | 40.24% | ★★★★ | +1.15 |
| <i>Follow-Up Care for Children Prescribed ADHD Meds—Continuation and Maintenance Phase</i> | 46.93% | 47.04% | ★★★★ | +0.11 |
| Women—Adult Care | | | | |
| <i>Breast Cancer Screening¹</i> | 57.41% | 62.56% | ★★★★ | +5.15 |
| <i>Cervical Cancer Screening²</i> | 72.60% | 71.34% | ★★★★ | -1.26 |

2013–2014 Comparison Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline from the prior year.

¹ There were several changes in the HEDIS 2014 specifications for this measure, including updated age ranges from 40–69 years to 50–74 years and an extended numerator time frame from 24 months to 27 months. These changes have the potential to increase the HEDIS 2014 rates. Consequently, the observed significant increase in the statewide rate may be due to both measure specification changes and the MHPs’ efforts to improve breast cancer screening. Additionally, when compared to the national HEDIS 2013 percentiles, the statewide average may achieve a higher percentile ranking due not solely to the MHPs’ intervention efforts.

² It should be noted that, due to significant measure specification changes, any rate change for the *Cervical Cancer Screening* measure may not accurately reflect performance improvement or decline. HSAG suggests that the HEDIS 2014 rates be treated as baseline rates for future trending. Performance ranking based on HEDIS 2013 percentiles should be used for information only.

- ★★★★★ = 90th percentile and above
- ★★★★ = 75th to 89th percentile
- ★★★ = 50th to 74th percentile
- ★★ = 25th to 49th percentile
- ★ = Below 25th percentile

Table 3-2—Overall Statewide Averages for Performance Measures

| Performance Measure | 2013 MI Medicaid | 2014 MI Medicaid | Performance Level for 2014 | 2013–2014 Comparison |
|--|------------------|---------------------------|----------------------------|----------------------|
| Women—Adult Care (continued) | | | | |
| <i>Chlamydia Screening in Women—16 to 20 Years</i> | 62.50% | 60.15% | ★★★★ | -2.35 |
| <i>Chlamydia Screening in Women—21 to 24 Years</i> | 71.67% | 69.44% | ★★★ | -2.23 |
| <i>Chlamydia Screening in Women—Total</i> | 65.84% | 63.40% | ★★★ | -2.44 |
| Access to Care | | | | |
| <i>Children’s Access to Primary Care Practitioners—12 to 24 Months</i> | 97.30% | 96.73% | ★★ | -0.57 |
| <i>Children’s Access to Primary Care Practitioners—25 Months to 6 Years</i> | 90.14% | 88.91% | ★★ | -1.23 |
| <i>Children’s Access to Primary Care Practitioners—7 to 11 Years</i> | 92.15% | 91.68% | ★★★ | -0.47 |
| <i>Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i> | 90.89% | 90.48% | ★★★ | -0.41 |
| <i>Adults’ Access to Preventive/Ambulatory Health Services—20 to 44 Years</i> | 84.53% | 84.30% | ★★★ | -0.23 |
| <i>Adults’ Access to Preventive/Ambulatory Health Services—45 to 64 Years</i> | 90.77% | 90.93% | ★★★★ | +0.16 |
| <i>Adults’ Access to Preventive/Ambulatory Health Services—65+ Years</i> | 92.12% | 90.29% | ★★★ | -1.83 |
| <i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i> | 86.68% | 86.75% | ★★★★ | +0.07 |
| Obesity | | | | |
| <i>Children/Adolescents—BMI Assessment—Total</i> | 69.62% | 70.07% | ★★★★ | +0.45 |
| <i>Children/Adolescents—Counseling for Nutrition—Total</i> | 59.39% | 64.72% | ★★★ | +5.33 |
| <i>Children/Adolescents—Counseling for Physical Activity—Total</i> | 48.98% | 52.99% | ★★★ | +4.01 |
| <i>Adult BMI Assessment</i> | 80.39% | 86.05% | ★★★★★ | +5.66 |
| Pregnancy Care | | | | |
| <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> | 89.61% | 88.92% | ★★★ | -0.69 |
| <i>Prenatal and Postpartum Care—Postpartum Care</i> | 70.56% | 70.84% | ★★★★ | +0.28 |
| <i>Frequency of Ongoing Prenatal Care—≥ 81 Percent</i> | 68.74% | 66.36% | ★★★ | -2.38 |
| Living With Illness | | | | |
| <i>Comprehensive Diabetes Care—HbA1c Testing</i> | 85.21% | 85.45% | ★★★ | +0.24 |
| <i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*</i> | 36.06% | 37.23% | ★★★ | +1.17 |
| <i>Comprehensive Diabetes Care—HbA1c Control (<8.0%)</i> | 54.57% | 53.74% | ★★★ | -0.83 |
| <i>Comprehensive Diabetes Care—Eye Exam</i> | 59.42% | 63.01% | ★★★★ | +3.59 |
| <i>Comprehensive Diabetes Care—LDL-C Screening</i> | 79.91% | 78.67% | ★★★ | -1.24 |
| 2013–2014 Comparison Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline from the prior year. | | | | |
| * For this indicator, a lower rate indicates better performance. | | | | |
| ★★★★★ | = | 90th percentile and above | | |
| ★★★★ | = | 75th to 89th percentile | | |
| ★★★ | = | 50th to 74th percentile | | |
| ★★ | = | 25th to 49th percentile | | |
| ★ | = | Below 25th percentile | | |

Table 3-2—Overall Statewide Averages for Performance Measures

| Performance Measure | 2013 MI Medicaid | 2014 MI Medicaid | Performance Level for 2014 | 2013–2014 Comparison |
|---|------------------|------------------|----------------------------|----------------------|
| Living With Illness (continued) | | | | |
| <i>Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)</i> | 39.16% | 40.83% | ★★★★ | +1.67 |
| <i>Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy</i> | 82.41% | 82.00% | ★★★ | -0.41 |
| <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/80 mm Hg)</i> | 43.73% | 41.41% | ★★★ | -2.32 |
| <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> | 66.22% | 63.56% | ★★★ | -2.66 |
| <i>Use of Appropriate Medications for People With Asthma—Total</i> | 82.13% | 81.19% | ★★ | -0.94 |
| <i>Controlling High Blood Pressure</i> | 65.71% | 63.58% | ★★★★ | -2.13 |
| <i>Smoking and Tobacco Use Cessation—Advising Smokers to Quit</i> | 79.97% | 80.35% | — | +0.38 |
| <i>Smoking and Tobacco Use Cessation—Discussing Cessation Medications</i> | 52.38% | 53.75% | — | +1.37 |
| <i>Smoking and Tobacco Use Cessation—Discussing Cessation Strategies</i> | 45.07% | 46.12% | — | +1.05 |
| <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i> | 83.47% | 83.54% | ★★★★ | +0.07 |
| <i>Diabetes Monitoring for People With Diabetes and Schizophrenia</i> | 64.27% | 72.60% | ★★★★ | +8.33 |
| <i>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</i> | 70.96% | 60.14% | ★ | -10.82 |
| <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i> | 52.71% | 60.49% | ★★ | +7.78 |
| Utilization | | | | |
| <i>Ambulatory Care—Outpatient Visits per 1,000 Member Months</i> | 344.16 | 325.25 | ★★ | -18.91† |
| <i>Ambulatory Care—ED Visits per 1,000 Member Months*</i> | 74.85 | 73.41 | ★★ | -1.44† |
| 2013–2014 Comparison Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline from the prior year. * For this indicator, a lower rate indicates better performance. — = The national HEDIS 2013 Medicaid percentiles are not available. † Statistical tests across years were not performed for this indicator. Additionally, values displayed are number of visits, not percentage points as with other measures. | | | | |
| ★★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile | | | | |

The HEDIS 2014 average rates for 29 of the 58 measures showed an increase from the prior year, with 15 of these rate increases reaching statistical significance. Rates for 29 measures declined from the HEDIS 2013 results, 12 of which were statistically significant declines. Three rates, all under *Childhood Immunization Status*, had a significant increase of more than 10 percentage points. The *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure showed a significant rate decline of close to 11 percentage points from 2013.

Measure rate changes from 2013 to 2014 within three of the seven dimensions (Pregnancy Care, Living With Illness, and Utilization) were minimal. Most of the significant rate changes (increases and declines) were in the Child and Adolescent Care dimension (eight of 15 significant increases

and three of the 12 significant declines). In terms of the magnitude of significant increases, Child and Adolescent Care also had the largest improvement. The second largest performance improvement was in the Obesity dimension, where all but one measure had a significant increase from 2013, with the magnitude of increases between 4 and 5 percentage points. Both Women—Adult Care and Access to Care dimensions showed more measures with significant declines than improvements. For Women—Adult Care, three of the five rates reported significant declines close to 2.5 percentage points, although it had one rate showing significant increase of slightly over 5 percentage points. In the Access to Care dimension, five of the eight rates reported significant declines, though none of them exceeded 2 percentage points.

Table 3-3 presents, by measure, the number of MHPs that performed at each performance level. The counts include only measures with a valid, reportable rate that could be benchmarked to national standards.

| Table 3-3—Count of MHPs by Performance Level | | | | | |
|---|-----------------|----|-----|------|-------|
| Performance Measure | Number of Stars | | | | |
| | ★ | ★★ | ★★★ | ★★★★ | ★★★★★ |
| Child and Adolescent Care | | | | | |
| <i>Childhood Immunization—Combination 2</i> | 2 | 3 | 5 | 1 | 2 |
| <i>Childhood Immunization—Combination 3</i> | 2 | 4 | 3 | 2 | 2 |
| <i>Childhood Immunization—Combination 4</i> | 1 | 1 | 8 | 2 | 1 |
| <i>Childhood Immunization—Combination 5</i> | 1 | 3 | 5 | 3 | 1 |
| <i>Childhood Immunization—Combination 6</i> | 3 | 4 | 5 | 0 | 1 |
| <i>Childhood Immunization—Combination 7</i> | 1 | 2 | 6 | 3 | 1 |
| <i>Childhood Immunization—Combination 8</i> | 3 | 4 | 3 | 2 | 1 |
| <i>Childhood Immunization—Combination 9</i> | 3 | 3 | 4 | 2 | 1 |
| <i>Childhood Immunization—Combination 10</i> | 3 | 3 | 3 | 3 | 1 |
| <i>Immunizations for Adolescents—Combination 1</i> | 0 | 0 | 0 | 1 | 11 |
| <i>Well-Child Visits, First 15 Months—6 or More Visits</i> | 2 | 4 | 0 | 3 | 3 |
| <i>Well-Child Visits, Third Through Sixth Years of Life</i> | 2 | 3 | 6 | 1 | 1 |
| <i>Adolescent Well-Care Visits</i> | 1 | 1 | 6 | 4 | 1 |
| <i>Lead Screening in Children</i> | 0 | 2 | 5 | 6 | 0 |
| <i>Appropriate Treatment for Children With URI</i> | 1 | 3 | 6 | 0 | 3 |
| <i>Appropriate Testing for Children With Pharyngitis</i> | 7 | 2 | 3 | 0 | 0 |
| <i>Follow-Up Care for Children Prescribed ADHD Meds—Initiation Phase</i> | 1 | 5 | 4 | 0 | 0 |
| <i>Follow-Up Care for Children Prescribed ADHD Meds—Continuation and Maintenance Phase</i> | 2 | 2 | 5 | 0 | 0 |
| ★★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile | | | | | |

Table 3-3—Count of MHPs by Performance Level

| Performance Measure | Number of Stars | | | | |
|--|-----------------|----|-----|------|-------|
| | ★ | ★★ | ★★★ | ★★★★ | ★★★★★ |
| Women—Adult Care | | | | | |
| <i>Breast Cancer Screening¹</i> | 1 | 1 | 2 | 4 | 5 |
| <i>Cervical Cancer Screening²</i> | 1 | 2 | 6 | 2 | 2 |
| <i>Chlamydia Screening in Women—16 to 20 Years</i> | 1 | 2 | 2 | 5 | 2 |
| <i>Chlamydia Screening in Women—21 to 24 Years</i> | 1 | 1 | 5 | 3 | 2 |
| <i>Chlamydia Screening in Women—Total</i> | 1 | 1 | 4 | 4 | 2 |
| Access to Care | | | | | |
| <i>Children’s Access—12 to 24 Months</i> | 4 | 3 | 5 | 1 | 0 |
| <i>Children’s Access—25 Months to 6 Years</i> | 7 | 2 | 3 | 1 | 0 |
| <i>Children’s Access—7 to 11 Years</i> | 2 | 5 | 4 | 2 | 0 |
| <i>Adolescents’ Access—12 to 19 Years</i> | 3 | 4 | 2 | 4 | 0 |
| <i>Adults’ Access—20 to 44 Years</i> | 1 | 6 | 2 | 4 | 0 |
| <i>Adults’ Access—45 to 64 Years</i> | 1 | 2 | 4 | 1 | 5 |
| <i>Adults’ Access—65+ Years</i> | 1 | 3 | 0 | 5 | 1 |
| <i>Adults’ Access—Total</i> | 1 | 6 | 0 | 6 | 0 |
| Obesity | | | | | |
| <i>Children/Adolescents—BMI Percentile, 3 to 11 years</i> | 0 | 0 | 5 | 6 | 2 |
| <i>Children/Adolescents—BMI Percentile, 12 to 17 years</i> | 0 | 0 | 2 | 5 | 5 |
| <i>Children/Adolescents—BMI Percentile, Total</i> | 0 | 0 | 5 | 6 | 2 |
| <i>Children/Adolescents—Nutrition, 3 to 11 years</i> | 0 | 2 | 9 | 1 | 1 |
| <i>Children/Adolescents—Nutrition, 12 to 17 years</i> | 0 | 3 | 3 | 4 | 2 |
| <i>Children/Adolescents—Nutrition, Total</i> | 0 | 2 | 9 | 1 | 1 |
| <i>Children/Adolescents—Physical Activity, 3 to 11 years</i> | 0 | 1 | 8 | 3 | 1 |
| <i>Children/Adolescents—Physical Activity, 12 to 17 years</i> | 0 | 2 | 4 | 4 | 2 |
| <i>Children/Adolescents—Physical Activity, Total</i> | 0 | 1 | 6 | 5 | 1 |
| <i>Adult BMI Assessment</i> | 0 | 0 | 0 | 3 | 10 |
| <p>¹ Changes in the HEDIS 2014 specifications for this measure may have the potential to increase the HEDIS 2014 plan rates. Consequently, when compared to the national HEDIS 2013 percentiles, each MHP may also achieve a higher percentile ranking due not solely to its intervention efforts.</p> <p>² Due to significant measure specification changes, NCQA indicates that the <i>Cervical Cancer Screening</i> rate is not publicly reported. Since the stars are generated based on a comparison of each MHP’s rate against the HEDIS 2013 Medicaid percentile values, please use caution when interpreting these results.</p> <p>★★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile</p> | | | | | |

Table 3-3—Count of MHPs by Performance Level

| Performance Measure | Number of Stars | | | | |
|---|-----------------|----|-----|------|-------|
| | ★ | ★★ | ★★★ | ★★★★ | ★★★★★ |
| Pregnancy Care | | | | | |
| <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> | 3 | 2 | 2 | 4 | 2 |
| <i>Prenatal and Postpartum Care—Postpartum Care</i> | 2 | 1 | 4 | 3 | 3 |
| <i>Frequency of Ongoing Prenatal Care—≥ 81 Percent</i> | 5 | 2 | 2 | 2 | 2 |
| Living With Illness | | | | | |
| <i>Comprehensive Diabetes Care—HbA1c Testing</i> | 0 | 3 | 6 | 3 | 1 |
| <i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*</i> | 1 | 2 | 5 | 1 | 4 |
| <i>Comprehensive Diabetes Care—HbA1c Control (<8.0%)</i> | 1 | 3 | 3 | 2 | 4 |
| <i>Comprehensive Diabetes Care—Eye Exam</i> | 2 | 0 | 3 | 7 | 1 |
| <i>Comprehensive Diabetes Care—LDL-C Screening</i> | 0 | 2 | 10 | 0 | 1 |
| <i>Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)</i> | 2 | 0 | 3 | 5 | 3 |
| <i>Comprehensive Diabetes Care—Nephropathy</i> | 0 | 1 | 5 | 5 | 2 |
| <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/80)</i> | 2 | 2 | 4 | 3 | 2 |
| <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90)</i> | 3 | 2 | 4 | 3 | 1 |
| <i>Use of Appropriate Medications for People With Asthma—5 to 11 Years</i> | 4 | 2 | 2 | 3 | 1 |
| <i>Use of Appropriate Medications for People With Asthma—12 to 18 Years</i> | 3 | 2 | 5 | 0 | 2 |
| <i>Use of Appropriate Medications for People With Asthma—19 to 50 Years</i> | 3 | 2 | 5 | 1 | 1 |
| <i>Use of Appropriate Medications for People With Asthma—51 to 64 Years</i> | 5 | 4 | 1 | 0 | 0 |
| <i>Use of Appropriate Medications for People With Asthma—Total</i> | 4 | 4 | 2 | 1 | 1 |
| <i>Controlling High Blood Pressure</i> | 2 | 2 | 3 | 3 | 3 |
| <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i> | 0 | 1 | 1 | 5 | 1 |
| <i>Diabetes Monitoring for People With Diabetes and Schizophrenia</i> | 3 | 2 | 1 | 0 | 2 |
| <i>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</i> | 1 | 0 | 1 | 1 | 0 |
| <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i> | 1 | 1 | 2 | 4 | 0 |
| ★★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile | | | | | |

| Table 3-3—Count of MHPs by Performance Level | | | | | |
|--|-----------------|------------|------------|------------|------------|
| Performance Measure | Number of Stars | | | | |
| | ★ | ★★ | ★★★ | ★★★★ | ★★★★★ |
| Utilization | | | | | |
| <i>Ambulatory Care—Total (Visits per 1,000 Member Months): Outpatient—Total</i> | 5 | 4 | 4 | 0 | 0 |
| <i>Ambulatory Care—Total (Visits per 1,000 Member Months): ED—Total*</i> | 6 | 3 | 4 | 0 | 0 |
| Total | 118 | 145 | 249 | 169 | 113 |
| * For this indicator, a lower rate indicates better performance (i.e., low rate of ED visits indicates better care). Therefore, the percentiles were reversed to align with performance (e.g., if the <i>ED—Total</i> rate was above the 75th percentile, it would be inverted to be below the 25th percentile with a one-star performance displayed). | | | | | |
| ★★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile | | | | | |

Table 3-3 shows that 31.4 percent of all performance measure rates (249 of 794) reported by all MHPs fell into the average (★★★) range relative to national Medicaid results. While 14.2 percent of all performance measure rates ranked in the 90th percentile and above (★★★★★), 33.1 percent of all performance measure rates fell below the national HEDIS 2013 Medicaid 50th percentile, providing opportunities for improvement.

Performance Improvement Projects (PIPs)

Table 3-4 presents a summary of the MHPs’ PIP validation status results. All PIPs submitted for the 2012–2013 validation continued with the third year of the State-mandated topic, *Childhood Obesity*. For the 2013–2014 validation, the MHPs provided their first-year submissions on a new PIP topic they selected to address a specific targeted subpopulation. All PIPs received a validation status of *Met*, reflecting continued strong performance.

| Table 3-4—MHPs’ PIP Validation Status | | |
|---------------------------------------|--------------------|-----------|
| Validation Status | Percentage of PIPs | |
| | 2012–2013 | 2013–2014 |
| <i>Met</i> | 100% | 100% |
| <i>Partially Met</i> | 0% | 0% |
| <i>Not Met</i> | 0% | 0% |

The following presents a summary of the validation results for the MHPs for the activities from the CMS PIP protocol. For the 2013–2014 cycle, HSAG validated all first-year PIP submissions for Activity I—Select the Study Topic through Activity VII—Analyze Data and Interpret Study Results. Seven PIPs progressed to Activity VIII—Implement Interventions and Improvement Strategies.

Table 3-5 shows the percentage of MHPs that met all of the applicable evaluation or critical elements within each of the ten activities.

| Table 3-5—Summary of Data From Validation of Performance Improvement Projects | | | |
|---|---|--|--------------|
| Review Activities | | Percentage Meeting All Elements/ Percentage Meeting All Critical Elements | |
| | | 2012–2013 | 2013–2014 |
| I. | Select the Study Topic | 100%/100% | 100%/100% |
| II. | Define the Study Question(s) | 100%/100% | 100%/100% |
| III. | Use a Representative and Generalizable Study Population | 100%/100% | 100%/100% |
| IV. | Select the Study Indicator(s) | 100%/100% | 100%/100% |
| V. | Use Sound Sampling Techniques* | 100%/100% | 100%/100% |
| VI. | Reliably Collect Data | 100%/100% | 85%/100% |
| VII. | Analyze Data and Interpret Study Results | 69%/100% | 100%/100% |
| VIII. | Implement Interventions and Improvement Strategies | 92%/100% | 71%/100% |
| IX. | Assess for Real Improvement | 62%/NCE | Not Assessed |
| X. | Assess for Sustained Improvement | 92%/NCE | Not Assessed |

NCE = No Critical Elements * This activity is assessed only for PIPs that conduct sampling.

The results from the 2013–2014 validation continued to reflect strong performance. The PIP validation evaluated the technical methods of the PIP (i.e., the study design and implementation/evaluation) associated with the baseline data reported. Based on its technical review, HSAG determined the overall methodological validity of the PIPs, all of which received a validation status of *Met*. All 13 MHPs received scores of *Met* for each applicable evaluation element in Activities I through V as well as for each applicable critical element across all activities assessed. Nine of the MHPs met all applicable evaluation and critical elements across all activities completed. The remaining MHPs received scores of less than *Met* for one element in Activity VI—Reliably Collect Data or Activity VIII—Implement Interventions and Improvement Strategies. The recommendations addressed the needs to outline the MHP’s process to determine the percentage of its administrative data completeness, to present consistent and accurate documentation regarding the data collection process, and to have an independent process to evaluate the effectiveness of each intervention. HSAG did not identify any statewide opportunities for improvement.

The new PIP topics selected by the MHPs targeted specific groups of enrollees defined by age, race, county of residence, or diagnosis. Several PIPs were designed to improve timeliness of prenatal and/or postpartum care, rates of well-care visits or immunizations for children, access to care for adults and adolescents, and prevention or management of chronic health conditions. Among the MHPs that progressed to Activity VIII—Implement Interventions and Improvement Strategies, several MHPs identified barriers to performance. Barriers included lack of parental knowledge about the importance of well-child visits, lack of current data or tracking processes for noncompliant enrollees, and lack of incentives both for providers to get members in for an appointment and for enrollees to obtain tests and screenings. To overcome these barriers, MHPs implemented interventions including educational and reminder messages, materials tailored to the targeted population, provider education and dissemination of practice guidelines, and incentive programs for enrollees and providers. As the PIPs progress, the MHPs should evaluate the effectiveness of each implemented intervention to determine which interventions to continue, revise, or abandon.

Conclusions/Summary

The review of the MHPs showed both strengths and opportunities for improvement statewide.

Results of the 2013–2014 annual compliance reviews reflected continued strong performance by the MHPs, demonstrating high levels of compliance with contractual requirements in all areas assessed. The *Administrative*, *Providers*, *Members*, and *MIS* standards continued to represent statewide strengths. Compliance with MDCH-specified minimum performance standards—assessed in the *Quality* standard—remained a statewide opportunity for improvement.

Michigan’s statewide HEDIS 2014 performance showed both strengths and opportunities for improvement. Fifty percent of the 58 comparable measures reflected improved performance from 2012–2013, with 15 indicators having statistically significant increases. Significant improvements were concentrated in the Child and Adolescent Care and Obesity dimensions. Three rates—all in the Child and Adolescent Care dimension—showed significant improvement of more than 10 percentage points. Despite these strengths, more rates experienced declines than last year. Overall, 29 rates showed a decline from the prior year, 12 of which were statistically significant declines.

Most significant declines concentrated in the Women—Adult Care and Access to Care dimensions. Nonetheless, only one measure had a significant decline of more than 10 percentage points.

The 2013–2014 validation of the PIPs reflected high levels of compliance with the requirements for Activities I–VIII of the CMS PIP protocol. All 13 PIPs received a validation status of *Met* for their first-year submission of a PIP on improving quality outcomes—specifically, the quality, timeliness, and accessibility of care and services for a selected subpopulation of enrollees. The MHPs designed methodologically sound studies with a foundation on which to progress to subsequent PIP stages.

Overview

The following appendices summarize MHP-specific key findings for the three mandatory EQR-related activities: compliance monitoring, validation of performance measures, and validation of PIPs. For a more detailed description of the results of the mandatory EQR-related activities, refer to the aggregate and MHP-specific reports, including:

- ◆ Reports of the 2013–2014 compliance review findings for each MHP
- ◆ Michigan Medicaid HEDIS 2014 results reports
- ◆ 2014 PIP validation reports

Michigan Medicaid Health Plan Names

MDCH uses a three-letter acronym for each MHP. The acronyms are illustrated in the table below and are used throughout this report.

| Table 4-1—List of Appendices With Michigan MHP Acronyms and Formal Names | | |
|---|---------|-----------------------------------|
| Appendix | Acronym | MHP Name |
| A | BCC | Blue Cross Complete of Michigan |
| B | COV | CoventryCares of Michigan, Inc. |
| C | HAR | Harbor Health Plan |
| D | HPP | HealthPlus Partners |
| E | MCL | McLaren Health Plan |
| F | MER | Meridian Health Plan of Michigan |
| G | MID | HAP Midwest Health Plan, Inc. |
| H | MOL | Molina Healthcare of Michigan |
| I | PHP | Physicians Health Plan—FamilyCare |
| J | PRI | Priority Health Choice, Inc. |
| K | THC | Total Health Care, Inc. |
| L | UNI | UnitedHealthcare Community Plan |
| M | UPP | Upper Peninsula Health Plan |

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations’ compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH evaluated **MER**’s compliance with federal and State requirements related to the six standards shown in Table F-1 over the course of the 2013–2014 State fiscal year. For a detailed explanation of the scoring methodology, please see Section 2 of this report.

Table F-1 below presents **MER**’s compliance review results.

| Standard | Number of Scores | | | | Compliance Score | |
|---------------------|------------------|------------|----------|----------------|------------------|------------|
| | Pass | Incomplete | Fail | Not Applicable | MHP | Statewide |
| 1 Administrative | 3 | 1 | 0 | 0 | 88% | 97% |
| 2 Providers | 8 | 1 | 0 | 0 | 94% | 97% |
| 3 Members | 5 | 1 | 0 | 0 | 92% | 96% |
| 4 Quality | 8 | 1 | 0 | 0 | 94% | 93% |
| 5 MIS | 3 | 0 | 0 | 0 | 100% | 95% |
| 6 Program Integrity | 16 | 0 | 0 | 0 | 100% | 100% |
| Overall | 43 | 4 | 0 | 0 | 96% | 97% |

MER showed strengths in the *MIS* and *Program Integrity* standards, demonstrating compliance with all contractual requirements. **MER**’s performance on these standards exceeded or matched the statewide scores. The 2013–2014 compliance review identified opportunities for improvement for the *Administrative*, *Providers*, *Members*, and *Quality* standards. While **MER**’s compliance score for the *Quality* standard was higher than the statewide average, its scores for the *Administrative*, *Providers*, and *Members* standards fell below the statewide scores. **MER**’s strong performance fell below the statewide average, with an overall compliance score of 96 percent.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table F-2. The table shows each of the performance measures, the rate for each measure for 2014, and the categorized performance for 2014 relative to national Medicaid results.

| Dimension | Performance Measure | Rate for 2014 | Performance Level for 2014 |
|----------------------------------|--|---------------|----------------------------|
| Child and Adolescent Care | <i>Childhood Immunization—Combination 2</i> | 85.42% | ★★★★★ |
| | <i>Childhood Immunization—Combination 3</i> | 80.79% | ★★★★ |
| | <i>Childhood Immunization—Combination 4</i> | 72.92% | ★★★★ |
| | <i>Childhood Immunization—Combination 5</i> | 65.51% | ★★★★ |
| | <i>Childhood Immunization—Combination 6</i> | 47.69% | ★★★ |
| | <i>Childhood Immunization—Combination 7</i> | 60.65% | ★★★★ |
| | <i>Childhood Immunization—Combination 8</i> | 44.91% | ★★★ |
| | <i>Childhood Immunization—Combination 9</i> | 40.28% | ★★★ |
| | <i>Childhood Immunization—Combination 10</i> | 38.66% | ★★★★ |
| | <i>Immunizations for Adolescents—Combination 1</i> | 89.73% | ★★★★★ |
| | <i>Well-Child 1st 15 Months—6+ Visits[^]</i> | 78.24% | ★★★★★ |
| | <i>Well-Child 3rd–6th Years of Life[^]</i> | 82.52% | ★★★★★ |
| | <i>Adolescent Well-Care Visits[^]</i> | 62.33% | ★★★★ |
| | <i>Lead Screening in Children</i> | 83.33% | ★★★★ |
| | <i>Appropriate Treatment of URI</i> | 86.55% | ★★★ |
| | <i>Children With Pharyngitis</i> | 65.56% | ★★ |
| | <i>F/U Care for Children Prescribed ADHD Meds—Initiation Phase</i> | 43.97% | ★★★ |
| | <i>F/U Care for Children Prescribed ADHD Meds—Continuation and Maintenance Phase</i> | 51.04% | ★★★ |

[^] Plan chose to rotate the measure. Measure rotation allows the health plan to use the audited and reportable rate from the previous year as specified by NCQA in the *HEDIS 2014 Technical Specifications for Health Plans, Volume 2*.

| | |
|-------|-----------------------------|
| ★★★★★ | = 90th percentile and above |
| ★★★★ | = 75th to 89th percentile |
| ★★★ | = 50th to 74th percentile |
| ★★ | = 25th to 49th percentile |
| ★ | = Below 25th percentile |

Table F-2—Scores for Performance Measures for MER

| Dimension | Performance Measure | Rate for 2014 | Performance Level for 2014 |
|-------------------------|--|---------------|----------------------------|
| Women—Adult Care | <i>Breast Cancer Screening¹</i> | 68.69% | ★★★★★ |
| | <i>Cervical Cancer Screening²</i> | 74.71% | ★★★★ |
| | <i>Chlamydia Screening—16 to 20 Years</i> | 60.19% | ★★★★ |
| | <i>Chlamydia Screening—21 to 24 Years</i> | 70.32% | ★★★ |
| | <i>Chlamydia Screening—Total</i> | 64.11% | ★★★★ |
| Access to Care | <i>Children’s Access—12 to 24 Months</i> | 97.74% | ★★★ |
| | <i>Children’s Access—25 Months to 6 Years</i> | 91.85% | ★★★★ |
| | <i>Children’s Access—7 to 11 Years</i> | 93.84% | ★★★★ |
| | <i>Adolescents’ Access—12 to 19 Years</i> | 93.65% | ★★★★ |
| | <i>Adults’ Access—20 to 44 Years</i> | 87.08% | ★★★★ |
| | <i>Adults’ Access—45 to 64 Years</i> | 92.41% | ★★★★★ |
| | <i>Adults’ Access—65+ Years</i> | 92.31% | ★★★★ |
| Obesity | <i>Children/Adolescents—BMI Percentile, 3 to 11 years</i> | 57.89% | ★★★ |
| | <i>Children/Adolescents—BMI Percentile, 12 to 17 years</i> | 60.96% | ★★★ |
| | <i>Children/Adolescents—BMI Percentile, Total</i> | 58.93% | ★★★ |
| | <i>Children/Adolescents—Nutrition, 3 to 11 years</i> | 65.26% | ★★★ |
| | <i>Children/Adolescents—Nutrition, 12 to 17 years</i> | 56.85% | ★★★ |
| | <i>Children/Adolescents—Nutrition, Total</i> | 62.41% | ★★★ |
| | <i>Children/Adolescents—Physical Activity, 3 to 11 years</i> | 46.32% | ★★★ |
| | <i>Children/Adolescents—Physical Activity, 12 to 17 years</i> | 53.42% | ★★★ |
| | <i>Children/Adolescents—Physical Activity, Total</i> | 48.72% | ★★★ |
| | <i>Adult BMI Assessment</i> | 87.50% | ★★★★★ |
| Pregnancy Care | <i>Timeliness of Prenatal Care[^]</i> | 94.13% | ★★★★★ |
| | <i>Postpartum Care</i> | 76.35% | ★★★★★ |
| | <i>Weeks of Pregnancy at Time of Enrollment—≤ 0 Weeks</i> | 26.74% | — |
| | <i>Weeks of Pregnancy at Time of Enrollment—1 to 12 Weeks</i> | 9.88% | — |
| | <i>Weeks of Pregnancy at Time of Enrollment—13 to 27 Weeks</i> | 45.50% | — |

¹ Since several changes in the HEDIS 2014 specifications for this measure have the potential to increase the HEDIS 2014 rate, the observed percentile ranking may be a result of both the specification changes and the MHP’s efforts to improve breast cancer screening.

² Due to significant measure specification changes noted by NCQA, the observed percentile ranking based on HEDIS 2013 percentiles may be a result of both the specification changes and the MHP’s efforts to improve cervical cancer screening. The ranking should be used for information only.

[^] Plan chose to rotate the measure. Measure rotation allows the health plan to use the audited and reportable rate from the previous year as specified by NCQA in the *HEDIS 2014 Technical Specifications for Health Plans, Volume 2*.

— = The national HEDIS 2013 Medicaid percentiles are not available.

| | |
|-------|-----------------------------|
| ★★★★★ | = 90th percentile and above |
| ★★★★ | = 75th to 89th percentile |
| ★★★ | = 50th to 74th percentile |
| ★★ | = 25th to 49th percentile |
| ★ | = Below 25th percentile |

Table F-2—Scores for Performance Measures for MER

| Dimension | Performance Measure | Rate for 2014 | Performance Level for 2014 |
|---|---|---------------|----------------------------|
| Pregnancy Care (continued) | <i>Weeks of Pregnancy at Time of Enrollment—28 or More Weeks</i> | 17.72% | — |
| | <i>Weeks of Pregnancy at Time of Enrollment—Unknown</i> | 0.15% | — |
| | <i>Frequency of Ongoing Prenatal Care—< 21 Percent*</i> [^] | 0.70% | NC |
| | <i>Frequency of Ongoing Prenatal Care—21 to 40 Percent</i> [^] | 1.64% | NC |
| | <i>Frequency of Ongoing Prenatal Care—41 to 60 Percent</i> [^] | 2.82% | NC |
| | <i>Frequency of Ongoing Prenatal Care—61 to 80 Percent</i> [^] | 7.75% | NC |
| | <i>Frequency of Ongoing Prenatal Care—≥ 81 Percent</i> [^] | 87.09% | ★★★★★ |
| Living With Illness | <i>Diabetes Care—HbA1c Testing</i> | 90.31% | ★★★★★ |
| | <i>Diabetes Care—Poor HbA1c Control (>9.0%)*</i> | 30.21% | ★★★★★ |
| | <i>Diabetes Care—HbA1c Control (<8.0%)</i> | 60.26% | ★★★★★ |
| | <i>Diabetes Care—Eye Exam</i> | 62.84% | ★★★★★ |
| | <i>Diabetes Care—LDL-C Screening</i> | 77.71% | ★★★ |
| | <i>Diabetes Care—LDL-C Control (<100mg/dL)</i> | 40.06% | ★★★★★ |
| | <i>Diabetes Care—Nephropathy</i> | 78.03% | ★★ |
| | <i>Diabetes Care—Blood Pressure Control (<140/80 mm Hg)</i> | 51.53% | ★★★★★ |
| | <i>Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> | 77.06% | ★★★★★ |
| | <i>Asthma—5 to 11 Years</i> | 91.27% | ★★★ |
| | <i>Asthma—12 to 18 Years</i> | 86.32% | ★★★ |
| | <i>Asthma—19 to 50 Years</i> | 75.03% | ★★★ |
| | <i>Asthma—51 to 64 Years</i> | 70.44% | ★★ |
| | <i>Asthma—Total</i> | 84.00% | ★★ |
| | <i>Controlling High Blood Pressure</i> [^] | 76.69% | ★★★★★ |
| | <i>Advising Smokers and Tobacco Users to Quit</i> | 80.81% | — |
| | <i>Discussing Cessation Medications</i> | 55.28% | — |
| | <i>Discussing Cessation Strategies</i> | 47.80% | — |
| | <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i> | 85.85% | ★★★★★ |
| | <i>Diabetes Monitoring for People With Diabetes and Schizophrenia</i> | 90.91% | ★★★★★ |
| <i>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</i> | 57.54% | ★ | |
| <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i> | 53.69% | ★ | |

[^] Plan chose to rotate the measure. Measure rotation allows the health plan to use the audited and reportable rate from the previous year as specified by NCQA in the *HEDIS 2014 Technical Specifications for Health Plans, Volume 2*.

* For this measure, a lower rate indicates better performance.

NC = Not Comparable (i.e., measure not comparable to national percentiles)

— = The national HEDIS 2013 Medicaid percentiles are not available.

- ★★★★★ = 90th percentile and above
- ★★★★ = 75th to 89th percentile
- ★★★ = 50th to 74th percentile
- ★★ = 25th to 49th percentile
- ★ = Below 25th percentile

Table F-2—Scores for Performance Measures for MER

| Dimension | Performance Measure | Rate for 2014 | Performance Level for 2014 |
|--|---|---------------|----------------------------|
| Health Plan Diversity | <i>Race/Ethnicity—White</i> | 64.87% | NC |
| | <i>Race/Ethnicity—Black or African-American</i> | 21.47% | NC |
| | <i>Race/Ethnicity—American-Indian and Alaska Native</i> | 0.15% | NC |
| | <i>Race/Ethnicity—Asian</i> | 1.03% | NC |
| | <i>Race/Ethnicity—Native Hawaiian and Other Pacific Islanders</i> | 0.07% | NC |
| | <i>Race/Ethnicity—Some Other Race</i> | 0.00% | NC |
| | <i>Race/Ethnicity—Two or More Races</i> | 0.00% | NC |
| | <i>Race/Ethnicity—Unknown</i> | 5.92% | NC |
| | <i>Race/Ethnicity—Declined</i> | 6.49% | NC |
| | <i>Race/Ethnicity—Hispanic[£]</i> | 5.92% | NC |
| | <i>Language Diversity: Spoken Language—English</i> | 97.73% | NC |
| | <i>Language Diversity: Spoken Language—Non-English</i> | 2.27% | NC |
| | <i>Language Diversity: Spoken Language—Unknown</i> | 0.00% | NC |
| | <i>Language Diversity: Spoken Language—Declined</i> | 0.00% | NC |
| | <i>Language Diversity: Written Language—English</i> | 97.73% | NC |
| | <i>Language Diversity: Written Language—Non-English</i> | 2.27% | NC |
| | <i>Language Diversity: Written Language—Unknown</i> | 0.00% | NC |
| | <i>Language Diversity: Written Language—Declined</i> | 0.00% | NC |
| | <i>Language Diversity: Other Language Needs—English</i> | 97.73% | NC |
| | <i>Language Diversity: Other Language Needs—Non-English</i> | 2.27% | NC |
| <i>Language Diversity: Other Language Needs—Unknown</i> | 0.00% | NC | |
| <i>Language Diversity: Other Language Needs—Declined</i> | 0.00% | NC | |
| Utilization | <i>Ambulatory Care: Outpatient—Total</i> | 368.55 | ★★★★ |
| | <i>Ambulatory Care: ED—Total*</i> | 78.89 | ★ |
| | <i>Inpatient Utilization: Discharges, Total Inpatient—Total</i> | 7.40 | NC |
| | <i>Inpatient Utilization: Discharges, Medicine—Total</i> | 3.15 | NC |
| | <i>Inpatient Utilization: Discharges, Surgery—Total</i> | 0.92 | NC |
| | <i>Inpatient Utilization: Discharges, Maternity—Total</i> | 5.71 | NC |
| | <i>Inpatient Utilization: ALOS, Total Inpatient—Total</i> | 3.62 | NC |
| | <i>Inpatient Utilization: ALOS, Medicine—Total</i> | 4.16 | NC |
| | <i>Inpatient Utilization: ALOS, Surgery—Total</i> | 6.04 | NC |
| <i>Inpatient Utilization: ALOS, Maternity—Total</i> | 2.44 | NC | |

* For this measure, a lower rate indicates better performance.

£ The rate was calculated by HSAG; national benchmarks are not comparable.

NC = Not Comparable (i.e., measure not comparable to national percentiles)

ALOS = Average Length of Stay

- ★★★★★ = 90th percentile and above
- ★★★★ = 75th to 89th percentile
- ★★★ = 50th to 74th percentile
- ★★ = 25th to 49th percentile
- ★ = Below 25th percentile

Table F-2 shows that **MER** had 16 measures ranking at or above the national HEDIS 2013 Medicaid 90th percentile and another 20 at or above the 75th percentile. Seven measures ranked below the 50th percentile, three of which ranked below the 25th percentile. Measures ranking at or above the 90th percentile spanned multiple dimensions, including Child and Adolescent Care (*Childhood Immunization—Combination 2, Immunizations for Adolescents—Combination 1, and both measures for Well-Child Visits*), Women—Adult Care (*Breast Cancer Screening*), Access to Care (*Adults’ Access to Primary Care Practitioners: 45 to 64 Years*), Obesity (*Adult BMI Assessment*), Pregnancy Care (both measures), and Living With Illness (*Comprehensive Diabetes Care—HbA1c Poor Control, HbA1c Control <8.0%*, and two *Blood Pressure Control* indicators—*Controlling High Blood Pressure* and *Diabetes Monitoring for People With Diabetes and Schizophrenia*). Two of the three measures ranking below the 25th percentile were in Living with Illness (*Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*). These measures, along with *Ambulatory Care: ED Visits—Total*, represent opportunities for improvement for **MER**.

Performance Improvement Projects (PIPs)

Table F-3 presents the scoring for each of the activities in the CMS PIP protocol. The table shows the number of elements within each activity and, of those, the number that were scored *Met*, *Partially Met*, *Not Met*, or *Not Applicable (NA)*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

| Table F-3—2013–2014 PIP Validation Results for MER | | | | | | |
|--|---|--------------------|--------------|---------------|----------|-----------|
| Activity | | Number of Elements | | | | |
| | | Total | Met | Partially Met | Not Met | NA |
| I. | Select the Study Topic | 2 | 2 | 0 | 0 | 0 |
| II. | Define the Study Question(s) | 1 | 1 | 0 | 0 | 0 |
| III. | Use a Representative and Generalizable Study Population | 1 | 1 | 0 | 0 | 0 |
| IV. | Select the Study Indicator(s) | 3 | 3 | 0 | 0 | 0 |
| V. | Use Sound Sampling Techniques | 6 | 0 | 0 | 0 | 6 |
| VI. | Reliably Collect Data | 6 | 4 | 0 | 0 | 2 |
| VII. | Analyze Data and Interpret Study Results | 9 | 4 | 0 | 0 | 5 |
| VIII. | Implement Intervention and Improvement Strategies | 4 | 2 | 0 | 0 | 2 |
| IX. | Assess for Real Improvement | 4 | Not Assessed | | | |
| X. | Assess for Sustained Improvement | 1 | Not Assessed | | | |
| Totals for All Activities | | 37 | 17 | 0 | 0 | 15 |
| Percentage Score of Evaluation Elements Met | | 100% | | | | |
| Percentage Score of Critical Elements Met | | 100% | | | | |
| Validation Status | | Met | | | | |

For the 2013–2014 first-year validation of **MER**'s PIP on *Improving Diabetic Screening Among African Americans*, HSAG validated Activities I through VIII, resulting in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the reported results.

MER's PIP on *Improving Diabetic Screening Among African Americans* was designed to increase compliance with diabetic screenings for **MER**'s African American enrollees 18 to 75 years of age who have a diagnosis of diabetes. **MER** determined through data analysis that this subpopulation posed an area of improvement for the MHP. Diabetic enrollees who do not receive proper screenings are at a higher risk for poor disease management and further complications related to diabetes. **MER**'s goal is to increase the percentage of African American enrollees 18 to 75 years of age and diagnosed with diabetes who have an HbA1c test and Diabetic eye exam completed from 82.1 percent and 50 percent, respectively, at baseline, to the NCQA 50th percentile at Remeasurement 1.

The performance of this PIP suggests a thorough application of the PIP design and implementation of initial interventions. **MER**'s documentation provided evidence that the MHP appropriately selected a study topic both driven by data and which demonstrated an area for improvement. The study question set the framework for the PIP, and the study population and study indicators were completely and accurately defined. The MHP collected baseline data using a systematic data collection process that can be used to collect remeasurement data in a consistent manner. **MER** reported and interpreted its baseline data accurately. Initial interventions developed and implemented were based on identified and prioritized barriers. **MER** developed a methodologically sound project and has set the foundation from which to move forward.

Assessment of Follow-Up on Prior Recommendations

Annual Compliance Reviews

MER successfully addressed two recommendations from the 2012–2013 compliance review. **MER** met the established standards for all performance measures. Additionally, **MER** demonstrated having, as required, a tracking and enrollment process for newborns.

Performance Measures

In 2013, **MER** had only one rate that fell below the 25th percentile, *Ambulatory Care: ED Visits—Total*. This measure continued to fall below the 25th percentile for 2014. The *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* indicator (which reported significant decline from 2012 to 2013) reported significant improvement in 2014. The **MER** 2013 Quality Improvement Annual Evaluation noted that, while the rates for both ADHD measures increased, the internal goal was not met. **MER** identified that providers may be unfamiliar with ADHD treatment guidelines or may not have a follow-up recall system. The plan developed a provider education piece with treatment guidelines for children 6 through 12 years of age.

Performance Improvement Projects (PIPs)

For the 2013–2014 PIP validation, **MER** submitted a study on a new PIP topic focused on a unique subpopulation of enrollees. The next technical report will address follow-up on recommendations identified in this validation cycle.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **MER** showed both strengths and opportunities for improvement.

MER demonstrated strong performance across the domains of **quality** and **timeliness** of and **access** to services provided by the MHP. The 2013–2014 compliance review also identified opportunities for improvement across the three domains. For the *Administrative* standard, addressing the **quality** domain, **MER** should provide information about the administrative positions, including proof of notification of changes and copies of clinical licenses or certifications. To improve performance on the *Providers* and *Members* standards—related to all three domains—**MER** should provide the required information about subcontractors and submit monitoring documentation, the prior authorization policy and procedure for each subcontractor, and a report indicating that member identification cards were mailed within the ten-day requirement. For the *Quality* standard, addressing the domains of **quality** and **access**, **MER** should submit documentation of its plans for future accreditation by the Utilization Review Accreditation Commission (URAC).

Compared to the national HEDIS 2013 benchmarks, **MER**'s performance varied across all three domains. Nonetheless, very few low-performing measures were noted. **MER** also had many high-performing measures in each domain, especially in the **timeliness** domain, where all measures ranked at or above the 50th percentile.

In the **quality** domain, 13 measures benchmarked at or above the national 90th percentile, and two were below the 25th percentile. The top-performing measures spanned multiple dimensions, including Child and Adolescent Care (*Childhood Immunization—Combination 2, Immunizations for Adolescents—Combination 1, Well-Child Visits in the First 15 Months of Life*), Women—Adult Care (*Breast Cancer Screening*), Access to Care (*Adults' Access to Preventive/Ambulatory Health Services—45 to 64 Years*), Obesity (*Adult BMI Assessment*), Pregnancy Care (all measures), and Living With Illness (*Comprehensive Diabetes Care—HbA1c Poor Control, HbA1c Control <8.0%*, and two *Blood Pressure Control* indicators; *Controlling High Blood Pressure and Diabetes Monitoring for People With Diabetes and Schizophrenia*). The measures ranking below the 25th percentile were in the Living with Illness dimension (*Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*).

In the **timeliness** domain, **MER** had four measures with rates at or above the 90th percentile and six others with rates above the 75th percentile. The plan had five additional rates above the 50th percentile. None of the **timeliness**-related measures ranked below the 25th percentile. Eight measures in this domain reported significant improvement from 2013.

In the **access** domain, **MER** had four measures with rates at or above the 90th percentile and one (*Ambulatory Care: ED Visits—Total*) below the 25th percentile. Three of the top-performing measures were in the Pregnancy Care dimension. All remaining **access**-related measures ranked above the 50th percentile.

Related to all domains, **MER** should continue efforts to improve the completeness and accuracy of data used for calculating all HEDIS measures and, specifically, the rates for low-performing measures.

MER's PIP addressed the **quality, timeliness, and access** domains. The MHP demonstrated both strong performance related to the quality of its PIP and a thorough application of the requirements for Activities I through VIII of the CMS protocol for conducting PIPs. The 2013–2014 validation did not identify any *Partially Met* or *Not Met* evaluation elements as opportunities for improvement; however, to strengthen the PIP, the MHP should address the *Points of Clarification*.

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|----|--------------|---|--------------------|--------------------|--------------------|------------------|----------------|
| 1 | | New Hampshire Care Management Implementation | 643.25 days | Mon 1/30/12 | Wed 7/16/14 | 87% | |
| 2 | | Implementation Milestones | 343 days | Wed 8/8/12 | Sun 12/1/13 | 0% | |
| 3 | | Readiness Checkpoint | 0 days | Wed 8/8/12 | Wed 8/8/12 | 100% | |
| 4 | 5FS-22 days | Network Access | 0 days | Thu 8/1/13 | Thu 8/1/13 | 100% | |
| 5 | 9FS-65 days | Readiness Review, 7.6.3.1 | 0 days | Thu 9/5/13 | Thu 9/5/13 | 100% | |
| 6 | 5FS+2 days | Enrollment Period Begins | 0 days | Tue 9/10/13 | Tue 9/10/13 | 100% | |
| 7 | 9FS-22 days | Readiness Review, 7.6.3.1 | 0 days | Mon 11/4/13 | Mon 11/4/13 | 0% | |
| 8 | 9FS-20 days | Soft Go Live | 0 days | Mon 11/4/13 | Mon 11/4/13 | 0% | |
| 9 | | Go Live | 0 days | Sun 12/1/13 | Sun 12/1/13 | 0% | |
| 10 | 9FS-1 day | Implementation Support Team to NH | 0 days | Fri 11/29/13 | Fri 11/29/13 | 0% PMO, TRNG | |
| 11 | | Pre-Contract Project Planning | 9 days | Mon 1/30/12 | Thu 2/9/12 | 100% PMO | |
| 12 | | PMO Team Selection | 1 day | Mon 1/30/12 | Mon 1/30/12 | 100% PMO | |
| 13 | | Create Project Charter | 2 days | Tue 1/31/12 | Wed 2/1/12 | 100% PMO | |
| 14 | | Develop Project Plan | 3 days | Wed 2/1/12 | Fri 2/3/12 | 100% PMO | |
| 15 | | Project Plan Approval | 1 day | Fri 2/3/12 | Fri 2/3/12 | 100% PMO | |
| 16 | | Develop Status Report Template | 2 days | Mon 2/6/12 | Tue 2/7/12 | 100% PMO | |
| 17 | | Develop Risk Register | 2 days | Mon 2/6/12 | Tue 2/7/12 | 100% PMO | |
| 18 | | Setup Project Drive/Wiki | 2 days | Mon 2/6/12 | Tue 2/7/12 | 100% PMO | |
| 19 | | Kickoff Meeting Materials | 2 days | Tue 2/7/12 | Wed 2/8/12 | 100% PMO | |
| 20 | | Kickoff Meeting | 1 day | Thu 2/9/12 | Thu 2/9/12 | 100% PMO | |
| 21 | | Pre-Contract Analysis | 28 days | Wed 2/1/12 | Fri 3/9/12 | 100% PMO | |
| 22 | | PMO | 6 days | Wed 2/8/12 | Wed 2/15/12 | 100% | |
| 23 | | Create FEA | 3 days | Wed 2/8/12 | Fri 2/10/12 | 100% PMO | |
| 24 | | Department Meetings for FEA | 5 days | Wed 2/8/12 | Tue 2/14/12 | 100% PMO | |
| 25 | | Summary Results of FEA | 1 day | Tue 2/14/12 | Tue 2/14/12 | 100% PMO | |
| 26 | | FEA Status Review | 2 days | Tue 2/14/12 | Wed 2/15/12 | 100% PMO | |
| 27 | | Communications | 16 days | Mon 2/6/12 | Mon 2/27/12 | 100% COMM | |
| 28 | | Template Development | 16 days | Mon 2/6/12 | Mon 2/27/12 | 100% COMM | |
| 29 | | NH Style Guide | 15 days | Mon 2/6/12 | Fri 2/24/12 | 100% COMM | |
| 30 | | Logo | 15 days | Mon 2/6/12 | Fri 2/24/12 | 100% COMM | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|----|--------------|---|--------------------|--------------------|--------------------|-------------|----------------------|
| 31 | | Letterhead | 5 days | Mon 2/20/12 | Fri 2/24/12 | 100% | COMM |
| 32 | | P&P Template | 5 days | Mon 2/20/12 | Fri 2/24/12 | 100% | COMM |
| 33 | | ID Card Template | 5 days | Mon 2/20/12 | Fri 2/24/12 | 100% | COMM |
| 34 | | Provider Handbook Template | 5 days | Mon 2/20/12 | Fri 2/24/12 | 100% | COMM |
| 35 | | Member Handbook Template | 5 days | Mon 2/20/12 | Fri 2/24/12 | 100% | COMM |
| 36 | | Executive Approval | 1 day | Mon 2/27/12 | Mon 2/27/12 | 100% | COMM |
| 37 | | Post Contract Analysis | 15 days | Wed 2/29/12 | Tue 3/20/12 | 100% | PMO |
| 38 | | Receive Draft Contract | 1 day | Wed 2/29/12 | Wed 2/29/12 | 100% | |
| 39 | | FEA Review Based on Draft Contract | 5 days | Mon 3/5/12 | Fri 3/9/12 | 100% | |
| 40 | | FEA Status Review | 1 day | Fri 3/9/12 | Fri 3/9/12 | 100% | |
| 41 | | Create Final Contract Crosswalk | 3 days | Fri 3/16/12 | Tue 3/20/12 | 100% | PMO |
| 42 | | Determine Final Contract Requirements | 3 days | Fri 3/16/12 | Tue 3/20/12 | 100% | PMO |
| 43 | | Review/Update Project Plan | 3 days | Fri 3/16/12 | Tue 3/20/12 | 100% | PMO |
| 44 | | Contract Execution | 614.25 days | Fri 3/9/12 | Wed 7/16/14 | 88% | PMO,CLMS,COMM |
| 45 | 5FS-20 days | DHHS Response to Questions/Clarifications | 20 days | Mon 8/5/13 | Fri 8/30/13 | 50% | PMO |
| 46 | | PMO | 81 days | Mon 5/14/12 | Mon 9/3/12 | 100% | |
| 47 | | Submit Program Implementation Plan, 7.6.1.1 | 1 day | Wed 5/23/12 | Wed 5/23/12 | 100% | PMO |
| 48 | | Submit Program Management Plan, 7.4.1 | 1 day | Mon 9/3/12 | Mon 9/3/12 | 100% | PMO |
| 49 | | Changepoint Setup | 10 days | Mon 5/14/12 | Fri 5/25/12 | 100% | |
| 50 | | Configure For Work Requests | 10 days | Mon 5/14/12 | Fri 5/25/12 | 100% | PMO |
| 51 | | Configure For New Users | 10 days | Mon 5/14/12 | Fri 5/25/12 | 100% | PMO |
| 52 | | Create Reports/Portlets | 10 days | Mon 5/14/12 | Fri 5/25/12 | 100% | PMO |
| 53 | | Test Workflows | 10 days | Mon 5/14/12 | Fri 5/25/12 | 100% | PMO |
| 54 | | Human Resources | 411 days | Sat 4/7/12 | Mon 11/4/13 | 99% | |
| 55 | | Submit Staffing Contingency Plan, 6.1.12 | 2 days | Thu 6/14/12 | Fri 6/15/12 | 100% | HR |
| 56 | | Policies & Procedures | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | HR |
| 57 | | Training & Job Aids | 55 days | Mon 6/18/12 | Fri 8/31/12 | 100% | HR |
| 58 | | Career Fair(s) | 1 day | Sat 4/7/12 | Sat 4/7/12 | 100% | HR |
| 59 | | Career Fair(s) | 1 day | Fri 7/27/12 | Fri 7/27/12 | 100% | HR |
| 60 | 9FS-45 days | Submit Emergency Response Plan, 7.5.1 | 1 day | Mon 10/1/12 | Mon 10/1/12 | 100% | HR,ISDV,ISOP |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|----|--------------|--|-----------------|--------------------|---------------------|-----------------|----------------|
| 61 | 9FS-45 days | Submit Staffing Approvals/Alternate Staffing Plan, 6.1.3 | 1 day | Mon 10/1/12 | Mon 10/1/12 | 100% HR | |
| 62 | | Staffing Key Personnel | 332 days | Fri 7/27/12 | Mon 11/4/13 | 99% HR | |
| 63 | | Hire Executive Director (COO) | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 64 | 5 | Hire Finance Officer | 46 days | Tue 4/2/13 | Tue 6/4/13 | 100% HR | |
| 65 | 7 | Hire Medical Director | 1 day | Mon 11/4/13 | Mon 11/4/13 | 0% HR | |
| 66 | | Hire Quality Improvement Director | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 67 | | Hire Special Needs Coordinator | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 68 | 7 | Rehire Special Needs Coordinator | 1 day | Mon 11/4/13 | Mon 11/4/13 | 0% HR | |
| 69 | | Hire Behavioral Health Coordinator | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 70 | 7 | Rehire Behavioral Health Coordinator | 1 day | Mon 11/4/13 | Mon 11/4/13 | 0% HR | |
| 71 | | Hire Developmental Disabilities Coordinator | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 72 | | Hire Network Management Director | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 73 | | Hire Member Services Manager | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 74 | | Hire Utilization Management Director | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 75 | | Hire Systems Director/Manager | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 76 | | Hire Claims/Encounter Manager | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 77 | | Hire Grievance Coordinator | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 78 | | Hire FWA Coordinator | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 79 | | Hire Compliance Officer | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 80 | | Hire BH NHH Liaison | 46 days | Fri 7/27/12 | Fri 9/28/12 | 100% HR | |
| 81 | | Compliance | 451 days | Fri 3/9/12 | Fri 11/29/13 | 93% COMP | |
| 82 | | Policies & Procedures | 16 days | Mon 5/14/12 | Mon 6/4/12 | 100% COMP | |
| 83 | | Training & Job Aids | 55 days | Mon 6/18/12 | Fri 8/31/12 | 100% COMP | |
| 84 | | State Specific: Applications and Licenses, 4.1.1.1 | 47 days | Fri 3/9/12 | Mon 5/14/12 | 100% COMP | |
| 85 | | State Specific: Articles and Bylaws, 4.2 | 86 days | Fri 3/9/12 | Fri 7/6/12 | 100% COMP | |
| 86 | 9FS-30 days | Modify/Develop BOD Election Process | 30 days | Tue 5/21/13 | Mon 7/1/13 | 100% COMP | |
| 87 | 9FS-30 days | Establish BOD | 30 days | Mon 10/21/13 | Fri 11/29/13 | 0% COMP | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|---|-----------------|--------------------|---------------------|-------------|-------------------------|
| 88 | 8FS-30 days | Conduct Contract Compliance Assessment | 30 days | Mon 9/23/13 | Fri 11/1/13 | 0% | COMP |
| 89 | | Review Vendor Subcontract Efforts and Access for BAA Needs | 166 days | Fri 3/9/12 | Fri 10/26/12 | 100% | CLMS, COMM, COMM |
| 90 | | Review Vendor Subcontract Efforts and Access for BAA Needs | 136 days | Fri 3/9/12 | Fri 9/14/12 | 100% | COMP |
| 91 | | Send BAA to Business Associates for Signature | 90 days | Mon 5/14/12 | Fri 9/14/12 | 100% | COMP |
| 92 | | Obtain Signed BAA from Business Associate | 115 days | Mon 5/14/12 | Fri 10/19/12 | 100% | COMP |
| 93 | | Review Signed BAA for Completeness | 120 days | Mon 5/14/12 | Fri 10/26/12 | 100% | COMP |
| 94 | 9FS-45 days | Submit Subcontractor Agreements to DHHS, 5.2.1 | 1 day | Mon 10/1/12 | Mon 10/1/12 | 100% | COMP |
| 95 | | Regulatory Reporting | 377 days | Fri 3/9/12 | Mon 8/19/13 | 100% | |
| 96 | | Review contract for Reporting Requirements | 86 days | Fri 3/9/12 | Fri 7/6/12 | 100% | COMP |
| 97 | 5FS-15 days | Receive Reporting Requirements From State | 1 day | Mon 8/12/13 | Mon 8/12/13 | 100% | |
| 98 | 97 | Update Reporting Grid with Regulatory Reports | 5 days | Tue 8/13/13 | Mon 8/19/13 | 100% | COMP |
| 99 | | Communications | 299 days | Wed 3/21/12 | Mon 5/13/13 | 100% | COMM |
| 100 | | Policies & Procedures | 0 days | Mon 5/14/12 | Fri 6/15/12 | 100% | COMM |
| 101 | 9FS-45 days | Submit Communications Plan to DHHS, 7.4.2 | 1 day | Mon 10/1/12 | Mon 10/1/12 | 100% | COMM, COMP, PM |
| 102 | | Communications Development | 299 days | Wed 3/21/12 | Mon 5/13/13 | 100% | |
| 103 | | Press Release | 5 days | Mon 5/14/12 | Fri 5/18/12 | 100% | COMM |
| 104 | | HR/Staffing Needs | 83 days | Wed 3/21/12 | Fri 7/13/12 | 100% | |
| 105 | | Website Update for Job Postings | 5 days | Mon 5/14/12 | Fri 5/18/12 | 100% | COMM, ISDV |
| 106 | | Career Fair Business Cards | 8 days | Wed 3/21/12 | Fri 3/30/12 | 100% | COMM |
| 107 | | Career Fair 2 Business Cards | 20 days | Mon 6/18/12 | Fri 7/13/12 | 100% | COMM |
| 108 | | Career Fair Swag | 8 days | Wed 3/21/12 | Fri 3/30/12 | 100% | COMM |
| 109 | | Provider Materials | 106 days | Mon 5/21/12 | Mon 10/15/12 | 100% | PS, COMM |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|--|----------------|--------------------|---------------------|-------------|----------------|
| 110 | | Bi-Folds | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | |
| 111 | | Breast and Cervical Cancer Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | PS, COMM |
| 112 | | Cervical Cancer Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, PS |
| 113 | | Diabetes | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, PS |
| 114 | | Immunizations | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, PS |
| 115 | | Chlamydia Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, PS |
| 116 | | Lead Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, PS |
| 117 | | Well Child Visits 0-15 Mths | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, PS |
| 118 | | Well Child Visits 12-21 Mths | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, PS |
| 119 | | Well Child 3-6 Years | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, PS |
| 120 | | Yearly Physical Exam 18-21 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, PS |
| 121 | | Yearly Physical Exam 12-17 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, PS |
| 122 | | Letters | 30 days | Mon 5/21/12 | Fri 6/29/12 | 100% | |
| 123 | | Provider Contracting MCARE and MCAID | 30 days | Mon 5/21/12 | Fri 6/29/12 | 100% | COMM |
| 124 | | Provider Credentialing MCAID | 30 days | Mon 5/21/12 | Fri 6/29/12 | 100% | COMM |
| 125 | | Provider Education Verification | 30 days | Mon 5/21/12 | Fri 6/29/12 | 100% | COMM |
| 126 | | Provider Missing Information | 30 days | Mon 5/21/12 | Fri 6/29/12 | 100% | COMM |
| 127 | | Provider Recredential | 30 days | Mon 5/21/12 | Fri 6/29/12 | 100% | COMM |
| 128 | | Provider Welcome | 30 days | Mon 5/21/12 | Fri 6/29/12 | 100% | COMM |
| 129 | | 180 Day Letter - MCS Generated | 30 days | Mon 5/21/12 | Fri 6/29/12 | 100% | COMM |
| 130 | | Skilled Nursing Home Agreement | 30 days | Mon 5/21/12 | Fri 6/29/12 | 100% | COMM |
| 131 | | Materials | 91 days | Mon 6/11/12 | Mon 10/15/12 | 100% | |
| 132 | | Breast and Cervical Cancer Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | PS, COMM |
| 133 | | BMI Measurement and Counseling for Nutrition and Physical Activity | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, PS |
| 134 | | HPV and Chlamydia Talking Points | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, PS |
| 135 | 441 | PCMH Incentive Program | 30 days | Tue 9/4/12 | Mon 10/15/12 | 100% | COMM, PS |
| 136 | | Contact Information | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, PS |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|---|-----------------|--------------------|--------------------|-------------|----------------|
| 137 | | Open Enrollment | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 138 | | Provider Portal Education | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 139 | | The CAHPS Health Plan Survey – An Overview | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 140 | | Appropriate Treatment for Children with Upper Respiratory Infection (URI) | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 141 | | Well-Care Exams | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 142 | | Lead Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 143 | | Prescribing for Asthma | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 144 | | Assuring Better Child Health and Development (ABCD Screening) | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 145 | | Tobacco Cessation | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 146 | | Access to Care | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 147 | | Comprehensive Diabetes Care | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 148 | | Scheduling Postpartum Care | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 149 | | Chlamydia Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 150 | | Prenatal Care | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 151 | | Provider ID Update | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 152 | | Ordering HEDIS Postcards | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 153 | | Childhood and Adolescent Immunizations | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 154 | | Provider Manual | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 155 | | Provider Orientation | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 156 | | Provider Orientation - Specialist | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 157 | | Provider Overview | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 158 | | Provider Directory | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 159 | | HEDIS Self-Reporting Guide | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,PS |
| 160 | | Website Updates | 15 days | Mon 8/6/12 | Fri 8/24/12 | 100% | COMM,PS,ISDV |
| 161 | | Member Services | 241 days | Mon 6/11/12 | Mon 5/13/13 | 100% | |
| 162 | | Print | 241 days | Mon 6/11/12 | Mon 5/13/13 | 100% | COMM,MS |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|---------------------------------------|-----------------|--------------------|--------------------|-------------|----------------|
| 163 | 45 | Development | 241 days | Mon 6/11/12 | Mon 5/13/13 | 100% | COMM,MS |
| 164 | | ID Card | 161 days | Mon 9/3/12 | Mon 4/15/13 | 100% | COMM,MS |
| 165 | 5 | ID Card- 2 or Less | 20 days | Mon 9/3/12 | Mon 4/15/13 | 100% | COMM,MS |
| 166 | 5 | ID Card- 3 or More | 20 days | Mon 9/3/12 | Mon 4/15/13 | 100% | COMM,MS |
| 167 | 5 | Member ID Card | 20 days | Mon 9/3/12 | Mon 4/15/13 | 100% | COMM,MS |
| 168 | | Letters | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 169 | | Grievance Level 1 Acknowledgement | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 170 | | Grievance Level 1 Resolution | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 171 | | Grievance Level 1 Resolution Plan | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 172 | | Grievance Level 2 Acknowledgement | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 173 | | Grievance Level 2 Resolution | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 174 | | Invalid Phone Number | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 175 | | PCP No New Members | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 176 | | PCP Age Restriction | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 177 | | PCP Discharge | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 178 | | PCP Left Network | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 179 | | Replacement ID Card | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 180 | | Handbook Request | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 181 | | First Recovery Medicaid Questionnaire | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 182 | | Unable to Contact | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 183 | | MBR PCP Change Request | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 184 | | MPORT | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 185 | | PCP No New Members | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 186 | | PCP No New Members | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 187 | | PCP Initiated Change | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 188 | | PCP Initiated Change | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 189 | | PCP Left Network | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|--------------------------------|-----------------|--------------------|---------------------|-------------|-------------------|
| 190 | | PCP Left Network | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 191 | | PCP Changed Office Locations | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 192 | | PCP Changed Office Locations | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 193 | | PCP Changed Office Locations | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 194 | | PCP Age Restriction | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 195 | | PCP Age Restriction | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 196 | | PCP Age Restriction | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 197 | | Access to Care | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 198 | | Generic Cover Letter | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 199 | | Member Handbook Packet | 55 days | Mon 6/11/12 | Fri 8/24/12 | 100% | COMM,MS |
| 200 | | Member Handbook | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 201 | | Handbook Cover | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 202 | | Submit Member Handbook to DHHS | 25 days | Mon 7/23/12 | Fri 8/24/12 | 100% | COMM,MS |
| 203 | | Member Welcome Packet | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 204 | | Welcome Newsletter- Flu | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 205 | | Welcome Newsletter- No Flu | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 206 | | Newsletters | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 207 | | Bi-annual Member Newsletter | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 208 | | Biannual DM Newsletter | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 209 | | ER Newsletter | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 210 | | Other | 241 days | Mon 6/11/12 | Mon 5/13/13 | 100% | COMM,MS |
| 211 | | Health Plan Overview | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 212 | | Monthly Member Emails | 30 days | Tue 4/2/13 | Mon 5/13/13 | 100% | COMM,MS |
| 213 | | Certificates of Coverage | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 214 | 5FS-20 days | State Approval | 10 days | Tue 3/5/13 | Mon 3/18/13 | 100% | COMM,MS |
| 215 | 5 | Website | 5 days | Mon 8/6/12 | Thu 4/4/13 | 100% | COMM,MS,ISDV |
| 216 | | Member Care | 91 days | Mon 6/11/12 | Mon 10/15/12 | 100% | QI,UM |
| 217 | | Communications | 91 days | Mon 6/11/12 | Mon 10/15/12 | 100% | QI,UM,COMM |
| 218 | | Print | 91 days | Mon 6/11/12 | Mon 10/15/12 | 100% | QI,UM,COMM |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|--|----------------|--------------------|---------------------|------------------------|----------------|
| 219 | 45 | Development | 91 days | Mon 6/11/12 | Mon 10/15/12 | 100% QI,UM,COMM | |
| 220 | | Prenatal Packet | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 221 | | Prenatal Cover | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 222 | | Baby Basics | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 223 | | Stay Healthy | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 224 | | Stay Healthy Flu Season | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 225 | | Tobacco Pregnancy and Postpartum | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 226 | | Text4Baby | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 227 | | Postpartum Packet | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 228 | | Postpartum Cover | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 229 | | Baby Basics | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 230 | | Stay Healthy Flu Season | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 231 | | Lead Poisoning | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 232 | | Diaper Raffle | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 233 | | Pack n Play Raffle | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 234 | | Baby's Immunization and Testing | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 235 | | Text4Baby | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 236 | | Bi-Folds/HEDIS | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 237 | | Yearly Physical for Adolescents 12-17 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 238 | | Yearly Physical 18-21 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 239 | | Trying to Reach You Yearly Physical 12-17 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 240 | | Trying to Reach You Yearly Physical 18-21 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 241 | | Breast Cancer Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 242 | | Trying to Reach You- Breast Cancer Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |
| 243 | | Cervical Cancer Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% QI,COMM | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|---|----------------|--------------------|--------------------|-------------|-----------------|
| 244 | | Trying to Reach You- Cervical Cancer Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 245 | | Diabetes Care | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 246 | | Trying to Reach You- Diabetes Care | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 247 | | Lead Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 248 | | Trying to Reach You- Lead Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 249 | | Postpartum Visit | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 250 | | Well Child Visit 0-15 Mths | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 251 | | Well Child Visit 3-6 Years | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 252 | | Trying to Reach You- Well Child Visit 3-6 Years | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 253 | | Well Child Visit 0-15 Mths- 6th Visit | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 254 | | Health Screenings Are Up To You | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 255 | | Preteen Immunizations | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 256 | | Postcards | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 257 | | Well Child Visit (15 mo) 4th Visit Raffle | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 258 | | Well Child Visit (15 mo) 6th Visit Raffle | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 259 | | Winter Happy and Healthy Well Child Visit \$100 Gift Card | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 260 | | Adolescence Well Child Visit Postcard - Ipad giveaway | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 261 | | Well Child Visit Postcard - Nintendo Dsi giveaway | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|--|----------------|--------------------|---------------------|-------------|----------------|
| 262 | | Cervical Cancer Screening Postcard - Ipad giveaway | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 263 | | Spring Watch Me Grow | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 264 | | Back to School/Sports Physical | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 265 | | HEDIS Birthday Card | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 266 | | Letters | 91 days | Mon 6/11/12 | Mon 10/15/12 | 100% | QI,COMM |
| 267 | | Prenatal Screening | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 268 | | Asthma Action Plan | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 269 | | Asthma Post Discharge | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 270 | | COPD Post Discharge | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 271 | | COPD w/Benefits | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 272 | | Diabetes Follow Up | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 273 | | Diabetes Post Discharge | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 274 | | Asthma Follow Up | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 275 | | Asthma DM Program | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 276 | | Diabetes Follow Up Call | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 277 | | EDU Materials | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 278 | | Diabetes Program w/Benefits | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 279 | | Strat Asthma | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 280 | | Cardio Program w/Benefits | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 281 | | Unable to Contact | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 282 | | Prenatal Unable to Reach | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 283 | | Postpartum Visit | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 284 | | Heart Disease Follow Up | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 285 | | Heart Disease Post Discharge | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 286 | | Smoking Cessation | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 287 | | Weight Management - Commitment | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|---|----------|-------------|-------------|------------|----------------|
| 288 | | Weight Management - Dismissal CNM | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 289 | | Weight Management - Dismissal | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 290 | | Weight Management - Successful | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 291 | | Weight Management - Welcome | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 292 | | Weight Management - Medical Weight Loss | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 293 | | Intro to CM | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 294 | | HRA | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 295 | | Care Management Not Needed | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 296 | | ER Visit | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 297 | | ER Visits Certified | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 298 | | Health Management | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 299 | | Care Management Follow Up | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 300 | | Discharged | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 301 | | Care Management Intro | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 302 | | Unable to Contact | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 303 | | Welcome Call Asthma | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 304 | | Welcome Call Diabetes | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 305 | | No Care Management | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 306 | | No Interest in Care Management | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 307 | | ER Intro | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 308 | | Organ Transplant | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 309 | | A03 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 310 | | A04 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 311 | | D01 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|--------------------------------------|----------|-------------|-------------|------------|----------------|
| 312 | | D02 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 313 | | D04a | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 314 | | D05 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 315 | | D06 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 316 | | D10 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 317 | | D11 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 318 | | D25 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 319 | | MA01 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 320 | | MA02 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 321 | | MA03 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 322 | | MA04 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 323 | | MA06 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 324 | | MA07 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 325 | | MA08 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 326 | | MA10 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 327 | | MA11 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 328 | | MA12 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 329 | | MA15 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 330 | | Member Appeal Developmental Delay | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 331 | | PA1 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 332 | | PA2 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 333 | | PSA1 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 334 | | PSA2 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 335 | | Appointment Reminder | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 336 | | PCP ER Record Request | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 337 | | Compliance Transportation | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 338 | | Unable to Reach with ER Education | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 339 | | ER Reminder | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |

Granite Care-Meridian Health Plan
New Hampshire Project Plan 11.01.mpp

Fri 9/13/13

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|---|----------------|--------------------|--------------------|-------------|----------------|
| 340 | | PCP Office Notes Requested | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM |
| 341 | 441 | PCMH Letter | 30 days | Tue 9/4/12 | Mon 10/15/12 | 100% | COMM |
| 342 | | Flyers | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 343 | | Member Portal Sign-up Incentive - \$50 raffle | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 344 | | Exercise and Asthma Order Doc | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 345 | | The Facts About Asthma Order Doc | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 346 | | Your Child and Asthma Order Doc | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 347 | | Stages of Change - Tobacco | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 348 | | Stages of Change - Weight Management | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 349 | | It's Time for your child's Hib vaccine | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 350 | | WIC Program - Nutrition for Women, Infants and Children | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 351 | | Chlamydia Screening - Get Tested Stay Healthy | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 352 | | Keep your child safe from lead poisoning | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 353 | | 4th PCV Shot - Keep your child on track | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 354 | | Well-Child Exams 0-6 mo | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 355 | | Well-Child Exams 6-15 mo | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 356 | | HPV Vaccinations | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |
| 357 | | Intro to Case Management | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MS |
| 358 | | HRA One-Pagers | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI,COMM |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|---|----------------|--------------------|--------------------|-------------|-------------------|
| 359 | | Understanding Substance Abuse | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 360 | | Understanding Depression | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 361 | | Understanding How to Talk to Your Teen about STDs | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 362 | | Understanding STDs | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 363 | | Understanding Seatbelt Safety | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 364 | | Understanding Stress | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 365 | | Understanding Alcohol Abuse | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 366 | | Understanding How to Help You Quit Smoking | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 367 | | Understanding Exercise | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 368 | | Understanding Healthy Eating | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 369 | | Understanding High Blood Pressure | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, COMM |
| 370 | | Educational Materials | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | QI, UM, COMM |
| 371 | | Compliance | 36 days | Mon 6/11/12 | Mon 7/30/12 | 100% | COMM, COMP |
| 372 | | Letters | 36 days | Mon 6/11/12 | Mon 7/30/12 | 100% | COMM, COMP |
| 373 | | EOB | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, COMP |
| 374 | | PHI Form - Authorization of Release of Protected Health Information | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, COMP |
| 375 | | PHI - Request for PHI | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, COMP |
| 376 | | PHI - Revocation of Authorization | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, COMP |
| 377 | | PHI Release Cover | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, COMP |
| 378 | | Pharmacy Lock | 30 days | Tue 6/19/12 | Mon 7/30/12 | 100% | COMM, COMP |
| 379 | | Pharmacy Lock | 30 days | Tue 6/19/12 | Mon 7/30/12 | 100% | COMM, COMP |
| 380 | | MIRx | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, MIRx |
| 381 | | Letters | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM, MIRx |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|-------------------------------|----------------|--------------------|--------------------|-------------|------------------|
| 382 | | MRx Grievance Acknowledgement | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 383 | | MRx Grievance Resolution Form | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 384 | | Transition | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 385 | | Drug Recall | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 386 | | MTM Invitation | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 387 | | MTM Follow-Up | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 388 | | Claim Intervention | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 389 | | PA Intervention | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 390 | | General Fax Cover Letter | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 391 | | Denial | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 392 | | Member Appeals | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 393 | | Provider Appeals | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 394 | | COBC Verification | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 395 | | Medicare PA | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,MRx |
| 396 | | Claims | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 397 | | Letters | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 398 | | C00 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 399 | | C01 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 400 | | C02 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 401 | | C03 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 402 | | C04 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 403 | | C04A | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 404 | | C05 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 405 | | C06 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 406 | | C07 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 407 | | C08 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 408 | | C09 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 409 | | C09A | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 410 | | C10 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 411 | | C11 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 412 | | C12 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|---|-----------------|--------------------|--------------------|------------------|----------------|
| 413 | | C13 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 414 | | C14 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 415 | | C15 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 416 | | C16 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 417 | | C17 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 418 | | C19 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 419 | | C20 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 420 | | C21 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 421 | | C22 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 422 | | C23 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 423 | | C24 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 424 | | C25 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 425 | | C26 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 426 | | C27 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 427 | | C28 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 428 | | C29 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 429 | | C30 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 430 | | C31 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 431 | | C32 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 432 | | C33 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 433 | | C34 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 434 | | C35 | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% | COMM,CLMS |
| 435 | | Provider Credentialing/Contracting | 504 days | Wed 3/21/12 | Fri 2/21/14 | 88% PS | |
| 436 | | Policies & Procedures | 25 days | Wed 3/21/12 | Tue 4/24/12 | 100% PS | |
| 437 | | Physician Credentialing | 25 days | Wed 3/21/12 | Tue 4/24/12 | 100% PS | |
| 438 | | Physician Re-Credentialing | 25 days | Wed 3/21/12 | Tue 4/24/12 | 100% PS | |
| 439 | | Training & Job Aids | 55 days | Mon 6/18/12 | Fri 8/31/12 | 100% PS | |
| 440 | | Provider Manual | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% PS | |
| 441 | 9FS-65 days | Submit Payment Reform Plan, 9.1.1 | 1 day | Mon 9/3/12 | Mon 9/3/12 | 100% PS,NH,QI,UM | |
| 442 | | Submit Network documentation, 18.1.2 | 1 day | Fri 5/25/12 | Fri 5/25/12 | 100% PS | |
| 443 | 7 | Submit Network documentation, 18.1.2 | 6 days | Mon 8/27/12 | Mon 9/3/12 | 100% PS | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|---------------|---|-----------------|---------------------|---------------------|--------------------------|--------------------------|
| 444 | | CMHCs | 5 days | Mon 8/27/12 | Fri 8/31/12 | 100% PS | 100% PS |
| 445 | | Geo Access Report | 5 days | Mon 8/27/12 | Fri 8/31/12 | 100% PS | 100% PS |
| 446 | | Submission | 1 day | Mon 9/3/12 | Mon 9/3/12 | 100% PS | 100% PS |
| 447 | 5 | Submit Model Provider Contracts, 19.2.7 | 1 day | Fri 6/15/12 | Fri 6/15/12 | 100% PS | 100% PS |
| 448 | 5 | Submit Provider training materials, 19.2.12 | 1 day | Fri 6/15/12 | Fri 6/15/12 | 100% COMM,PS,TRNG | 100% COMM,PS,TRNG |
| 449 | 450FS-21 days | Submit Draft Provider Directory to DHHS, 15.8.7 | 1 day | Fri 8/24/12 | Fri 8/24/12 | 100% COMM,PS | 100% COMM,PS |
| 450 | 9FS-45 days | Submit Provider Directory to DHHS, 15.8.7 | 1 day | Mon 9/3/12 | Mon 9/3/12 | 100% COMM,PS | 100% COMM,PS |
| 451 | 6SS-5 days | Post Provider Directory, 15.9.3 | 5 days | Mon 9/24/12 | Fri 9/28/12 | 100% COMM,PS | 100% COMM,PS |
| 452 | | Provider Advisory Board, 19.4.1 | 41 days | Fri 12/27/13 | Fri 2/21/14 | 0% COMM,PS | 0% COMM,PS |
| 453 | 9FS+20 days | Selection & Notification | 20 days | Fri 12/27/13 | Thu 1/23/14 | 0% COMM,PS | 0% COMM,PS |
| 454 | 9FS+60 days | First Quarterly Meeting | 1 day | Fri 2/21/14 | Fri 2/21/14 | 0% COMM,PS | 0% COMM,PS |
| 455 | | Provider Payments | 399 days | Mon 5/14/12 | Thu 11/21/13 | 74% CLMS | 74% CLMS |
| 456 | 45 | Policies & Procedures | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% CLMS | 100% CLMS |
| 457 | | Claims Processing and Payment Guidelines | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% CLMS | 100% CLMS |
| 458 | | Prevention and Monitoring Fraud and Abuse | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% CLMS | 100% CLMS |
| 459 | | Claims Quality Assurance Monitoring | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% CLMS | 100% CLMS |
| 460 | | Provider Appeals | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% CLMS | 100% CLMS |
| 461 | | Training & Job Aids for Internal Employees | 55 days | Mon 6/18/12 | Fri 8/31/12 | 100% CLMS | 100% CLMS |
| 462 | | Program Requirements | 399 days | Mon 5/14/12 | Thu 11/21/13 | 67% ISDV,FIN,CLMS | 67% ISDV,FIN,CLMS |
| 463 | | FTP | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% ISDV,FIN,CLMS | 100% ISDV,FIN,CLMS |
| 464 | | Encounter Data | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% ISDV,FIN,CLMS | 100% ISDV,FIN,CLMS |
| 465 | | Eligibility Load Processing | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% ISDV,FIN,CLMS | 100% ISDV,FIN,CLMS |
| 466 | | Capitation | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% ISDV,FIN,CLMS | 100% ISDV,FIN,CLMS |
| 467 | | EDI | 10 days | Tue 6/4/13 | Mon 6/17/13 | 0% CLMS,ISDV,FIN | 0% CLMS,ISDV,FIN |
| 468 | 8 | Obtain Payer ID | 5 days | Tue 6/4/13 | Mon 6/10/13 | 0% CLMS,ISDV,FIN | 0% CLMS,ISDV,FIN |
| 469 | 8 | Clearinghouses | 10 days | Tue 6/4/13 | Mon 6/17/13 | 0% CLMS,ISDV,FIN | 0% CLMS,ISDV,FIN |
| 470 | 8 | Third Party Liability | 10 days | Tue 6/4/13 | Mon 6/17/13 | 0% CLMS,ISDV,FIN | 0% CLMS,ISDV,FIN |
| 471 | | Financial Accounts | 399 days | Mon 5/14/12 | Thu 11/21/13 | 63% FIN | 63% FIN |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|---|-----------------|--------------------|--------------------|----------------|----------------|
| 472 | | Review Budget | 65 days | Mon 5/14/12 | Fri 8/10/12 | 100% FIN | |
| 473 | | Actuarial Assistance | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% FIN | |
| 474 | | Statutory Deposit/Minimum Funding | 19 days | Mon 10/1/12 | Thu 10/25/12 | 100% FIN | |
| 475 | | Licensure Process | 19 days | Mon 10/1/12 | Thu 10/25/12 | 100% FIN | |
| 476 | | Obtain FEIN # | 19 days | Mon 10/1/12 | Thu 10/25/12 | 100% FIN | |
| 477 | | Obtain NAIC # | 19 days | Mon 10/1/12 | Thu 10/25/12 | 100% FIN | |
| 478 | | Inform Deloitte (New Company information) | 19 days | Mon 10/1/12 | Thu 10/25/12 | 100% FIN | |
| 479 | | Set General Ledger and Accounts Payable | 19 days | Mon 10/1/12 | Thu 10/25/12 | 100% FIN | |
| 480 | 9FS-25 days | Bank Setup | 19 days | Tue 5/28/13 | Fri 6/21/13 | 0% FIN | |
| 481 | | Benefit Structure | 19 days | Mon 10/1/12 | Thu 10/25/12 | 100% FIN,HR | |
| 482 | 9FS-25 days | Positive Pay | 19 days | Tue 5/28/13 | Fri 6/21/13 | 0% FIN | |
| 483 | 9FS-25 days | Configure Claims Payable | 19 days | Tue 5/28/13 | Fri 6/21/13 | 0% FIN | |
| 484 | 9FS-25 days | Modify Claims Payable Jobs | 19 days | Mon 10/28/13 | Thu 11/21/13 | 0% FIN | |
| 485 | 9FS-25 days | Set EFT Configuration- Pay from State, Pay to Vendors | 19 days | Mon 10/28/13 | Thu 11/21/13 | 0% FIN | |
| 486 | 9FS-25 days | Set EFT/ERA | 19 days | Mon 10/28/13 | Thu 11/21/13 | 0% FIN | |
| 487 | | EFTPS- State and Federal Tax | 19 days | Mon 10/1/12 | Thu 10/25/12 | 100% FIN | |
| 488 | | Set Reporting and Forecasting-Financial Statements | 19 days | Mon 10/1/12 | Thu 10/25/12 | 100% FIN | |
| 489 | 9FS-25 days | Reinsurance Requirements | 19 days | Mon 10/28/13 | Thu 11/21/13 | 0% FIN | |
| 490 | 9FS-25 days | Test Configuration | 19 days | Mon 10/28/13 | Thu 11/21/13 | 0% FIN | |
| 491 | | Member Services | 445 days | Mon 5/14/12 | Thu 1/23/14 | 97% MS | |
| 492 | 45 | Policies & Procedures | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% MS | |
| 493 | | Enrollee Rights & Responsibilities | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% MS | |
| 494 | | Enrollee Education | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% MS | |
| 495 | | Advising Members on Advance Directives | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% MS | |
| 496 | | Member Access to Provider Directories | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% MS | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|--|--------------------|--------------------|---------------------|-------------------|----------------|
| 497 | | Coordination of Non-Emergent Medical Transportation | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | MS |
| 498 | | PCP Assignment | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | MS |
| 499 | | Pediatrician WHCP Assignment | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | MS |
| 500 | | Access to Member Services | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | MS |
| 501 | | Interpretation and Translation Services | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | MS |
| 502 | | Member Requests for Disenrollment due to Medical Exceptions or Cause | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | MS |
| 503 | | Enrollee Demographic Changes | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | MS |
| 504 | | Telephone Answering Standards | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | MS |
| 505 | | Member Services Assessment | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | MS |
| 506 | | Continuity of Care | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | MS |
| 507 | | Training & Job Aids | 55 days | Mon 6/18/12 | Fri 8/31/12 | 100% | MS |
| 508 | | Welcome Call Script | 1 day | Mon 9/3/12 | Mon 9/3/12 | 100% | MS |
| 509 | | Member Advisory Board | 89 days | Tue 9/24/13 | Thu 1/23/14 | 0% MS | |
| 510 | 9FS+30 days | Selection & Notification, 15.7.1 | 10 days | Fri 1/10/14 | Thu 1/23/14 | 0% | MS,QI |
| 511 | 9FS+60 days | First Quarterly Meeting | 1 day | Tue 9/24/13 | Tue 9/24/13 | 0% | MS,QI |
| 512 | 9FS+90 days | First Bi-Annual Regional Meeting, 15.7.2 | 1 day | Tue 11/5/13 | Tue 11/5/13 | 0% | MS,QI |
| 513 | 45 | Member Enrollment | 171 days | Tue 3/19/13 | Tue 11/12/13 | 7% ISDV,MS | |
| 514 | 6FS-25 days | Create Call Scripts | 1 day | Tue 3/19/13 | Tue 3/19/13 | 100% | MS |
| 515 | 6FS-25 days | Assign Reps | 1 day | Tue 3/19/13 | Tue 3/19/13 | 100% | MS |
| 516 | 6FS-10 days | Create Welcome Outreach Campaign | 5 days | Tue 4/9/13 | Mon 4/15/13 | 50% | MS |
| 517 | 6FS-10 days | Create HRA Outreach Campaign | 5 days | Mon 9/2/13 | Fri 9/6/13 | 0% | MS |
| 518 | 6FS-10 days | Create HEDIS Outreach Campaign | 5 days | Tue 4/9/13 | Mon 4/15/13 | 50% | MS |
| 519 | 6SS | Enrollment Period Welcome Calls | 45 days | Wed 9/11/13 | Tue 11/12/13 | 0% | MS |
| 520 | 6SS | Enrollment Period ID Cards | 45 days | Wed 9/11/13 | Tue 11/12/13 | 0% | MS |
| 521 | | Non-Emergent Transportation Services (TMS) | 19 days | Tue 10/2/12 | Fri 10/26/12 | 100% | |
| 522 | 94,497 | Communication Protocols | 19 days | Tue 10/2/12 | Fri 10/26/12 | 100% | MS |
| 523 | 94,497 | Oversight Reports | 19 days | Tue 10/2/12 | Fri 10/26/12 | 100% | MS |
| 524 | | Pharmacy Management (MeridianRx) | 607.25 days | Tue 3/20/12 | Wed 7/16/14 | 42% | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|--|-----------------|--------------------|--------------------|-------------|----------------|
| 525 | | Policies & Procedures | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | MRx |
| 526 | | Training & Job Aids | 55 days | Mon 6/18/12 | Fri 8/31/12 | 100% | MRx |
| 527 | | Submit formulary and pharmacy PA criteria | 1 day | Mon 6/18/12 | Mon 6/18/12 | 100% | MRx |
| 528 | | Submit policies related to maintenance dru | 1 day | Mon 6/18/12 | Mon 6/18/12 | 100% | MRx |
| 529 | | Project Planning | 97 days | Tue 3/20/12 | Wed 8/1/12 | 100% | |
| 530 | | Establish Team and Roles | 2 days | Tue 3/20/12 | Wed 3/21/12 | 100% | |
| 531 | | MeridianRx Team | 1 day | Tue 3/20/12 | Tue 3/20/12 | 100% | MRx |
| 532 | | NH Team | 1 day | Wed 3/21/12 | Wed 3/21/12 | 100% | MRx |
| 533 | | Team and Roles established | 0 days | Tue 3/20/12 | Tue 3/20/12 | 100% | MRx |
| 534 | | Develop Charter | 1 day | Wed 3/21/12 | Wed 3/21/12 | 100% | |
| 535 | | Project Deliverables | 1 day | Wed 3/21/12 | Wed 3/21/12 | 100% | MRx |
| 536 | | Key Stakeholders | 1 day | Wed 3/21/12 | Wed 3/21/12 | 100% | MRx |
| 537 | | Assumptions and Constraints | 1 day | Wed 3/21/12 | Wed 3/21/12 | 100% | MRx |
| 538 | | Project Management Authority | 1 day | Wed 3/21/12 | Wed 3/21/12 | 100% | MRx |
| 539 | | Resources (technical & business) | 1 day | Wed 3/21/12 | Wed 3/21/12 | 100% | MRx |
| 540 | | Project Charter | 0 days | Wed 3/21/12 | Wed 3/21/12 | 100% | MRx |
| 541 | | Training Requirements | 34 days | Fri 6/15/12 | Wed 8/1/12 | 100% | |
| 542 | | Training Plan | 34 days | Fri 6/15/12 | Wed 8/1/12 | 100% | TRNG |
| 543 | | Training Scheduled | 34 days | Fri 6/15/12 | Wed 8/1/12 | 100% | TRNG |
| 544 | | Risk Assessment & Response Planning | 0 days | Tue 3/20/12 | Tue 3/20/12 | 100% | |
| 545 | | Risk and Response Plan | 0 days | Tue 3/20/12 | Tue 3/20/12 | 100% | MRx |
| 546 | | Communication Planning | 1 day | Fri 6/1/12 | Fri 6/1/12 | 100% | |
| 547 | | Communication Plan | 0 days | Fri 6/1/12 | Fri 6/1/12 | 100% | MRx |
| 548 | | Change Management Planning | 0 days | Tue 3/20/12 | Tue 3/20/12 | 100% | |
| 549 | | Change Management Plan | 0 days | Tue 3/20/12 | Tue 3/20/12 | 100% | MRx |
| 550 | | Project Plan | 53 days | Tue 3/20/12 | Thu 5/31/12 | 100% | |
| 551 | | Preliminary Time line | 5 days | Tue 3/20/12 | Mon 3/26/12 | 100% | MRx |
| 552 | | Second Preliminary Time line | 1 day | Fri 5/11/12 | Fri 5/11/12 | 100% | MRx |
| 553 | | Finalized Time Line | 5 days | Fri 5/25/12 | Thu 5/31/12 | 100% | MRx |
| 554 | | Analysis Phase | 562 days | Mon 5/7/12 | Mon 6/30/14 | 57% | |
| 555 | | Requirement Gathering and Analysis | 562 days | Mon 5/7/12 | Mon 6/30/14 | 56% | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|---------------------------------------|-------------------|--------------------|--------------------|-------------|----------------|
| 556 | | Group Requirements | 299.5 days | Mon 6/18/12 | Fri 8/9/13 | 97% | |
| 557 | | Establish Plan/Group | 2 days | Mon 6/18/12 | Tue 6/19/12 | 100% MRx | |
| 558 | | Define Lines of Business | 2 days | Mon 6/18/12 | Tue 6/19/12 | 100% MRx | |
| 559 | | Prior Auth List | 2 days | Mon 6/18/12 | Tue 6/19/12 | 100% MRx | |
| 560 | | PA Timing Requirements | 2 days | Mon 6/18/12 | Tue 6/19/12 | 100% MRx | |
| 561 | 5FS-20 days | Step Therapies | 2 days | Mon 6/18/12 | Mon 8/5/13 | 100% MRx | |
| 562 | | DUR Rules | 2 days | Mon 6/18/12 | Tue 6/19/12 | 100% MRx | |
| 563 | | Prescriber Overrides | 2 days | Mon 6/18/12 | Tue 6/19/12 | 100% MRx | |
| 564 | | Claim Interventions | 2 days | Mon 6/18/12 | Tue 6/19/12 | 100% MRx | |
| 565 | 5FS-20 days | Custom Rule Requirements | 2 days | Mon 6/18/12 | Fri 8/9/13 | 75% MRx | |
| 566 | | Benefit Design Requirements | 0.25 days | Mon 6/18/12 | Mon 6/18/12 | 100% | |
| 567 | | Deductibles | 0.25 days | Mon 6/18/12 | Mon 6/18/12 | 100% MRx | |
| 568 | | OOP Limits | 0.25 days | Mon 6/18/12 | Mon 6/18/12 | 100% MRx | |
| 569 | | Maximums | 0.25 days | Mon 6/18/12 | Mon 6/18/12 | 100% MRx | |
| 570 | | Administration Fees | 0.25 days | Mon 6/18/12 | Mon 6/18/12 | 100% MRx | |
| 571 | | DAW Fees | 0.25 days | Mon 6/18/12 | Mon 6/18/12 | 100% MRx | |
| 572 | | Pricing | 0.25 days | Mon 6/18/12 | Mon 6/18/12 | 100% MRx | |
| 573 | | Copay Structure | 0.25 days | Mon 6/18/12 | Mon 6/18/12 | 100% MRx | |
| 574 | | Clinical Programs Requirements | 306 days | Fri 6/8/12 | Fri 8/9/13 | 100% | |
| 575 | 5FS-20 days | Jcode Reviews | 5 days | Fri 6/8/12 | Fri 8/9/13 | 100% MRx | |
| 576 | | Care Management | 1 day | Mon 6/18/12 | Mon 6/18/12 | 100% | |
| 577 | | MTM | 1 day | Mon 6/18/12 | Mon 6/18/12 | 100% MRx | |
| 578 | | MAP | 0.25 days | Mon 6/18/12 | Mon 6/18/12 | 100% MRx | |
| 579 | | Interventions | 0.25 days | Mon 6/18/12 | Mon 6/18/12 | 100% MRx | |
| 580 | | HEDIS requirements | 0.25 days | Mon 7/2/12 | Mon 7/2/12 | 100% | |
| 581 | | HEDIS Messaging | 0 days | Mon 7/2/12 | Mon 7/2/12 | 100% MRx | |
| 582 | | Formulary | 316 days | Mon 6/4/12 | Mon 8/19/13 | 100% | |
| 583 | | NH Formulary | 316 days | Mon 6/4/12 | Mon 8/19/13 | 100% | |
| 584 | | Format defined for import | 2 days | Mon 6/4/12 | Tue 6/5/12 | 100% MRx | |
| 585 | 5FS-10 days | NH Formulary verification | 2 days | Mon 6/18/12 | Mon 8/19/13 | 100% MRx | |
| 586 | | MAC | 2 days | Mon 6/18/12 | Tue 6/19/12 | 100% | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|--|-------------------|--------------------|--------------------|-------------|----------------|
| 589 | | Pharmacy Network | 300 days | Mon 6/18/12 | Fri 8/9/13 | 67% | |
| 590 | | Review pharmacy Network (June) | 1 day | Mon 6/18/12 | Mon 6/18/12 | 100% MRx | |
| 591 | | Review pharmacy Network (August) | 1 day | Fri 8/3/12 | Fri 8/3/12 | 100% MRx | |
| 592 | 5FS-20 days | Review pharmacy network | 1 day | Fri 8/9/13 | Fri 8/9/13 | 0% | |
| 593 | | Letters | 266 days | Fri 8/3/12 | Fri 8/9/13 | 50% | |
| 594 | 5FS-20 days | Sample Letters received | 1 day | Fri 8/3/12 | Fri 8/9/13 | 50% MRx | |
| 595 | 5FS-20 days | Letter customization Requirements | 2 days | Mon 8/6/12 | Fri 8/9/13 | 50% MRx | |
| 596 | | Dashboard | 65 days | Mon 5/7/12 | Fri 8/3/12 | 100% | |
| 597 | | Establish Dashboard Requirements | 0 days | Mon 5/7/12 | Fri 8/3/12 | 100% MRx | |
| 598 | | Administration | 266.5 days | Fri 8/3/12 | Mon 8/12/13 | 70% | |
| 599 | 5FS-20 days | Claim Rules | 3 days | Fri 8/3/12 | Mon 8/12/13 | 50% MRx | |
| 600 | | Claim Alerts | 2 days | Fri 8/3/12 | Mon 8/6/12 | 100% MRx | |
| 601 | | Menus | 1 day | Fri 8/3/12 | Fri 8/3/12 | 100% MRx | |
| 602 | 5FS-20 days | Users | 1 day | Fri 8/3/12 | Fri 8/9/13 | 75% MRx | |
| 603 | 5FS-20 days | Lists | 1 day | Fri 8/3/12 | Fri 8/9/13 | 50% MRx | |
| 604 | 5FS-20 days | Options | 1 day | Mon 8/5/13 | Fri 8/9/13 | 50% MRx | |
| 605 | 5FS-20 days | PBM Rules | 3 days | Mon 8/5/13 | Mon 8/12/13 | 50% MRx | |
| 606 | 5FS-20 days | Report Settings | 2 days | Mon 8/5/13 | Tue 8/6/13 | 100% MRx | |
| 607 | | EDI Information | 0.25 days | Fri 8/3/12 | Fri 8/3/12 | 100% MRx | |
| 608 | | Grievance Management | 2 days | Fri 8/3/12 | Mon 8/6/12 | 100% | |
| 609 | | Establish processes for NH Grievance | 0 days | Fri 8/3/12 | Mon 8/6/12 | 100% MRx | |
| 610 | | Reporting Requirements | 496 days | Tue 8/7/12 | Mon 6/30/14 | 50% | |
| 611 | 98 | Sample reports | 226 days | Tue 8/7/12 | Mon 6/30/14 | 50% MRx | |
| 612 | 98 | Custom Reporting Requirements | 3 days | Tue 8/7/12 | Wed 8/21/13 | 50% MRx | |
| 613 | | Payer Sheet | 262 days | Fri 8/10/12 | Mon 8/12/13 | 35% | |
| 614 | 5FS-20 days | Review Current Payer Sheet | 1 day | Fri 8/10/12 | Fri 8/9/13 | 75% MRx | |
| 615 | 5FS-20 days | Evaluate changes to Payer Sheet | 1 day | Mon 8/13/12 | Mon 8/5/13 | 100% MRx | |
| 616 | 5FS-20 days | Draft updated MRx Payer sheet | 2 days | Fri 8/9/13 | Mon 8/12/13 | 0% MRx | |
| 617 | 5FS-20 days | Payer Sheet Approval | 1 day | Fri 8/9/13 | Fri 8/9/13 | 0% MRx | |
| 618 | | Additional Requirement Analysis | 8 days | Mon 6/18/12 | Thu 6/28/12 | 100% | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|------------------------------------|--------------------|--------------------|--------------------|-------------|----------------|
| 619 | | Language Services and Requirements | 1 day | Mon 6/18/12 | Mon 6/18/12 | 100% | MRx |
| 620 | | Customer Service Requirements | 1 day | Tue 6/19/12 | Tue 6/19/12 | 100% | MRx |
| 621 | | Connectivity Needs | 1 day | Fri 6/22/12 | Fri 6/22/12 | 100% | MRx |
| 622 | | Phone/Fax line additions | 1 day | Mon 6/25/12 | Mon 6/25/12 | 100% | MRx |
| 623 | | Historic claim data requirements | 1 day | Wed 6/27/12 | Wed 6/27/12 | 100% | MRx |
| 624 | | Requirements Defined | 0 days | Thu 6/28/12 | Thu 6/28/12 | 100% | MRx |
| 625 | 5FS-20 days | Analysis Complete | 243 days | Thu 6/28/12 | Mon 7/14/14 | 0% | MRx |
| 626 | | Development Phase | 538.25 days | Mon 6/25/12 | Wed 7/16/14 | 22% | |
| 627 | | Design-Build | 538.25 days | Mon 6/25/12 | Wed 7/16/14 | 33% | |
| 628 | | Establish Environments | 7 days | Mon 6/25/12 | Tue 7/3/12 | 100% | |
| 635 | | Plan Configuration | 528.25 days | Mon 7/9/12 | Wed 7/16/14 | 78% | |
| 636 | | Group Setup | 528.25 days | Mon 7/9/12 | Wed 7/16/14 | 75% | |
| 637 | | Establish Plan/Group | 0.5 days | Mon 7/9/12 | Mon 7/9/12 | 100% | MRx |
| 638 | | Create Lines of Business | 0.5 days | Mon 7/9/12 | Mon 7/9/12 | 100% | MRx |
| 639 | | Prior Auth List | 0.5 days | Tue 7/10/12 | Tue 7/10/12 | 100% | MRx |
| 640 | 625 | Step Therapies | 0.5 days | Tue 7/10/12 | Tue 7/15/14 | 50% | MRx |
| 641 | | DUR Rules | 0.5 days | Wed 7/11/12 | Wed 7/11/12 | 100% | MRx |
| 642 | | Prescriber Overrides | 0.5 days | Wed 7/11/12 | Wed 7/11/12 | 100% | MRx |
| 643 | | Claim Interventions | 1 day | Thu 7/12/12 | Thu 7/12/12 | 100% | MRx |
| 644 | 640 | Custom Rule Setup | 1 day | Tue 7/15/14 | Wed 7/16/14 | 0% | MRx |
| 645 | | Benefit Design | 522.25 days | Mon 7/16/12 | Tue 7/15/14 | 86% | |
| 646 | | Deductibles | 0.25 days | Mon 7/16/12 | Mon 7/16/12 | 100% | MRx |
| 647 | | Limits | 0.25 days | Mon 7/16/12 | Mon 7/16/12 | 100% | MRx |
| 648 | | Maximums | 0.25 days | Mon 7/16/12 | Mon 7/16/12 | 100% | MRx |
| 649 | | Administration Fees | 0.25 days | Mon 7/16/12 | Mon 7/16/12 | 100% | MRx |
| 650 | | DAW Fees | 0.25 days | Tue 7/17/12 | Tue 7/17/12 | 100% | MRx |
| 651 | | Pricing | 0.25 days | Tue 7/17/12 | Tue 7/17/12 | 100% | MRx |
| 652 | 625 | Copay Structure | 0.25 days | Tue 7/15/14 | Tue 7/15/14 | 0% | MRx |
| 653 | | Formulary Configuration | 483 days | Mon 9/10/12 | Tue 7/15/14 | 83% | |
| 654 | | NH Formulary | 483 days | Mon 9/10/12 | Tue 7/15/14 | 67% | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|-------------------------------------|-------------------|--------------------|--------------------|-------------|----------------|
| 655 | | Formulary Upload | 1 day | Mon 9/10/12 | Mon 9/10/12 | 100% | MRx |
| 656 | 625 | Formulary Verification | 2 days | Tue 9/11/12 | Tue 7/15/14 | 50% | MRx |
| 657 | | MAC | 3 days | Mon 9/10/12 | Wed 9/12/12 | 100% | |
| 660 | | Batch Testing | 2 days | Mon 11/4/13 | Tue 11/5/13 | 0% | |
| 661 | 7 | Enrollment | 2 days | Mon 11/4/13 | Tue 11/5/13 | 0% | MRx |
| 662 | 7 | Locks | 2 days | Mon 11/4/13 | Tue 11/5/13 | 0% | MRx |
| 663 | 7 | COBC | 2 days | Mon 11/4/13 | Tue 11/5/13 | 0% | MRx |
| 664 | | Letters | 3 days | Mon 11/4/13 | Wed 11/6/13 | 0% | |
| 665 | 7 | Customize Letters as required | 3 days | Mon 11/4/13 | Wed 11/6/13 | 0% | MRx |
| 666 | 7 | UI For New Letter Process | 3 days | Mon 11/4/13 | Wed 11/6/13 | 0% | MRx |
| 667 | | Dashboard | 3 days | Mon 9/17/12 | Wed 9/19/12 | 100% | |
| 669 | | Administration Configuration | 4 days | Mon 11/4/13 | Thu 11/7/13 | 0% | |
| 670 | 7 | Claim Rules | 4 days | Mon 11/4/13 | Thu 11/7/13 | 0% | MRx |
| 671 | 7 | Claim Alerts | 2 days | Mon 11/4/13 | Tue 11/5/13 | 0% | MRx |
| 672 | 7 | Menus | 2 days | Mon 11/4/13 | Tue 11/5/13 | 0% | MRx |
| 673 | 7 | Users | 2 days | Mon 11/4/13 | Tue 11/5/13 | 0% | MRx |
| 674 | 7 | Lists | 1 day | Mon 11/4/13 | Mon 11/4/13 | 0% | MRx |
| 675 | 7 | Options | 1 day | Mon 11/4/13 | Mon 11/4/13 | 0% | MRx |
| 676 | 7 | PBM Rules | 3 days | Mon 11/4/13 | Wed 11/6/13 | 0% | MRx |
| 677 | 7 | Report Settings | 3 days | Mon 11/4/13 | Wed 11/6/13 | 0% | MRx |
| 678 | 7 | EDI setup | 1 day | Mon 11/4/13 | Mon 11/4/13 | 0% | MRx |
| 679 | 7 | Billing configured | 1 day | Mon 11/4/13 | Mon 11/4/13 | 0% | MRx |
| 680 | 7 | PBM Setup Complete | 0 days | Mon 11/4/13 | Mon 11/4/13 | 0% | MRx |
| 681 | | Conversion Items | 4 days | Wed 9/11/13 | Mon 9/16/13 | 0% | |
| 682 | 6 | Enrollment | 2 days | Wed 9/11/13 | Thu 9/12/13 | 0% | MRx |
| 683 | 6 | Prior Authorizations | 4 days | Wed 9/11/13 | Mon 9/16/13 | 0% | MRx |
| 684 | 6 | Formulary Upload | 2 days | Wed 9/11/13 | Thu 9/12/13 | 0% | MRx |
| 685 | 6 | COBC | 2 days | Wed 9/11/13 | Thu 9/12/13 | 0% | MRx |
| 686 | 6 | Claims History | 2 days | Wed 9/11/13 | Thu 9/12/13 | 0% | MRx |
| 687 | 6 | Locks | 2 days | Wed 9/11/13 | Thu 9/12/13 | 0% | MRx |
| 688 | | Pharmacy Network | 249.1 days | Mon 9/24/12 | Fri 9/6/13 | 0% | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|---|---------------|---------------------|---------------------|------------|----------------|
| 689 | 5 | Review Pharmacy Network | 0.1 days | Mon 9/24/12 | Fri 9/6/13 | 0% | MRx |
| 690 | | Account setup | 4 days | Tue 4/2/13 | Fri 4/5/13 | 0% | |
| 691 | 5 | NH Secure Login | 4 days | Tue 4/2/13 | Fri 4/5/13 | 0% | MRx |
| 692 | 5 | Website and NH Secure Login | 1 day | Tue 4/2/13 | Tue 4/2/13 | 0% | MRx |
| 693 | | Website | 7 days | Fri 9/6/13 | Mon 9/16/13 | 0% | |
| 694 | | Portal Setup | 7 days | Fri 9/6/13 | Mon 9/16/13 | 0% | |
| 695 | 6 | Member Portal | 0 days | Tue 9/10/13 | Tue 9/10/13 | 0% | MRx |
| 696 | 6 | Client Portal | 4 days | Wed 9/11/13 | Mon 9/16/13 | 0% | MRx |
| 697 | 5 | Provider Portal | 4 days | Fri 9/6/13 | Wed 9/11/13 | 0% | MRx |
| 698 | 6 | PBM External Setup Complete | 0 days | Tue 9/10/13 | Tue 9/10/13 | 0% | MRx |
| 699 | | Testing | 5 days | Mon 10/21/13 | Fri 10/25/13 | 0% | |
| 700 | 7FS-10 days | Pre Production Environment setup | 2 days | Mon 10/21/13 | Tue 10/22/13 | 0% | MRx |
| 701 | 7FS-10 days | Configure Pre production Setup | 2 days | Mon 10/21/13 | Tue 10/22/13 | 0% | MRx |
| 702 | 7FS-10 days | Verify Data Exchanges | 1 day | Mon 10/21/13 | Mon 10/21/13 | 0% | MRx |
| 703 | 7FS-10 days | System Testing | 4 days | Mon 10/21/13 | Thu 10/24/13 | 0% | MRx |
| 704 | 7FS-10 days | Receive Claims for batch testing | 0 days | Mon 10/21/13 | Mon 10/21/13 | 0% | MRx |
| 705 | 7FS-10 days | Test adjudication and configuration | 2 days | Mon 10/21/13 | Tue 10/22/13 | 0% | MRx |
| 706 | 7FS-10 days | Parallel testing of Claims Week 1 | 5 days | Mon 10/21/13 | Fri 10/25/13 | 0% | MRx |
| 707 | 7FS-10 days | Parallel testing of Claims Week 2 | 5 days | Mon 10/21/13 | Fri 10/25/13 | 0% | MRx |
| 708 | 7FS-10 days | Parallel testing of Claims Week 3 | 5 days | Mon 10/21/13 | Fri 10/25/13 | 0% | MRx |
| 709 | 7FS-10 days | Parallel testing of Claims Week 4 | 5 days | Mon 10/21/13 | Fri 10/25/13 | 0% | MRx |
| 710 | 7 | System Testing Complete | 0 days | Mon 11/4/13 | Mon 11/4/13 | 0% | MRx |
| 711 | | Deployment | 3 days | Mon 11/4/13 | Wed 11/6/13 | 0% | |
| 712 | | Production Environment Certification | 0 days | Mon 11/4/13 | Mon 11/4/13 | 0% | |
| 713 | 8 | Environment Ready | 0 days | Mon 11/4/13 | Mon 11/4/13 | 0% | MRx |
| 714 | | Claims Conversion | 2 days | Mon 11/4/13 | Tue 11/5/13 | 0% | |
| 715 | 8 | Production Eligibility Load | 2 days | Mon 11/4/13 | Tue 11/5/13 | 0% | MRx |
| 716 | 8 | PA Load | 2 days | Mon 11/4/13 | Tue 11/5/13 | 0% | MRx |
| 717 | 8 | Claim History Load | 2 days | Mon 11/4/13 | Tue 11/5/13 | 0% | MRx |
| 718 | 8 | Conversion Complete | 0 days | Mon 11/4/13 | Mon 11/4/13 | 0% | MRx |
| 719 | | Payer Sheet | 1 day | Mon 11/4/13 | Mon 11/4/13 | 0% | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|--|-----------------|--------------------|--------------------|-------------|-----------------|
| 720 | 8 | Execute changes to MeridianRx Payer | 1 day | Mon 11/4/13 | Mon 11/4/13 | 0% | MRx |
| 721 | 8 | Communicate to Pharmacy Network | 1 day | Mon 11/4/13 | Mon 11/4/13 | 0% | MRx |
| 722 | | Project Review | 3 days | Mon 11/4/13 | Wed 11/6/13 | 0% | |
| 723 | 8 | Go live timing plan | 0.5 days | Mon 11/4/13 | Mon 11/4/13 | 0% | MRx |
| 724 | 8 | Resource Plan | 3 days | Mon 11/4/13 | Wed 11/6/13 | 0% | MRx |
| 725 | 8 | Post Live Check List | 3 days | Mon 11/4/13 | Wed 11/6/13 | 0% | MRx |
| 726 | 8 | Post Live Monitoring Plan | 3 days | Mon 11/4/13 | Wed 11/6/13 | 0% | MRx |
| 727 | 8 | Go Live Ready | 3 days | Mon 11/4/13 | Wed 11/6/13 | 0% | MRx |
| 728 | | Go Live! | 5 days | Sun 12/1/13 | Thu 12/5/13 | 0% | |
| 729 | | Transition and cut off | 5 days | Sun 12/1/13 | Thu 12/5/13 | 0% | |
| 730 | 9 | Transition to post-live monitoring and | 5 days | Sun 12/1/13 | Thu 12/5/13 | 0% | |
| 731 | 45 | Care Management | 341 days | Mon 5/14/12 | Mon 9/2/13 | 95% | QI,UM,NH |
| 732 | | Policies & Procedures | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 733 | | Coordination of Medical and BH care | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 734 | | BH Authorization | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 735 | | Acute Behavioral Health Inpatient Review | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 736 | | Discharge Planning | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 737 | | Care Coordination for members with Complex Care | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 738 | | Care Coordination to Enhance Service Continuity for High Risk Consumers | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 739 | | Referral and Triage Process | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 740 | | Coordination of Mental Health Services with other Systems of Care | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 741 | | Crisis Services Policy | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 742 | | Ensuring Non-Discrimination of Service Provision for Consumers with Complex Care Needs | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 743 | | Integrated Crisis Systems | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 744 | | Level of Care and Authorization Criteria | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 745 | | Out of Network Referrals | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|-----------------|--|----------|-------------|-------------|------------|----------------|
| 746 | | Recovery & Resiliency | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 747 | | Rehabilitation Case Management | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 748 | | Intensive Case Management Program | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 749 | | Special Needs Population Care Coordination | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 750 | | Stabilization Services | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 751 | | Consent and Disclosure of Behavioral Health PHI | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 752 | | Coordination of Care Between Mental Health Providers and Primary Care Physicians | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 753 | | Smoking and Tobacco Cessation | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 754 | | Community Mental Health Center Services | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 755 | | Community Mental Health Center Staff Education | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 756 | | Transition of Care Between Mental Health Levels of Care and Home | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 757 | | Identification and Treatment of the Homeless Population | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 758 | | Reporting of Behavioral Health Data | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 759 | | Identification and Treatment of the Deaf Population | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 760 | | Barriers to Care, Physical-Language-Cultural Sensitivity and Competency | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 761 | | Communication Improves Care Coordination | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% | UM,QI,NH |
| 762 | 5 | Job Aids | 15 days | Tue 4/2/13 | Mon 4/22/13 | 0% | UM,QI,NH |
| 763 | 9FS-45 days,755 | Submit BH Training Plan, 12.1.10 | 1 day | Mon 10/1/12 | Mon 10/1/12 | 100% | NH |
| 764 | | Submit BH Hospital Readmissions Plan, 12.1.16.6 | 1 day | Tue 7/31/12 | Tue 7/31/12 | 100% | NH |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|-----------------|--|-----------------|--------------------|--------------------|----------------|----------------|
| 765 | 9FS-65 days | Submit EPSDT Plan, 11.1.3 | 1 day | Mon 9/3/12 | Mon 9/3/12 | 100% QI | |
| 766 | 9FS-65 days,732 | Submit policies governing the coordination of care with primary care providers and community mental health programs, 12.1.12 | 1 day | Mon 9/3/12 | Mon 9/3/12 | 100% NH,UM | |
| 767 | | Clinicians certified in the use of NH versions of CANS and ANSA, 12.1.6.1 | 1 day | Mon 9/2/13 | Mon 9/2/13 | 0% NH | |
| 768 | | Submit Proposal for new, innovative and cost effective models of providing crisis and emergency response services, 12.1.11.1 | 4 days | Fri 7/26/13 | Wed 7/31/13 | 100% UM | |
| 769 | | Submit HRA | 1 day | Fri 6/15/12 | Fri 6/15/12 | 100% | |
| 770 | 5 | Regionally Based Crisis Lines | 25 days | Tue 4/2/13 | Mon 5/6/13 | 0% PS | |
| 771 | 45 | Utilization Management | 246 days | Mon 5/14/12 | Mon 4/22/13 | 97% UM | |
| 772 | | Policies & Procedures | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 773 | | Affirmative Statement Regarding Incentives | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 774 | | Timeliness of Decision Making and Notification | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 775 | | Communication with External Entities | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 776 | | Concurrent Review Process | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 777 | | Authorization of Emergency Admissions | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 778 | | Pre-Service Authorization Process | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 779 | | Retrospective Review of Unauthorized Services | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 780 | | Clinical Information in UM Decision Making | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 781 | | Consideration of Member Needs and Local Delivery System when Rendering UM decision | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 782 | | Second Opinion | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|--|-------------------|--------------------|--------------------|--------------------|----------------|
| 783 | | Evaluation of New Technology | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 784 | | Inter-Rater Reliability | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 785 | | Satisfaction with the Utilization Management Process | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 786 | | Monitoring for Under- and Over-Utilization | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 787 | | Communication Services | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 788 | | Emergency Services Coverage | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 789 | | Primary Case Management | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 790 | | Complex Case Management | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 791 | | Discharge Planning Process | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 792 | | Development of Clinical Criteria | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 793 | | Peer to Peer Availability | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 794 | | Appropriate Professionals | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 795 | 5 | Job Aids | 15 days | Tue 4/2/13 | Mon 4/22/13 | 0% UM | |
| 796 | 5 | 21.1.3 Submit Policies | 0 days | Mon 6/18/12 | Mon 6/18/12 | 100% UM | |
| 797 | 45 | Service Limits | 10 days | Mon 6/18/12 | Fri 6/29/12 | 100% UM | |
| 798 | 45 | Grievance System | 246 days | Mon 5/14/12 | Mon 4/22/13 | 84% MS, UM | |
| 799 | | Policies & Procedures | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% MS, UM | |
| 800 | | Provider Appeals | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% UM | |
| 801 | | Enrollee Appeals of Adverse Determination | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% MS, UM | |
| 802 | | Appeal Record Documentation | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% MS, UM | |
| 803 | 5 | Job Aids | 15 days | Tue 4/2/13 | Mon 4/22/13 | 0% MS, UM | |
| 804 | | Submit description of policies, procedures, notices and forms of proposed Grievance System, 17.1.2 | 1 day | Fri 6/15/12 | Fri 6/15/12 | 100% | |
| 805 | 45 | Quality Management | 312.5 days | Mon 5/14/12 | Wed 7/24/13 | 96% QI | |
| 806 | | Policies & Procedures | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 807 | | Quality Assessment Program | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 808 | | Policy and Procedure Review | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|---|-------------------|-------------------|--------------------|------------|----------------|
| 809 | | Review of Adverse Events | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 810 | | Grievances & Appeals Reporting Methodology | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 811 | | Quality of Care Complaints | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 812 | | Continuity and Coordination of Care | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 813 | | Monitoring of Practitioner Office Site Quality | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 814 | | Evaluation of Practitioner Availability | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 815 | | Member Access Evaluation | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 816 | | Medical Record Review Process for HEDIS Collection | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 817 | | Internal and External Inter-Rater Reliability for HEDIS Data Collection, Supplemental Data Entry, and Auditing. | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 818 | | NH EPSDT Requirements and Outreach Program | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 819 | | Clinical Practice Guidelines | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 820 | | Standards for Medical Records | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 821 | | Preventative Health Guidelines | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 822 | | Incorporating Preventative Medicine in the Management of Enrollees | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 823 | | Delegation of Plan Functions | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 824 | | Special Reporting and Compliance Requirements | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% QI | |
| 825 | 5 | Job Aids | 15 days | Tue 4/2/13 | Mon 4/22/13 | 0% QI | |
| 826 | | Submission of Quality Improvement Program | 1 day | Fri 6/15/12 | Fri 6/15/12 | 100% QI | |
| 827 | | DM- Depression Program | 101.5 days | Tue 3/5/13 | Wed 7/24/13 | 50% | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|-----------------|---|-------------------|--------------------|--------------------|------------------|----------------|
| 828 | 6FS-35 days | Draft Program | 1 day | Tue 3/5/13 | Tue 3/5/13 | 100% QI | |
| 829 | 6FS-35 days | Draft Program Materials | 1 day | Tue 3/5/13 | Wed 7/24/13 | 50% QI | |
| 830 | 828 | Approve Program | 1 day | Wed 4/24/13 | Wed 4/24/13 | 0% QI | |
| 831 | | Fraud, Waste, and Abuse | 345 days | Mon 5/14/12 | Fri 9/6/13 | 36% COMP | |
| 832 | | Policies & Procedures | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% COMP | |
| 833 | | Fraud, Waste, and Abuse | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% COMP | |
| 834 | 5 | Job Aids | 15 days | Tue 4/2/13 | Mon 4/22/13 | 0% COMP | |
| 835 | 5 | EOB | 30 days | Tue 4/2/13 | Mon 5/13/13 | 0% COMP,MS | |
| 836 | 6SS-11 days,458 | Submit FWA- Program Integrity Plan, 24.1.11 day | 1 day | Fri 9/14/12 | Fri 9/14/12 | 100% COMP | |
| 837 | 5 | Review Overpayment & Recovery Process, 24.1.11 | 1 day | Fri 9/6/13 | Fri 9/6/13 | 0% COMP | |
| 838 | | Third-Party Liability | 295 days | Mon 5/14/12 | Mon 7/1/13 | 81% CLMS | |
| 839 | | Policies & Procedures | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% CLMS | |
| 840 | | Third Party Liability | 25 days | Mon 5/14/12 | Fri 6/15/12 | 100% CLMS | |
| 841 | 5 | Job Aids | 15 days | Tue 4/2/13 | Mon 4/22/13 | 0% CLMS,MS | |
| 842 | | TPL (First Recovery) | 194 days | Tue 10/2/12 | Mon 7/1/13 | 99% | |
| 843 | 94 | Communication Protocols | 19 days | Tue 10/2/12 | Fri 10/26/12 | 100% CLMS | |
| 844 | 94 | Oversight Reports | 19 days | Tue 10/2/12 | Fri 10/26/12 | 100% CLMS | |
| 845 | | Key Project Events | 65 days | Mon 4/1/13 | Fri 6/28/13 | 0% | |
| 846 | | Readiness Review 1 | 0 days | Mon 4/1/13 | Mon 4/1/13 | 0% | |
| 847 | | Open enrollment | 0 days | Wed 5/1/13 | Wed 5/1/13 | 0% | |
| 848 | | Readiness Review 2 | 0 days | Fri 5/31/13 | Fri 5/31/13 | 0% | |
| 849 | | Go Live | 0 days | Mon 7/1/13 | Mon 7/1/13 | 0% | |
| 850 | | MCIS | 346 days | Wed 5/23/12 | Wed 9/18/13 | 66% | |
| 851 | | Key Project Events | 60 days | Fri 9/6/13 | Sun 12/1/13 | 0% | |
| 852 | 855FF-3 mons | Readiness Review 1 | 0 days | Fri 9/6/13 | Fri 9/6/13 | 0% | |
| 853 | 852FF+1 wk | Start of Open Enrollment | 0 days | Fri 9/13/13 | Fri 9/13/13 | 0% | |
| 854 | 855FF-1 mon | Readiness Review 2 | 0 days | Fri 11/1/13 | Fri 11/1/13 | 0% | |
| 855 | | Go Live | 0 days | Sun 12/1/13 | Sun 12/1/13 | 0% | |
| 856 | | MCIS | 431.1 days | Wed 5/23/12 | Wed 1/15/14 | 66% | |
| 857 | | Policies & Procedures | 25 days | Mon 10/15/12 | Fri 11/16/12 | 100% IS | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|---|-------------------|--------------------|--------------------|-------------|----------------|
| 858 | 854FF | Job Aids | 15 days | Mon 10/14/13 | Fri 11/1/13 | 20% | COMM |
| 859 | | IS Contract and Audit Requirements | 431.1 days | Wed 5/23/12 | Wed 1/15/14 | 66% | |
| 860 | | Update and add Pandemic Plan to cur | 1 day | Mon 11/5/12 | Mon 11/5/12 | 100% | IS |
| 861 | | Submit Emergency Response Plan doc | 1 day | Mon 10/1/12 | Mon 10/1/12 | 100% | IS |
| 862 | | Facilities and Infrastructure | 167 days | Thu 5/31/12 | Fri 1/18/13 | 100% | |
| 863 | | Create and publish a maintenance | 85 days | Mon 7/16/12 | Fri 11/9/12 | 100% | IS |
| 864 | | Hardware Pre-Configuration in Detroit | 57 days | Tue 6/5/12 | Wed 8/22/12 | 100% | |
| 865 | | Configure Cisco 3750 Switches | 1 day | Mon 8/20/12 | Mon 8/20/12 | 100% | IS |
| 866 | | Configure Cisco ASA 5510 Firewall | 3 days | Mon 8/20/12 | Wed 8/22/12 | 100% | IS |
| 867 | | Configure Cisco Wireless LAN Controller | 1 day | Thu 8/16/12 | Thu 8/16/12 | 100% | IS |
| 868 | | Configure Cisco IronPort | 2 days | Tue 8/14/12 | Wed 8/15/12 | 100% | IS |
| 869 | | Configure EMC VNXe 3100 Storage | 2 days | Mon 8/20/12 | Tue 8/21/12 | 100% | IS |
| 870 | | Configure ESXi Servers | 1 day | Mon 8/20/12 | Mon 8/20/12 | 100% | IS |
| 871 | | Configure Data Domain | 4 days | Tue 6/5/12 | Fri 6/8/12 | 100% | IS |
| 872 | | Configure Teradici's | 2 days | Mon 8/20/12 | Tue 8/21/12 | 100% | IS |
| 873 | | Virtual Server and Desktop Pre-Configuration | 41 days | Fri 8/3/12 | Fri 9/28/12 | 100% | |
| 874 | | Install and Configure Windows 2008 R2 | 2 days | Mon 8/20/12 | Tue 8/21/12 | 100% | IS |
| 875 | | Install and Configure Windows 2008 R2 | 2 days | Wed 8/22/12 | Thu 8/23/12 | 100% | IS |
| 876 | | Install and Configure vCenter Server | 1 day | Mon 8/20/12 | Mon 8/20/12 | 100% | IS |
| 877 | | Configure View Base Image | 8 hrs | Fri 8/3/12 | Fri 8/3/12 | 100% | IS |
| 878 | 877 | Configure Virtual Machines | 8 hrs | Fri 9/28/12 | Fri 9/28/12 | 100% | IS |
| 879 | | New Back End Servers in Detroit | 31 days | Mon 8/20/12 | Mon 10/1/12 | 100% | |
| 880 | | Spec new MCS UAT Server | 1 day | Mon 8/20/12 | Mon 8/20/12 | 100% | IS |
| 881 | | Procure new MCS UAT server | 1 day | Mon 8/20/12 | Mon 8/20/12 | 100% | IS |
| 882 | | Build and Configure new MCS UAT | 10 days | Tue 8/21/12 | Mon 9/3/12 | 100% | IS |
| 883 | | Need Data Warehouse Hardware | 10 days | Tue 9/18/12 | Mon 10/1/12 | 100% | IS |
| 884 | | MCS Capacity & Load testing | 1 day | Thu 5/31/12 | Thu 5/31/12 | 100% | |
| 885 | | Determine capacity requirements | 1 day | Thu 5/31/12 | Thu 5/31/12 | 100% | IS |
| 886 | | Obtain additional storage space | 1 day | Thu 5/31/12 | Thu 5/31/12 | 100% | IS |
| 887 | | Conduct load testing | 1 day | Thu 5/31/12 | Thu 5/31/12 | 100% | IS |
| 888 | | Order & install additional hardware | 1 day | Thu 5/31/12 | Thu 5/31/12 | 100% | IS |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|-----------------------------------|----------------|--------------------|--------------------|-------------|----------------|
| 889 | | Shipping | 4 days | Wed 8/1/12 | Mon 8/6/12 | 100% | |
| 890 | | Identify best method of shipment | 1 day | Wed 8/1/12 | Wed 8/1/12 | 100% IS | |
| 891 | 890 | Prep all gear for shipping | 2 days | Thu 8/2/12 | Fri 8/3/12 | 100% IS | |
| 892 | 891 | Ship gear to new site | 1 day | Mon 8/6/12 | Mon 8/6/12 | 100% IS | |
| 893 | | Deployment - New Hampshire | 9 days | Mon 8/6/12 | Thu 8/16/12 | 100% | |
| 894 | | Rack all Hardware | 2 days | Fri 8/10/12 | Mon 8/13/12 | 100% IS | |
| 895 | | Patch Voice and Data to all Desk | 1 day | Sat 8/11/12 | Sat 8/11/12 | 100% IS | |
| 896 | | MPLS Test and Turn Up | 1 day | Mon 8/6/12 | Mon 8/6/12 | 100% IS | |
| 897 | | Deploy Virtual Desktops | 2 days | Wed 8/15/12 | Thu 8/16/12 | 100% IS | |
| 898 | | Phone System Installation | 60 days | Mon 6/18/12 | Fri 9/7/12 | 100% | |
| 899 | | Order Data Lines | 45 days | Mon 6/18/12 | Fri 8/17/12 | 100% IS | |
| 900 | | Order Voice Lines | 1 day | Wed 8/1/12 | Wed 8/1/12 | 100% IS | |
| 901 | | Order Equipment | 10 days | Mon 8/27/12 | Fri 9/7/12 | 100% IS | |
| 902 | | Document Call Flow Requirements | 1 day | Mon 7/23/12 | Mon 7/23/12 | 100% IS | |
| 903 | | Installation of Hardware | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 904 | | Provision System - Base System | 4 hrs | Tue 8/14/12 | Tue 8/14/12 | 100% IS | |
| 905 | | Test and Turn up PRIs | 2 hrs | Tue 8/14/12 | Tue 8/14/12 | 100% IS | |
| 906 | | Test Networking to all CMC sites | 2 hrs | Tue 8/14/12 | Tue 8/14/12 | 100% IS | |
| 907 | 906FS+1 day | Install Spectralink Wireless Phon | 4 hrs | Wed 8/15/12 | Wed 8/15/12 | 100% IS | |
| 908 | 906FS+1 day | Provision Taske for new agents | 2 hrs | Wed 8/15/12 | Wed 8/15/12 | 100% IS | |
| 909 | 908FS+1 day | Test Queues | 4 hrs | Thu 8/16/12 | Thu 8/16/12 | 100% IS | |
| 910 | 908FS+1 day | Test Taske | 2 hrs | Thu 8/16/12 | Thu 8/16/12 | 100% IS | |
| 911 | 908FS+1 day | Provision Tracer Call Recording | 2 hrs | Thu 8/16/12 | Thu 8/16/12 | 100% IS | |
| 912 | 911FS+1 day | Test Tracer Call Recording | 2 hrs | Fri 8/17/12 | Fri 8/17/12 | 100% IS | |
| 913 | 911FS+1 day | Test Phone Manager | 2 hrs | Fri 8/17/12 | Fri 8/17/12 | 100% IS | |
| 914 | | End User Training | 1 day | Tue 8/28/12 | Tue 8/28/12 | 100% IS | |
| 915 | | Printers | 50 days | Mon 7/23/12 | Fri 9/28/12 | 100% | |
| 916 | | Obtain Quote from Vendor | 1 day | Thu 8/23/12 | Thu 8/23/12 | 100% IS | |
| 917 | | Order Equipment | 10 days | Mon 7/23/12 | Fri 8/3/12 | 100% IS | |
| 918 | | Delivery and Installation | 13 days | Mon 8/13/12 | Wed 8/29/12 | 100% IS | |
| 919 | 918 | Configuration | 22 days | Thu 8/30/12 | Fri 9/28/12 | 100% IS | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|-------------------------------------|----------------|---------------------|--------------------|-------------|----------------|
| 920 | 918 | Testing | 176 hrs | Thu 8/30/12 | Fri 9/28/12 | 100% IS | |
| 921 | | Conference Room AV | 66 days | Mon 6/18/12 | Mon 9/17/12 | 100% | |
| 922 | | Vendor to design room to CMC r | 5 days | Mon 6/18/12 | Fri 6/22/12 | 100% IS | |
| 923 | | Procurement | 39 days | Tue 7/17/12 | Fri 9/7/12 | 100% IS | |
| 924 | | Implementation | 25 days | Mon 8/13/12 | Fri 9/14/12 | 100% IS | |
| 925 | 924 | Acceptance Testing | 1 day | Mon 9/17/12 | Mon 9/17/12 | 100% IS | |
| 926 | | Misc | 70 days | Mon 10/15/12 | Fri 1/18/13 | 100% | |
| 927 | | Hire new Help Desk person | 14 days | Mon 12/3/12 | Thu 12/20/12 | 100% IS | |
| 928 | 927 | Train new Help Desk person | 21 days | Fri 12/21/12 | Fri 1/18/13 | 100% IS | |
| 929 | | Install Postage Machine | 2 days | Mon 10/15/12 | Tue 10/16/12 | 100% IS | |
| 930 | | Building Preparations | 24 days | Fri 7/13/12 | Wed 8/15/12 | 100% | |
| 931 | | Demo data room electrical | 5 days | Wed 7/18/12 | Tue 7/24/12 | 100% IS | |
| 932 | | Begin building walls | 9 days | Tue 7/17/12 | Fri 7/27/12 | 100% IS | |
| 933 | | Prep work for A/C unit | 48 hrs | Sat 7/21/12 | Fri 7/27/12 | 100% IS | |
| 934 | | Delivery of APC-UPS & Racks | 1 day | Fri 7/27/12 | Fri 7/27/12 | 100% IS | |
| 935 | | Delivery of AC unit | 1 day | Fri 7/27/12 | Fri 7/27/12 | 100% IS | |
| 936 | | Installing data room | 5 days | Mon 7/23/12 | Fri 7/27/12 | 100% IS | |
| 937 | | Electrical connection for UPS | 2 days | Mon 7/30/12 | Tue 7/31/12 | 100% IS | |
| 938 | | Install UPS and setup racks | 3 days | Mon 7/30/12 | Wed 8/1/12 | 100% IS | |
| 939 | | UPS Startup | 1 day | Wed 8/1/12 | Wed 8/1/12 | 100% IS | |
| 940 | | Carpet installing | 4 days | Sun 7/29/12 | Wed 8/1/12 | 100% IS | |
| 941 | | Layout floor protection | 2 days | Thu 8/2/12 | Fri 8/3/12 | 100% IS | |
| 942 | | Deliver additional systems furnitu | 1 day | Fri 8/3/12 | Fri 8/3/12 | 100% IS | |
| 943 | | Floor coring for data & electrical | 5 days | Tue 7/31/12 | Mon 8/6/12 | 100% IS | |
| 944 | | Shipping equipment from Detroit | 5 days | Tue 7/31/12 | Mon 8/6/12 | 100% IS | |
| 945 | | Terming / punch down of data in | 1 day | Wed 8/8/12 | Wed 8/8/12 | 100% IS | |
| 946 | | Electrical connections for furnitui | 1 day | Thu 8/9/12 | Thu 8/9/12 | 100% IS | |
| 947 | | Installation of A/C in data room | 11 days | Fri 7/27/12 | Fri 8/10/12 | 100% IS | |
| 948 | | Testing A/C | 1 day | Fri 8/10/12 | Fri 8/10/12 | 100% IS | |
| 949 | | Installing data for cubes & offices | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 950 | | Painting started | 24 days | Fri 7/13/12 | Wed 8/15/12 | 100% IS | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|-----|--------------|--|-----------------|--------------------|--------------------|-------------|----------------|
| 951 | | Deliver additional furniture | 8 days | Mon 8/6/12 | Wed 8/15/12 | 100% IS | |
| 952 | | Complete installation | 1 day | Wed 8/15/12 | Wed 8/15/12 | 100% IS | |
| 953 | | Wipe down, Vacuum, remove floor | 6 days | Wed 8/8/12 | Wed 8/15/12 | 100% IS | |
| 954 | | Data testing | 1 day | Wed 8/15/12 | Wed 8/15/12 | 100% IS | |
| 955 | | MDF setup, build, test | 8 days | Mon 8/6/12 | Wed 8/15/12 | 100% IS | |
| 956 | | Workstation Setup/Test | 8 days | Mon 8/6/12 | Wed 8/15/12 | 100% IS | |
| 957 | | Install Signage | 1 day | Mon 8/6/12 | Mon 8/6/12 | 100% IS | |
| 958 | | Technical Environment Setup and Cor | 56 days | Mon 6/11/12 | Mon 8/27/12 | 100% | |
| 959 | | MCS Environments | 56 days | Mon 6/11/12 | Mon 8/27/12 | 100% | |
| 960 | | Setup Dev Environment | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% | |
| 961 | | Setup base data for dev datab | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 962 | | Setup QA Environment | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% | |
| 963 | | Setup base data for QA datab | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 964 | | Setup Production Environment | 3 days | Mon 8/20/12 | Wed 8/22/12 | 100% | |
| 965 | | Setup new file systems for NH | 1 day | Mon 8/20/12 | Mon 8/20/12 | 100% IS | |
| 966 | | Setup base data for Prod data | 1 day | Tue 8/21/12 | Tue 8/21/12 | 100% IS | |
| 967 | | Configure production | 1 day | Wed 8/22/12 | Wed 8/22/12 | 100% IS | |
| 968 | | Modify build scripts for NH | 1 day | Tue 8/21/12 | Tue 8/21/12 | 100% IS | |
| 969 | | Setup UAT Environment | 56 days | Mon 6/11/12 | Mon 8/27/12 | 100% | |
| 970 | | Spec new server | 1 day | Fri 8/24/12 | Fri 8/24/12 | 100% IS | |
| 971 | | Submit PO request for new se | 1 day | Mon 8/27/12 | Mon 8/27/12 | 100% IS | |
| 972 | | Change build scripts to create | 30 days | Mon 6/11/12 | Fri 7/20/12 | 100% IS | |
| 973 | | Select a "UAT Build" person to | 1 day | Wed 8/1/12 | Wed 8/1/12 | 100% IS | |
| 974 | 972FS+2 days | Define an MCS deployment pr | 3 days | Wed 8/1/12 | Fri 8/3/12 | 100% IS | |
| 975 | | MCS System Configuration | 280 days | Mon 8/13/12 | Fri 9/6/13 | 20% | |
| 976 | | Common Settings in UAT | 280 days | Mon 8/13/12 | Fri 9/6/13 | 20% | |
| 977 | | Initial | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% | |
| 978 | | Populate lists | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 979 | | Populate options | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 980 | | Populate menu permissions | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 981 | | Populate system control recor | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|--|-----------------|--------------------|---------------------|------------|----------------|
| 982 | | Populate procedure codes | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 983 | | Populate surgical procedure codes | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 984 | | Populate reason codes | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 985 | | Populate diagnosis codes | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 986 | | Populate drg codes | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 987 | | Populate contact codes | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 988 | | Populate inbox assignments | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 989 | | Populate authorization codes | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 990 | | Populate program codes | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 991 | | Updates | 280 days | Mon 8/13/12 | Fri 9/6/13 | 16% | |
| 992 | 852FF | Update lists | 55 days | Tue 4/23/13 | Mon 7/8/13 | 0% IS | |
| 993 | 852FF | Update options | 55 days | Tue 4/23/13 | Mon 7/8/13 | 0% IS | |
| 994 | | Update system control record | 1 day | Mon 8/13/12 | Mon 8/13/12 | 100% IS | |
| 995 | 852FF | Business (UM, QM, MS) suppliers | 9 days | Wed 6/26/13 | Mon 7/8/13 | 0% | |
| 996 | 995 | Update menu permissions | 5 days | Tue 7/9/13 | Mon 7/15/13 | 0% IS | |
| 997 | 995SS | Business (UM, QM, MS) suppliers | 9 days | Wed 6/26/13 | Mon 7/8/13 | 0% | |
| 998 | 996,997 | Update inbox assignments | 5 days | Tue 7/16/13 | Mon 7/22/13 | 0% IS | |
| 999 | 995SS | Business(UM, QM, MS) suppliers | 9 days | Wed 6/26/13 | Mon 7/8/13 | 0% | |
| 1000 | 998,999 | Update contact code | 5 days | Tue 7/23/13 | Mon 7/29/13 | 0% IS | |
| 1001 | 995SS | Business (UM) reviews and up | 9 days | Fri 9/7/12 | Wed 9/19/12 | 100% UM | |
| 1002 | 1001 | Update auth codes | 1 day | Wed 1/30/13 | Wed 1/30/13 | 100% IS | |
| 1003 | 995SS | Business (Claims) reviews and | 9 days | Fri 3/1/13 | Wed 3/13/13 | 100% | |
| 1004 | 852FF | Update procedure codes | 22 days | Fri 6/7/13 | Mon 7/8/13 | 0% IS | |
| 1005 | 995SS | Business (Claims) reviews and | 9 days | Fri 3/1/13 | Wed 3/13/13 | 100% | |
| 1006 | 852FF | Update surgical procedure codes | 22 days | Thu 8/8/13 | Fri 9/6/13 | 0% IS | |
| 1007 | 995SS | Business (Claims) reviews and | 9 days | Fri 3/1/13 | Wed 3/13/13 | 100% | |
| 1008 | 852FF | Update reason codes | 22 days | Thu 8/8/13 | Fri 9/6/13 | 0% IS | |
| 1009 | 995SS | Business (Claims) reviews and | 9 days | Fri 3/1/13 | Wed 3/13/13 | 100% | |
| 1010 | 852FF | Update diagnosis codes | 22 days | Thu 8/8/13 | Fri 9/6/13 | 0% IS | |
| 1011 | | Behavior Health | | | | | |
| 1012 | | MCS Modifications for Behavior Health | 356 days | Thu 6/28/12 | Thu 11/7/13 | 75% | |
| | | | 345 days | Thu 6/28/12 | Wed 10/23/13 | 88% | |

Granite Care-Meridian Health Plan
New Hampshire Project Plan 11.01.mpp

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|---|-----------------|--------------------|--------------------|-------------|----------------|
| 1013 | | Create Spec Doc | 167 days | Thu 6/28/12 | Fri 2/15/13 | 100% IS | |
| 1014 | 1013 | Review Spec Doc with Business at Development | 7 days | Mon 2/18/13 | Tue 2/26/13 | 100% IS | |
| 1015 | | Development | 3 wks | Mon 9/23/13 | Fri 10/11/13 | 0% | |
| 1016 | 1015 | QA | 1 wk | Mon 10/14/13 | Fri 10/18/13 | 0% | |
| 1017 | 1016 | UAT | 3 days | Mon 10/21/13 | Wed 10/23/13 | 0% NH | |
| 1018 | | BH Assessment (IS-2013-0002201) | 111 days | Mon 2/4/13 | Mon 7/8/13 | 100% | |
| 1019 | | Build vs Buy Evaluation | 10 days | Mon 2/4/13 | Fri 2/15/13 | 100% | |
| 1020 | | Contract Negotiations Complete | 0 days | Thu 3/28/13 | Thu 3/28/13 | 100% | |
| 1021 | 1020 | Implement LOCUS | 23 days | Mon 4/1/13 | Wed 5/1/13 | 100% | |
| 1022 | | Gather business requirements | 5 days | Mon 2/25/13 | Fri 3/1/13 | 100% IS | |
| 1023 | 1022 | Create spec doc | 12 days | Mon 4/1/13 | Tue 4/16/13 | 100% | |
| 1024 | 1023 | Review Spec Doc with Business at Development | 9 days | Wed 4/17/13 | Mon 4/29/13 | 100% NH | |
| 1025 | 1024 | Implement Full Assessment | 21 days | Mon 6/10/13 | Mon 7/8/13 | 100% | |
| 1026 | 1025 | QA/UAT | 5 days | Mon 2/4/13 | Fri 2/8/13 | 100% | |
| 1027 | | BH Addition to Inpatient Census (IS 24 days) | 24 days | Wed 3/13/13 | Mon 4/15/13 | 100% | |
| 1028 | | Development | 11 days | Wed 3/13/13 | Wed 3/27/13 | 100% | |
| 1029 | 1028 | QA/UAT | 13 days | Thu 3/28/13 | Mon 4/15/13 | 100% IS | |
| 1030 | | BH Depression Screening (IS-2013-(24 days) | 24 days | Mon 10/7/13 | Thu 11/7/13 | 0% | |
| 1031 | | Gather Business requirements | 1 day | Mon 10/7/13 | Mon 10/7/13 | 0% | |
| 1032 | 1031 | Create Spec Doc | 5 days | Tue 10/8/13 | Mon 10/14/13 | 0% | |
| 1033 | 1032 | Spec Approval | 3 days | Tue 10/15/13 | Thu 10/17/13 | 0% | |
| 1034 | 1033 | Development | 10 days | Fri 10/18/13 | Thu 10/31/13 | 0% | |
| 1035 | 1034 | QA/UAT | 5 days | Fri 11/1/13 | Thu 11/7/13 | 0% | |
| 1036 | | BH Assessment in 60 Days follow up (25 days) | 25 days | Mon 8/20/12 | Fri 9/21/12 | 0% | |
| 1037 | | Create Spec Doc | 5 days | Mon 8/20/12 | Fri 8/24/12 | 0% | |
| 1038 | 1037 | Spec Approval | 5 days | Mon 8/27/12 | Fri 8/31/12 | 0% | |
| 1039 | 1038 | Development | 10 days | Mon 9/3/12 | Fri 9/14/12 | 0% | |
| 1040 | 1039 | QA/UAT | 5 days | Mon 9/17/12 | Fri 9/21/12 | 0% | |
| 1041 | | BH Medication Report (IS-2012-000170 days) | 170 days | Mon 3/11/13 | Mon 11/4/13 | 0% | |
| 1042 | | Create Spec Doc for Pharmacy Re Approval | 0 days | Mon 3/11/13 | Mon 3/11/13 | 100% IS | |
| 1043 | 1042 | Pharmacy Spec Doc Approval | 10 days | Mon 10/7/13 | Fri 10/18/13 | 0% IS | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|---|-------------------|---------------------|---------------------|-------------|----------------|
| 1044 | 1043 | Development | 10 days | Mon 10/21/13 | Fri 11/1/13 | 0% IS | |
| 1045 | 1044 | QA/UAT | 1 day | Mon 11/4/13 | Mon 11/4/13 | 0% | |
| 1046 | | Update NH Referral Notification Form | 133 days | Mon 5/6/13 | Wed 11/6/13 | 63% | |
| 1047 | | Gather Business requirements | 5 days | Mon 5/6/13 | Fri 5/10/13 | 100% | |
| 1048 | | Development | 2 days | Mon 11/4/13 | Tue 11/5/13 | 0% | |
| 1049 | 1048 | QA/UAT | 1 day | Wed 11/6/13 | Wed 11/6/13 | 0% | |
| 1050 | | Develop NH TPL Letter (IS-2013-0001) | 25 days | Mon 10/28/13 | Fri 11/29/13 | 0% | |
| 1051 | | Develop Spec | 10 days | Mon 10/28/13 | Fri 11/8/13 | 0% | |
| 1052 | 1051 | Spec Approval | 5 days | Mon 11/11/13 | Fri 11/15/13 | 0% | |
| 1053 | 1051 | Development | 5 days | Mon 11/18/13 | Fri 11/22/13 | 0% | |
| 1054 | | QA/UAT | 5 days | Mon 11/25/13 | Fri 11/29/13 | 0% | |
| 1055 | | Care Coordination | 407.1 days | Tue 6/26/12 | Wed 1/15/14 | 78% | |
| 1056 | | POC Workflow (MCS Screens) (IS-21274) | days | Tue 6/26/12 | Fri 7/12/13 | 100% | |
| 1057 | | Create Spec Doc | 195 days | Tue 6/26/12 | Mon 3/25/13 | 100% IS | |
| 1058 | 1057 | Spec Approval | 2 days | Tue 3/19/13 | Tue 3/26/13 | 100% IS | |
| 1059 | | Develop | 19 days | Tue 6/11/13 | Fri 7/5/13 | 100% | |
| 1060 | 1059 | QA | 3 days | Mon 7/8/13 | Wed 7/10/13 | 100% | |
| 1061 | 1060 | UAT | 2 days | Thu 7/11/13 | Fri 7/12/13 | 100% | |
| 1062 | | Revisions to CoC (IS-2013-0002008) | 91 days | Fri 3/8/13 | Fri 7/12/13 | 100% | |
| 1063 | | Gather Requirements | 1 day | Fri 3/8/13 | Fri 3/8/13 | 100% | |
| 1064 | 1057,1063 | Create Spec | 9 days | Tue 3/19/13 | Thu 4/4/13 | 100% IS | |
| 1065 | 1064 | Approve Spec | 2 days | Thu 4/25/13 | Fri 4/26/13 | 100% IS | |
| 1066 | | Development | 43.7 days | Wed 4/24/13 | Fri 7/5/13 | 100% IS | |
| 1067 | 1066 | QA/UAT | 5 days | Mon 7/8/13 | Fri 7/12/13 | 100% | |
| 1068 | | POC Approval | 60 days | Mon 6/3/13 | Fri 8/23/13 | 21% | |
| 1069 | | Gather Business requirements | 1 day | Mon 6/3/13 | Mon 6/3/13 | 100% | |
| 1070 | 1069 | Create Spec Doc | 2 days | Tue 6/4/13 | Wed 6/5/13 | 100% | |
| 1071 | 1070 | Spec Approval | 1 day | Thu 6/6/13 | Thu 6/6/13 | 100% | |
| 1072 | | Development | 10 days | Mon 8/5/13 | Fri 8/16/13 | 0% | |
| 1073 | 1072 | QA/UAT | 5 days | Mon 8/19/13 | Fri 8/23/13 | 0% | |
| 1074 | | Develop Web Plan of Care (IS-2012-131) | days | Fri 2/22/13 | Fri 8/23/13 | 84% | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|---|------------------|--------------------|--------------------|-------------|----------------|
| 1075 | | Gather Business Requirements | 0 days | Fri 2/22/13 | Fri 2/22/13 | 100% IS | |
| 1076 | 1064,1075 | Create Spec Doc for Web Plan of | 10.9 days | Tue 3/26/13 | Fri 4/26/13 | 100% | |
| 1077 | 1076 | Route Spec for Approval | 2 days | Mon 4/29/13 | Tue 4/30/13 | 100% | |
| 1078 | | Messaging | 75 days | Mon 4/1/13 | Fri 7/12/13 | 100% | |
| 1079 | | Provider Portal Updates (Mess | 12 wks | Mon 4/1/13 | Fri 6/21/13 | 100% | |
| 1080 | | QA/UAT | 5 days | Mon 7/8/13 | Fri 7/12/13 | 100% | |
| 1081 | | POC Approval | 15 days | Mon 8/5/13 | Fri 8/23/13 | 0% | |
| 1082 | | Development | 10 days | Mon 8/5/13 | Fri 8/16/13 | 0% | |
| 1083 | 1082 | QA/UAT | 5 days | Mon 8/19/13 | Fri 8/23/13 | 0% | |
| 1084 | | Develop Web Plan of Care (IS-2012 | 98.1 days | Mon 9/2/13 | Wed 1/15/14 | 0% | |
| 1085 | | Gather Business Requirements | 10 days | Mon 9/2/13 | Fri 9/13/13 | 0% IS | |
| 1086 | 1085 | Create Spec Doc | 10 days | Mon 9/16/13 | Thu 10/17/13 | 0% | |
| 1087 | 1086 | Route Spec for Approval | 5 days | Thu 10/17/13 | Thu 10/24/13 | 0% | |
| 1088 | 1087 | Member Portal Updates | 8 wks | Thu 10/24/13 | Wed 12/18/13 | 0% IS | |
| 1089 | 1088 | Internal Testing | 10 days | Wed 12/18/13 | Wed 1/1/14 | 0% | |
| 1090 | 1089 | User Acceptance Testing | 10 days | Wed 1/1/14 | Wed 1/15/14 | 0% | |
| 1091 | | Integrated Progress Notes (IS-2013 | 95 days | Mon 3/4/13 | Fri 7/12/13 | 100% | |
| 1092 | | Phase 1 Revisions (IS-2012-0000 | 23 days | Thu 3/14/13 | Mon 4/15/13 | 100% | |
| 1093 | | Gather Business Requirements | 7 days | Mon 3/4/13 | Tue 3/12/13 | 100% IS | |
| 1094 | 1093 | Create Spec Doc | 36 days | Fri 3/8/13 | Fri 4/26/13 | 100% IS | |
| 1095 | 1094 | Spec Approval | 2 days | Mon 4/29/13 | Tue 4/30/13 | 100% IS | |
| 1096 | 1095 | Development | 49.5 days | Mon 3/25/13 | Mon 7/1/13 | 100% | |
| 1097 | 1096 | QA/UAT | 9 days | Tue 7/2/13 | Fri 7/12/13 | 100% | |
| 1098 | | Transition of Care Summary (IS-20199 | days | Tue 2/26/13 | Fri 7/12/13 | 100% | |
| 1099 | | Gather Business Requirements | 4 days | Tue 2/26/13 | Fri 3/1/13 | 100% IS | |
| 1100 | 1076,1099 | Document Spec | 9.45 days | Mon 4/8/13 | Mon 4/29/13 | 100% IS | |
| 1101 | 1100 | Spec Approval | 2.45 days | Mon 4/29/13 | Wed 5/1/13 | 100% IS | |
| 1102 | 1101 | Development | 20 days | Mon 6/10/13 | Fri 7/5/13 | 100% IS | |
| 1103 | 1102 | QA/UAT | 5 days | Mon 7/8/13 | Fri 7/12/13 | 100% | |
| 1104 | | Update POC Letters (IS-2013-00028 | 130 days | Mon 2/25/13 | Fri 8/23/13 | 44% | |
| 1105 | | Gather Business Requirements | 0 days | Mon 2/25/13 | Mon 2/25/13 | 100% IS | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|---|-----------------|--------------------|--------------------|-------------|----------------|
| 1106 | 1100,1105 | Document Spec | 9 days | Wed 4/24/13 | Mon 5/6/13 | 100% | |
| 1107 | 1106 | Spec Approval | 2 days | Tue 5/7/13 | Wed 5/8/13 | 100% | |
| 1108 | 1107 | Development | 9 days | Mon 8/5/13 | Thu 8/15/13 | 0% | |
| 1109 | 1108 | QA/UAT | 5 days | Mon 8/19/13 | Fri 8/23/13 | 0% | |
| 1110 | | POC Document (IS-2013-0001841) | 120 days | Mon 2/25/13 | Fri 8/9/13 | 55% | |
| 1111 | | Gather Business Requirements | 0 days | Mon 2/25/13 | Mon 2/25/13 | 100% IS | |
| 1112 | 1106,1111 | Document Spec | 5 days | Tue 5/7/13 | Mon 5/13/13 | 100% IS | |
| 1113 | 1112 | Spec Approval | 2 days | Tue 5/14/13 | Wed 5/15/13 | 100% IS | |
| 1114 | | Development | 9 days | Wed 6/26/13 | Mon 7/8/13 | 80% | |
| 1115 | | QA/UAT | 10 days | Mon 7/29/13 | Fri 8/9/13 | 0% | |
| 1116 | | IDCT (IS-2013-0001446) | 147 days | Fri 2/22/13 | Mon 9/16/13 | 80% | |
| 1117 | | Gather Business Requirements | 0 days | Fri 2/22/13 | Fri 2/22/13 | 100% | |
| 1118 | 1117 | Document Spec | 61.7 days | Mon 3/11/13 | Fri 6/28/13 | 100% | |
| 1119 | 1118 | Spec Approval | 2 days | Mon 7/1/13 | Tue 7/2/13 | 0% | |
| 1120 | 1119 | Development | 8 days | Thu 8/29/13 | Mon 9/9/13 | 0% IS | |
| 1121 | 1120 | QA/UAT | 5 days | Tue 9/10/13 | Mon 9/16/13 | 0% | |
| 1122 | | Member Objective Profile(IS-2013-145 days) | 145 days | Fri 2/22/13 | Thu 9/12/13 | 0% | |
| 1123 | | Gather Business Requirements | 0 days | Fri 2/22/13 | Fri 2/22/13 | 100% IS | |
| 1124 | 1123 | Document Spec | 8 days | Mon 6/24/13 | Wed 7/3/13 | 0% IS | |
| 1125 | 1124 | Spec Approval | 2 days | Thu 7/4/13 | Fri 7/5/13 | 0% IS | |
| 1126 | | Development | 9 days | Mon 9/2/13 | Thu 9/12/13 | 0% | |
| 1127 | | Provider Services | 12 days | Tue 8/14/12 | Wed 8/29/12 | 100% | |
| 1128 | | Provider Services Development | 4 days | Tue 8/14/12 | Fri 8/17/12 | 100% | |
| 1129 | | Disable all other modules except 1 day | 1 day | Tue 8/14/12 | Tue 8/14/12 | 100% IS | |
| 1130 | | Populate county lists and "create 1 day | 1 day | Tue 8/14/12 | Tue 8/14/12 | 100% IS | |
| 1131 | | Create provider plan records | 1 day | Tue 8/14/12 | Tue 8/14/12 | 100% IS | |
| 1132 | | Populate Master County list | 1 day | Tue 8/14/12 | Tue 8/14/12 | 100% IS | |
| 1133 | | Update service counties in DB ta 1 day | 1 day | Tue 8/14/12 | Tue 8/14/12 | 100% IS | |
| 1134 | | Turn on batch processing (trigge 1 day | 1 day | Tue 8/14/12 | Tue 8/14/12 | 100% IS | |
| 1135 | | Program changes for Provider Re 2 days | 2 days | Thu 8/16/12 | Fri 8/17/12 | 100% IS | |
| 1136 | | Setup provider letters in PlanetP 2 days | 2 days | Thu 8/16/12 | Fri 8/17/12 | 100% IS | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|---|-----------------|--------------------|---------------------|--------------|----------------|
| 1137 | | Unit test Provider Services in QA | 9 days | Fri 8/17/12 | Wed 8/29/12 | 100% | |
| 1138 | | Load QA MCS on PS, Finance and | 1 day | Fri 8/17/12 | Fri 8/17/12 | 100% IS | |
| 1139 | | Provider Services inputs provider | 3 days | Fri 8/17/12 | Tue 8/21/12 | 100% IS | |
| 1140 | | Finance enters contracts for prov | 3 days | Wed 8/22/12 | Fri 8/24/12 | 100% IS | |
| 1141 | | Credentialing enters credential d | 3 days | Mon 8/27/12 | Wed 8/29/12 | 100% IS | |
| 1142 | | Setup Provider Services in Product | 4 days | Tue 8/21/12 | Fri 8/24/12 | 100% | |
| 1143 | | Set up Production MCS using QA | 1 day | Wed 8/22/12 | Wed 8/22/12 | 100% IS | |
| 1144 | | Load Production MCS on PS, Financ | 1 day | Thu 8/23/12 | Thu 8/23/12 | 100% IS | |
| 1145 | | Copy lists and options from QA | 1 day | Fri 8/24/12 | Fri 8/24/12 | 100% IS | |
| 1146 | | Copy County Detail records from | 1 day | Fri 8/24/12 | Fri 8/24/12 | 100% IS | |
| 1147 | | Create provider plan records | 1 day | Fri 8/24/12 | Fri 8/24/12 | 100% IS | |
| 1148 | | Turn on batch processing (trigge | 1 day | Fri 8/24/12 | Fri 8/24/12 | 100% IS | |
| 1149 | | Receive provider letters from Co | 1 day | Wed 8/22/12 | Wed 8/22/12 | 100% IS | |
| 1150 | | Setup provider letters in PlanetP | 2 days | Thu 8/23/12 | Fri 8/24/12 | 100% IS | |
| 1151 | | Provider letter generation to cor | 1 day | Tue 8/21/12 | Tue 8/21/12 | 100% IS | |
| 1152 | | Setup Claims (IS-2013-0000608) | 164 days | Fri 3/8/13 | Wed 10/23/13 | 6% IS | |
| 1153 | | Populate fee screens | 156 days | Fri 3/15/13 | Fri 10/18/13 | 9% | |
| 1154 | | Requirements | 1 day | Fri 3/15/13 | Fri 3/15/13 | 100% | |
| 1155 | 1154 | Development | 5 days | Mon 10/7/13 | Fri 10/11/13 | 0% IS | |
| 1156 | 1155 | QA/UAT | 5 days | Mon 10/14/13 | Fri 10/18/13 | 0% | |
| 1157 | 1153 | Update DRG codes | 158 days | Fri 3/8/13 | Tue 10/15/13 | 4% | |
| 1158 | | Requirements | 1 day | Fri 3/8/13 | Fri 3/8/13 | 100% | |
| 1159 | 1158 | Development | 22 days | Mon 9/16/13 | Tue 10/15/13 | 0% IS | |
| 1160 | | Determine NH requirements for gr | 1 day | Tue 4/2/13 | Tue 4/2/13 | 100% IS | |
| 1161 | 1159FF | Implement grouper software | 0 days | Tue 10/15/13 | Tue 10/15/13 | 0% IS | |
| 1162 | 1161 | Load test claims | 6 days | Wed 10/16/13 | Wed 10/23/13 | 0% IS | |
| 1163 | 852FF | Setup Member Module - Member | £9 days | Tue 8/27/13 | Fri 9/6/13 | 0% IS | |
| 1164 | | Setup Care Management | 10 days | Tue 7/9/13 | Mon 7/22/13 | 100% | |
| 1165 | 1163 | Program changes for Authorization | 10 days | Tue 7/9/13 | Mon 7/22/13 | 100% IS | |
| 1166 | 1163 | Setup Disease Management (IS-2013-209 days | 209 days | Mon 2/11/13 | Thu 11/28/13 | 0% | |
| 1167 | | Business Requirements Available | 0 days | Mon 2/11/13 | Mon 2/11/13 | 100% | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|-----------------|--|-----------------|--------------------|--------------------|-------------|----------------|
| 1168 | 854FF,1100,1167 | Document Spec | 10 days | Mon 10/21/13 | Fri 11/1/13 | 0% | IS |
| 1169 | 1168 | Spec Approval | 3 days | Mon 11/4/13 | Wed 11/6/13 | 0% | |
| 1170 | 1169 | Development | 11 days | Thu 11/7/13 | Thu 11/21/13 | 0% | |
| 1171 | 1170 | QA/UAT | 5 days | Fri 11/22/13 | Thu 11/28/13 | 0% | |
| 1172 | | Setup Medical Management | 0 days | Mon 3/25/13 | Mon 3/25/13 | 100% | |
| 1173 | | Business Requirements Available | 0 days | Mon 3/25/13 | Mon 3/25/13 | 100% | |
| 1174 | | Set up new Behavioral Health capabilities | 232 days | Thu 6/21/12 | Fri 5/10/13 | 51% | |
| 1175 | | Feasibility Assessment | 37 days | Thu 6/21/12 | Fri 8/10/12 | 100% | |
| 1176 | | Perform feasibility and gap analysis | 32 days | Thu 6/21/12 | Fri 8/3/12 | 100% | IS,ISDV |
| 1177 | 1176 | Create a plan to address gaps (if any) | 5 days | Mon 8/6/12 | Fri 8/10/12 | 100% | IS |
| 1178 | | Development | 175 days | Mon 9/10/12 | Fri 5/10/13 | 19% | |
| 1179 | | Design features to fill gap in web | 5 days | Mon 9/10/12 | Fri 9/14/12 | 100% | IS |
| 1180 | | Generate the Enrollment test data | 10 days | Tue 1/22/13 | Mon 2/4/13 | 100% | IS |
| 1181 | | Identify representative set of test cases | 5 days | Mon 4/1/13 | Fri 4/5/13 | 0% | IS |
| 1182 | | Letter and Logo Changes | 60 days | Mon 2/18/13 | Fri 5/10/13 | 0% | COMM |
| 1183 | | Code Migration | 15 days | Mon 8/13/12 | Fri 8/31/12 | 100% | |
| 1184 | 1182 | Develop code migration processes | 15 days | Mon 8/13/12 | Fri 8/31/12 | 100% | IS |
| 1185 | | EDI / Clearinghouse Workstream | 398 days | Wed 5/23/12 | Sun 12/1/13 | 51% | |
| 1186 | | Date the contract is executed to start | 1 day | Wed 5/23/12 | Wed 5/23/12 | 100% | |
| 1187 | | Clearinghouse Setup | 325 days | Mon 6/11/12 | Fri 9/6/13 | 80% | |
| 1188 | | Establish Payer ID | 40 days | Mon 6/11/12 | Fri 8/3/12 | 100% | IS |
| 1189 | | Determine other clearinghouses | 0 days | Fri 3/1/13 | Fri 3/1/13 | 100% | IS |
| 1190 | 852FF | Contact existing clearinghouses | 10 days | Mon 8/26/13 | Fri 9/6/13 | 0% | IS |
| 1191 | | EDI Real-time Transactions | 114 days | Fri 8/24/12 | Wed 1/30/13 | 100% | |
| 1192 | | Setup web service | 1 day | Fri 8/24/12 | Fri 8/24/12 | 100% | ISDV |
| 1193 | | Eligibility - 270/271 (State - 20/28 days) | 1 day | Mon 1/21/13 | Wed 1/30/13 | 100% | |
| 1194 | 1190 | Gap analysis | 1 day | Mon 1/21/13 | Mon 1/21/13 | 100% | IS |
| 1195 | 1194 | Programming | 5 days | Tue 1/22/13 | Mon 1/28/13 | 100% | IS |
| 1196 | 1195 | Unit Testing | 2 days | Tue 1/29/13 | Wed 1/30/13 | 100% | IS |
| 1197 | | Eligibility Inquiry (Providers - 22 8 days) | 1 day | Mon 1/21/13 | Wed 1/30/13 | 100% | |
| 1198 | | Determine availability | 1 day | Mon 1/21/13 | Mon 1/21/13 | 100% | IS |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|---|-----------------|--------------------|---------------------|------------|----------------|
| 1199 | 1198 | Programming | 5 days | Tue 1/22/13 | Mon 1/28/13 | 100% IS | |
| 1200 | 1199 | Unit Testing | 2 days | Tue 1/29/13 | Wed 1/30/13 | 100% IS | |
| 1201 | | EDI Batch Transactions | 362 days | Thu 7/12/12 | Sun 12/1/13 | 50% | |
| 1202 | | Enrollment Outbound (834) - NH | 296 days | Mon 7/16/12 | Tue 9/3/13 | 99% | |
| 1203 | | Gap analysis | 15 days | Mon 7/16/12 | Fri 8/3/12 | 100% IS | |
| 1204 | 1203 | Disenrollment Code cross-walk | 20 days | Mon 8/6/12 | Fri 8/31/12 | 100% | |
| 1205 | 1204 | Programming | 5 days | Fri 9/7/12 | Thu 9/13/12 | 100% IS | |
| 1206 | 1206 | Receive test files from DHHS | 25 days | Mon 9/17/12 | Fri 10/19/12 | 100% IS | |
| 1207 | | Unit Testing | 87 days | Fri 10/19/12 | Mon 2/18/13 | 100% IS | |
| 1208 | | Receive monthly test roster (A) 86 days | | Fri 9/28/12 | Fri 1/25/13 | 100% IS | |
| 1209 | | New Heights DHHS System Tes | 108 days | Fri 8/24/12 | Tue 1/22/13 | 100% | |
| 1210 | | Production Interface Begins (@0 days | | Tue 9/3/13 | Tue 9/3/13 | 0% | |
| 1211 | | Enrollment Inbound (834) - MHF | 222 days | Thu 1/24/13 | Sun 12/1/13 | 40% | |
| 1212 | | Finalize layout | 0 days | Thu 1/24/13 | Thu 1/24/13 | 100% IS | |
| 1213 | | Output Development | 10 days | Fri 1/25/13 | Thu 2/7/13 | 75% IS | |
| 1214 | 1213 | Programming/Unit Test | 15 days | Mon 9/23/13 | Fri 10/11/13 | 0% IS | |
| 1215 | | Test interface with DHHS | 4 days | Tue 2/5/13 | Fri 2/8/13 | 100% IS | |
| 1216 | | Production Interface Begins (@0 days | | Sun 12/1/13 | Sun 12/1/13 | 0% | |
| 1217 | | Capitation Payment Outbound (154 days | | Tue 4/30/13 | Sun 12/1/13 | 0% | |
| 1218 | | Finalize Layout | 0 days | Tue 4/30/13 | Tue 4/30/13 | 99% IS | |
| 1219 | | Programming/Unit Test | 15 days | Mon 9/23/13 | Fri 10/11/13 | 0% IS | |
| 1220 | 1219 | Test Files Available | 0 days | Fri 10/11/13 | Fri 10/11/13 | 0% IS | |
| 1221 | 1220 | System Testing with DHHS | 14 days | Mon 10/14/13 | Thu 10/31/13 | 0% IS | |
| 1222 | 1221 | UAT Interface (Xerox) | 15 days | Fri 11/1/13 | Thu 11/21/13 | 0% IS | |
| 1223 | 1222 | Interface Ready | 0 days | Thu 11/21/13 | Thu 11/21/13 | 0% | |
| 1224 | | Production Interface Begins | 0 days | Sun 12/1/13 | Sun 12/1/13 | 0% | |
| 1225 | | Medical Claim History (NH2MHF | 287 days | Fri 9/7/12 | Tue 10/15/13 | 9% | |
| 1226 | | Determine availability and for 10 days | | Tue 2/5/13 | Mon 2/18/13 | 0% IS | |
| 1227 | | Receipt of 2 years of medical, 1 day | | Fri 9/7/12 | Fri 9/7/12 | 100% IS | |
| 1228 | | Production Interface Begins (X)0 days | | Tue 10/15/13 | Tue 10/15/13 | 0% | |
| 1229 | | Provider Interfaces | 158 days | Thu 7/12/12 | Mon 2/18/13 | 95% | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|--|-----------------|--------------------|---------------------|-------------|----------------|
| 1230 | | DHHS File Outbound (NH2MH) 92 days | | Thu 7/12/12 | Mon 11/19/12 | 100% | |
| 1231 | | Finalize layout | 37 days | Thu 7/12/12 | Fri 8/31/12 | 100% IS | |
| 1232 | 1231 | Programming/Unit test | 28 days | Mon 9/3/12 | Wed 10/10/12 | 100% IS | |
| 1233 | 1232 | Test Interface with DHHS | 40 days | Mon 9/17/12 | Fri 11/9/12 | 100% IS | |
| 1234 | | Production Interface Begins | 0 days | Mon 11/19/12 | Mon 11/19/12 | 100% | |
| 1235 | | DHHS File Inbound (MHP2NH) 133 days | | Thu 8/16/12 | Mon 2/18/13 | 89% | |
| 1236 | | Finalize layout | 0 days | Thu 8/16/12 | Thu 8/16/12 | 100% IS | |
| 1237 | 1236 | Programming/Unit Test (Dai) | 10 days | Mon 9/17/12 | Fri 9/28/12 | 100% IS | |
| 1238 | | Review with Provider Service | 10 days | Tue 2/5/13 | Mon 2/18/13 | 0% | |
| 1239 | | Test Interface with DHHS (D) | 67 days | Thu 8/30/12 | Fri 11/30/12 | 100% IS | |
| 1240 | | Daily Interface Begins | 0 days | Wed 12/12/12 | Wed 12/12/12 | 100% | |
| 1241 | | Service Auth Interfaces | 218 days | Tue 1/29/13 | Sun 12/1/13 | 9% | |
| 1242 | | FFS Service Auths - Outbound | 152 days | Thu 2/14/13 | Sun 9/15/13 | 16% | |
| 1243 | | Finalize layout | 0 days | Tue 4/16/13 | Tue 4/16/13 | 75% IS | |
| 1244 | 1243 | Programming/Unit test | 14 days | Thu 2/14/13 | Wed 4/24/13 | 50% IS | |
| 1245 | | Test Files Available | 0 days | Tue 2/26/13 | Tue 2/26/13 | 0% IS | |
| 1246 | | Internal QA | 22 days | Mon 3/25/13 | Tue 4/23/13 | 10% | |
| 1247 | 1245 | System Testing with DHHS | 10 days | Mon 8/5/13 | Fri 8/16/13 | 0% IS | |
| 1248 | 1247 | UAT Interface (Xerox) | 12 days | Mon 8/19/13 | Tue 9/3/13 | 0% | |
| 1249 | 1248 | Interface Ready | 0 days | Tue 9/3/13 | Tue 9/3/13 | 0% | |
| 1250 | | Production Interface Begins | 0 days | Sun 9/15/13 | Sun 9/15/13 | 0% | |
| 1251 | | MCO Services Auths - Inbound | 164 days | Tue 4/16/13 | Sun 12/1/13 | 0% | |
| 1252 | | Finalize layout | 0 days | Tue 4/16/13 | Tue 4/16/13 | 68% IS | |
| 1253 | 1252 | Programming/Unit test | 20 days | Mon 9/16/13 | Fri 10/11/13 | 0% IS | |
| 1254 | 1253 | System Testing with DHHS | 15 days | Mon 10/14/13 | Fri 11/1/13 | 0% IS | |
| 1255 | 1254 | UAT Interface (Xerox) | 15 days | Mon 11/4/13 | Fri 11/22/13 | 0% | |
| 1256 | 1255 | Interface Ready | 1 day | Mon 11/25/13 | Mon 11/25/13 | 0% | |
| 1257 | | Production Interface Begins | 0 days | Sun 12/1/13 | Sun 12/1/13 | 0% | |
| 1258 | | PBM Service Auths - Outbound | 185 days | Tue 1/29/13 | Tue 10/15/13 | 20% | |
| 1259 | | Finalize layout | 1 day | Fri 5/31/13 | Fri 5/31/13 | 0% IS | |
| 1260 | 1259 | Authorization codes cross-w | 0 days | Tue 1/29/13 | Tue 1/29/13 | 100% UM | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|---|-----------------|--------------------|---------------------|------------|----------------|
| 1261 | 1244,1260 | Programming/Unit test | 16.5 days | Wed 1/30/13 | Wed 5/1/13 | 75% IS | |
| 1262 | | Test Interface with DHHS (EI20 days | | Mon 8/5/13 | Fri 8/30/13 | 0% IS | |
| 1263 | 1262 | System Testing with DHHS (>20 days | | Mon 9/2/13 | Fri 9/27/13 | 0% IS | |
| 1264 | 1263 | UAT Interface (Xerox) | 1 day | Mon 9/30/13 | Mon 9/30/13 | 0% | |
| 1265 | 1264 | Interface Ready | 1 day | Tue 10/1/13 | Tue 10/1/13 | 0% | |
| 1266 | | Production Interface Begins 1 day | | Tue 10/15/13 | Tue 10/15/13 | 0% | |
| 1267 | | PBM Service Auths - Inbound 131 days | | Fri 5/31/13 | Sun 12/1/13 | 0% | |
| 1268 | | Finalize layout | 0 days | Fri 5/31/13 | Fri 5/31/13 | 0% IS | |
| 1269 | | Programming/Unit test | 20 days | Mon 9/2/13 | Fri 9/27/13 | 0% IS | |
| 1270 | 1269 | System Testing with DHHS | 20 days | Mon 9/30/13 | Fri 10/25/13 | 0% IS | |
| 1271 | 1270 | UAT Interface (Xerox) | 21 days | Mon 10/28/13 | Mon 11/25/13 | 0% IS | |
| 1272 | 1271 | Interface Ready | 0 days | Mon 11/25/13 | Mon 11/25/13 | 0% | |
| 1273 | | Production Interface Begins 0 days | | Sun 12/1/13 | Sun 12/1/13 | 0% | |
| 1274 | | TPL Interfaces | 196 days | Fri 3/1/13 | Sun 12/1/13 | 18% | |
| 1275 | | TPL Interface - Outbound | 162 days | Fri 3/1/13 | Tue 10/15/13 | 13% | |
| 1276 | | Finalize layout | 0 days | Fri 5/31/13 | Fri 5/31/13 | 0% IS | |
| 1277 | 1276FF | Programming/Unit test | 79 days | Fri 3/1/13 | Mon 8/5/13 | 20% IS | |
| 1278 | | System Testing with DHHS | 20 days | Mon 8/19/13 | Fri 9/13/13 | 0% IS | |
| 1279 | 1278 | UAT Interface (Xerox) | 20 days | Mon 9/16/13 | Fri 10/11/13 | 0% IS | |
| 1280 | 1279 | Interface Ready | 0 days | Fri 10/11/13 | Fri 10/11/13 | 0% | |
| 1281 | | Production Interface Begins 0 days | | Tue 10/15/13 | Tue 10/15/13 | 0% | |
| 1282 | | TPL Interface - Inbound | 196 days | Fri 3/1/13 | Sun 12/1/13 | 23% | |
| 1283 | | Finalize layout | 25 days | Mon 4/29/13 | Fri 5/31/13 | 0% IS | |
| 1284 | 1283FF | Programming/Unit test | 30 days | Fri 3/1/13 | Fri 5/31/13 | 75% IS | |
| 1285 | | System Testing with DHHS | 20 days | Tue 9/24/13 | Mon 10/21/13 | 0% IS | |
| 1286 | 1285 | UAT Interface (Xerox) | 24 days | Tue 10/22/13 | Fri 11/22/13 | 0% IS | |
| 1287 | 1286 | Interface Ready | 0 days | Fri 11/22/13 | Fri 11/22/13 | 0% | |
| 1288 | | Production Interface Begins 0 days | | Sun 12/1/13 | Sun 12/1/13 | 0% | |
| 1289 | | Claims/Encounter Interfaces | 209 days | Tue 2/12/13 | Sun 12/1/13 | 20% | |
| 1290 | | FFS & Pharmacy Claims - Outb | 175 days | Tue 2/12/13 | Tue 10/15/13 | 51% | |
| 1291 | | Finalize layout | 0 days | Tue 4/16/13 | Tue 4/16/13 | 37% IS | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|--|-----------------|--------------------|---------------------|------------|----------------|
| 1292 | | Test Files Available | 0 days | Tue 2/12/13 | Tue 2/12/13 | 100% IS | |
| 1293 | 1291 | Programming/Unit test | 32 days | Fri 2/15/13 | Thu 4/25/13 | 75% IS | |
| 1294 | | System Testing with DHHS | 5 days | Mon 9/23/13 | Fri 9/27/13 | 0% IS | |
| 1295 | 1294 | UAT Interface | 10 days | Mon 9/30/13 | Fri 10/11/13 | 0% IS | |
| 1296 | 1295 | Interface Ready | 0 days | Fri 10/11/13 | Fri 10/11/13 | 0% IS | |
| 1297 | | Production Interface Begins | 0 days | Tue 10/15/13 | Tue 10/15/13 | 0% | |
| 1298 | | MCO Encounters 837 - Inbound | 206 days | Fri 2/15/13 | Sun 12/1/13 | 0% | |
| 1299 | | Finalize layout | 0 days | Fri 4/19/13 | Fri 4/19/13 | 0% IS | |
| 1300 | | Test File from MCO | 0 days | Fri 2/15/13 | Fri 2/15/13 | 0% IS | |
| 1301 | | Programming/Unit test | 18 days | Mon 8/19/13 | Wed 9/11/13 | 0% IS | |
| 1302 | 1301 | Test Interface with DHHS (EI) | 10 days | Thu 9/12/13 | Wed 9/25/13 | 0% IS | |
| 1303 | 1302 | System Testing with DHHS (I) | 20 days | Thu 9/26/13 | Wed 10/23/13 | 0% IS | |
| 1304 | 1303 | UAT Interface (Xerox) | 20 days | Thu 10/24/13 | Wed 11/20/13 | 0% IS | |
| 1305 | 1304 | Interface Ready | 0 days | Wed 11/20/13 | Wed 11/20/13 | 0% | |
| 1306 | | Production Interface Begins | 0 days | Sun 12/1/13 | Sun 12/1/13 | 0% | |
| 1307 | | MCO PBM Encounters - Inbound | 196 days | Fri 3/1/13 | Sun 12/1/13 | 19% | |
| 1308 | | Finalize layout | 0 days | Tue 4/30/13 | Tue 4/30/13 | 0% IS | |
| 1309 | 1308 | Programming/Unit test | 22 days | Fri 3/1/13 | Tue 5/7/13 | 75% IS | |
| 1310 | | Test Interface with DHHS (EI) | 19 days | Mon 9/2/13 | Thu 9/26/13 | 0% IS | |
| 1311 | 1310 | System Testing with DHHS (I) | 20 days | Fri 9/27/13 | Thu 10/24/13 | 0% IS | |
| 1312 | 1311 | UAT Interface (Xerox) | 24 days | Fri 10/25/13 | Wed 11/27/13 | 0% IS | |
| 1313 | 1312 | Interface Ready | 0 days | Wed 11/27/13 | Wed 11/27/13 | 0% | |
| 1314 | | Production Interface Begins | 0 days | Sun 12/1/13 | Sun 12/1/13 | 0% | |
| 1315 | | Claim Payment | 168 days | Tue 3/5/13 | Thu 10/24/13 | 17% | |
| 1316 | | Determine payment methodology | 1 day | Tue 3/5/13 | Tue 3/5/13 | 100% | |
| 1317 | 1316 | Gap analysis | 1 day | Wed 3/6/13 | Wed 3/6/13 | 100% | |
| 1318 | | Service Limit counts & increments | 159 days | Tue 3/5/13 | Fri 10/11/13 | 17% | |
| 1319 | | Document Spec | 19 days | Tue 3/5/13 | Fri 3/29/13 | 45% IS | |
| 1320 | 1319 | Approve Spec | 2 days | Mon 4/1/13 | Tue 4/2/13 | 0% | |
| 1321 | 1320 | Programming | 30 days | Mon 9/2/13 | Fri 10/11/13 | 0% IS | |
| 1322 | 1321 | Fee screen setup | 1 day | Mon 10/14/13 | Mon 10/14/13 | 0% | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|---|-----------------|--------------------|--------------------|----------------|----------------|
| 1323 | 1322 | Scanning data export | 1 day | Tue 10/15/13 | Tue 10/15/13 | 0% | |
| 1324 | 1323 | ABF Check Setup | 1 day | Wed 10/16/13 | Wed 10/16/13 | 0% | |
| 1325 | 1324 | ACH Setup | 1 day | Thu 10/17/13 | Thu 10/17/13 | 0% | |
| 1326 | 1325 | Unit Testing | 5 days | Fri 10/18/13 | Thu 10/24/13 | 0% | |
| 1327 | | Scanning | 23 days | Mon 8/5/13 | Wed 9/4/13 | 0% | |
| 1328 | | Load New Hampshire Members in / 9 days | 9 days | Fri 8/9/13 | Wed 8/21/13 | 0% | |
| 1329 | 852FF | Download Member data from M | 3 days | Fri 8/9/13 | Tue 8/13/13 | 0% IS | |
| 1330 | 1329 | Add table to SSIS package for aut | 5 days | Wed 8/14/13 | Tue 8/20/13 | 0% IS | |
| 1331 | 1330 | Modify AnyDoc | 1 day | Wed 8/21/13 | Wed 8/21/13 | 0% | |
| 1332 | | Load NH Providers into AnyDoc dat | 8 days | Mon 8/5/13 | Wed 8/14/13 | 0% | |
| 1333 | 852FF | Download Member data from M | 3 days | Mon 8/5/13 | Wed 8/7/13 | 0% IS | |
| 1334 | 1333 | Add table to SSIS package for aut | 5 days | Thu 8/8/13 | Wed 8/14/13 | 0% IS | |
| 1335 | | Set Plan ID by Member ID Lookup | 15 days | Thu 8/15/13 | Wed 9/4/13 | 0% | |
| 1336 | 1334 | Unit Test | 5 days | Thu 8/15/13 | Wed 8/21/13 | 0% IS | |
| 1337 | 1336 | System Test | 5 days | Thu 8/22/13 | Wed 8/28/13 | 0% IS | |
| 1338 | 1337 | Implement | 5 days | Thu 8/29/13 | Wed 9/4/13 | 0% IS | |
| 1339 | | Communications Milestones | 276 days | Mon 7/16/12 | Mon 8/5/13 | 97% | |
| 1340 | | Final list of languages needed ident | 30 days | Mon 7/16/12 | Fri 8/24/12 | 100% IS | |
| 1341 | 852FF,1340 | Final list of print and online materi | 1 day | Mon 8/5/13 | Mon 8/5/13 | 0% IS | |
| 1342 | | Print Materials (IS-2013-0001072) | 7 days | Mon 8/26/13 | Tue 9/3/13 | 0% | |
| 1343 | 852FF-3 days | Implement letter and logo changes | 7 days | Mon 8/26/13 | Tue 9/3/13 | 0% IS | |
| 1344 | 852FF-3 days | Print new member ID cards (within 7 days | 7 days | Mon 8/26/13 | Tue 9/3/13 | 0% IS | |
| 1345 | 852FF-3 days | Print and mail new member handb | 7 days | Mon 8/26/13 | Tue 9/3/13 | 0% IS | |
| 1346 | | Public Website Setup | 321 days | Fri 6/15/12 | Mon 9/9/13 | 94% | |
| 1347 | | Review of public web sites to identi | 3 days | Fri 8/17/12 | Tue 8/21/12 | 100% COMP | |
| 1348 | | NH job posting setup / test and go | 1 day | Fri 8/31/12 | Fri 8/31/12 | 100% ISDV | |
| 1349 | | Validation web site template | 0 days | Fri 6/15/12 | Fri 6/15/12 | 100% COMP,COMM | |
| 1350 | | Startup Version | 37 days | Mon 6/18/12 | Tue 8/7/12 | 100% | |
| 1351 | | Content | 32 days | Mon 6/18/12 | Tue 7/31/12 | 100% IS | |
| 1352 | | Development | 9 days | Mon 7/23/12 | Thu 8/2/12 | 100% IS | |
| 1353 | | QA | 2 days | Fri 8/3/12 | Mon 8/6/12 | 100% COMM | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|-------------------|---|-----------------|--------------------|-------------------|------------|----------------|
| 1354 | | Go-live | 1 day | Tue 8/7/12 | Tue 8/7/12 | 100% | |
| 1355 | | Complete Production Version | 1 day | Fri 11/2/12 | Fri 11/2/12 | 100% | |
| 1356 | | Language version compatibility with 1 day | 1 day | Tue 7/31/12 | Tue 7/31/12 | 100% | ISDV |
| 1357 | | Build NH website from template | 24 days | Mon 6/25/12 | Thu 7/26/12 | 100% | ISDV |
| 1358 | | QA build / Unit testing | 2 days | Thu 7/26/12 | Fri 7/27/12 | 100% | IS |
| 1359 | | Member section | 174 days | Tue 1/8/13 | Fri 9/6/13 | 93% | |
| 1360 | 1365 | Content Delivery | 15 days | Tue 1/8/13 | Mon 1/28/13 | 100% | IS |
| 1361 | 1360 | Fill in NH content | 10 days | Tue 1/29/13 | Mon 2/11/13 | 100% | IS |
| 1362 | 852FF | QA Review / Changes / Approval | 2 days | Mon 2/25/13 | Fri 9/6/13 | 1% | |
| 1363 | | Go Live | 0 days | | | 0% | |
| 1364 | | Provider section | 220 days | Mon 11/5/12 | Fri 9/6/13 | 97% | |
| 1365 | | Content Delivery | 55 days | Mon 11/5/12 | Fri 1/18/13 | 100% | IS |
| 1366 | 1365 | Fill in NH content | 10 days | Fri 1/18/13 | Thu 1/31/13 | 100% | IS |
| 1367 | 1365 | Provider Directory search setup | 3 days | Mon 1/21/13 | Wed 1/23/13 | 100% | IS |
| 1368 | 852FF | QA Review / Changes / Approval | 2 days | Mon 2/25/13 | Fri 9/6/13 | 1% | |
| 1369 | | Go Live | 0 days | | | 0% | |
| 1370 | | Corporate section | 167 days | Thu 1/17/13 | Fri 9/6/13 | 67% | |
| 1371 | 1360 | Content Delivery | 5 days | Thu 1/17/13 | Wed 1/23/13 | 100% | IS |
| 1372 | 1371 | Fill in NH content | 5 days | Thu 1/24/13 | Wed 1/30/13 | 100% | IS |
| 1373 | 852FF | QA Review / Changes / Approval | 5 days | Mon 2/25/13 | Fri 9/6/13 | 1% | |
| 1374 | | Go Live | 0 days | | | 0% | |
| 1375 | 852FF,1372 | Shortcut URL's | 1 day | Fri 9/6/13 | Fri 9/6/13 | 0% | IS |
| 1376 | 1375 | Member unsubscribe | 1 day | Mon 9/9/13 | Mon 9/9/13 | 0% | IS |
| 1377 | 1376 | Setup Site Search | 2 days | Mon 1/28/13 | Tue 1/29/13 | 100% | IS |
| 1378 | | Provider Webportal Setup | 291 days | Tue 7/24/12 | Tue 9/3/13 | 71% | |
| 1379 | | NH State configuration DEVL/QA/PF | 45 days | Mon 2/4/13 | Fri 4/5/13 | 75% | IS |
| 1380 | 1379 | Update build scripts | 1 day | Tue 7/24/12 | Tue 7/24/12 | 100% | ISDV |
| 1381 | 1380 | Web Service Setup DEVL/QA/PROD | 43 days | Mon 2/4/13 | Wed 4/3/13 | 100% | IS |
| 1382 | 1381 | Content delivery - Contact Info | 1 day | Thu 7/26/12 | Wed 8/8/12 | 100% | COMM |
| 1383 | 1382 | Content delivery - Graphics | 1 day | Fri 7/27/12 | Fri 7/27/12 | 100% | COMM |
| 1384 | 852FF-3 days,1383 | Content delivery - Welcome Packag | 1 day | Tue 9/3/13 | Tue 9/3/13 | 0% | COMM |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|-------------------|--|-----------------|--------------------|---------------------|-------------|----------------|
| 1385 | 1384 | Content delivery - validate/approve | 1 day | Mon 9/24/12 | Mon 9/24/12 | 100% | COMM |
| 1386 | 852FF-3 days | Updates to state logical checks-n-bl | 22 days | Mon 8/5/13 | Tue 9/3/13 | 3% | IS |
| 1387 | | Member Webportal Setup | 329 days | Thu 5/31/12 | Tue 9/3/13 | 77% | |
| 1388 | | NH State configuration DEVL/QA/PFO | 0 days | Thu 8/2/12 | Thu 8/2/12 | 100% | IS |
| 1389 | 852FF-3 days,1388 | Update build scripts | 214.2 days | Thu 5/31/12 | Tue 9/3/13 | 76% | IS |
| 1390 | 1389 | Web Service Setup DEVL/QA/PROD | 1.5 days | Tue 8/7/12 | Wed 8/8/12 | 100% | IS |
| 1391 | 1382 | Content delivery - Contact Info | 2 days | Wed 8/8/12 | Fri 8/10/12 | 100% | IS |
| 1392 | 1390 | Content delivery - Graphics | 0 days | Thu 8/9/12 | Thu 8/9/12 | 100% | COMM |
| 1393 | | Content delivery - PA Request form | 0.9 days | Mon 8/13/12 | Tue 8/14/12 | 100% | COMM |
| 1394 | | Content delivery - PHI Request form | 0.9 days | Tue 8/14/12 | Wed 8/15/12 | 100% | COMM |
| 1395 | | Content delivery - PHI Claim Request | 0.9 days | Wed 8/15/12 | Thu 8/16/12 | 100% | COMM |
| 1396 | | Member Address Verification | 1 day | Mon 9/17/12 | Mon 9/17/12 | 100% | |
| 1397 | | Migrate software to a Server | 1 day | Mon 9/17/12 | Mon 9/17/12 | 100% | IS |
| 1398 | | Data Warehouse & Ad hoc Reporting | 29 days | Thu 7/25/13 | Tue 9/3/13 | 25% | |
| 1399 | 852FF-3 days | Obtain requirements | 29 days | Thu 7/25/13 | Tue 9/3/13 | 25% | IS |
| 1400 | | MCS Documentation & User Manuals | 5 days | Wed 8/28/13 | Tue 9/3/13 | 50% | |
| 1401 | 852FF-3 days | MCS Documentation | 5 days | Wed 8/28/13 | Tue 9/3/13 | 50% | COMM |
| 1402 | 852FF-3 days | User Manuals | 5 days | Wed 8/28/13 | Tue 9/3/13 | 50% | COMM |
| 1403 | | Systems Operation & Support | 106 days | Mon 2/4/13 | Mon 7/1/13 | 73% | |
| 1404 | | On-call procedures & Contacts | 5 days | Mon 2/4/13 | Fri 2/8/13 | 100% | IS |
| 1405 | | Job scheduling & failure notification | 5 days | Mon 2/4/13 | Fri 2/8/13 | 100% | IS |
| 1406 | | Secure encrypted data transmission | 5 days | Mon 2/4/13 | Fri 2/8/13 | 100% | IS |
| 1407 | | Interface acknowledgements and er | 5 days | Mon 2/4/13 | Fri 2/8/13 | 100% | IS |
| 1408 | | Technical issue escalation procedur | 5 days | Mon 2/4/13 | Fri 2/8/13 | 100% | IS |
| 1409 | | Business and member notification p | 5 days | Mon 2/4/13 | Fri 2/8/13 | 100% | IS |
| 1410 | 852FF-1 wk | Documented data interface specific | 5 days | Tue 6/25/13 | Mon 7/1/13 | 0% | IS |
| 1411 | | Journaling and internal backup proc | 5 days | Mon 2/4/13 | Fri 2/8/13 | 100% | IS |
| 1412 | | Communications and escalation pla | 5 days | Mon 2/4/13 | Fri 2/8/13 | 100% | IS |
| 1413 | 852FF-2 wks | Develop Run-book Documentation | 10 days | Tue 6/11/13 | Mon 6/24/13 | 0% | ISDV |
| 1414 | 852FF-1 wk | Infrastructure Monitoring and Alert | 0 days | Mon 7/1/13 | Mon 7/1/13 | 0% | ISDV |
| 1415 | | QI Measure Requirements | 30 days | Fri 11/1/13 | Wed 12/11/13 | 50% | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|--|-----------------|--------------------|--------------------|----------------------|----------------|
| 1416 | | Update HEDIS Measures in MCS | 30 days | Fri 11/1/13 | Wed 12/11/13 | 50% | |
| 1417 | | MCS Business requirement changes fr | 148 days | Thu 6/28/12 | Mon 1/21/13 | 100% | |
| 1418 | | Obtain MCS Business requirement | 27 days | Thu 6/28/12 | Fri 8/3/12 | 100% | |
| 1419 | | Member Services | 5 days | Mon 7/16/12 | Fri 7/20/12 | 100% IS | |
| 1420 | 1419 | Quality Management | 5 days | Mon 7/23/12 | Fri 7/27/12 | 100% IS | |
| 1421 | | Utilization Management | 27 days | Thu 6/28/12 | Fri 8/3/12 | 100% IS | |
| 1422 | | Loading of Prior Auths - Spec Doc | 24 days | Tue 8/14/12 | Fri 9/14/12 | 100% IS | |
| 1423 | 1420 | Analyze Business Requirements | 3 days | Mon 7/30/12 | Wed 8/1/12 | 100% IS | |
| 1424 | 1422 | Create Spec Doc's | 10 days | Mon 9/17/12 | Fri 9/28/12 | 100% IS | |
| 1425 | 1424 | Review Spec Doc's with Business | 2 days | Mon 10/1/12 | Tue 10/2/12 | 100% IS | |
| 1426 | 1425 | Make updates to Spec Doc's as necc | 1 day | Wed 10/3/12 | Wed 10/3/12 | 100% IS | |
| 1427 | 1426 | Review Spec Doc's with Business & | 1 day | Thu 10/4/12 | Thu 10/4/12 | 100% IS | |
| 1428 | 1427 | Estimate Development effort for Bu | 76 days | Fri 10/5/12 | Fri 1/18/13 | 100% IS | |
| 1429 | 1428 | Add MCS development tasks for Bu: | 1 day | Mon 1/21/13 | Mon 1/21/13 | 100% IS | |
| 1430 | | Production Smoke Test | 1 day | Mon 11/25/13 | Mon 11/25/13 | 0% IS | |
| 1431 | 855FF | Go-live | 0 days | Sun 12/1/13 | Sun 12/1/13 | 0% | |
| 1432 | | Reports | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1433 | 9FF+20 days | Ambulance PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1434 | 9FF+20 days | Average Member Months | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1435 | 9FF+20 days | Chemo Drugs - Facility PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1436 | 9FF+20 days | Chemo Drugs - Professional PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1437 | 9FF+20 days | Claims PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1438 | 9FF+20 days | Diagnosis Code | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1439 | 9FF+20 days | Diagnosis Description | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1440 | 9FF+20 days | Dialysis PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1441 | 9FF+20 days | DME PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1442 | 9FF+20 days | Eligibility/Enrollment Status | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1443 | 9FF+20 days | Emergency Room PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1444 | 9FF+20 days | Emergency Room Facility | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1445 | 9FF+20 days | Emergency Room Professional | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |
| 1446 | 9FF+20 days | ER/UC Visits | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% FIN,ISDV | |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|------------------------------|----------|------------|-------------|------------|----------------|
| 1447 | 9FF+20 days | Hearing PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1448 | 9FF+20 days | HHC PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1449 | 9FF+20 days | Hospice PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1450 | 9FF+20 days | Injectibles PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1451 | 9FF+20 days | Inpatient Facility | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1452 | 9FF+20 days | Inpatient PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1453 | 9FF+20 days | Inpatient Professional | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1454 | 9FF+20 days | IP Facilities | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1455 | 9FF+20 days | IP Facility Paid | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1456 | 9FF+20 days | Lab - Ancillary PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1457 | 9FF+20 days | Lab - Facility PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1458 | 9FF+20 days | Lab - Professional PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1459 | 9FF+20 days | Member Costs by Category | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1460 | 9FF+20 days | Member Months | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1461 | 9FF+20 days | Mental Health PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1462 | 9FF+20 days | MSS/ISS PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1463 | 9FF+20 days | Observations | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1464 | 9FF+20 days | Office Visits | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1465 | 9FF+20 days | Orthotics PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1466 | 9FF+20 days | Outpatient Facility | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1467 | 9FF+20 days | Outpatient PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1468 | 9FF+20 days | Outpatient Surgery | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1469 | 9FF+20 days | Paid Amount | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1470 | 9FF+20 days | PCP History | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1471 | 9FF+20 days | PCP Profile | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1472 | 9FF+20 days | PCP Profile PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1473 | 9FF+20 days | Pharmacy PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1474 | 9FF+20 days | Professional - Office Visits | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1475 | 9FF+20 days | Professional - Other | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1476 | 9FF+20 days | Professional PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1477 | 9FF+20 days | Program Group | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|----------------------------------|----------------|--------------------|--------------------|-------------|----------------|
| 1478 | 9FF+20 days | Prosthetics PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1479 | 9FF+20 days | Radiology - Ancillary PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1480 | 9FF+20 days | Radiology - Facility PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1481 | 9FF+20 days | Radiology - Professional PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1482 | 9FF+20 days | Readmissions | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1483 | 9FF+20 days | Rehab Physical Therapy PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1484 | 9FF+20 days | Rx | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1485 | 9FF+20 days | Rx Claims by Therapeutic Class | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1486 | 9FF+20 days | Rx PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1487 | 9FF+20 days | Rx Utilization Detail | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1488 | 9FF+20 days | Skilled Nursing PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1489 | 9FF+20 days | Specialty Profile: PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1490 | 9FF+20 days | Top 10 ER/UC Claims Paid | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1491 | 9FF+20 days | Top 10 Outpatient Diagnosis Paid | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1492 | 9FF+20 days | Top 25 Diagnoses Paid | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1493 | 9FF+20 days | Top 25 Diagnosis Categories | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1494 | 9FF+20 days | Top 25 DRGs Paid | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1495 | 9FF+20 days | Top 25 Members Paid | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1496 | 9FF+20 days | Top 25 OP Procedure Codes | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1497 | 9FF+20 days | Top 25 Professional Claims Paid | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1498 | 9FF+20 days | Top Analysis by PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1499 | 9FF+20 days | Top PCP Analysis by PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1500 | 9FF+20 days | Top Professional Claims Paid | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1501 | 9FF+20 days | Urgent Care Facility | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1502 | 9FF+20 days | Urgent Care PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1503 | 9FF+20 days | Vision PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1504 | 9FF+20 days | Wheelchair PMPM | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1505 | 9FF+20 days | HEDIS Completed | 30 days | Mon 3/4/13 | Fri 4/12/13 | 100% | FIN,ISDV |
| 1506 | | DHHS Requests | 21 days | Fri 2/22/13 | Fri 3/22/13 | 100% | |
| 1507 | | Program Implementation Plan | 1 day | Fri 3/1/13 | Fri 3/1/13 | 100% | PMO |
| 1508 | | TPL P&P | 1 day | Fri 2/22/13 | Fri 2/22/13 | 100% | CLMS |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|---|-----------------|---------------------|---------------------|------------|----------------|
| 1509 | | SME Update | 1 day | Fri 2/22/13 | Fri 2/22/13 | 100% | CLMS |
| 1510 | 1509 | Compliance Review | 1 day | Mon 2/25/13 | Mon 2/25/13 | 100% | COMP |
| 1511 | | Credentiaing P&P | 10 days | Mon 3/4/13 | Fri 3/15/13 | 100% | PS |
| 1512 | | UM P&P | 10 days | Mon 3/11/13 | Fri 3/22/13 | 100% | UM |
| 1513 | | Training | 405 days | Mon 6/18/12 | Thu 1/2/14 | 39% | TRNG |
| 1514 | | Training & Job Aids | 55 days | Mon 6/18/12 | Fri 8/31/12 | 100% | TRNG |
| 1515 | | Training Implementation Schedule | 330 days | Mon 10/1/12 | Thu 1/2/14 | 12% | TRNG |
| 1516 | 8 | Corporate Orientation | 72.5 days | Mon 10/1/12 | Sat 8/31/13 | 10% | |
| 1517 | 8 | Job Specific Training | 27 days | Mon 10/15/12 | Fri 11/29/13 | 28% | |
| 1518 | 9 | Continuing Education | 25 days | Sun 12/1/13 | Thu 1/2/14 | 0% | |
| 1519 | | New Development (State Requests or Internal Needs) | 84 days | Mon 7/8/13 | Thu 10/31/13 | 97% | |
| 1520 | | Brochures/Posters- COMM-2013-0000720 | 16 days | Wed 7/10/13 | Wed 7/31/13 | 100% | COMM |
| 1521 | | Grievance and Appeals Letter Updates | 8 days | Wed 7/10/13 | Fri 7/19/13 | 100% | COMP |
| 1522 | | UM Materials | 10 days | Mon 7/8/13 | Fri 7/19/13 | 100% | UM |
| 1523 | | Claims Forms | 7 days | Thu 7/25/13 | Fri 8/2/13 | 100% | CLMS |
| 1524 | | Member Handbook | 6 days | Fri 7/26/13 | Fri 8/2/13 | 100% | COMM |
| 1525 | | Resubmit 6.05 | 8 days | Wed 7/31/13 | Fri 8/9/13 | 100% | COMP |
| 1526 | | Resubmit 6.23 | 8 days | Wed 7/31/13 | Fri 8/9/13 | 100% | UM |
| 1527 | | Resubmit 4.74 | 8 days | Wed 7/31/13 | Fri 8/9/13 | 100% | UM |
| 1528 | | IS Readiness Document Submission | 10 days | Mon 8/5/13 | Fri 8/16/13 | 100% | IS |
| 1529 | | Member Website | 15 days | Mon 7/29/13 | Fri 8/16/13 | 100% | COMM |
| 1530 | | BH Documents | 11 days | Fri 8/2/13 | Fri 8/16/13 | 100% | NH |
| 1531 | | G&A Letters | 1 day | Fri 9/6/13 | Fri 9/6/13 | 100% | COMP |
| 1532 | | DHHS Provider Outreach | 3 days | Tue 10/29/13 | Thu 10/31/13 | 0% | |
| 1533 | | Meeting Date | 3 days | Tue 10/29/13 | Thu 10/31/13 | 0% | |
| 1534 | | Project Transition and Closure | 85 days | Tue 7/2/13 | Mon 10/28/13 | 0% | PMO |
| 1535 | | Project Support | 60 days | Tue 7/2/13 | Mon 9/23/13 | 0% | PMO |
| 1536 | 9 | Project Reporting and Documentation | 60 days | Tue 7/2/13 | Mon 9/23/13 | 0% | PMO |
| 1537 | 9 | Training | 60 days | Tue 7/2/13 | Mon 9/23/13 | 0% | |
| 1538 | | Project Transition | 20 days | Tue 9/24/13 | Mon 10/21/13 | 0% | PMO |

| ID | Predecessors | Task Name | Duration | Start | Finish | % Complete | Resource Group |
|------|--------------|--|---------------|---------------------|---------------------|------------|----------------|
| 1539 | 1536 | Project Survey | 20 days | Tue 9/24/13 | Mon 10/21/13 | 0% | PMO |
| 1540 | | PMO Plan/Implementation Review | 5 days | Tue 10/22/13 | Mon 10/28/13 | 0% | PMO |
| 1541 | 1539 | Review Survey Results | 1 day | Tue 10/22/13 | Tue 10/22/13 | 0% | PMO |
| 1542 | 1541 | Evaluation and Continuous Improvement | 3 days | Wed 10/23/13 | Fri 10/25/13 | 0% | PMO |
| 1543 | 1542 | Finalize Documentation and Update Project File | 1 day | Mon 10/28/13 | Mon 10/28/13 | 0% | PMO |

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Measure

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|--|
| Adult BMI Assessment |
| Antidepressant Medication Management - Acute |
| Antidepressant Medication Management - Continuation |
| Appropriate Testing for Children with Pharyngitis |
| Appropriate Treatment for Children with Upper Respiratory Infection |
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis |
| Breast Cancer Screening (combined rate) |
| CDC - Eye Exam |
| CDC - HbA1c Poor Control (>9%) |
| CDC - HbA1c Testing |
| CDC - LDL-C Screening |
| CDC - Nephropathy |
| Cervical Cancer Screening * |
| Childhood Immunizations – Combo 2 |
| Chlamydia Screening in Women (combined rate) |
| CMC - LDL-C Screening |
| Controlling High Blood Pressure |
| Follow up After Hospitalization for Mental Illness - 7 days |
| Follow-up for Children Prescribed ADHD Medication - Continuation & Maintenance Phase |
| Follow-up for Children Prescribed ADHD Medication - Initiation Phase |
| Pharmacotherapy Management of COPD Exacerbation - Bronchodilator |
| Pharmacotherapy Management of COPD Exacerbation - Corticosteroid |
| PPC - Postpartum Care |
| PPC - Timeliness of Prenatal Care |
| Use of Appropriate Medications for People with Asthma (combined Rate) |
| Use of Imaging Studies for Low Back Pain |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD |
| WCC - BMI Percentile (Total) |
| WCC - Counseling for Nutrition (Total) |
| WCC - Counseling for Physical Activity (Total) |
| Customer Service |
| Getting Care Quickly |
| Getting Needed Care |
| How Well Doctors Communicate |
| Medical Assistance with Smoking and Tobacco Cessation (Advising Users to Quit) |
| Overall Rating of Health Plan |
| Rating of All Healthcare |
| Rating of Personal Doctor |
| Rating of Specialist Seen Most Often |
| Adherence to Antipsychotic Meds for People with Schizophrenia |
| Adult Access 20-44 yrs |

| |
|--|
| Adult Access 45-64 yrs |
| Alcohol/Drug Dependence Treatment - Engagement of Treatment |
| Alcohol/Drug Dependence Treatment - Initiation of Treatment |
| Asthma Medication Ratio (All Ages) |
| Cardio Monitoring for People with Cardio and Schizophrenia |
| CDC - Blood Pressure Control (<140/80) |
| CDC - Blood Pressure Control (<140/90) |
| CDC - HbA1c Controlled (<8%) |
| CDC - LDL-C Controlled (<100mg/dL) |
| Childhood Immunizations – Combo 3 |
| Children's Access to Primary Care Practitioners - 12-19 years |
| Children's Access to Primary Care Practitioners 12-24 mos |
| Children's Access to Primary Care Practitioners - 25 mos - 6 years |
| Children's Access to Primary Care Practitioners - 7-11 years |
| CMC - LDL-C Control (<100mg/dL) |
| Diabetes Screening for People with Diabetes and Schizophrenia |
| Diabetes Screening for People with Schizophrenia or Bi-polar Disorder |
| Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis |
| Human Papilloma Vaccine for Adolescents |
| Immunizations for Adolescents - Combo 1 |
| Lead Screening in Children |
| Medication Management for People with Asthma (75% rate - total) |
| Monitoring of Persistent Medications |
| Use of Appropriate Medications for People with Asthma (5-11) |
| Well Child Visits - Adolescent |
| Well-Child Visits in the First 15 Months of Life (6+) |
| Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life |
| Aspirin Use |
| Care Coordination |
| Health Promotion and Education (Yes) |
| Medical Assistance with Smoking and Tobacco Cessation (Medications for Quitting) |
| Medical Assistance with Smoking and Tobacco Cessation (Strategies for Quitting) |
| Shared Decision Making |

*Measure was not reportable for HEDIS 2014, HEDIS 2013 QC percentiles are used as benchmarks and there are n

aid Rates and Percentiles

| Data Source | NCQA Medicaid Plan Ranking Measures | NCQA Medicaid Accreditation Measures | Michigan Medicaid | Final HEDIS 2014 Rate | Final HEDIS 2014 Quality Compass Percentile | Final HEDIS 2014 Accreditation Percentile |
|-------------|-------------------------------------|--------------------------------------|-------------------|-----------------------|---|---|
| HEDIS | X | X | X | 87.50% | 75th | 90th |
| HEDIS | X | X | | 70.94% | 90th | 90th |
| HEDIS | X | X | | 53.97% | 90th | 90th |
| HEDIS | X | X | | 65.56% | <50th | 25th |
| HEDIS | X | X | X | 86.55% | 50th | 25th |
| HEDIS | X | X | | 22.29% | <50th | 25th |
| HEDIS | X | X | X | 68.69% | 75th | 75th |
| HEDIS | X | X | | 62.84% | 50th | 50th |
| HEDIS | | X | | 30.21% | 90th | 75th |
| HEDIS | X | X | X | 90.31% | 75th | 90th |
| HEDIS | X | X | | 77.71% | 50th | 50th |
| HEDIS | X | X | | 78.03% | <50th | 50th |
| HEDIS | | X | X | 74.71% | 75th | NA |
| HEDIS | X | X | | 85.42% | 90th | 90th |
| HEDIS | X | X | X | 64.11% | 75th | 90th |
| HEDIS | X | X | | 82.60% | 50th | 50th |
| HEDIS | X | X | X | 76.69% | 90th | 90th |
| HEDIS | X | X | | NB | NB | NB |
| HEDIS | X | X | | 51.04% | 50th | 50th |
| HEDIS | X | X | | 43.97% | 50th | 50th |
| HEDIS | X | X | | 85.95% | 50th | 50th |
| HEDIS | X | X | | 72.75% | 50th | 75th |
| HEDIS | X | X | X | 76.35% | 90th | 90th |
| HEDIS | X | X | X | 94.13% | 90th | 90th |
| HEDIS | | X | X | 84.00% | <50th | 50th |
| HEDIS | X | X | | 73.35% | <50th | <25th |
| HEDIS | X | X | | 36.17% | 50th | 75th |
| HEDIS | X | X | X | 58.93% | 50th | 50th |
| HEDIS | X | X | | 62.41% | 50th | 50th |
| HEDIS | X | X | | 48.72% | <50th | 50th |
| CAHPS | X | X | | 91.23% | 90th | 90th |
| CAHPS | X | X | X | 85.24% | 75th | 75th |
| CAHPS | X | X | X | 87.94% | 90th | 90th |
| CAHPS | X | X | | 90.02% | 50th | 90th |
| CAHPS | X | X | X | 80.81% | 75th | 90th |
| CAHPS | X | X | X | 79.69% | 75th | 90th |
| CAHPS | X | X | | 72.04% | 50th | 50th |
| CAHPS | X | X | | 80.98% | 75th | 50th |
| CAHPS | X | X | | 82.03% | 50th | 90th |
| HEDIS | X | | | 53.69% | <50th | - |
| HEDIS | | | X | 87.08% | 75th | - |

| | | | | | | |
|-------|---|--|---|--------|-------|---|
| HEDIS | | | X | 92.41% | 90th | - |
| HEDIS | X | | | NB | NB | - |
| HEDIS | X | | | NB | NB | - |
| HEDIS | X | | | 63.86% | <50th | - |
| HEDIS | X | | | 57.54% | <50th | - |
| HEDIS | X | | | 51.53% | 75th | - |
| HEDIS | X | | | 77.06% | 90th | - |
| HEDIS | X | | | 60.26% | 90th | - |
| HEDIS | X | | | 40.06% | 50th | - |
| HEDIS | | | X | 80.79% | 75th | - |
| HEDIS | | | X | 93.65% | 75th | - |
| HEDIS | | | X | 97.74% | 50th | - |
| HEDIS | | | X | 91.85% | 75th | - |
| HEDIS | X | | X | 93.84% | 75th | - |
| HEDIS | X | | | 48.96% | 75th | - |
| HEDIS | X | | | 90.91% | 90th | - |
| HEDIS | X | | | 85.85% | 90th | - |
| HEDIS | X | | | 69.53% | <50th | - |
| HEDIS | X | | | 26.68% | 75th | - |
| HEDIS | X | | | 89.73% | 90th | - |
| HEDIS | X | | X | 83.33% | 75th | - |
| HEDIS | X | | | 50.47% | 90th | - |
| HEDIS | X | | | 85.30% | <50th | - |
| HEDIS | | | X | 91.27% | 50th | - |
| HEDIS | X | | X | 62.33% | 75th | - |
| HEDIS | X | | X | 78.24% | 90th | - |
| HEDIS | X | | X | 82.52% | 75th | - |
| CAHPS | X | | | NA | NA | - |
| CAHPS | X | | | NA | NA | - |
| CAHPS | X | | | 77.85% | 90th | - |
| CAHPS | X | | X | 55.28% | 75th | - |
| CAHPS | X | | X | 47.80% | 75th | - |
| CAHPS | X | | | 60.61% | 90th | - |

io Accreditation benchmarks available

| NCQA Quality Compass Percentiles | | | Accreditation Percentiles | | | |
|----------------------------------|--------|--------|---------------------------|------|------|------|
| 50th | 75th | 90th | 25th | 50th | 75th | 90th |
| 78.81% | 85.23% | 90.82% | 63% | 72% | 79% | 86% |
| 49.66% | 54.31% | 59.92% | 45% | 50% | 54% | 61% |
| 33.93% | 38.23% | 44.08% | 30% | 34% | 38% | 45% |
| 68.53% | 77.96% | 83.66% | 61% | 70% | 78% | 85% |
| 86.11% | 91.21% | 94.39% | 83% | 88% | 92% | 95% |
| 24.31% | 30.54% | 38.66% | 21% | 25% | 29% | 35% |
| 57.37% | 65.12% | 71.35% | 51% | 57% | 65% | 71% |
| 54.14% | 63.14% | 68.04% | 45% | 54% | 64% | 70% |
| 44.69% | 36.52% | 30.28% | 51% | 42% | 34% | 28% |
| 83.88% | 87.59% | 91.73% | 79% | 82% | 87% | 91% |
| 76.88% | 80.18% | 83.71% | 69% | 75% | 80% | 84% |
| 80.05% | 83.11% | 86.86% | 73% | 79% | 83% | 87% |
| 66.42% | 71.96% | 76.64% | NA | NA | NA | NA |
| 75.18% | 79.72% | 83.33% | 69% | 77% | 82% | 86% |
| 54.93% | 62.75% | 67.19% | 53% | 58% | 64% | 69% |
| 81.46% | 84.91% | 87.84% | 78% | 81% | 85% | 89% |
| 56.46% | 63.76% | 69.79% | 48% | 56% | 64% | 68% |
| 42.30% | 54.45% | 63.21% | 33% | 46% | 58% | 70% |
| 49.51% | 57.55% | 63.10% | 38% | 47% | 56% | 64% |
| 41.09% | 46.99% | 53.03% | 33% | 40% | 46% | 52% |
| 83.82% | 87.61% | 90.32% | 78% | 83% | 87% | 90% |
| 68.91% | 74.94% | 78.20% | 61% | 67% | 73% | 77% |
| 62.84% | 69.47% | 74.03% | 60% | 65% | 71% | 75% |
| 84.30% | 89.62% | 93.10% | 80% | 86% | 90% | 93% |
| 84.96% | 87.26% | 91.47% | 81% | 85% | 87% | 91% |
| 75.25% | 78.53% | 84.03% | 75% | 78% | 83% | 85% |
| 30.08% | 36.73% | 42.37% | 26% | 32% | 38% | 47% |
| 57.40% | 73.72% | 82.46% | 38% | 53% | 70% | 80% |
| 60.58% | 69.21% | 77.47% | 48% | 59% | 68% | 78% |
| 51.16% | 60.82% | 69.76% | 35% | 46% | 56% | 65% |
| 87.05% | 88.64% | 90.28% | 2.48 | 2.54 | 2.58 | 2.61 |
| 81.75% | 83.75% | 85.52% | 2.37 | 2.41 | 2.45 | 2.49 |
| 80.90% | 84.27% | 85.59% | 2.31 | 2.37 | 2.41 | 2.46 |
| 89.76% | 91.11% | 92.42% | 2.48 | 2.54 | 2.58 | 2.64 |
| 76.80% | 79.32% | 81.42% | 72% | 76% | 80% | 81% |
| 75.52% | 78.77% | 81.49% | 2.32 | 2.4 | 2.46 | 2.54 |
| 71.53% | 74.06% | 76.95% | 2.27 | 2.32 | 2.38 | 2.42 |
| 78.82% | 80.97% | 83.10% | 2.43 | 2.5 | 2.53 | 2.57 |
| 80.61% | 82.47% | 85.31% | 2.48 | 2.51 | 2.56 | 2.59 |
| 61.37% | 67.13% | 73.15% | - | - | - | - |
| 83.27% | 86.21% | 88.52% | - | - | - | - |

| | | | | | | |
|--------|--------|--------|---|---|---|---|
| 88.74% | 90.98% | 92.16% | - | - | - | - |
| 10.33% | 14.97% | 19.14% | - | - | - | - |
| 37.49% | 43.48% | 47.06% | - | - | - | - |
| 66.38% | 70.88% | 76.23% | - | - | - | - |
| 81.20% | 84.21% | 87.88% | - | - | - | - |
| 39.42% | 45.50% | 53.20% | - | - | - | - |
| 61.31% | 70.07% | 75.18% | - | - | - | - |
| 46.43% | 52.89% | 59.37% | - | - | - | - |
| 34.00% | 40.44% | 45.59% | - | - | - | - |
| 72.33% | 77.78% | 80.86% | - | - | - | - |
| 89.94% | 92.17% | 94.42% | - | - | - | - |
| 96.96% | 97.86% | 98.53% | - | - | - | - |
| 89.08% | 91.73% | 93.58% | - | - | - | - |
| 91.15% | 93.50% | 95.19% | - | - | - | - |
| 41.43% | 47.64% | 53.04% | - | - | - | - |
| 70.05% | 73.76% | 76.69% | - | - | - | - |
| 79.38% | 82.88% | 85.71% | - | - | - | - |
| 70.71% | 77.17% | 82.32% | - | - | - | - |
| 19.21% | 23.62% | 28.90% | - | - | - | - |
| 71.29% | 80.90% | 86.46% | - | - | - | - |
| 70.86% | 80.83% | 85.84% | - | - | - | - |
| 30.16% | 34.96% | 42.79% | - | - | - | - |
| 86.14% | 88.25% | 89.81% | - | - | - | - |
| 91.11% | 93.59% | 95.16% | - | - | - | - |
| 48.51% | 59.21% | 65.56% | - | - | - | - |
| 62.86% | 69.75% | 76.92% | - | - | - | - |
| 71.76% | 77.26% | 82.69% | - | - | - | - |
| NA | NA | NA | - | - | - | - |
| NA | NA | NA | - | - | - | - |
| 71.93% | 74.07% | 76.23% | - | - | - | - |
| 45.87% | 51.68% | 57.11% | - | - | - | - |
| 41.57% | 45.27% | 50.89% | - | - | - | - |
| 50.89% | 53.69% | 55.49% | - | - | - | - |